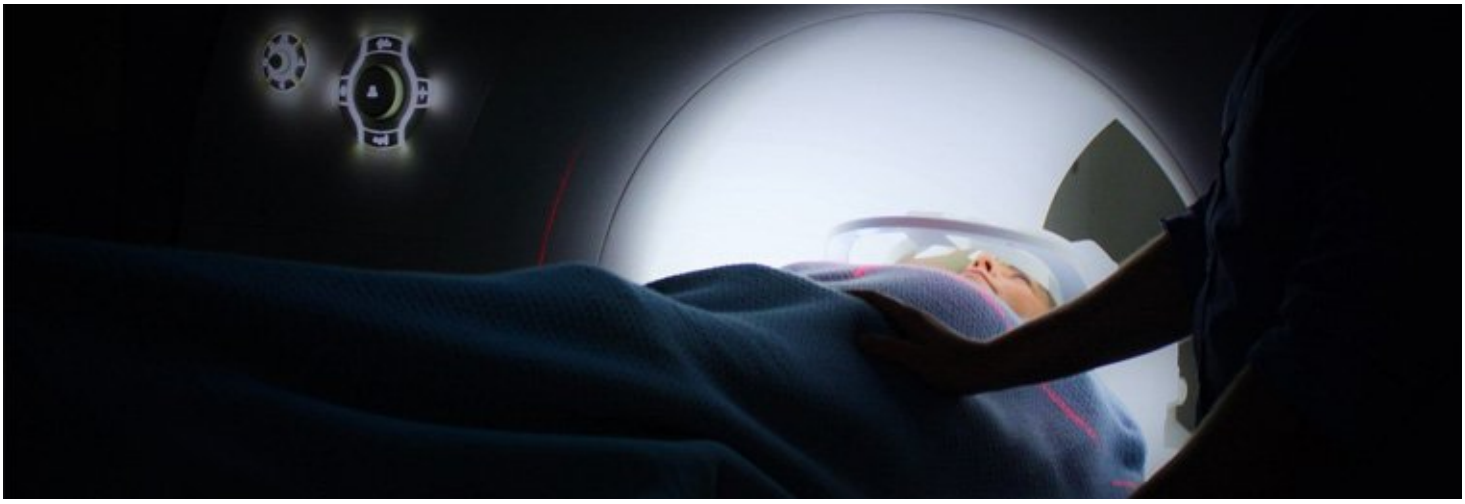

# No Surprises Act creates new model for commercial payors and providers

Healthcare Alert

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On December 28, 2020, Congress passed an appropriations act for coronavirus relief that included the No Surprises Act. This Act generally prohibits balance billing and contains other consumer protection and transparency requirements that may fundamentally change health payor and provider operations.

One key aspect of this Act is the new framework for rate disputes between commercial payors and providers. Under the Act, provider rates will be determined by various methods, depending upon whether the provider is in network or out of network, with special terms applicable to emergency services and air ambulance services.

Section 103 of the No Surprises Act establishes the process for non-emergency medical services rendered by out-of-network providers. The Act establishes an Independent Dispute Resolution (IDR) process that must be administered by a certified IDR entity unless applicable state law has already defined a rate for the service at issue.

When an out-of-network provider submits a claim for reimbursement, the payor may pay the requested rate, send an adjusted initial payment, or send a notice of denial. Upon receipt of the payor's notice, the parties have 30 days in which to initiate an "open negotiation period," which begins on the date of initiation and runs for 30 days.

During the open initiation period, the provider and payor attempt to determine an agreed rate, including any patient cost-sharing obligations, for the item or service.

If the parties fail to reach an agreement within that period, either party may notify the US Department of Health and Human Services (HHS) and the adverse party of its intent to initiate the IDR process. The notice must be submitted within four days after the open negotiation period has closed.

HHS will develop a method for certifying qualified IDR entities. The Act prohibits group health plans, health insurance issuers offering group or individual health coverage, providers, facilities, professional and trade associations, and their affiliates and subsidiaries are disqualified from serving as certified IDR entities, and it contains conflict of interest provisions.

Under the expedited binding IDR process, each party submits a proposed payment amount along with additional supporting information to an arbitrator within 10 days after the arbitrator has been selected. The final award must be issued within 30 days after selection.

The arbitrator must select one of the parties' proposals. The Act does not authorize the arbitrator to modify either proposal or determine a different rate.

The arbitrator must consider the "qualifying payment amount," as defined by the Act. Generally, the qualifying payment amount is the median of the contracted rates for comparable items or services recognized by the payor in the same insurance market on January 31, 2019 as adjusted annually by the consumer price index percentage increases.

The parties may also submit evidence of the provider's training, experience, quality and outcomes, market share, patient acuity, case mix, scope of services, previous good faith efforts to enter into network provider agreements, and any contracted rates between the parties during the prior four (4) years. The arbitrator is prohibited, however, from considering the provider's usual and customary rates, the amount the provider would have billed if it had been allowed to balance bill the patient, or the rates established by Medicare and other federally funded health programs.

The party whose proposal was rejected must pay the arbitration costs. If the parties negotiate an agreed settlement before the award has been issued, the costs are either split between the parties or otherwise allocated by agreement.

Once the arbitration award has been issued, the parties cannot demand another arbitration against the same adverse party regarding the same item or service for 90 days. The parties may batch all claims for the same item or service occurring within a 30-day period within the same year into a single arbitration proceeding.

Non-emergency service out-of-network providers are not eligible to elect the IDR process if they have obtained an advance beneficiary notice and consent to balance billing. The balance billing notice and consent form must be provided at least 72 hours in advance of the service, and must clearly inform the patient that the provider is out of network, provide a good faith estimate of the additional charges that will be billed to the patient, include a list of any other in-network providers in the same facility who can furnish the same services, and state any prior authorization requirements.

The Act requires HHS to adopt implementing regulations by December 2021 and these terms generally become effective on January 1, 2022. Beginning in the first quarter of 2022, HHS must post on its website the number of IDR notices submitted and certain awards data. HHS must also report to Congress by December 2022 whether any health plans or health insurance issuers have developed a pattern or practice of routine denial, low payment, downcoding, or other rate abuses during the 90-day resubmission bar. HHS, in consultation with the Department of Labor, will develop a balance billing advance beneficiary notice and consent form.

Although the ultimate effects of the Act remain unclear, the qualified payment amount calculations, discontinuation of balance billing, and IDR process could have material impacts on payor and provider fiscal projections and

business models. We recommend that payors and providers continue to monitor the regulatory developments as this Act is implemented. For further information, please contact your DLA Piper relationship lawyer or any member of DLA Piper's Healthcare Sector.

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