Healthcare Law Alert: The Federal "No Surprises Act" and Related Regulations Prohibiting Surprise Medical Bills Came Into Effect January 1, 2022

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On December 27, 2020, President Donald Trump signed into law the "No Surprises Act" (NSA) to protect American consumers against excessive out-of-pocket costs due to surprise medical bills and balance billing by certain healthcare providers. During 2021, multiple federal agencies published regulations to implement the new federal law. On July 13, 2021, the Department of Health and Human Services (HHS), the Department of Labor, the Department of the Treasury, and the Office of Personnel Management published the "Requirements Related to Surprise Billing; Part I" interim final rule and on September 30, 2021, they issued the "Requirements Related to Surprise Billing; Part II" interim final rule. Effective January 1, 2022, the NSA provides, among other things, the following protections for insured and non-insured individuals.

Insured Individuals – Protection from Balance Billing

For people who have health coverage through an employer, a Health Insurance Marketplace, or an individual health plan purchased directly from an insurer, including self-funded plans, the NSA:

- Bans surprise bills for emergency care services by out-of-network (OON) providers or OON emergency facilities, and requires that cost-sharing for these services (e.g., co-pays) be based on in-network rates, even when care is received without prior authorization.
- Bans surprise bills for covered non-emergency care services, including stabilization services, by certain OON providers at in-network facilities (hospitals, hospital outpatient departments, and ambulatory surgical centers).
- Bans surprise bills for air ambulance services by OON air ambulance providers.
- Requires providers and facilities to share with patients easy-to-understand *notices* that explain the applicable billing protections and who to contact if they have concerns that a provider or facility has violated the new surprise billing protections. The form of the notice designed by HHS can be found here. Providers must use the form in its original format; no edits are permitted.
- Permits OON providers and facilities to obtain waivers from insured patients to permit balance billing under certain circumstances, but prohibits waivers for ancillary services such as anesthesia, pathology, radiology, neonatology, and the services of hospitalists, intensivists, and assistant surgeons.
- Establishes the federal independent dispute resolution (IDR) process that OON providers, facilities, providers of air ambulance services, plans, and issuers in the group and individual markets may use to determine the OON rate for applicable items or services after an unsuccessful open negotiation.
- Does not apply to Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE.

Non-Insured and Self-Pay Individuals – Right to Advanced Knowledge of Costs

For people who do not have health insurance or those who desire to pay for care on their own, the NSA:

- Requires most providers to give a good faith estimate of costs before providing non-emergency care.
- Requires the good faith estimate to include expected charges for the primary item or service, as well as any other items or services that would reasonably be expected. For example, when getting surgery, the estimate must include the cost of

the surgery, as well as any labs, tests, and anesthesia services that might be used with the procedure. However, other items or services related to the surgery that might be scheduled separately, like pre-surgery appointments or physical therapy in the weeks after the surgery, do not have to be disclosed in the good faith estimate.

- Provides a model notice, "The Right to Receive a Good Faith Estimate of Expected Charges" and a "Good Faith Estimate Template" to be provided to all uninsured and self-pay patients. The notice and good faith estimate template can be found here.
- Provides a specific timeframe for giving the good faith estimate to patients.
- Provides a process for patients to dispute final charges that exceed the good faith estimate by $400 or more.

Remedies

The NSA and the detailed regulations promulgated thereunder are effective January 1, 2022. Providers and facilities must ensure compliance to avoid complaints, citations, and civil monetary penalties up to $10,000. Miscellaneous information and fact sheets are available on the CMS website. Providers can file a complaint against health plans they believe are not complying with the NSA online or by calling 1-800-985-3059. Consumers can find information about the NSA, initiate a payment dispute, and submit complaints directly on the CMS website.

Interplay Between the NSA and New Jersey's Out-of-Network Law

Implementation of the NSA is complicated in New Jersey due to the fact that New Jersey has its own law governing out-of-network billing. New Jersey's "Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act" (the NJ OON Law) became effective in August of 2018. Like the NSA, the NJ OON Law provides notice requirements, balance billing limitations, and an arbitration procedure for out-of-network claims that are covered by the law. However, the NJ OON Law is not consistent with the NSA in all respects.

Often when federal and state law conflict, federal law preempts state law. In the interplay between the NSA and the NJ OON Law, this is not always the case. In this case, the NSA creates a "floor" of protections against surprise bills from out-of-network providers, but does not preempt state laws that provide at least the same or greater protections against surprise bills and higher cost-sharing as is provided by the NSA. Therefore, because the NSA has, to a large extent more stringent notice and consent requirements than the NJ OON Law, providers will be required to use the federal notice forms when applicable. However, because the NJ OON Law does require that certain disclosures be made beyond what is required in the NSA, when the NJ OON Law is applicable, providers will be required to make both federally mandated disclosures and New Jersey required disclosures.

Moreover, with respect to arbitration, so long as a state's dispute resolution process meets or exceeds the minimum requirements under the federal IDR, the Department of Health and Human Services will defer to the state process. New Jersey's dispute resolution process appears to meet or exceed the federal requirements. Therefore, New Jersey's dispute resolution process will take precedence over the federal IDR for matters that are within the jurisdiction of New Jersey's process. This includes matters that arise from claims for services rendered to patients that are covered under New Jersey licensed health benefit plans. The New Jersey process does not, however, apply to disputes that arise from claims for services rendered to patients that are covered under the Federal Employees Health Benefit program, or self-funded plans (i.e., ERISA plans) that do not opt into the New Jersey process. These disputes would need to proceed under the federal IDR.

More to Come...

On November 17, 2021, the "Prescription Drug and Health Care Spending," a third interim final rule was issued and is currently open for public comments. Part III of the NSA rules implements new requirements for group health plans and issuers to submit certain information about prescription drug and health care spending. They will have to report information on the most frequently dispensed and costliest drugs and enrollment and premium information, including average monthly premiums paid by

employees versus employers.

For additional information about the No Surprises Act, its interplay with the NJ OON Law, and its requirements, please contact the attorneys below. Access the January 12, 2022 Brach Eichler webinar about the NSA by clicking here or register for our upcoming webinar on March 2, 2022, "Part 2: The No Surprises Act: What Providers Need to Know – Practical Takeaways for Implementation."

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