

White Paper

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The No Surprises Act

An Overview with Recommendations for Physician Practices

Change Healthcare has been assessing the No Surprises Act since late 2020 and has made necessary modifications to its billing policies and procedures to support compliance with the NSA provisions that took effect Jan. 1, 2022. This document provides physicians, billing staff, and others with a detailed summary of the law's key requirements and mechanisms, as well as recommendations to help support compliance.

What is the No Surprises Act?

The No Surprises Act (NSA) provides individuals and families covered by group and individual health plans protection against unexpected, high-priced medical bills for services delivered at in-network facilities by out-of-network (OON) providers.

The law also establishes an independent dispute resolution (IDR) process for payment disputes between plans and providers. It also creates dispute-resolution opportunities for uninsured and self-pay individuals who receive a medical bill that's substantially higher than the good faith estimate (GFE) they'd previously received from the provider. The federal government estimates the law will impact about 10 million medical bills a year.

Why Was It Necessary?

Prior to implementation of the NSA, if an individual had health insurance and received care from an OON provider or an OON facility, even unknowingly, their health plan wasn't obligated to cover the entire OON cost. That frequently left the patient with higher costs than would have been the case had they received care from an in-network provider or facility.

As an example: A person had surgery at an in-network facility but unwittingly received care from an out-of-network anesthesiologist. Along with any OON cost-sharing the patient might owe, the OON provider—unless prohibited by state law—could also balance bill, or “surprise bill” the patient for the difference between the billed charge and the amount paid by the patient's health plan.

What About Existing State Laws?

Eighteen states already had comprehensive balance-billing consumer protections prior to passage of the NSA, while 15 more had less-robust consumer safeguards. The most substantial state rules include both emergency and inpatient settings, apply to all types of insurance, protect consumers from balance billing and extra provider charges, and incorporate either an adequate payment standard or dispute-resolution process for resolving provider-payer reimbursement disputes.

Significantly, however, state balancing billing laws, for the most part, cover only fully insured members and don't apply to self-insured benefit plans or members. Because self-insured plans cover about 67% of workers with employer-based coverage, the NSA was created to extend protections to this population.

It's important to note that the NSA supplements state billing laws and does not supersede them. The NSA essentially creates a floor for consumer protections against surprise bills from OON providers and related, higher cost-sharing responsibilities for patients. As long as a state law provides at least the same level of safeguards as the NSA, the state law applies.

What Does the Act Stipulate?

If a person receives health coverage through their employer, a Health Insurance Marketplace, or an individual health insurance plan purchased directly from an insurance company, the NSA:

1. Bans surprise bills for most emergency services, even if received from an OON provider and without prior authorization.
2. Bans OON cost-sharing (e.g., co-insurance, copayments) for most emergency and some nonemergency services. Individuals cannot be charged more than the in-network cost-sharing amounts for these services.
3. Bans OON charges and balance bills for certain additional services (e.g., anesthesiology, radiology, pathology) furnished by OON providers as part of a patient's visit to an in-network facility.
4. Requires providers and facilities to provide patients with an easy-to-understand notice explaining applicable billing protections and

who they should contact if they're concerned a provider or facility may have violated the protections. Patients must also be informed that patient consent is required to waive billing protections (i.e., a patient must receive notice of and consent to being balance billed by an OON provider).

The federal government estimates the No Surprises Act will impact about 10 million medical bills a year.

What Are NSA's Emergent Care Provisions?

The NSA applies to emergent care if the items/services are furnished in one of the three Emergency Services Settings. These include:

- Hospital emergency department
- Independent, free-standing emergency department
- Urgent care center licensed to provide emergency services

Emergency Services under the NSA include:

- An appropriate medical-screening examination
- Further medical examination and treatment to stabilize
- Post-stabilization services, defined as covered services furnished after the patient is stabilized and as part of outpatient observation or inpatient or outpatient stay with respect to the visit for the emergency services

It should be noted that, upon satisfaction of certain notice and consent exception requirements, patients may waive the NSA's balance-billing prohibitions for post-stabilization services.

Items and services furnished in connection with a visit for Emergency Services covered by the NSA include but are not limited to:

- Equipment and devices
- Telemedicine services
- Preoperative and postoperative services

- Items/services that are included in a global payment for the original service provided by:
 - » Assistant surgeons
 - » Hospitalists
 - » Intensivists
- Items/services related to:
 - » Neonatology
 - » Anesthesiology
 - » Pathology

What Non-emergency Services Are Covered?

To qualify as an NSA-covered Non-Emergency Service, three conditions must be met:

- The care setting must have been in-network
- The patient’s visit must have started in one of four Non-Emergency Services settings:
 - » Hospital
 - » Hospital outpatient department
 - » Critical access hospital
 - » Ambulatory surgical center
- The items/services furnished to the patient in connection with Non-Emergency Services include all items/services provided until the patient’s departure from the facility where the visit for Non-Emergency Services was initiated.

Importantly, it’s the patient’s location in an in-network care setting during the visit, not the provider’s location, that determines whether Non-Emergency Services are subject to the NSA’s balance-billing prohibitions.

For example, telehealth or lab services from an OON facility would still be covered by the NSA if the patient visit occurred at an in-network care setting. Items/services provided in connection with a visit for Non-Emergency Services covered by the NSA are the same as those listed above for Emergency Services.

How Does OON Claims Processing and Payment Work?

Under the NSA, payers are required to make an initial payment or a denial of payment within 30 days of submission of a clean claim. They also must send the payment notice directly to the provider. Historically, some payers have paid the patient

directly if a provider was OON, a practice which often resulted in collection headaches for providers. Receiving payments directly from the payer should, in theory, decrease a group’s overall accounts receivable days.

How Are Payment Disputes Handled?

If the provider disagrees with the amount offered by the payer, both parties must engage in a 30-business-day open-negotiation period to reach an agreement regarding the total OON rate. The open-negotiation period begins the day the initiating party sends the open-negotiation notice to the other party.

When is Arbitration Initiated?

If open negotiations don’t produce an agreement between the parties by the end of the 30-business-day period, either party may then initiate the federal Independent Dispute Resolution (IDR) process. This must be done during the four-business-day period beginning on the 31st business day after the start of the open-negotiation period. The initiating party must provide a written Notice of IDR Initiation to the other party, as well as to the Departments of Treasury, Labor, and Health and Human Services, via the federal IDR portal.

How Does Arbitration Work?

Payment disputes are resolved by an independent arbitrator or IDR entity who is authorized to employ baseball-style arbitration, e.g., choosing one of the two offers. When selecting between the provider’s requested payment and the plan’s offer, the IDR entity is required to consider the qualifying payment amount (QPA), the training and experience of the provider, the market share of the plan and provider, any contract history, quality of outcomes, patient acuity, prior contract history between the two parties, and the services provided.

The QPA is defined as the lesser of the provider’s billed charge or the plan’s median contracted rate for the same or similar service in the geographic region where the service is performed as of Jan. 31, 2019, adjusted for inflation. This last point is significant, given that some of Change Healthcare’s competitors have mistakenly reported that in preparation for the NSA, some payers attempted to lower provider rates in order to drive down the QPA.

Is the Resolution Process Settled Law?

Not quite. On Feb. 23, 2022, a federal judge vacated portions of the NSA's IDR process in response to a suit brought by the Texas Medical Association. The suit argued that the final rule unlawfully created a presumption in favor of the median in-network rate, and in so doing, skewed the IDR process in favor of insurers. The judge agreed and ruled that all previously enumerated variables, including the QPA, training, market share, outcomes, services provided, and contract history must be considered fully and equally by arbitrators when determining an appropriate price. HHS and other federal agencies have said they're reviewing the ruling to determine next steps and that they've withdrawn guidance documents that refer to "the portions of the Rule that the court invalidated."

Who Pays for Arbitration?

The IDR implementation rule imposes a "loser pays" model wherein the administrative costs of arbitration become the responsibility of the losing party. This approach presumably is designed to encourage settlement and deter overly aggressive positions on either side.

At present, 10 organizations have been selected to handle arbitrations. Each party to arbitration must pay an administrative fee of \$50 in addition to the costs of resolving a dispute, which reportedly range from \$299 to \$500 per claim. The rule requires that both sides pay the administrative and IDR fees upfront with their respective IDR submissions.

The prevailing party will then receive a refund of the resolution fees within 30 business days of the arbitration award. In the case of batched claims, the party with the fewest determinations in its favor is considered the non-prevailing party and is responsible for the IDR resolution fee.

Given the not-insignificant costs involved, disputing a payment may not be worth the time and money for some providers, even if numerous claims are batched during the same arbitration session. Change Healthcare predicts many disputes ultimately will be resolved by providers and payers agreeing to enter into a participating provider agreement.

What About the Good Faith Estimate Requirements?

The act requires that providers and facilities assess a patient's insurance coverage at the time of scheduling and, if the patient is uninsured or self-pay, inform them of their right to a good faith estimate (GFE) of the amount they can expect to be charged for the service.

The estimate, which should also be made available on request when patients are shopping for services, must include the costs of both the provider responsible for scheduling the service as well as the co-providers who typically furnish services as part of the primary item or service.

It's important to note that this element of the rule is not yet fully enforced; HHS has indicated it will exercise discretion regarding co-provider estimates during CY 2022.

At some point, however, the convening facility will be responsible for coordinating and consolidating anticipated co-provider charges for the GFE. Estimated charges are defined in the act as the cash pay rate for an uninsured or self-pay individual and must reflect any available discounts or adjustments.

Change Healthcare NSA Recommendations

1. Contact your Change Healthcare client manager for any specific questions regarding the NSA. For example, under what circumstances, if any, could an office visit fall under the NSA's patient balance-billing prohibitions? Also, if the patient's health plan does not respond to the OON provider within a given time frame, can the provider bill the patient the full amount for the service without violating the NSA's patient balance-billing prohibitions?
2. Any groups that are OON with specific commercial payers should compare the allowed amounts for 2022 services to allowed amounts for 2021 services. For example, by being OON with Payer X—which historically has resulted in reimbursement approximating 180% of the Medicare Fee Schedule—is your group now being reimbursed at 120% of Medicare, and if so, what is the projected annual impact to the practice?

3. Be aware of the numerous steps associated with the Open Negotiation and IDR processes, including any notice requirements and the associated timelines. Also, understand the requirements for batching claims.
4. Speak with your client manager or monitor [Change Healthcare's Industry Insights](#) page for information about any changes in NSA provisions that took effect Jan. 1, 2022, as well as any updates concerning the provisions that have been delayed. Delayed provisions include:
 - a. The requirement of providers to provide a Good Faith Estimate (GFE) for insured members to payers. Payers will also be responsible for providing an Advanced Explanation of Benefits to patients so patients can better predict their out-of-pocket expenses.
 - b. The requirement whereby the convening provider or facility, the entity that receives a GFE request from an uninsured/self-pay individual, coordinates all related estimates. For example, an orthopedic surgeon's office for a knee surgery would need to contact anesthesia, assistant surgeons, prescription drugs, and durable medical equipment to create the consolidated estimate. For services rendered in 2022, HHS will exercise enforcement discretion regarding expected charges from co-providers or co-facilities for estimates issued during CY 2022 and is encouraging states to take a similar approach.
5. Consider using consultants from Change Healthcare should your group decide to pursue a participating provider agreement with a payer.

1. FAQs and flowcharts, Change Healthcare Technology Enabled Services division, Business Integrity Unit
2. Document related to the Open Negotiation Notice, CMS
3. Document related to the Notice of IDR Initiation, CMS
4. "No Surprises: Understand Your Rights Against Surprise Medical Bills," CMS
5. "Overview of Public Health Service (PHS) Act Provider and Facility Requirements," CMS
6. "FAQs About Affordable Care Act And Consolidated Appropriations Act, 2021 Implementation Part 49"
7. Memorandum Regarding Continuing Surprise Billing Protections for Consumers, Department of Labor
8. "Evidence on Surprise Billing: Protecting Consumers with the No Surprises Act," Assistant Secretary for Planning and Evaluation, Office of Health Policy



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About Change Healthcare

Change Healthcare (Nasdaq: CHNG) is a leading healthcare technology company, focused on insights, innovation and accelerating the transformation of the U.S. healthcare system through the power of the Change Healthcare Platform. We provide data and analytics-driven solutions to improve clinical, financial, administrative, and patient engagement outcomes in the U.S. healthcare system.

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