THE FEDERAL NO SURPRISES ACT AND ITS ARBITRATION PROVISIONS

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Health Care Alert

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On 28 December 2020, the federal No Surprises Act (Act)[1] was enacted. The Act seeks to protect patients from so-called “surprise medical bills” in certain emergency and nonemergency settings for out-of-network patients. This alert focuses on the Act's arbitration provisions but first provides necessary background to those provisions.

Key takeaways include:

- The Act, and its arbitration provisions, include both emergent and nonemergent care in certain out-of-network contexts. See Parts I and II.
- The Act requires payors to treat out-of-network patients as though they are in-network for purposes of: prior authorizations, coverage limits, cost sharing obligations, and out-of-pocket maximums. See Part III.
- The Act sets forth a detailed procedural process for providers and payors to elect to arbitrate out-of-network payment disputes, delineating: (a) the arbitration style; (b) much of the criteria for arbitrators to consider; (c) cost shifting to the losing party; (d) how cases may be batched for arbitration; and (e) public reporting of arbitration outcomes. See Part IV.
- Other features of the arbitration process will be fleshed out in regulations to be adopted in 2021. The Act requires rulemaking by 1 July 2021, and certain rules must be in place by the Act's 1 January 2022 effective date in order to implement the arbitration process. See Part IV.

The Act's protections are effective for plan or policy years beginning on or after 1 January 2022.

EMERGENCY SERVICES COVERED BY THE ACT

Patients will be protected from what the Act defines as “surprise medical bills” for emergency services from the point of evaluation and treatment until they are stabilized and can consent to being transferred to an in-network facility. Protections apply in the following three emergency categories:

- Emergency services received at an out-of-network (OON) facility,[2] which would include facility fees;
- Emergency services rendered by an OON individual provider (e.g., emergency physician), whether the facility rendering services is in- or out-of-network; and
- Emergency services provided by OON *air* ambulances (ground ambulances are *not* covered by the Act).

NONEMERGENCY SERVICES COVERED BY THE ACT

Patients are protected from surprise medical bills for *non*emergency services provided by:

- An OON individual provider at an in-network facility; and
- OON air ambulance services.

For example, patients might receive a “surprise bill” from a nonemergency OON provider of ancillary services (e.g., anesthesiologist or radiologist) or a specialist (e.g., cardiologist). Moreover, OON air ambulance services are covered regardless of whether or not emergent.

Limited Waivers – At Patient's Behest

Under these nonemergent conditions, patients can waive the Act's protections by knowingly and voluntarily agreeing to use an OON practitioner. In these instances, patients can waive the protections, choose an OON practitioner, and thus can be balance billed. Because of the consent, the bill is not considered to be a “surprise bill” receiving the Act's protections.

Limited Consent for Nonemergencies – Requested by Provider

In very narrow nonemergent instances, the Act also allows certain providers to request a patient's written consent to a waiver of the Act's protections. However, such waivers are prohibited if:

- There is no in-network provider available in the facility;
- The care is for unforeseen or urgent services; or
- The provider is an ancillary provider that a patient typically does not select (e.g., a radiologist, anesthesiologist, pathologist, and neonatologist).

Certain providers are precluded from seeking a waiver under the Act. The Act identifies an initial list of such providers, and regulators may identify additional “precluded providers” in future rulemaking. For providers who are allowed to obtain patient consent waivers, the provider must generally notify the would-be patient in writing 72 hours before services are scheduled to be delivered. This notification must include a good-faith cost estimate and identify available in-network options for obtaining the service.

PATIENT PROTECTIONS

The Act requires payors to treat OON patients as though they are in-network for purposes of:

- Prior authorizations;
- Coverage limits;
- Cost sharing obligations; and
- Out-of-pocket maximums.

The gist of the Act's focus here is to place a patient who seeks services in a “surprise context”[3] on equal-payment-obligation footing as an in-network patient.

ARBITRATION PROCESS

The Act establishes an arbitration process for disputes between providers and payors.

The 30-Day Negotiation Period

After a provider receives a response from the payor, the provider and payor have 30 days to negotiate—to seek voluntary resolution of the dispute if possible before opting into arbitration.

The Four-Day Period to Request Arbitration

If the provider/payor negotiations fail within the 30-day period, either party may request arbitration within four (4) days.

Who is the Arbitrator?

The arbitration process will be administered by independent dispute resolution entities (i.e., arbitration service providers) subject to conflict-of-interest standards. The federal government, via regulation, will establish the independent dispute resolution process, including a list of qualifying arbitration service providers. See Part IV(K) below for more discussion.

What Type of Arbitration?

The Act adopts "baseball-style" arbitration rules. This is a very specific type of arbitration that is not the typical process for most parties experiencing arbitration.

In a baseball-style arbitration:

- Each party offers a single payment amount to resolve the dispute; and
- The arbitrator selects one amount or the other with no ability to split the difference or arrive at any other conclusion.

Like most arbitrations pursuant to an arbitration agreement, the arbitration decision is binding on the parties. However, as with any other arbitration decision subject to confirmation[4] or vacatur[5] by the courts, the parties can continue to negotiate or settle after the arbitration decision.

Batching Cases for Arbitration

Multiple cases can be batched together in a single arbitration proceeding to encourage efficiency, but those batched cases must involve:

- The same provider or facility;
- The same insurer;
- Treatment of the same or similar medical condition; and
- Cases occurring within a single 30-day period.

Loser Pays Arbitration Costs

In a dramatic departure from normal domestic litigation and arbitration norms, Congress imposed the administrative costs of arbitration on the losing party. Presumably, this is intended to encourage settlement and deter overly aggressive positions on either side.

90-Day Lockout Period Following a Decision

The party that initiates the arbitration process is "locked out" from taking the same party to arbitration for the same item or service for 90 days following a decision. The goal of this provision is to encourage settlement of similar claims. Any claims that occur during the lockout period, however, qualify for arbitration after the period ends.

Factors for Arbitrators

Arbitrators will have flexibility to consider a range of factors. Certain factors are specified in the Act. See Part IV(H)(1) below. However, the arbitrator may also consider any relevant factors raised by the parties, subject to the specific exclusions described in Part IV(H)(2) below.

Factors Arbitrators Are Instructed to Consider

Arbitrators are instructed to consider the following factors:

- The level of training or experience of the provider or facility;
- Quality and outcomes measurements of the provider or facility;
- Market share held by the OON provider or facility, or by the plan or issuer in the geographic region in which the item or service was provided;
- Patient acuity and complexity of services provided;
- Teaching status, case mix, and scope of services of the facility;
- Any good faith effort—or lack thereof—to join the insurer's network;
- Any prior contracted rates over the previous four years; and
- The “qualifying payments amount” as described in Part IV(J) below.

More factor-related guidance may ensue by implementing regulations. The same general factors apply to air ambulance providers, with additional factors such as: (a) the location where the patient was picked up and the population density of that location; and (b) the air ambulance vehicle type and medical capabilities.

Factors Arbitrators May Not Consider

The Act specifically precludes arbitrators from considering the following:

- The arbitrating provider's usual and customary charge or billed charge; and
- Public payor reimbursement rates (e.g., Medicare, Medicaid, CHIP, or TRICARE).

Thus, although the providers are precluded from advocating their charges as a factor, payors are precluded from advocating the increasingly common “Medicare-plus” reference-based pricing used by payors in some OON disputes.

Public Reporting of Arbitration Outcomes

The Act also requires DHHS to publicly report the outcomes of all arbitration cases quarterly on its website.

Qualifying Payment Amount

The public reporting of arbitration awards is required to be presented as a percentage of the “qualifying payment amount.” The Act defines the “qualifying payment amount” as the median of contracted rates for a given service in the geographic region within the same insurance market across all of an issuer's health plans as a of 31 January 2019, inflated forward by the Consumer Price Index for All Urban Consumers.

The Act requires DHHS to adopt regulations to determine the methodology health insurance issuers must use to calculate the qualifying payment amount. Regular audits are required to verify that insurers are properly calculating this median amount. The qualifying payment amount is also the metric used to determine patient cost sharing limits under the Act and a factor to be considered by the arbitrator. See Part IV(H)(1) above.

Arbitration Features To Be Determined by Regulation

Numerous features of the Act's arbitration process are yet to be determined and must be fleshed out by rulemaking during 2021. Other aspects of the arbitration process may or may not be addressed by regulation.

Regulators must determine how to certify arbitrator entities, which would likely entail certification of existing arbitration service providers such as the American Health Law Association (AHLA) and the American Arbitration Association (AAA), both of which already have their own specialized healthcare arbitrator panels.

Regulation must also specify how the government selects the arbitrator if the parties cannot agree on one. One approach could be to default to certain service provider rules for arbitration selection where those provisions already exist (e.g., AHLA Commercial Rule 3.2 and AAA Commercial Rule R-12(b)).

It is unclear what other arbitration process features might be the subject of 2021 regulations, but the Act leaves the door open to adding factors for arbitrators' consideration.

WHAT TO EXPECT NEXT

Much of the arbitration implementation story will be told in the coming year as regulations are adopted. The Act requires rulemaking by 1 July 2021. Also, as a practical matter, rules must be in place by the Act's 1 January 2022 effective date in order to implement the arbitration process.

Providers with any level of OON exposure should be assessing how to approach this arbitration process during 2021 in order to be prepared for the January 2022 implementation.

K&L Gates' health care practice has teams of healthcare litigators who handle disputes (including arbitrations) on behalf of providers against payors. Our firm routinely monitors developments in this area, and our attorneys are available to assist providers in disputes arising under this new Act.

FOOTNOTES

[1] The Act is included within the Consolidated Appropriations Act, 2021.

[2] The Act's emergency services provisions apply to hospital emergency departments and independent freestanding emergency departments.

[3] The “surprise contexts,” as defined by the Act, are outlined in Parts I and II above.

[4] If a losing party in arbitration refuses to comply with the arbitration award, the award is enforceable in a court (i.e., confirming an award).

[5] In rare circumstances, arbitration awards are vacated by courts.

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