# The Federal No Surprises Act Creates a Dual Framework To Protect New York Patients from Balance Billing

By William P. Keefer and Louis Q. Reynolds

The No Surprises Act (NSA) was signed into law by President Donald J. Trump on December 27, 2020 as part of the Consolidated Appropriations Act. The NSA's major provisions went into effect on January 1, 2022.

The NSA provides individuals covered under group and individual health plans protection from receiving surprise medical bills after they receive most emergency services, non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance providers.[1] For these types of services, the NSA prohibits "balance billing." That is, the NSA makes it illegal for health care providers to bill patients covered under individual and group health plans more than their cost-sharing responsibility had the service been performed by a provider in the patient's health plan's network.[2] These bills for fees above patients' cost sharing responsibility under their health plans are called "surprise bills." The NSA also includes a number of requirements related to cost transparency.

In addition to its prohibition on balance-billing patients, the NSA provides a detailed independent dispute resolution (IDR) process for payers and providers to resolve disputes related to payment for out-of-network services.[3] The NSA requires that disputing providers and payers first attempt to negotiate a payment amount for 30 days before accessing the IDR process.[4] The federal IDR process provides a baseball-style arbitration in which a neutral IDR entity selects one of the two offers submitted by the parties.[5]

In determining the payment amount, the IDR entity is to consider the following six factors:

- the "qualifying payment amount (QPA)";
- the level of training, experience, and quality and outcomes measurements of the provider or facility;
- the market share held by the nonparticipating provider or facility;
- the acuity of the individual receiving such item or service;
- the teaching status, case mix, and scope of services of the nonparticipating facility; and
- the demonstrations of good faith efforts (or lack thereof) made by the provider and insurer to enter into a network agreement.[6]

The QPA is defined as "the median of the contracted rates recognized by the plan or issuer on January 31, 2019, for the same or similar item or service that is provided by a provider in the same or similar specialty and provided in a geographic region in which the item or service is furnished, increased for inflation."[7]

The NSA also imposes a number of requirements on payers and providers relating to transparency for consumers. The NSA requires providers to issue notices to plans and issuers whose patients are set to receive services. The plans or issuers are then required to furnish patients with an "advanced explanation of benefits." The advanced explanation of benefits must disclose whether the provider or facility is in-network or out-of-network with a patient's plan, the contracted rate for the item or service if it is in network, a good faith estimate of the expected charges from the provider or facility (if applicable) based on applicable medical billing codes, an estimate of the amount of such charges for which the plan or coverage is responsible, and a good faith estimate of any cost sharing for which participant, beneficiary or enrollee is responsible.[8]

Other transparency provisions in the NSA require payers to verify the accuracy of their provider directories every 90 days;[9] to maintain a price-comparison tool;[10] and to display deductible and out-of-pocket maximum costs on patients' ID cards.[11]

## New York State's Surprise Bill Protections

Prior to the enactment of the NSA, many states, including New York, already had their own laws to protect health plan participants from receiving surprise bills. New York's Emergency Medical Service and Surprise Bills Law went into effect in 2015.[12] Though it defines a surprise bill and bills for emergency services differently than the NSA, New York's law also prohibits non-participating physicians and non-participating emergency service providers from billing patients more than the patients' applicable copayment, coinsurance, or deductible had the services been performed by physicians participating in the patients' plans.[13]

New York provides its own dispute resolution process that also uses baseball-style arbitration with an independent dispute resolution entity, but with less rigid timelines than the federal process.[14] Unlike the federal IDR process, New York does not require a 30-day negotiation period between the parties as a pre-requisite for accessing its IDR process. After the process is initiated, however, IDR entities may direct the parties to attempt good faith settlement

negotiations for a 10-day period, which would run concurrently with the IDR entity's allotted 30-day review period to resolve the dispute.[15]

The IDR entities tasked with determining a reasonable "out-of-network" fee under the New York Emergency Medical Service and Surprise Bills Law must consider the following factors when reaching their decision:

- whether there is a gross disparity between the fee charged by the physician or hospital for services rendered as compared to—
- fees paid to the involved physician or hospital for the same services rendered by the physician or hospital to other patients in health care plans in which the physician or hospital is not participating, and
- in the case of a dispute involving a health care plan, fees paid by the health care plan to reimburse similarly qualified physicians or hospitals for the same services in the same region who are not participating with the health care plan;
- the level of training, education and experience of the physician, and in the case of a hospital, the teaching staff, scope of services and case mix;
- the physician's and hospital's usual charge for comparable services with regard to patients in health care plans in which the physician or hospital is not participating;
- the circumstances and complexity of the particular case, including time and place of the service;
- individual patient characteristics; and,
- with regard to physician services, the usual and customary cost of the service.[16]

From 2015 until January 1, 2022, New York's Emergency and Medical Services and Surprise Bills Law left emergency service providers with no clear method of obtaining payment for certain excluded services from payers with which they did not participate. Following the enactment of the NSA, New York's Department of Financial Services published new guidance that broadens the application of the New York law to provide dispute resolution for many more claims subject to the balance billing or surprise bill prohibition.[17]

## A Dual Framework Provides Patients Additional Protection

The NSA is a gap-filler, not a displacer. It establishes the minimum standard for protections against balance bill-

ing, and defers to similar state laws that go beyond these minimum protections.[18] When a state specifies a total payment amount from which patient cost-sharing is calculated or creates its own arbitration process, the state law will apply.[19] If a state's surprise or emergency services billing law excludes a certain type of provider or a certain type of service from its dispute resolution process or payment determination amount method, then the federal law will be available for the excluded providers or services.

For example, if a state law governs the method for calculating the out-of-network rate to be paid to the provider, but specifically excludes neonatal providers from the process, the federal method for determining the out-of-network rate to be paid to neonatal providers should be used.[20]

Before the federal law went into effect, certain state exclusions created seemingly remediless situations for providers of services that were excluded from dispute resolution processes by state law. This was the case in New York, which prior to January 1, 2022, excluded from eligibility several current procedural terminology (CPT) codes for emergency services from its dispute resolution process.[21] Excluded codes included evaluation and management in the emergency department, critical care services in the emergency department, and initial and subsequent observation in the emergency department and the inpatient setting following an emergency department visit.[22] Non-participating emergency providers billing those codes could not balance-bill patients for these services, but had no remedy if they did not participate with a payer and that payer either refused to pay for a service or unilaterally set a below-market rate unacceptable to the provider.

This confusion and lack of available solution for providers was litigated in the *Buffalo Emergency Associates* cases in which a group of emergency service providers unsuccessfully sought payment from a group of payers with which the group was not a participating provider. Payment was sought for services excluded from New York's dispute resolution process by Financial Services Law § 602(b).[23] The court concluded that the New York Emergency Medical Service and Surprise Bills Law[24] does not create a private right for non-participating providers to dispute the amount of reimbursement from payers. The court's rule confirmed that there was no legal remedy and no administrative remedy for emergency service providers seeking payment for these exempted services.

The introduction of the NSA and its own dispute resolution process provided a solution for emergency service providers, as the NSA has no similar CPT code exclusion. These codes could now be arbitrated using the federal process effective January 1, 2022. Citing an effort to avoid confusion, the Department of Financial Services issued a circular letter on December 17, 2021 providing that starting January 1, 2022, the New York dispute resolution process could be used for services previously excluded by Financial Services Law § 602(b).[25] As a result, there are no longer any CPT codes specifically excluded from New York's dispute resolution process.

## The NSA Will Apply in New York in Certain Situations

New York's dispute resolution process is still not available for all types of emergency services and all types of payers. The NSA's provisions will apply instead of a state's surprise and emergency billing requirements in the case of air ambulance services and where Employee Retirement Income Security Act (ERISA) preemption applies.

The NSA grants federal officials with clear authority to establish payment methodologies and dispute resolution processes for air ambulance services, and the New York State Department of Financial Services has confirmed that the federal process under the NSA will apply to payment disputes concerning air ambulance services.[26]

The NSA will also apply to claims submitted by ERISA governed-group health plans. On account of ERISA preemption standards, emergency and surprise bill disputes arising over services provided to patients covered by self-insured plans should be arbitrated using the federal process.[27] Self-funded plans may not be deemed insurance for the purposes of regulation by a state's insurance laws, keeping them out of the reach of the New York Emergency Medical Service and Surprise Bills Law and leaving the NSA to fill the gap.[28]

The following is summary of the scenarios described above setting forth for each whether state or federal law will apply:

- Bill for surprise or emergency medical services rendered on or after January 1, 2022 + CPT code not excluded by Financial Services Law § 602(b) + NYS patient covered in a fully-insured plan = New York Emergency Medical Service and Surprise Bills Law applies
- Bill for surprise or emergency medical services rendered on or after January 1, 2022 + CPT code excluded by Financial Services Law § 602(b) + NYS patient covered in a fully-insured plan = New York Emergency Medical Service and Surprise Bills Law applies
- Bill for surprise or emergency medical services rendered on or after January 1, 2022 + NYS patient covered in a self-funded plan= NSA applies
- Bill for surprise or emergency medical services before January 1, 2022 + CPT code not excluded by Financial Services Law § 602(b) + NYS Patient covered in a fully-insured plan = New York Emergency Medical Service and Surprise Bills Law Applies
- Bill for surprise or emergency medical services rendered before January 1, 2022 + NYS patient covered

in a self-funded plan = Neither New York Emergency Medical Service and Surprise Bills Law or NSA applies

- Bill for surprise or emergency medical services rendered before January 1, 2022 + NYS patient covered in a fully-insured plan+ CPT code excluded by Financial Services Law § 602(b) = Neither New York Emergency Medical Service and Surprise Bills Law nor NSA applies

## Conclusions

Patients are the biggest beneficiaries of the enactment of the NSA and the resulting changes in New York's enforcement of its Emergency Medical Services and Surprise Bills Law. Research indicates that about one in five emergency room visits result in a surprise bill, and about one in ten elective inpatient admissions result in a surprise bill.[29] Insured patients now have protection against surprise bills for qualified services, regardless of whether they are covered by fully insured or self-insured health plans. An estimated two-thirds of America's workforce covered by employer-sponsored insurance are covered under self-funded arrangements.[30] The NSA's applicability to self-funded plans ensures that this large portion of the group health plan beneficiary population is protected against surprise medical bills.

One possible drawback for patients is potential insurance premium increases that typically result when administrative costs to payers increase. Starting in 2022, accessing the federal IDR process will first cost each participating party a $50 administrative fee.[31] Based on research by the U.S. Department of Health and Human Services (HHS) on existing IDR processes in states with similar surprise billing laws, it estimates a $400 average fee from IDR entities per arbitration. As a result, HHS's chargeable fee range for IDR entities in 2022 is $200-$500 for single determinations and $268-$670 for batched determinations.[32] Accordingly, it is possible that increases in administrative costs related to the dispute resolution process may translate to premium increases.

The Congressional Budget Office, on the other hand, suggests that the increased balance billing protections will save beneficiaries money due to lower premiums, lower cost-sharing, and no longer receiving surprise bills.[33] With the reduction in payments to providers anticipated by these protections, policy makers will want to monitor the extent to which payments to providers are actually reduced and whether such reductions translate to premium reductions for health care consumers.

Providers now have a formal process to dispute reimbursement for qualified services at both the state and federal level. Payers can no longer ignore claims for payment from non-participating providers. Even if a state specifically excludes a type of provider or service from its dispute resolution process for surprise or emergency bills, a federal process is now available. Additionally, the federal dispute resolution process allows for the batching of multiple disputed services into a single proceeding.[34]

## Recent Development

The October 7, 2021 Requirements Related to Surprise Billing rule had established a rebuttable presumption favoring the QPA in IDR proceedings.[35] Many providers objected to such a rebuttable presumption. These providers argued that the presumption would pressure providers to reduce their payment offers to equal the QPA, resulting, in many cases, in unjustifiably reducing provider reimbursement. Several providers filed lawsuits challenging the presumption favoring the QPA in the arbitrator's decision making as a violation of agency rulemaking power under the Administrative Procedure Act (APA).[36] Plaintiffs argued that the presumption encouraged IDR entities to ignore other factors intended to be considered in deciding out-of-network rate disputes.[37] Further, plaintiffs argued that the rule's presumption created a one-sided evidentiary burden in favor of payers that would allow payers to drive down reimbursement rates for applicable services.[38]

On February 23, 2022, the District Court for the Eastern District of Texas decided in *Texas Med. Ass'n, et al. v. U.S. Dep't Health & Human Servs., et al.* that the rebuttable presumption in favor of the QPA and the requirement that arbitrators select the payment offer closest to the QPA violated the APA.[39] The district court held that the rule's requirements concerning the QPA were arbitrary and capricious.[40] In analyzing the rule under *Chevron*, the court stated that the NSA "unambiguously establishes the framework for deciding payment disputes" and concluded that "the rule conflicts with the statutory text."[41] Continuing, the court emphasized that the text of the NSA lists the QPA along with five other factors for arbitrators to consider when selecting a payment offer. The text, however, includes no indication that any one of the factors should be weighed more heavily than the others.[42] Moreover, the rule *required* the arbitrator to select the payment offer closest to the QPA, and to deviate from that number only if "credible information" "clearly demonstrates" that the QPA is "materially different from the appropriate out-of-network rate."[43] The district court concluded that, because the rule essentially "rewrote" statutory terms, it must be held unlawful and set aside.[44] Alternatively, the district court ruled that the rulemaking also failed to comply with notice and comment procedures under the APA in issuing the rule.[45]

The Centers for Medicare and Medicaid Services (CMS) published a Memorandum on February 28, 2022 providing that although the district court's order in *Texas Med. Ass'n* invalidates components of the rulemaking concerning the weight afforded to the QPA in the IDR process, the remainder of the rulemaking for the NSA remains valid.[46]

## Endnotes

1. *No Surprises: Understand Your Rights Against Surprise Medical Bills*, CMS.gov Newsroom (Jan. 03, 2022), https://www.cms.gov/newsroom/fact-sheets/no-surprises-understand-your-rights-against-surprise-medical-bills#:~:text=The%20No%20Surprises%20Act%20protects,network%20air%20ambulance%20service%20providers.
2. Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55,980, 55,981 (Oct. 7, 2021).
3. Uninsured patients may also use the IDR process to challenge billed charges. *See generally* 86 Fed. Reg. 55,980.
4. *Id.* at 55,984.
5. *Id.* at 56,050.
6. 42 U.S.C. § 300gg-111(c)(5)(C)(ii).
7. *Id.* at 36,888.
8. Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, Div. BB § 111, 134 Stat. 1182, 2861 (Consumer Protections Through Health Plan Requirement for Fair and Honest Advance Cost Estimate).
9. *Id.* Div. BB § 116 (Protecting Patients and Improving the Accuracy of Provider Directory Information).
10. *Id.* Div. BB § 114 (Maintenance of Price Comparison Tool).
11. *Id.* Div. BB § 107 (Transparency Regarding In-Network and Out-Of-Network Deductibles and Out-Of-Pocket Limitations).
12. *See* N.Y. Fin. Serv. Law §§ 601–08.
13. *Id.* § 606.
14. *Id.* §§ 605, 607.
15. *Id.* § 605.
16. § 604
17. Insurance Circular Letter No, 10 (December 17, 2021), https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2021_10.
18. Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36,872, 36,887 (July 13, 2021).
19. *Id.* at 36,885.
20. *Id.*
21. Financial Services Law § 602(b) exempts CPT codes 99281-99285, 99288, 99291-99292, 99217-99220, 99224-99226, and 99234-99236 from the New York IDR process if the bill does not exceed 120% of the usual and customary cost and the fee disputed is $714.64 (adjusted annually for inflation rates) or less after any applicable coinsurance, copayment, and deductible.
22. *See* CPT at 99281, Under New or Established Patient Emergency Department Services, Codify by AAPC, https://www.aapc.com/codes/cpt-codes/99281 (last visited March 4, 2022).
23. *See Buffalo Emergency Assocs., LLP v. Aetna Health, Inc. (N.Y.)*, 167 A.D.3d 461 (1st Dep't 2018); *Buffalo Emergency Assocs., LLP. v. Aetna Health, Inc. (N.Y.)*, No. 651937/2017, 2017 WL 5668420 (Sup. Ct. N.Y. Cnty. Nov. 27, 2017), *aff'd*, 167 A.D.3d 461 (1st Dep't 2018).
24. *See* N.Y. Fin. Serv. Law §§ 601–08.
25. Insurance Circular Letter No. 10 (December 17, 2021), https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2021_10.
26. *See generally* Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36,872; Insurance Circular Letter No. 10 (December 17, 2021), https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2021_10.
27. This is true for self-insured plans that have not opted-in to state law protections that prescribe a method for determining the cost-sharing amount or total amount payable under the plan. The No Surprises Act permits self-funded plans to opt-in to state surprise billing laws. *See* Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. at 36,944.
28. *See generally* ERISA § 514; ERISA Preemption Primer, NASHP, https://www.nashp.org/wp-content/uploads/sites/default/files/ERISA_Primer.pdf (last visited March 4, 2022).
29. Christopher Garmon & Benjamin Chartock, *One In Five Inpatient Emergency Department Cases May Lead to Surprise Bills*, Health Affairs (Jan. 2017), https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0970.
30. Karen Pollitz, *No Surprises Act Implementation: What to Expect in 2022*, Kaiser Family Foundation (Dec. 10, 2021) , https://www.kff.org/health-reform/issue-brief/no-surprises-act-implementation-what-to-expect-in-2022/.
31. Technical Guidance No. 2021-01, *Calendar Year 2022 Guidance for the Federal Independent Dispute Resolution Process under the No Surprises Act*, CMS (Sept. 30, 2021), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Technical-Guidance-CY2022-Fee-Guidance-Federal-Independent-Dispute-Resolution-Process-NSA.pdf.
32. *Id.*
33. Congressional Budget Office, Estimate for Divisions O Through FF, H.R. 133, Consolidated Appropriations Act, 2021 Public Law 116-260 (January 14, 2021), https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf. (Enacted Dec. 27, 2020).
34. *See* Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. at 55,994; Gary S. Qualls, *Agencies Propose Rules to Implement No Surprises Act Federal IDR Process*, National Law Review (Oct. 28, 2021).
35. *See* 86 Fed. Reg. at 56,056–61.
36. *See* Complaint, *Am. Med. Ass'n v. U.S. Dep't Health & Human Servs. et al.* (filed Dec. 9, 2021, D.D.C.) (No. 1:21-cv-03231); Complaint, *Ass'n Air Med. Servs. v. U.S. Dep't Health & Hum. Servs. et al.* (filed Nov. 16, 2021, D.D.C.) (No. 1:21-cv-03031); Complaint, *Texas Med. Ass'n et al. v. U.S. Dep't Health & Hum. Servs. et al.* (filed Oct. 28, 2021, E.D. Tex.) (No. 6:21-cv-00425).
37. *See, e.g.*, Complaint at 5–7, *Am. Med. Ass'n v. U.S. Dep't Health & Human Servs.* (filed Dec. 9, 2021, D.D.C.) (No. 1:21-cv-03231).
38. *Id.*
39. No. 6:21-cv-425 (Feb. 23, 2022, E.D. Tex.).
40. *See id.* at 18, 21.
41. *Id.* at 15.
42. *Id.* at 16–17.
43. *Id.* at 20.
44. *Id.* at 21.
45. *Id.* at 31.
46. *Memorandum Regarding Continuing Surprise Billing Protections for Consumers*, CMS (Feb. 28, 2022).

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