The No Surprises Act: What Providers Need to Know

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The No Surprises Act - Overview

- Bipartisan legislation signed into law by President Trump on Dec 27, 2020, included in the Consolidated Appropriations Act, 2021 (Public Law 116-260).
- Effective January 1, 2022.
- Regulations (Interim Final Rules) were jointly issued by HHS, DOL and IRS in July 2021 (Part I) and September 2021 (Part II).
- Provides patient protections from balance billing of out-of-network (OON) services.

The No Surprises Act – Overview *(continued)*

- Prohibits balance billing for:
  1. Emergency services by an OON provider or OON emergency facility. (45 CFR 149.410)
  2. Non-emergency services, including post-stabilization services, by OON providers at certain in-network healthcare facilities, unless Notice and Consent is given to patients in limited circumstances. (45 CFR 149.420)
     - Except, the balance billing protections can never be waived by patients for certain ancillary services (anesthesiology, pathology, radiology, neonatology).
  3. Air ambulance services by nonparticipating air ambulance providers. (45 CFR 149.440)

The No Surprises Act – Overview *(continued)*

- Requires disclosure of patient protections against balance billing. (45 CFR 149.430)
  - Disclosures must be made by all licensed providers, in-network and out-of-network.
- For uninsured or self-pay individuals, requires good faith estimate in advance of scheduled services, or upon request. (45 CFR 149.610)
- Establishes an independent dispute resolution (IDR) process that allows plans and issuers and OON providers and facilities to resolve disputes over out-of-network rates. (45 CFR 149.510)

To What and Whom Do the Rules Apply?

- Applies to **covered** benefits, items, and services provided to individuals enrolled in:
  - Employment-based group health plans (self-insured and fully-insured);
  - Group or individual health insurance coverage on or off the federal and state exchanges;
  - Federal Employees Health Benefit plans; and
  - Employees on state and local government health plans.
- Certain protections also apply to uninsured and self-pay patients.
- Does **NOT** apply to Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE.
- Does **NOT** apply to items and services not covered under a patient's health plan and to non-emergency services at OON facility.

No Balance Billing for Out-of-Network Emergency Services

- Cannot bill or hold liable individuals who received *emergency services* at a hospital or an independent freestanding emergency department for a payment amount greater than the in-network cost-sharing requirement for such services.
- Definition of "Emergency Services:" "With respect to an emergency medical condition, an appropriate medical screening examination within an emergency department of a hospital or a freestanding emergency department, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and such further medical examination and treatment to stabilize the patient, **regardless** of the department of the hospital where the treatment is provided."
- Cannot waive this requirement with patient consent.

Exclusion from Emergency Services Definition – Post-Stabilization Services

- Items and services excluded from the definition of emergency service are the following (26 CFR 54.9816-4T(c)(2)(i)):
  - Items and services that are covered under the patient's insurance plan and "are furnished by a nonparticipating provider or nonparticipating emergency facility (regardless of the department of the hospital in which such items or services are furnished) **after the participant or beneficiary is stabilized** and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the [emergency] services are furnished, are not included as emergency services **if all of the conditions in 45 CFR 149.410(b)** are met."

Exception to No Balance Billing for OON Post-Stabilization Services – Notice and Consent

- Nonparticipating providers and facilities may balance bill for post-stabilization services only after the attending emergency physician or treating provider determines that the patient:
  - Can travel using non-medical or non-emergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into account the individual's medical condition;
  - Is in a condition to receive notice and provide informed consent;
  - Receives written notice and provides written consent within the prescribed timeframe (see Notice and Consent Form, Slide #16); and
  - The OON provider or facility satisfies any additional state law requirements.

Exception to No Balance Billing for OON Post-Stabilization Services – Notice and Consent *(continued)*

- Exception to the exception: An OON provider or facility cannot balance bill for items or services furnished as a result of **unforeseen**, **urgent** medical needs that arise at the time an item or service is furnished, regardless of whether the OON provider or facility previously satisfied the notice and consent criteria.
- Note that this applies to both emergency and non-emergency services.

No Balance Billing for Non-Emergency Services by Out-of-Network Providers at In-Network Healthcare Facilities

- Cannot balance bill or hold liable patients who received covered non-emergency services with respect to a visit at an in-network *healthcare facility* by an OON provider for a payment amount greater than the in-network cost-sharing requirement for such services, unless Notice and Consent requirements are met.
- Healthcare facilities include hospitals, hospital outpatient departments, critical access hospitals, and ambulatory surgical centers.
  - Do **NOT** include private practice offices (unless an outpatient department).

No Balance Billing for Non-Emergency Services by Out-of-Network Providers at In-Network Healthcare Facilities *(continued)*

- The Notice and Consent does **NOT** apply to (and can never be obtained for) the following ancillary services:
  - Emergency medicine
  - Anesthesiology
  - Pathology
  - Radiology
  - Neonatology
  - Items and services provided by assistant surgeons, hospitalists, and intensivist
  - Diagnostic services, including radiology and laboratory services
  - Items and services provided by a nonparticipating provider, if there is no participating provider who can provide such item or service at such facility

Disclosure of Patient Protections Against Balance Billing

- The NSA requires that a provider or facility must disclose to any patient to whom the provider or facility furnishes items and services, all the following information:
  - The restrictions on providers and facilities regarding balance billing;
  - Any applicable state law protections against balance billing; and
  - Information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing.

Disclosure of Patient Protections Against Balance Billing *(continued)*

- The disclosure requirement is applicable to **all** providers, both in-network and OON.
- The provider or facility must post this information:
  - Prominently at the location of the provider or facility;
  - On their public website (if applicable); and
  - Provide it to the patient in a specific manner and timeframe.
- The disclosure is not required if the provider never provides services at a healthcare facility or if the individual patient will not be receiving services at a healthcare facility.

Required Forms – Disclosure Form

1. Disclosure Form

- CMS has issued a model Disclosure Form available at: https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf
- Providers and facilities are not required to use this form, but any form used must include the information described in the prior two slides.
- If a state develops model language for its disclosure notice *that is consistent* with the federal requirements, use of the state-developed model language is compliant.

Disclosure Form *(continued)*

- Must be one-page, double-sided
- Must be made public by being displayed prominently in the provider's office or facility **and** be posted on the provider's or the facility's website.
- The Disclosure Form must also be provided directly to patients who will be receiving services at a facility:
  - No later than the date and time on which the provider or the facility request payment from the individual who will be receiving the services (including requests for copayment or coinsurance at the time of a visit to the provider or facility).
  - If the provider or facility does not request payment from the individual, the disclosure must be provided no later than the date on which the provider or facility submits a claim for payment to the plan or issuer.

Required Forms – Notice and Consent

2. Notice and Consent

- CMS has issued a **mandatory Notice and Consent Form** that must be used by:
  - OON provider or OON emergency facility when furnishing certain post-stabilization services; and
  - OON provider or facility on behalf of the provider when furnishing non-emergency services at certain participating healthcare facilities, excluding ancillary services.
- The form with instructions can be found at:

https://www.cms.gov/files/document/standard-notice-consent-forms-nonparticipating-providers-emergency-facilities-regarding-consumer.pdf

Notice and Consent *(continued)*

- **The language of the mandatory Notice and Consent may NOT be modified in any way, except to fill in the blanks**.
- The documents must be given physically separate from, and not attached to or incorporated into, any other documents. They must not be hidden among other forms.
- A representative of the provider or facility must be physically present or available by phone to explain the documents and estimates to the individual.
- The documents must be provided on paper, or electronically if selected by the individual.
- A copy of the signed consent document must be provided to the individual in-person, by mail, or via email, as selected by the individual.

Notice and Consent *(continued)*

- The Notice and Consent must include a **good faith estimate** of what the OON provider expects to charge an insurer for furnishing such items or services, **even if** the provider intends to bill the plan or coverage directly.
  - Must include any item or service that the OON provider reasonably expects to provide in conjunction with such items and services.
  - Not required to include an estimate of what other providers at the facility may charge.
- HHS knows that OON providers are unable to calculate what an individual's final out-of-pocket costs will be (including balance bills), and the estimate is not a contract.
- HHS will issue additional regulations in the future on the method for calculating the good faith estimate.

Notice and Consent *(continued)*

- In cases where post-stabilization services are being furnished by an OON provider at an in-network facility, the notice must include a list of any participating providers at the participating facility who are able to furnish the items or services involved on an in-network basis.

Notice and Consent - Timeframe

- **For appointments made at least 72 hours in advance:**
  - Notice and Consent must be provided to the individual or their representative at least 72 hours before the date of the appointment.
- **For appointments made within 72 hours:**
  - Notice and Consent must be provided on the day the appointment is made.
- **For same-day appointments:**
  - Notice and Consent must be provided at least 3 hours prior to furnishing the items or services, including for post-stabilization services.

Notice and Consent – Key Points

- The Notice and Consent Form and the good faith estimate do **NOT** apply when an OON provider is providing services to an insured patient **in a physician office**.
  - Only required, when permitted, to obtain an insured patient's consent to be balance billed for OON non-emergency or post-stabilization services being provided at an **in-network facility**.
- The Notice and Consent Form is separate and distinct from the Disclosure Form.
- Uninsured and self-pay patients must receive a **separate** notice form and good faith estimate.

Obligations of Providers and Facilities for Uninsured and Self-Pay Patients

- All healthcare providers and facilities must inquire within a regulated timeframe:
  - If an individual who schedules an item or service is enrolled in a group health plan, group or individual health insurance coverage offered by a health insurance issuer, a Federal healthcare program or a Federal Employees Health Benefit plan; and
  - If the individual is seeking to have their claims for such item or service submitted to plan.
- If uninsured or self-pay, the provider or facility must provide clear notification of a good faith estimate of expected charges, expected service, and diagnostic codes of scheduled services.

Good Faith Estimates for Uninsured and Self-Pay Patients

- The good faith estimate must include:
  - Expected charges for the primary item or service; and
  - Expected charges for items or services that are reasonably expected to be provided in conjunction with the primary item or service.
    - Including items or services that may be provided by other providers and facilities in conjunction with the primary item or service (Co-Providers).
- Calculation of good faith estimate: $ amount expected to be paid after potential discounts and adjustments.
- Good faith estimates are **NOT** deemed a contract.

Good Faith Estimates for Uninsured and Self-Pay Patients – Timeframe

- Notice must be publicly disclosed by all providers and facilities in a prominent location and on the provider's or facility's website.
- Convening Provider must provide good faith estimate within 3 business days of patient's request.
- Convening Provider must contact all anticipated Co-Providers within 1 business day of patient's request.
- Co-Providers must provide their estimates within 1 business day of the Convening Provider's request.
- Co-Providers can submit any anticipated changes to good faith estimates no later than 1 business day before the furnishing of services to the patient.

Good Faith Estimates for Uninsured and Self-Pay Patients – Timeframe *(continued)*

- CMS acknowledges some items or services may not be included in a good faith estimate "because they are not typically scheduled in advance and not typically the subject of a requested GFE (such as urgent, emergent trauma, or emergency items or services); however, to the extent that such care is scheduled at least 3 days in advance, a provider or facility would be required to provide a good faith estimate."
- From 1/1/2022 through 12/31/2022, HHS will exercise enforcement discretion "where an estimate provided to an uninsured/self-pay patient does not include expected charges from co-providers or co-facilities."

Good Faith Estimates for Uninsured and Self-Pay Patients – Model Notice

- Model notice titled **The Right to Receive a Good Faith Estimate of Expected Charges** and a **Good Faith Estimate Template** to be provided to all uninsured and self-pay patients can be found at:

  https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791

Uninsured and Self-Pay Patients – Patient-Provider Dispute Resolution

- A patient-provider dispute resolution process is available for uninsured or self-pay patients who receive a bill from a provider of at least $400 more than the expected charges on the good faith estimate.
- The patient or their authorized representative may initiate the dispute process.
- An independent dispute resolution entity is brought in to determine the appropriate amount the patient must pay.

How is the Fee Determined for an OON Provider Who Cannot Balance Bill?

- Patient cost-sharing amounts for emergency services furnished by OON providers, and for non-emergency services furnished by OON providers at certain in-network facilities, must be calculated based on one of the following amounts:
  - An amount determined by an applicable All-Payer Model Agreement;
  - If no All-Payer Model Agreement, an amount determined by a specified state law; or
  - If no All-Payer Model Agreement or specified state law, the lesser of the billed charge or the plan's or issuer's median contracted rate, referred to as the qualifying payment amount (QPA).

How is the Fee Determined for an OON Provider Who Cannot Balance Bill? *(continued)*

- The balance owed is determined through open negotiations between the provider and the plan for 30 days after the initial payment by the plan to the provider.
- If the provider and plan cannot agree on a rate, either the provider or the plan may initiate the federal Independent Dispute Resolution (IDR) process.

The Independent Dispute Resolution (IDR) Process

- OON providers, facilities, providers of air ambulance services, plans, and issuers may use the IDR process to determine the OON rate for applicable items or services after unsuccessful open negotiations.
- The IDR process is only available for services for which balance billing is prohibited, i.e., emergency services, OON non-emergency ancillary services at an in-network facility, including anesthesia, pathology, radiology, lab, and neonatology; and OON services at an in-network facility if proper notice and consent is not obtained (notice and consent can never be used for the above ancillary services).

The Independent Dispute Resolution (IDR) Process *(continued)*

- The parties select an IDR entity.
- Through baseball-style arbitration, each party submits its offer for payment with supporting documentation.
- The IDR entity will select one of the offers.
- The IDR must presume first that the QPA is the appropriate rate and may only deviate if the party submits information demonstrating that the service is **materially different** from the QPA.

The Independent Dispute Resolution (IDR) Process *(continued)*

- The IDR is prohibited from considering the provider's UCR rate or Medicare rates.
  - May consider the provider's level of training, case complexity, the provider's prior quality and outcome metrics, the provider's market share, etc.
- The IDR determination is binding.
- Judicial review of IDR is only available if fraudulent information was presented or if the arbitrator engaged in fraud, corruption, misconduct or exceeded powers.
- Losing party is responsible for the IDR entity's fee.

The Independent Dispute Resolution (IDR) Process *(continued)*

- Lawsuit was filed on December 9, 2021 by the American Hospital Association, American Medical Association, and individual hospitals and physicians seeking to stay (pause) the IDR process of the NSA on the grounds that IDR entity must first consider the health plan's median in-network rate (the QPA) as the appropriate reimbursement amount before considering other factors.
- The lawsuit argues this is not the original Congressional intent of the law — a balanced, patient-centered law without the heavy-handed influence of an IDR process that unfairly favors health plans.
- No court rulings have yet been issued.

The Independent Dispute Resolution (IDR) Process *(continued)*

- If an OON provider believes a health plan is not complying with the IDR process, the provider may file a complaint with the No Surprises Help desk by:
  - Calling 1-800-985-3059
  - Submitting a complaint online at: https://www.cms.gov/nosurprises/policies-and-resources/providers-submit-a-billing-complaint

Enforcement of No Surprises Act

- States will have primary role in enforcing NSA rules against health providers, with federal enforcement as back up.
- The No Surprises Act imposes civil monetary penalties of up to $10,000 for violations.
  - CMS may consider degree of culpability, history and frequency of prior violations, the impact on affected individuals, the gravity of the violation, and whether any violations have been corrected.
- HHS has proposed that it will conduct random or targeted investigations into potential violations of NSA requirements by providers.

New Jersey – Out-of-Network Consumer Protection, Transparency, Cost Containment, and Accountability Act

- Effective August 30, 2018.
- Intended to increase transparency, enhance consumer protections, and create an arbitration system.
- Broad disclosure requirement to all healthcare providers where a covered patient may get OON services and be billed at OON rates.
- Protections for consumers for certain OON bills.
- Arbitration to resolve reimbursement disputes arising from emergent/inadvertent services.
- Prohibition of cost-sharing waiver.

NJ Disclosure Requirement – Facility

- Before scheduling a non-emergency or elective procedures with a covered person, facility is now required to disclose whether the facility is in-network for non-emergency services.
- Also advise the covered person to (i) ask his or her physician whether the physician is in-network or OON and (ii) contact his or her carrier for further consultation on costs.
- Must make available to the public a list of their standard charges, consistent with federal law.
- Must post on its website a list of health benefit plans in which the facility is a participating provider and a statement that individual physician services are not included in the facility's charges, along with a disclaimer that some physicians may not participate with the same health benefit plans as the facility.

NJ Disclosure Requirement – Provider

- Before scheduling a non-emergency procedure, inform patients that the amount (or the estimated amount) that they will bill for the procedure and the associated CPT codes are available upon request (and such disclosure must be made, if requested).
- Inform patients that they will be financially liable for OON services in excess of the copayment, deductible, or coinsurance and that they may be responsible for costs in excess of those allowed by a health benefits plan.
- Advise patients to contact their health benefits plan for consultation on costs.
- Also, to the extent possible, make disclosures to patients about the services of other providers who will be involved in their care, including the following: anesthesiology; pathology; radiology; and assistant surgeons.

Billing Restrictions Apply to Inadvertent, Emergency and Urgent OON Services

- **Inadvertent Services:**
  - Services that are covered under a health benefit plan that provides a network and are provided by an OON provider when a covered person utilized an in-network facility for covered services and, for any reason, in-network services are unavailable.
- **Emergency and Urgent Services:**
  - Adopts the federal Emergency Medical Treatment and Active Labor Act (EMTALA), which is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions this includes services required when there is inadequate time to effect a safe transfer to another hospital before delivery or when the transfer may pose a threat to the health or safety of the woman or the unborn child.

Billing Restrictions – Inadvertent, Emergency or Urgent Services

- When a patient receives inadvertent, emergency or urgent OON services:
  - Neither the hospital nor the provider may bill the patient in excess of the applicable in-network co-payment and deductible.
  - In the event that the hospital and/or provider cannot reach agreement with the carrier with respect to reimbursement for the balance of the fee may pursue binding arbitration.
  - Self-funded plans governed by the provisions of the federal ERISA may elect to adopt Act provisions.

Arbitration Timeline

- Within 20 days after receiving claims (Emergency/Urgent and Inadvertent OON bills) – Carrier must pay or inform provider that the claim is excessive, or partially pay bill.
- Within next 30 days – parties negotiate bill.
- Within the next 30 days, the Carrier, Physician, or Patient may initiate binding arbitration.
- Self-funded plans may elect to adopt Act provisions.

Arbitration Procedure

- Party requesting arbitration must notify other party of final offer prior to arbitration.
  - Carrier's offer must be the paid amount.
- Parties' final offers must be at least $1,000 apart.
- Binding arbitration is initiated by request to Department of Banking and Insurance (DOBI).
  - DOBI will contract with an entity that has experience in healthcare pricing arbitration.
  - Health Claims Authorization, Processing and Payment Act (HCAPPA) applies in interim (MAXIMUS).

Arbitration Process and Awards

- Parties will make written submissions to arbitrator.
- Within 30 days of request, arbitrator must issue a "baseball-style" award.
  - Arbitrator selects one of the party's final offers.
- Arbitrator fees and costs – split by parties.
  - Exception where arbitrator finds the carrier's final offer was not made in good faith.
- Parties responsible for their own costs including legal fees.
- Excess payment by carrier, if any, to be made within 20 days, without interest, until 20 days post award.

Arbitration Process and Awards *(continued)*

- 2020: The New Jersey Department of Banking and Insurance received 5,715 arbitration requests.
- Of 5,715 cases, 5,428 cases have been resolved by issuance of a decision, by withdrawal request by the initiating party or by dismissal for ineligibility.
- Of 5,715 cases received, decisions were issued in 4,173 cases; 813 cases were dismissed as ineligible and 729 cases were withdrawn.
- Carriers prevailed in 1,489 cases or 36% of the total and providers prevailed in 2,683 of the cases or 64% of the total.
  - Carriers Awarded: $5,222,355
  - Providers Awarded: $31,434,988
- NJ OON Act Data Reporting (This report covers arbitrations in 2020.)

Arbitration Process and Awards *(continued)*

Takeaways from the 2020 NJ OON Act Data Reporting

- Through the rate review process, carriers reported a reduction in spending on involuntary OON services by 56% for the individual health coverage market; 38% for the small employer health coverage market; 48% for the large group market.
- Many large employers with self-funded plans, that are not required to comply with the law, are voluntarily joining the process.
  - 137 such groups opted-in to the law to protect their employees.
- From 2019 to 2020, the number of arbitrations increased from 1,760 to 4,208.
- Overall, providers prevail more than carriers.
- Majority of the awards were for amounts under $10,000.

Proposed Changes to NJ Surprise Bill Act

- S3458
  - 6/24/2021: Passed by Senate.
  - 1/3/2022: Reported out of Assembly Committee; 2nd Reading.
- This proposed statute:
  - Increases the time frames for when parties can attempt to reach a settlement.
  - Eliminates the requirement that the final offers submitted by the insurer and provider be more than $1,000 apart.
  - Eliminates the clause requiring the arbitrators to be from the American Arbitration Association. Instead, the Department of Health will certify arbitrators.
  - Eliminates the requirement that the "arbitrator's decision shall be one of the two amounts submitted by the parties as their final offers and shall be binding on both parties." Instead, the "arbitrator shall determine a **usual, reasonable, and customary fee** that shall be one of the two amounts submitted by the parties."

Intersection of Federal NSA and NJ Law

- The federal NSA is in addition to the NJ surprise billing law; it does not preempt in all respects.
- The federal law creates a “floor” of protections against surprise bills from out-of-network providers.
- As long as the NJ surprise billing law provides at least the same level of consumer protections against surprise bills as does the NSA, the NJ law generally will apply.

Intersection of Federal NSA and NJ Law – Disclosure Requirements

- With respect to disclosure and notice requirements, providers must follow the federal Disclosure and Notice and Consent forms unless NJ develops notice and consent forms that meet the federal statutory and regulatory requirements.
  - The NJ disclosure and notice requirements in general are not as stringent as the federal requirements.
  - The NJ Board of Medical Examiners has not developed such forms for providers.
  - The NJ Department of Health has developed such forms for facilities, but the requirements are not as stringent as the federal law.

Intersection of Federal NSA and NJ Law – Disclosure Requirements *(continued)*

- Cost Estimate and CPT Codes
  - Federal: Requires the OON provider to include on the Notice and Consent the cost estimate and CPT code.
  - NJ: Only requires notice that the cost estimate and CPT code will be provided upon request by the patient.
- Post-stabilization services by an OON provider at an in-network facility.
  - Federal: Requires the OON provider to list any participating in-network providers at the facility that are able to furnish the items or services described in this notice.
  - NJ: Disclosure requirement does not require such a list.

Intersection of Federal NSA and NJ Law – Disclosure Requirements *(continued)*

- Ancillary Services
  - Federal: Consent may not be obtained to balance bill ancillary services.
  - NJ: Does not have such a limitation and therefore the federal law applies.
- Disclosures must be made to patients enrolled in:
  - Federal: Any group health plan or group or individual health insurance coverage, including self-insured plans and Federal Employees Health Benefits.
  - NJ: Only required for patients enrolled in a New Jersey health plan and excludes self-insured plans.

Intersection of Federal NSA and NJ Law – Disclosure Requirements *(continued)*

- Notice and Consent:
  - Federal: Providers may not modify the language in the federal Notice and Consent in any manner, which must also be given physically separate from and not attached to or incorporated into any other forms.
  - NJ: Disclosures do not have such express requirements.

Intersection of Federal NSA and NJ Law – Dispute Resolution

- So long as a state dispute resolution process meets or exceeds the minimum requirements under the federal IDR then HHS will defer to the state process and would not accept such disputes into the federal process.
- Although HHS has not formally said so, it is thought that the NJ arbitration process will be deemed to meet or exceed the federal requirements for arbitration.
- However, NJ law does not apply to all patients and health plans covered by the federal law.

Intersection of Federal NSA and NJ Law – Dispute Resolution *(continued)*

- The NJ dispute resolution governs disputes between insurers and OON providers located within NJ for fully insured NJ licensed plans. The federal IDR would apply to claims not subject to state law.
- State insurance laws are generally limited to insurance policies issued in NJ, so a NJ resident insured under an employer's NY group policy may not fall under the protection of NJ law.
- Federal law governs self-insured ERISA plans and the federal IDR process will apply to ERISA plans that do not opt to participate in NJ's arbitration process.
- Federal law governs certain government programs, such as Federal Employees Health Benefits Plan covering federal employees, and will preempt the NJ law.

How the Federal and NJ IDRs Differ

- Standard
  - Federal: Baseball style; qualifying payment amount (QPA) will be the presumptive reimbursement amount.
  - NJ: Baseball style; review of two written submission by both parties.
- Cost of Arbitration
  - Federal: Losing party pays.
  - NJ: Both parties split the cost (pays for their own legal fees).

Federal NSA and NJ Law Comparison

	Federal - NSA	NJ – Surprise Bill Act
Covered Services	• Emergency services by an OON provider or OON emergency facility. • Non-emergency services, by OON providers at in-network facilities and for which patients do not consent. • OON air ambulance services.	• Inadvertent OON services. • Emergency/Urgent services. o Urgent medical condition is a non-life-threatening condition that requires care by a provider within 24 hours.
Services Not Covered	• Non-emergency services at an OON facility. • Non-covered items and services under patient's health plan. • Non-emergency or post-stabilization services by an OON provider at an in-network facility for which the patient consents to be balance billed, when permitted (can never consent to certain ancillary services).	• Knowing, voluntary, and specific selection of OON provider by patient where patient could have chosen in-network services.
Disclosure Requirement	Model Disclosure Notice • Disclosure of balance billing protections must be made by all licensed providers. • For uninsured or self-pay individuals, notice and good faith estimate must be provided. • Exceptions: If the provider never furnishes services at a healthcare facility or if the individual patient will not be receiving services at a facility.	• No specific Disclosure Form available. • Before scheduling a non-emergency or elective procedures with a covered person, facility is now required to disclose whether the facility is in-network for non-emergency services. • Also advise the covered person to (i) ask his or her physician whether the physician is in-network or OON and (ii) contact his or her carrier for further consultation on costs. • Must make available to the public a list of their standard charges, consistent with federal law. • Must post on its website a list of health benefit plans in which the facility is a participating provider and a statement that individual physicians' services are not included in the facility's charges, along with a disclaimer that some physicians may not participate with the same health benefit plans as the facility. • Individual healthcare professionals must (i) disclose the health benefit plans with which they participate; (ii) disclose to a particular covered person if they are OON with the person's plan; (iii) provide the covered person with a billing estimate and with affiliated CPT codes, if requested; (iv) advise the covered person that he or she has the financial responsibility to pay for any OON services; and (v) promptly notify the covered person if their network status changes during the course of treatment.

Federal NSA and NJ Law Comparison

	Federal - NSA	NJ – Surprise Bill Act
Notice and Consent Requirement	Standard Notice and Consent Documents • This form cannot be modified. • Given to obtain a patient's consent to be balance billed for OON non-emergency or post-stabilization services at an in-network facility, except for ancillary services. • Must include a good faith estimate for furnishing such items or services. • Must be provided at least 72 hours before the date the items and services are to be furnished. • If the appointment is made within 72 hours of the date of the items or services are to furnished, the Notice and Consent must be provided on the date the appointment is made. • For same-day appointments, Notice and Consent must be provided at least 3 hours prior to furnishing the services.	• There is no inadvertent OON service where a covered person "knowingly, voluntarily, and specifically" selects an OON provider for services with full knowledge that the provider is OON with respect to the covered person's health benefits plan, under circumstances that indicate that the covered person had the opportunity to be serviced by an in-network provider, but instead selected the OON provider.
Good Faith Estimates for Uninsured and Self-pay	Notice to Uninsured/Self-Pay and Good Faith Estimate Template • Good faith estimate must include expected charges for the items or services that are reasonably expected to be provided, in conjunction with the primary item or services, including items or services that may be provided by co-providers and co-facilities, after discounts.	• A facility must make available to the public a list of the facility's standard charges for all items and services provided by the facility. • Silent on the disclosure requirements to uninsured and self-pay. Professionals must provide a covered person with both a billing estimate and the associated CPT codes, if requested.
Independent Dispute Resolution (IDR) Timeline **(OON Provider v. Plans)**	• Within 30 days – Parties negotiate. • Parties may submit dispute to IDR process within 4 business days of the end of the negotiation period. • Parties choose IDR entity; Secretary chooses if parties cannot agree. • Parties submit their offers and materials to arbitrator within 10 days of the date of selection of the IDR entity. • IDR chooses one of the parties' offers within 30 days of selection of the IDR entity. • Payment to the OON provider no later than 30 days after IDR decision. **NOTE:** If a state has its own payment standard and/or IDR process in place, that process can continue to apply for services covered by state-regulated health plans if meets or exceeds the federal standards.	• Within 20 days – Carrier must pay or notify the provider that it considers the bill to be excessive. • Within next 30 days – Parties negotiate. • If negotiation fails, the carrier will make a payment for the amount of its final offer. • Within next 30 days – Initiate arbitration. • Within 30 days – Arbitrator must issue award. • Excess payment by carrier, if any, to be made within 20 days.

Federal NSA and NJ Law Comparison

	Federal - NSA	NJ – Surprise Bill Act
IDR Decision Factors	• "Baseball-style" arbitration process. • Qualifying payment amount (QPA) will be used as the presumptive reimbursement amount. • Other factors may be considered if a party submits information demonstrating the service is materially different from the QPA.	• "Baseball-style" arbitration process. • Review of written submissions by both parties.
IDR Procedure	• Parties select a certified IDR entity. • Each party submits its offer for payment with documentation. • IDR entity select one of the offers. • Losing party is responsible for the IDR entity's fee.	• Party requesting arbitration must notify of final offer prior to arbitration. • DOBI chooses the arbitrator. • Final offers must be at least $1,000 apart. • Parties split the cost of arbitration, and each party pays their own attorney's fees.
Uninsured/Self-Pay Patient – Provider Dispute Resolution (Uninsured or Self Pay Patient v. Provider)	• Available when patient gets a bill from a provider at least $400 more than good faith estimate. • Patient or their authorized representative may initiate the dispute process. • Patient must file for dispute claim within 120 days of the date on the bill.	• In NJ, there is no arbitration procedure between an uninsured/self-pay patient against the provider.
Self-Funded Plan That Opted In v. OON Provider	N/A	• Self-funded plan (that has elected to be subject to the Law) and an OON provider are unable to resolve a payment dispute. • DOBI will select experienced arbitrators. • Arbitrator must take both positions into account and must ultimately produce written findings.
Covered Person With Self-Funded Plan That Does Not Opt In v. OON Provider	N/A	• The member of the self-funded plan that does not elect to opt-in or the OON provider may request binding arbitration after no resolution within 30 days. • DOBI will select experienced arbitrators. • Arbitration decision must be issued within 30 days after the request for arbitration is filed with the DOBI.
Penalties	• The NSA allows HHS to impose penalties of up to $10,000 per violation.	• Up to $100 per violation for healthcare professionals. • Up to $1,000 per violation for carriers and healthcare facilities (every day qualifies as a separate violation, but no provider will be liable for more than $25,000 per occurrence).

Questions?

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