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What are some of the key features that are in the No Surprises Act?

- The Consolidated Appropriations Act of 2021 was enacted on December 27, 2020 and contains many provisions to help protect consumers from surprise bills, including the No Surprises Act. The No Surprises Act of the Consolidated Appropriations Act (NSA) creates new requirements that apply to health insurance plans/issuers, healthcare providers (including air ambulance providers) and facilities, regarding such topics as cost-sharing rules, prohibitions on balance billing for certain items and services, notice and consent requirements, and requirements related to disclosures about balance billing protections.
- The No Surprises Act establishes an Independent Dispute Resolution (IDR) process, also referred to as arbitration, to resolve disputes between out-of-network providers and insurers/health plans and prohibits balance billing by out-of-network providers with certain exceptions. The law does not apply if the member chooses to receive items and services from an out-of-network provider.

What providers and facilities does the No Surprises Act Apply to?

No Surprises Act applies to three types of healthcare providers and facilities:

- Out-of-network emergency-covered items and services.
- Covered medical items and services performed by an out-of-network provider at an in-network facility.
- Out-of-network air ambulance items and services.

How are prior authorization, coverage limits, and member cost-sharing treated for out-of-network services subject to the No Surprises Act?

- Insurers/health plans are prohibited from requiring prior authorization for out-of-network emergency services and may not apply coverage limitations for out-of-network emergency services that are more restrictive than those for in-network services.
- Insurers/health plans cannot apply cost-sharing for out-of-network covered items and services that are greater than cost-sharing applied to in-network covered items and services (e.g., 10% coinsurance for the same in-network and out-of-network covered items and services). All out-of-network cost-sharing must be counted toward any in-network deductible and cost-sharing limits.

Who can request an Independent Dispute Resolution (IDR)?
Either an insurer/health plan or a provider may request independent dispute resolution. There is a 30-day negotiation period to resolve disputes over reimbursement for out-of-network covered items and services. The negotiation period starts after the provider receives payment or a claim denial as discussed above. Four days after the end of the 30-day negotiation period, either the insurer/health plan or the provider can request an IDR.

How does the IDR process work?

- The law includes a measure to have insurers/health plans and providers first try to resolve any payment differences through negotiation on their own. If negotiation does not work, either party may request the IDR process, which is a form of arbitration.
- Both the insurer/health plan and the provider will submit an offer along with any documentation supporting their position to the IDR entity, which will choose between them.
- In choosing either the insurer/health plan or provider offer, the IDR can consider certain factors such as the median contracted rate for the disputed items and services, the provider's market share, the provider's training and qualifications, and the severity of the patient's condition.
- When making a decision, the IDR entity cannot consider government program rates (Medicare, Medicaid, Tricare), provider billed charges, or usual and customary charges.

Is there a minimum threshold requirement to request an IDR?
There is no minimum threshold.

Can claims be batched when requesting dispute resolution?
Claims that are related to the original out-of-network covered items and services that were furnished by the same provider within a 30-day period may be combined for purposes of dispute resolution.

How does the balance billing notice provision work?
Out-of-network providers at in-network facilities that are providing "non-ancillary services" must provide advance notice to members that the services are out-of-network and a good faith estimate of the cost. If the member makes an appointment for the out-of-network services at least 72 hours in advance, the notice must be provided no later than 72 hours before the date of service. If the member schedules the appointment within 72 hours of the date of service, the notice must be provided on the date of service.

The notice may be in writing or electronic at the option of the member. The notice must include the following information:

- That the provider is out-of-network.
- Good faith estimates of the cost for any items and services.
- Consent to obtain out-of-network items and services is voluntary.

- That the member may choose to receive the items or services from an in-network provider.
- If applicable, identify in-network providers at the facility who can provide the items or services.
- Information about whether prior authorization may be required. The member must sign an acknowledgment that they received the notice and understand that any cost-sharing will apply to the member's out-of-network deductible and cost-sharing limits and that they will be responsible for any balance bill.

Will the law apply if a member chooses to use an out-of-network provider?
No. The No Surprises Act does not impact claims related to members who choose to use out-of-network providers. Balance billing may continue with those claims.

Does the federal No Surprises Act pre-empt state surprise billing laws?
The law may not pre-empt state surprise billing laws that establish a process for determining out-of-network reimbursement for covered items and services for insurers subject to the state's law. However, South Carolina does not have a no surprise billing law.

What insurer and health plan responsibilities are included in the No Surprises Act?
The insurer and health plan have certain responsibilities if a member gets out-of-network notice from a provider prior to service, including:

- Include in-network and out-of-network deductibles and the in-network and out-of-network out-of-pocket max on the ID Card.
- Count all cost-share toward plan deductible and out-of-pocket max unless the member agreed to receive out-of-network care.
- Cap member cost-share at the plan's network cost-share level.
- Provide an estimate of the cost of care and member cost-share if a member chooses to go out-of-network.
- Provide information to members on how to receive the items and services in-network.

Are there requirements that must be included on ID cards?
Yes. Insurers and health plans must include the in-network and out-of-network deductibles and out-of-pocket max on the member's ID Card.