NO SURPRISES ACT: RELIEF FROM SURPRISE MEDICAL BILLING BECOMES LAW

On December 27, 2020, President Trump signed into law the $2.3 trillion Consolidated Appropriations Act of 2021 (CAA), which funds the government for the next nine months and also includes $900 billion in stimulus funding in response to the ongoing COVID-19 pandemic and its impact on various sectors of the economy. This *Briefing* will summarize the surprise medical billing provision in the No Surprises Act, a section of the law that is designed to protect health plan members from balance-billing by out-of-network (OON) providers under certain circumstances. We will issue separate *Briefings* on other aspects of the law.

Effective on January 1, 2022, the No Surprises Act law will cap a plan member's cost-sharing obligations for OON services to the plan's applicable in-network cost-sharing level for the following three categories of services:

1. Emergency services performed by an OON provider or facility and post-stabilization care if the patient cannot be moved to an in-network facility;

2. Non-emergency services performed by OON providers at in-network facilities, including hospitals, ambulatory surgical centers, labs, radiology facilities and imaging centers, subject to the limited exception described below; and

3. Air ambulance services provided by OON providers. Note that the cap on cost-sharing in the bill does not apply to regular ambulance services, a common source of "surprise" bills.

The law does contain a limited exception to the balance billing prohibition for non-emergency service providers performed by OON providers at in-network facilities. Those providers may balance-bill a member if all of the following conditions are met:

1. The bill is NOT for "ancillary services," which the law defines to include:

    a. Emergency medicine, anesthesiology, pathology, radiology and neonatology;

    b. Items and services provided by assistant surgeons, hospitalists and intensivists;

    c. Diagnostic services (unless they are later exempted through regulations); and

    d. Items and services provided by the non-participating providers if there are no participating providers at the same facility who can furnish such items or services.

2. The patient receives both oral and written notification of all of the following at least 72 hours in advance of the appointment (or on the day of the appointment if it is made less than 72 hours in advance):

    a. Notification that the provider is OON;

    b. A statement that consent to receive such services from an OON provider is optional and that the services may be received from a provider who will bill within the in-network cost structure;

    c. A good faith estimate of the amount the patient will be charged if the patient consents to treatment by the OON provider; and

    d. In the case of an OON facility, a list of in-network providers at that facility who can provide the same item or service.

3. The patient signs a notice to consent to the treatment by the OON provider and is provided a copy of the signed consent form.

States are also permitted to impose other OON provider requirements that go beyond the federal requirements, and it remains to be seen how many states enact more stringent requirements. The law directs the U.S. Department of Health and Human Services (HHS) to propose regulations to enact the No Surprises Act by July 1, 2021. We will update this *Briefing* when regulations are finalized.

