CHEAT SHEET

for U.S. hospitals and health systems and industry stakeholders

The No Surprises Act

Detailing federal legislative requirements

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Key takeaways

- Congress passed the No Surprises Act in December 2020 to mitigate patients' exposure to surprise medical bills and require insurers and providers to resolve payment disputes for out-of-network care independently or use a new arbitration process.
- The federal law achieves the primary goal of surprise billing legislation: patients will be held harmless once the new law becomes effective on January 1, 2022.
- While the federal law will create a clear process for resolving out-of-network payment disputes, it raises broader pricing, contracting, and billing questions for providers and insurers.

What is it?

Surprise billing occurs when a patient unwittingly receives care from an out-of-network provider and is responsible for all or a large portion of the cost. This can occur when patients are unable to choose an in-network facility or provider because they are receiving emergency care or scheduled care and their care team includes an out-of-network ancillary provider.

Surprise billing is not new; it is a result of preferred provider networks that create differential benefits and prices between in-network and out-of-network providers. Thirty-two states had surprise billing laws as of 2020, but those protections vary by state and exclude more than 100 million Americans nationwide who receive their health insurance through federally regulated self-funded plans.

Growing media attention and public outcry made surprise billing a priority for Congress. In 2019, Congress nearly passed legislation to address surprise billing, but progress stalled in part because policymakers disagreed about how to resolve payment disputes for out-of-network care. Hospital and provider groups advocated for a baseball-style arbitration process, while insurers favored a benchmark payment standard. In December 2020, Congress reached a last-minute compromise and passed the No Surprises Act as part of the Consolidated Appropriations Act, 2021.

The law, which takes effect on January 1, 2022, resolves two underlying drivers of surprise bills. First, the law requires insurers to reclassify specific out-of-network care as in-network when determining a patient's financial obligations, resolving instances in which insurers set higher cost-sharing requirements for out-of-network versus in-network care. Second, the law prohibits providers from billing patients for more than in-network cost-sharing for most out-of-network care, resolving instances in which providers directly bill patients when insurers do not cover their full price, a practice known as balance billing.

Source: "Self-Insured Employer Health Benefits Strategy Established a Negative Cost Trend While Improving Performance," *Population Health Management;* Advisory Board interviews and analysis.

How does it work?

The No Surprises Act is designed to protect commercially insured patients from surprise bills, including those enrolled in individual, group fully funded, and group self-funded plans. The law does this by prohibiting providers from billing patients for more than in-network cost-sharing amounts for most out-of-network care that previously led to surprise bills and requiring insurers to classify such care as in-network when determining a patient's financial obligations.

Services that cannot be balance billed

The law protects patients from receiving surprise bills under most scenarios in which surprise billing generally occurs:

- All out-of-network emergency care, including certain post-stabilization care
- Ancillary services delivered by an out-of-network provider at an in-network facility related to anesthesiology, emergency care, laboratory, neonatology, pathology, and radiology, as well as services provided by assistant surgeons, hospitalists, and intensivists
- Out-of-network air ambulance transportation that would have been covered if the air ambulance was in-network
- Non-emergency care delivered by an out-of-network provider at an in-network facility without obtaining patient consent 72 hours in advance

Services that can be balance billed

The law includes a notable exception for ground ambulance transportation: patients who are transported to a facility by an out-of-network ground ambulance can still receive a balance bill from the ambulance provider. One study based on data from a large national insurance plan estimated 79% of ground ambulances providers used for emergencies were out-of-network.

Source: Advisory Board interviews and analysis.

How does it work? (cont.)

The law also outlines specific criteria that, if met, permits certain out-of-network providers to balance bill patients for non-emergency services. However, this does not apply to the ancillary services listed on the previous page.

Eligible out-of-network providers may balance bill if the patient consents to receiving the care. To obtain consent, the provider must give the patient a written notice at least 72 hours before the date of service clearly explaining that the provider is out-of-network, consent is optional, and the patient can choose to seek care from an in-network provider, as well as any information on prior authorization. In addition, the notice must include an estimate of the amount the patient would be charged. The patient must sign and date the notice.

Payment for services that cannot be balance billed

Beyond eliminating most balance billing, the law also aims to keep patients out of payment disputes by creating a new process for insurers and providers to reach an agreement on the final payment amount for out-of-network care. The new approach can stretch up to several months.

Initial payment

The law requires insurers to make an initial payment or submit a denial of payment to the provider within 30 days of the service. The law does not set a minimum payment amount and sunsets the Affordable Care Act's so-called "greatest of three" rule.[1]

1. The greatest of three rule refers to the minimum floor set for what health plans must pay for out-of-network emergency care.

Source: "Most Patients Undergoing Ground And Air Ambulance Transportation Receive Sizable Out-Of-Network Bills," *Health Affairs*; Advisory Board interviews and analysis.

How does it work? (cont.)

Independent dispute resolution and arbitration processes

At this point, either the out-of-network provider or the insurer can trigger a new independent dispute resolution (IDR), which begins with a 30-day open negotiation period. If the parties do not reach a payment agreement, either one can initiate the law's formal arbitration process. Providers and insurers also have the option to combine several payment disputes into one arbitration proceeding.

The process gives both parties three days to select a certified, third-party arbitrator; if they do not, HHS will appoint one within six days. Once an arbitrator is chosen, the provider and insurer each have 10 days to submit a final payment offer, as well as any additional information for the arbitrator to review. The arbitrator then has 30 days to select one of the two offers. When making these decisions, the law encourages arbitrators to consider several factors, including:

- The insurer's 2019 median in-network rate for similar services in that geographic area, adjusted based on inflation
- Demonstrations of good faith efforts to reach an agreement
- Contracted rates between the insurer and provider for the previous four years
- Both parties' market share
- Patient acuity
- The provider's level of training, experience, and quality, or the facility's teaching status, case mix, and scope of services

Arbitrators are not allowed to consider the provider's billed charges, Medicare rates, or Medicaid rates. Once the arbitrator selects the final payment amount, the insurer has 30 days to make the payment, and the losing party must pay the administrative costs for the arbitration process.

Source: Advisory Board interviews and analysis.

Why does it matter?

The No Surprises Act creates new **strategic implications** for providers and insurers.

1. Bargaining powers may shift in contract negotiations. The ability to balance bill patients historically has given providers leverage in contract negotiations with insurers. In removing that tool, the law adds new complexities to contract negotiations and could shift the balance of power. Insurers likely will face less financial risk from providers being out-of-network, which could allow them to negotiate lower prices—although insurers will still have to contend with selling products that exclude specific providers. The arbitration process (which providers advocated for) also introduces a new degree of uncertainty for insurers and providers, which could encourage them to complete contracting negotiations.

2. The law may create downward pricing pressure—but the extent is unclear. The law's ultimate impact on pricing is uncertain because shifts in bargaining power will not materialize immediately or uniformly nationwide—plus in some cases, existing state law will supersede this new federal law, preempting additional change. That said, similar pieces of legislation enacted at the state level offer some insight. After New York implemented a ban on surprise billing, providers experienced a 13% average reduction in payments. But individual arbitration awards remained high as the law directed arbitrators to consider the 80th percentile of providers' charges, which differs from the new federal law. Ultimately, the law's impact on networks, provider payments, and bargaining dynamics will be influenced by the specific details that will emerge across 2021 through HHS' regulatory process.

3. Providers and insurers may benefit from improved patient financial experience. The No Surprises Act will reduce surprise bills and improve the consumer experience for commercially insured patients—a positive for patients, but also for providers and insurers. In general, delivering a positive financial experience yields a tangible return on investment for providers, as satisfied patients are more likely to return to the hospital, recommend the hospital, and pay their bill in full. Insurers also stand to benefit from fewer surprise bills, as polling data show that many patients blame insurers for their surprise bills. But challenges remain. Patients who receive non-emergency services may consent to balance billing and as noted above, are subject to additional exceptions for ancillary services.

Source: "81% of Americans primarily blame insurers for surprise medical bills, poll finds," *Becker's Healthcare*; "Patient Experience's Impact on Revenue," *binaryfountain*; Pollitz, "US Statistics on Surprise Medical Billing," *JAMA*, 2020; Advisory Board interviews and analysis.

Why does it matter? (cont.)

The No Surprises Act also creates new **practical implications** for providers and insurers. They will need to:

1. Adjust billing and communication strategies. Providers and insurers will need to adjust their billing systems and processes to account for the new requirements. For example, leaders need to ensure that eligible bills only include patients' in-network cost-sharing obligations for services that cannot be balance billed. For the specific services that are eligible for balance billing, leaders must build a process for obtaining consent for out-of-network care that complies with the new law. They must also prepare to clearly communicate the implications of out-of-network care to patients.

2. Prepare for the new arbitration process. Except in states where existing surprise billing laws supersede the No Surprises Act, providers and insurers will need to prepare for the new dispute resolution and arbitration model. For example, leaders will need to assign staff to manage the process, design a method for determining their final offer amounts, and refine their arbitration strategy as they gain experience and see arbitration results over time.

3. Conduct a cost-benefit analysis of when to pursue arbitration. The new arbitration model establishes a formal and structured process for resolving payment disputes between providers and insurers, but it can also result in payment delays and administrative costs. The legislation requires the losing party to pay the administrative costs of arbitration to deter excessive use. Additionally, the initiating party is prohibited from instigating arbitration for the same service with the same stakeholder for 90 days. As a result, stakeholders will need to evaluate the best cases for arbitration.

Source: Advisory Board interviews and analysis.

What is the implementation process?

While the No Surprises Act outlines specific parameters that providers, insurers, and arbitrators must follow, HHS will need to develop detailed regulations to implement the law. Because the law takes effect on January 1, 2022, HHS will need to issue proposed and final rules in 2021. The federal rulemaking process requires HHS to publish a proposed rule and collect public comment for at least 60 days before finalizing regulations.

Those regulations could ultimately shape the law's impact on network strategy, payments amounts, and any changes in bargaining power. Health care leaders should watch to see:

- What criteria arbitrators will need to meet for certification
- The methodology insurers will use to determine the qualifying payment amount for emergency services
- The geographic regions that insurers use to calculate median in-network rates
- How HHS will select an arbitrator if parties do not reach a decision
- If HHS expands the list of specialties that are prohibited from balance billing patients for care delivered by out-of-network clinicians at in-network facilities
- If HHS alters the list of advanced diagnostic lab tests that qualify for balance billing under the law
- Whether HHS will offer arbitrators guidance on how to use the law's list of factors they can consider

In addition, the law requires HHS, in consultation with the Departments of Labor and Treasury, to develop guidance surrounding the notice and consent requirements. That guidance is due by July 1, 2021.

Source: Advisory Board interviews and analysis.

Conversations you should be having

01 Evaluate your current exposure: audit billing data to identify the extent of surprise billing at your organization.

02 Examine the local regulatory environment: review any existing surprise billing laws in your state, as the federal law defers to state precedent in certain scenarios.

03 Determine your patient communication strategy: prepare to inform patients of their consumer rights and improve price transparency.

04 Prepare for negotiation and arbitration: identify any changes in bargaining strength to prepare for provider-insurer contract negotiations and prepare for the new dispute resolution process and arbitration model.

05 Consider your feedback options: provide public comment on forthcoming rules or defer to trade organizations to represent your perspective.

These conversations might reveal that your organization is largely unaffected or that the organization should prepare for possible externalities.

Source: Advisory Board interviews and analysis.

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