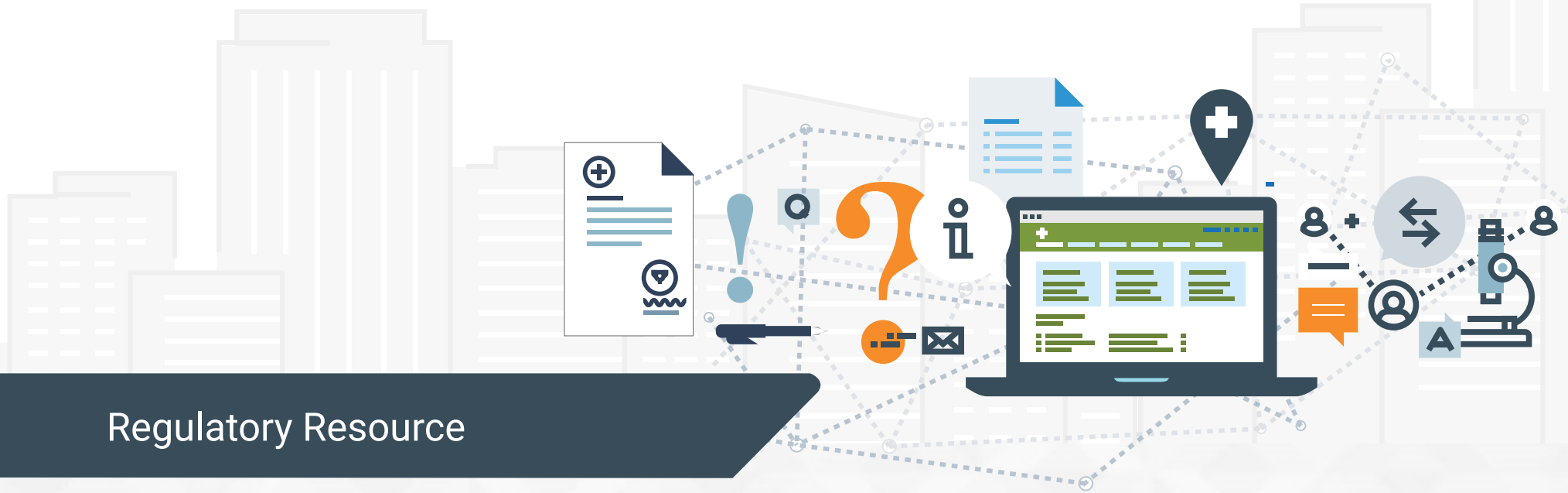

Regulatory Resource

Operationalizing the No Surprises Act

Get a clear overview of the operational implications of the No Surprises Act to ensure your revenue cycle is ready for January 2022.

July 2021

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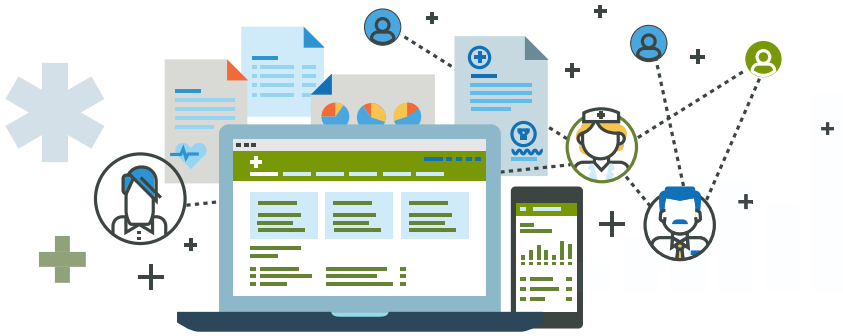

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The No Surprises Act at a glance

The No Surprises Act ("The Act" or "NSA") was included in the Consolidated Appropriations Act, 2021 (PL 116-260), located at Title I of Division BB, page 1576. This guide breaks down what you need to know in order to prepare your revenue cycle operations, ensure compliance, and prevent performance disruption when The Act takes effect.

When

Effective
1/1/2022

What

Balance Billing is wholly prohibited for:

- Emergency and post-stabilization services (OBS, OP, IP) rendered by an out-of-network (OON) facility or by an OON provider at an in-network (INN) facility
- Air ambulance services[3]

Balance Billing is permitted when

- Appropriate notice and consent is obtained from patient and patient agrees to OON cost sharing amounts for non-emergency services performed by OON providers at certain INN facilities.

How

Providers and facilities must make publicly available a one-page notice in clear and easily understood language containing:

- The Act's requirements for providers and facilities regarding balance billing for emergency services and non-emergency services
- Applicable state law regarding patient charges
- Contact information for the relevant state and federal agencies to discuss a potential violation of The Act
- In conjunction with the Interim Final Rule, a model notice was published which satisfies these requirements but providers may elect to draft their own version of a notice/consent document

Download the Model Disclosure Notice here

So What

A violation of the applicable requirements under the Act to the provider/facility in question **may result in a monetary penalty not to exceed $10,000 per violation.**[18]

Who is Affected?

Services

Service Types Affected

Balance Billing is Wholly Prohibited for:

- Emergency and post-stabilization services (OBS, OP, IP) rendered by an OON facility or by an OON provider at an INN facility (Pages 1578, 1587, 1643)

  Note: OON cost sharing will apply to OON post-stabilization services, furnished on an inpatient or outpatient basis, if the following conditions are met: (1) the individual is stable and the provider or facility determines that the individual is able to travel using nonmedical transportation or non-emergency medical transportation; (2) the provider furnishing the additional items and services satisfies the notice and consent criteria; (3) the individual is in a condition to receive the information and to provide informed consent (in accordance with State law) and such other conditions as specified by the Secretary, such as conditions relating to coordinating care transitions to participating providers and facilities.

- Air ambulance services (Page 1650).

Balance Billing is permitted when appropriate notice and consent is obtained from patient and patient agrees to OON cost sharing amounts for:

- Non-emergency services performed by OON providers at certain INN facilities (Pages 1587, 1642-1646).

Plans

Plan Types Affected[4]

Group health plans (Page 1588)

- ERISA governed plans (Page 1625)
- Federal Employee Health Benefits (Page 1616)[5]
- Grandfathered health plans (Page 1616)[6]

Individual health plans (Page 1588)

Plan Types Not Affected

The Act does not affect **third-party liability-based coverage** (auto, workers' compensation, etc.), **short term limited duration plans, health care sharing ministry plans, and other types of coverage not specifically outlined above.**

Providers

Clinician Providers Affected[7]

The Act defines a "nonparticipating provider" as **"a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who does not have a contractual relationship with the plan or issuer"** (Page 1586).

Facility Providers Affected[8]

Health Care Facilities are defined under the Act to include (Pages 1589, 1601, 1613, and 1647):

- **Hospitals[9];**
- **Hospital outpatient departments;**
- **Critical access hospitals;**
- **Ambulatory surgical centers; and**
- **Any other facility that provides items or services for which coverage is provided under the plan or coverage.**

Nonparticipating facilities and participating facilities are specifically defined when discussing balance billing requirement regarding non-emergency services performed by an OON provider as certain INN facilities (Page 1647).

Download the Standard Notice and Consent here

Notice and Consent Requirements to Allow Balance Billing[11]

Only applicable to non-emergent services

An OON provider/OON facility satisfies the notice and consent criteria if:

(1) The OON clinician (or INN facility on behalf of the OON clinician) or OON facility provides the patient a written notice in paper or electronic form, as selected by the patient, where the notice:

- States consent to receive items and services from an OON provider/OON facility is optional.
- Consent from the patient to be treated by the OON clinician/OON facility must be signed and dated before such items or services are furnished.
- Affirms the patient may instead seek care from an INN clinician provider/INN facility where the applicable cost-sharing requirement would apply;
- Is available in the 15 most common languages in the geographic region of the applicable facility; and

(2) Provides the patient with a signed copy of the consent via mail or email as selected by the patient.

(3) Additional requirements for the written notice include the following (Pages 1644-1645):

- Notification that the provider/facility is OON;
- Notification of the "good faith estimated" amount that may be charged to the patient for the items/services along with a disclaimer that this estimated amount does not form a contract around charges;
- Provide a list of any INN providers who can provide the items/services in the case of an INN facility utilizing an OON provider and notify the patient that he/she may opt to use one of the INN providers;
- Information about whether prior authorization or other care management limitations may be required in advance of receiving scheduled services; and
- The patient **must receive written notice** at least 72 hours prior to the date of service in either paper or electronic form **as selected by the patient** (Page 1645)[12]. **Exception:** If the appointment is made within 72 hours of the anticipated service, then the patient must receive notice on the day the appointment is scheduled.

The notice and consent requirements do not apply to:[12]

Ancillary services, which include:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a physician or non-physician practitioner, and items and services provided by assistant surgeons, hospitalists, and intensivists unless the Secretary provides a rule stating otherwise
- Diagnostic services (including radiology and laboratory services) unless the Secretary provides a rule stating otherwise
- Items and services provided by such other specialty practitioners, as the Secretary specifies through rulemaking
- Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility (Page 1644).

Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time such covered items/ services are furnished (Page 1644).

Additional requirements

Affirmation that the patient received "written notice" and the date on which such written notice was received

An OON facility, or INN facility with an OON provider, must **retain a copy of the notice/consent for seven (7) years** (Page 1646, 1647).

Required Refunds, Disclosure and Enforcement

Refunds & Disclosure

Refund Obligations[10]

Providers/facilities will be required to issue refunds to enrollees for any amount exceeding the normal cost-sharing applied for such services rendered by an INN provider plus interest, the rate of which shall be determined by HHS (Page 1707)

There is presently no specified timeline for remitting refunds

Required Disclosure[15]

Providers and facilities must make publicly available and, if applicable, also post on their website a one-page notice containing:

- The Act's requirements for providers and facilities regarding balance billing for emergency services and non-emergency services;
- Applicable state law regarding patient charges; and
- Contact information for the relevant state and federal agencies to discuss a potential violation of the above.

The notice must be in clear and easily understood language (Page 1648).

Provider Requirements Regarding Provider Directory Information[20]

No later than January 1, 2022, each health care clinician and facility subject to this Act must have business processes in place to ensure that they timely provide their provider directory information to a group health plan or a health insurance issuer to support compliance by plans or issuers with the sections requiring them to publish this information (Page 1706).[21]

Enforcement[16]

Enforcement Provisions

The Act does not supersede or cancel out a state's authority to require a clinician/facility (including an air ambulance provider) to comply with the requirements of the Act and any other applicable state laws pertaining to balance billing (Page 1648).

A State may notify the applicable Secretary/federal agency of a clinician or facility's violation of the requirements under the Act.[17]

If the notified Secretary/federal agency determines that the OON clinician or facility has failed to adhere to the Act, then they will be subject to the enforcement provisions.

A violation of the applicable requirements under the Act to the provider/facility in question may result in a monetary penalty not to exceed $10,000 per violation.[18]

Exception to Enforcement Provisions[19]

The penalties discussed above must be waived when a clinician or facility (including for air ambulance services) **does not knowingly violate the balance billing requirements** for emergency and/or non-emergency services with respect to a patient, **if such clinician or facility, withdraws the bill within 30 days of the violation** and reimburses the health plan or patient in an amount equal to the difference between the amount billed and the amount allowed to be billed under the provision, plus interest, at an interest rate to be determined by the Secretary (Page 1649).

Balance Billing Prohibitions Applicable to Health Plans

For Operator Reference Purposes During Claim Processing/Review

Emergency Services

Balance Billing is prohibited with no exceptions.

- When a patient receives emergency services (for which benefits are in place) for an emergency medical condition during an emergency department visit at a hospital or an independent freestanding emergency department:
  - If the hospital or department is an OON emergency facility, it must not bill the patient or hold the patient liable for a payment amount for such emergency services so furnished that is more than the cost-sharing requirement for such services (Page 1643).
  - If the services are rendered by an OON provider, the health care provider shall not bill the patient or hold the patient liable for a payment amount for an emergency service furnished that is more than the cost-sharing requirement for such services furnished by an INN provider (Page 1643).

In terms of emergency services, the definitions provided for OON facilities and INN facilities describe what services are considered emergency services:

- OON Facility is defined as:
  - An emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship with the plan or issuer, with respect to **emergency services**, and
  - A hospital or an independent freestanding emergency department, that does not have a contractual relationship with the plan or issuer with respect to items and services furnished by an OON provider or OON emergency facility after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the emergency services furnished and inclusive of items and services for which benefits are provided **unless specific conditions are met** (Page 1647, citing Page 1581).[22]
- INN Facility means:
  - An emergency department of a hospital, or an independent freestanding emergency department, that has a direct or indirect contractual relationship with the plan or issuer with respect to emergency services (Page 1647, citing Page 1581).
  - A hospital or an independent freestanding emergency department, that has a contractual relationship with the plan or coverage with respect to services that are included as emergency services.
    - This means items and services furnished by an OON provider or OON emergency facility after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the emergency services furnished and inclusive of items and services for which benefits are provided **unless specific conditions are met** (Page 1647, citing Page 1581).

The additional items and services provided after a patient is stabilized are not considered "emergency services" when:

- Such provider or facility determines such individual is able to travel using nonmedical transportation;
- Such provider furnishing such additional items and services satisfies the notice and consent criteria;
- The patient is in a condition to receive written notice and to provide informed consent; and
- Such other conditions, as specified by the Secretary, such as conditions relating to coordinating care transitions to participating providers and facilities are met (Pages 1581-1582).

Balance Billing Prohibitions Applicable to Health Plans

For Operator Reference Purposes During Claim Processing/Review

Non-Emergency Services Performed by OON Providers at Certain INN Facilities (2799B-2)

An OON Provider at an INN health care facility must not bill or hold a patient liable for a payment amount for such an item or service furnished by that which is more than the applicable cost-sharing requirement unless the provider satisfies the notice and consent criteria (Pages 1643-1644).

See chart for scenarios where the notice and consent exception does not apply.

Negotiation and Dispute Resolution Process Surrounding OON Rates (Sec. 103: P. 1616, P 1625 (ERISA), P. 1634 (IRC))

During the 30-day period beginning on the day the provider/facility receives an initial payment or denial notice from the plan/patient regarding a claim, the provider, facility, plan, or coverage may initiate open negotiations to agree to an amount for payment (including any cost-sharing) for such item or service.[23]

- The parties have thirty days (the "open negotiation period") beginning on the date of initiation to determine an acceptable payment.

If the parties cannot agree on payment during the 30-day negotiation period, then the provider, facility, plan, or coverage may initiate the independent dispute resolution process during the 4-day period after the open negotiation period (31-35 days from initial payment or denial) (Page 1617).

Once an IDR entity is chosen, the parties have 10 days to submit:

- An offer for payment for the item or service in question;
- Information relating to the offer as requested by the IDR entity; and
- Any information relating to the offers submitted by either party (Pages 1620-1621).

In general, the determination of the IDR entity is binding upon the parties (absent fraud/misrepresentation) and shall not be subject to judicial review.[24]

- After the IDR determination, the party that initiated the IDR may not initiate another IDR involving the same party(ies) regarding the same item/service during the 90-day period following such determination.
- **Exception:** Once the 90-day period following the IDR determination has elapsed, then a clinician or facility may request a subsequent request for IDR relating to all claims that occurred during the 90-day suspension relating to that item/service with the same plan or coverage.

Coverage/Payment Requirements Applicable to Plans

For Operator Reference Purposes During Claim Processing/Review

Emergency Services

Cost-sharing Limitations:

- Plans/issuers must not have a greater cost-sharing requirement than would be applied if the services where rendered by an INN provider/ INN emergency facility (Pages 1578, 1592 – Sec. 716 preventing surprise medical bills, and 1603 – Sec. 9816).

OON Rate Determinations for Providers/Emergency Facilities:

- The rate for an item or service is decided in the following order based on the first applicable provision (Pages 1587, 1599, and 1612):
  - If the State has an All-Payer Model Agreement, then the amount that State approves under such system shall apply to that item or service;
  - If the State has an applicable law regarding specifying the amount for the item or service with respect to the plan, patient, or issuer and the OON provider or OON emergency facility that will apply;
  - The amount decided upon by an IDR entity or the amount the parties agree to during open negotiations prior to engaging an IDR.[25]

OON Plan Payment Requirements TBD:

- Not later than October 1, 2021, the Secretary of HHS must establish through rulemaking a process under which group health plans and health insurance issuers offering group or individual health insurance coverage are audited by the Secretary, or applicable State authority, to ensure compliance with applying a "qualifying payment amount" that meets the standard the Act (Page 1579, 1665 – Sec. 9816).
- As of July 1st, several government agencies jointly published the Interim Final Rules with request for comment, which among other items, covers the below:
  - Methodology the group health plan or health insurance issuer offering group or individual health insurance coverage must use to determine the "qualifying payment amount," differentiating by individual market, large group market, and small group market;
  - The information such plan or issuer must share with the OON provider or OON facility, as applicable, when making such a determination;
  - The geographic regions applicable; and
  - A process to receive complaints of violations by group health plans and health insurance issuers offering group or individual health insurance coverage when applying the "qualified payment amounts" (Page 1580; 1665 – Sec. 9816).

Non-emergency Services (Performed by OON Providers at Certain INN Facilities)

Cost-sharing Limitations:

- Plan/coverage must not impose a cost-sharing requirement greater than the cost-sharing requirement applicable to an INN provider unless notice and consent requirements are met (Pages 1588, 1598, 1600, and 1612).
- This limit applies to "visits" which must, with respect to items and services furnished to an individual at a health care facility, include equipment and devices, telemedicine services, imaging services, laboratory services, preoperative and postoperative services, and such other items and services as the Secretary may specify, regardless of whether or not the provider furnishing such items or services is at the facility (Pages 1602 and 1613).

OON Balance Billing State Laws for NSA Deference to State Law Requirements

This information is intended to be a high-level overview and reference of selected state law(s). **More in-depth detail can be provided for any state not included, upon request from provider-partners.** The grids address which service types are covered by the state's law(s), how that state calculates reimbursement for affected services, provider ("clinician") considerations, facility considerations, payor obligations, patient considerations, an overview of the dispute process, and a link to the law(s) in question.

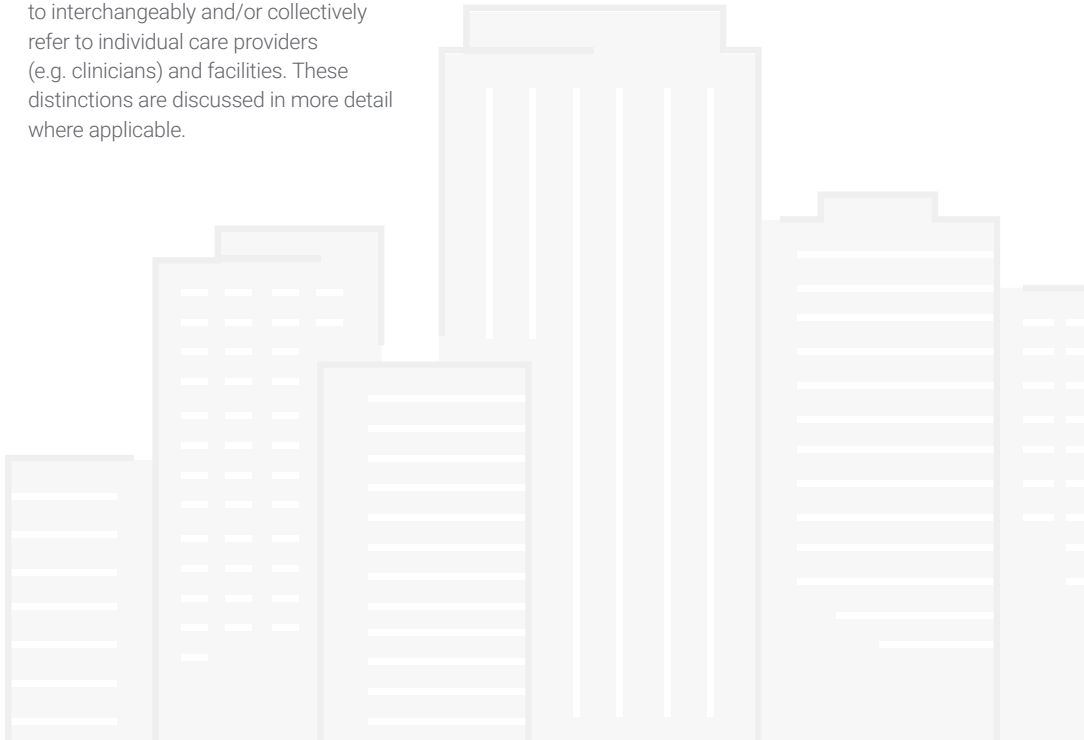
States With Passed and Effective Legislation

State	Statute(s)
Arizona	AZ Rev Stat §20-3111 through 20-3119
Connecticut	Conn. Gen. Stat. Ann. § 38a-477aa
Florida	Fla. Stat. § 627.64194
Maine	Me. Rev. Stat. tit. 22, § 1718-D Me. Rev. Stat. tit. 24-A, § 4301-A
Massachusetts	Mass. Gen. Laws Ann. ch. 176G, § 5 Mass. Gen. Laws Ann. ch. 176G, § 1 211 Mass. Code Regs. 51.05 Mass. Gen. Laws Ann. ch. 176O, § 6
Missouri	MO ST § 376.690 20 CSR 400-14.100
New Hampshire	NH Rev Stat § 329:31-b
New Jersey	NJ P.L.2018, C.32
New York	N.Y. Fin. Serv. § 601 et seq. NY DFS Surprise Medical Bills and Emergency Services
Texas	2019 Tex. Sess. Law Serv. Ch. 1342 (S.B. 1264) https://www.tdi.texas.gov/medical-billing/providers.html https://www.tdi.texas.gov/takefive/texas-protects-consumers-from-surprise-medical-bills.html
Virginia	VA Code Ann. § 38.2-3445.01 et seq. 14 VAC 5-405-10 – 14 VAC 5-405-90 https://scc.virginia.gov/pages/Balance-Billing-(1)

Passed But Not Yet Effective Legislation

State	Bill	Effective Date
Ohio	Ohio House Bill 388	01/12/2022

Please Note: Some states use "provider" to interchangeably and/or collectively refer to individual care providers (e.g. clinicians) and facilities. These distinctions are discussed in more detail where applicable.



OON Balance Billing State Laws for NSA Deference to State Law Requirements: Arizona

Topic	Details
Service Types Impacted	Emergency care is covered, as defined in AZ Rev Stat §20-2801, including conditions that pose serious risk to a patient's health, bodily functions, and/or any bodily organ or part. Health care services, including non-emergency services, would include treatment, services, medications, tests, equipment, devices, durable medical equipment, laboratory services or supplies rendered or provided to an enrollee for the purpose of diagnosing, preventing, alleviating, curing or healing human disease, illness, or injury. This statute does not apply to uncovered services by the enrollee's plan, limited benefit coverage, charges for health care services that are subject to a direct payment agreement, health plans that do not include coverage for OON services (unless otherwise required by law), state health and accident coverage, and self-funded employee benefit plans if preempted by ERISA.
Calculation of Reasonable Amount	Payment amounts that **are in dispute** are subject to arbitration where the decision maker will consider (1) the average contracted amount the payor remits for the services in question in the county where services were performed; (2) the average amount provider has contracted to accept for the services; (3) CMS reimbursement rates; and (4) any direct pay rate for the services the provider may have in place.
Providers Impacted	Arizona defines a health care provider as a person who is licensed, registered, or certified as a health care professional under title 32 or a laboratory or durable medical equipment provider that furnishes services to a patient in a network facility and that separately bills the patient for the services. OON providers may not balance bill patients (**except for those enrolled in PPOs**) for amounts beyond the INN level of cost-sharing. They must provide patient with notice of OON.
Facilities Impacted	Arizona defines a facility as a hospital, outpatient surgical center, health care laboratory, diagnostic imaging center, or urgent care center as defined under AZ Rev Stat §36-437. The law is less specific for facilities as opposed to providers, but a patient may not be balance billed by an OON facility for amounts beyond INN levels of cost-sharing unless the patient was given notice under AZ Rev Stat §20-3113 and consented accordingly.
Patient Refund Obligations	Arizona is silent on the matter of patient refunds for overpayments/credit balances. Rules regarding this matter will be subject to future regulations promulgated under the No Surprises Act by the Secretary of HHS, along with the Secretaries of Treasury and Labor as applicable. An update will be provided at that time.
Payor Obligations Under the Law(s)	Payors must hold patients harmless for amounts beyond INN levels of cost-sharing.
Patient Considerations Under the Law(s)	Arizona law does not apply to patients in HMOs. Patients may initiate a dispute.
Disputes	Disputes between payors and providers/facilities will go to an arbitrator (see above). Patient can dispute charges only if they were not informed in writing ahead of rendering of services that specific services would be provided by an OON provider or if they did not receive a good-faith estimate of cost of services.
Citation(s)	AZ Rev Stat §20-3111 through 20-3119

OON Balance Billing State Laws for NSA Deference to State Law Requirements: Connecticut

Topic	Details
Service Types Impacted	Both emergency and non-emergency services rendered by OON providers at INN facilities. Protections do not apply to OON facility charges for emergency services, enrollees who consent to non-emergency OON services, enrollees of self-funded plans, and/or ground ambulance services. "Emergency services" include medical screening examinations within the capability of a hospital emergency department, including ancillary services, and such further medical examinations and treatment to stabilize a patient.
Calculation of Reasonable Amount	For emergency services, insurer must reimburse the greatest of: (1) the amount the plan would pay for such services if rendered by an INN provider; (2) the usual, customary, and reasonable rate for such services (80th percentile of all charges for the particular service performed a provider in the same specialty in the same geographical area as reporting in a benchmarking database maintained by a nonprofit organization picked by the Insurance Commissioner); and (3) the Medicare reimbursement rate. For non-emergency services provided by OON providers at INN facilities, the insurer must reimburse the OON provider at the INN rate under the health plan as payment in full unless the insurer and provider agree otherwise.
Providers Impacted	A health care provider is an individual licensed to provide health care services under chapters 370 to 373 (Medicine and Surgery, Chiropractic, Naturopathy), chapters 375 to 383b (which includes Physical Therapists, Nurses, Opticians, and Psychologists), and chapters 384 to 384c (Veterinary Medicine, Massage Therapists, Dietitians and Acupuncturists). OON providers may not balance bill HMO and PPO enrollees for amounts beyond the INN level of cost-sharing for service types listed above.
Facilities Impacted	These regulations affect health systems, hospitals (an establishment for the lodging, care and treatment of persons suffering from disease or other abnormal physical or mental conditions and includes inpatient psychiatric services in general hospitals), and hospital-based facilities where hospital or professional medical services are provided. Connecticut does not place the same burdens on facilities as it does individual providers, but generally a patient cannot be billed for "surprise bills," which are defined here as "a bill for health care services, other than emergency services, received by an insured for services rendered by an out-of-network health care provider, where such services were rendered by such out-of-network provider at an in-network facility, during a service or procedure performed by an in-network provider or during a service or procedure previously approved or authorized by the health carrier and the insured did not knowingly elect to obtain such services from such out-of-network provider."
Patient Refund Obligations	Connecticut is silent on the matter of patient refunds for overpayments/credit balances. Rules regarding this matter will be subject to future regulations promulgated under the No Surprises Act by the Secretary of HHS, along with the Secretaries of Treasury and Labor as applicable. An update will be provided at that time.
Payor Obligations Under the Law(s)	Health carrier means an insurance company, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity that delivers, issues for delivery, renews, amends or continues a health care plan in this state. Payors must hold patients harmless for amounts beyond INN level of cost-sharing.
Patient Considerations Under the Law(s)	N/A.
Disputes	The statute does not provide a specific process for resolution of disputes.
Citation(s)	Conn. Gen. Stat. Ann. § 38a-477aa

OON Balance Billing State Laws for NSA Deference to State Law Requirements: Florida

Topic	Details
Service Types Impacted	Florida's law covers emergency services as defined in Fla. Stat. § 627.47: medical screening, examination, and evaluation by a physician or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists, and if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition within the service capability of a hospital. Florida further includes non-emergency services rendered by OON providers and/or at OON facilities which they define as services and care "that are not emergency services" as defined above.
Calculation of Reasonable Amount	For PPOs, the standard payment is calculated at the lesser of (1) the provider's billed charges; (2) the usual and customary provider charges for similar services in the community where services were provided; or (3) the charge mutually agreed to by the insurer and provider within 60-days of claim submittal.
Providers Impacted	OON Providers may not bill patients for any amount beyond INN level of cost sharing. Florida includes providers who are not a preferred provider as defined in Fla. Stat. § 627.6471 or an exclusive provider as defined by Fla. Stat. § 627.6472. A preferred provider is defined as any licensed health care provider with which an insurer has directly or indirectly contracted for an alternative or a reduced rate of payment. An exclusive provider is defined as a provider of health care, or a group of providers of health care. Any non-preferred and non-exclusive (OON) provider is prevented from billing a patient for emergency services beyond the what the INN rate would be. They may pursue noncovered services beyond this rate however.
Facilities Impacted	Florida law contemplates facilities as "nonparticipating provider[s]" if they are a licensed facility or an urgent care center. Pursuant to Fla. Stat. § 627.64194, a nonparticipating provider/facility may not collect or attempt to collect from the insured any amount greater than the INN level of cost sharing for emergency services. A facility may attempt to collect amounts for noncovered services. The statute cited at the bottom of this table defers to Fla. Stat. § 395.002 to define licensed facilities as a hospital or ambulatory surgical center licensed in accordance with Florida law. It further defines an urgent care center as a facility or clinic that provides immediate but not emergent medical care to patients. This includes an offsite emergency department of a hospital that is presented to the general public in any manner as a department where immediate and not specifically emergent medical care is provided.
Patient Refund Obligations	Florida is silent on the matter of patient refunds for overpayments/credit balances. Rules regarding this matter will be subject to future regulations promulgated under the No Surprises Act by the Secretary of HHS, along with the Secretaries of Treasury and Labor as applicable. An update will be provided at that time.
Payor Obligations Under the Law(s)	Must hold patients harmless for amounts beyond INN level of cost-sharing.
Patient Considerations Under the Law(s)	Florida does not apply above requirements when patients with PPO coverage consent to non-emergency OON services and/or to self-funded plans.
Disputes	For PPOs, any dispute of the payment standard is resolved either through state courts or through a voluntary dispute resolution (arbitration, etc.).
Citation(s)	Fla. Stat. § 627.64194

OON Balance Billing State Laws for NSA Deference to State Law Requirements: Maine

Topic	Details
Service Types Impacted	Applies to emergency services rendered by OON professionals, facilities, and ambulance providers, as well as non-emergency services provided by an OON professional at INN facilities. Protections do not apply to enrollees who consent to OON non-emergency treatment. "Emergency service" means a health care item or service furnished or required to evaluate and treat an emergency medical condition that is provided in an emergency facility or setting.
Calculation of Reasonable Amount	For non-ambulance services, the carrier is required to reimburse the greater of: (1) the carrier's median in-network rate paid for that health care service by a similar provider in the enrollee's geographic area; or (2) the median in-network rate paid by all carriers for that service by a similar provider in the enrollee's geographic area as determined by the state All Payor Claims Database (APCD). **For ambulance services, the carrier is required to reimburse at the carrier's out-of-network provider rate, however, this requirement will sunset in October 2021.** The state has established a committee to develop recommendations for reimbursement for ambulance services.
Providers Impacted	OON providers may not balance bill HMO and PPO enrollees for amounts beyond the INN level of cost-sharing. "Provider" means a practitioner or facility licensed, accredited or certified to perform specified health care services consistent with state law.
Facilities Impacted	The Maine legislation collectively refers to practitioners and facilities interchangeably as "provider" as those accredited or certified to perform specified health care services consistent with state law.
Patient Refund Obligations	Maine is silent on the matter of patient refunds for overpayments/credit balances. Rules regarding this matter will be subject to future regulations promulgated under the No Surprises Act by the Secretary of HHS, along with the Secretaries of Treasury and Labor as applicable. An update will be provided at that time.
Payor Obligations Under the Law(s)	Payors must hold patients harmless for amounts beyond INN level of cost-sharing. "Carrier" means (1) an insurance company licensed to provide health insurance; (2) an HMO licensed pursuant to chapter 56; (3) a preferred provider arrangement administrator registered pursuant to chapter 32; (4) a fraternal benefit society; (5) a nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24; (6) a MEWA licensed pursuant to chapter 81; (7) a self-insured employer subject to state regulation as described in section 2848-A; or (8) an entity offering coverage in this State that is subject to the requirements of the federal Affordable Care Act.
Patient Considerations Under the Law(s)	Protections for non-emergency services do not apply when an enrollee "knowingly elected to obtain services from that out-of-network provider."
Disputes	Only with respect to emergency services: if a provider is not satisfied with a reimbursement amount as determined by the payment standard above, the provider can file a request for independent dispute resolution. The Superintendent of Insurance will pick qualified arbitrators with billing and reimbursement expertise, and with no conflicts of interest. The arbitrator will then pick one of the two submitted final offers from either party. In making this decision, the arbitrator will consider the following factors: (1) provider's level of training, (2) any previously contracted rate, and (3) median in-network rate as determined by the state APCD. The decision of the arbitrator is binding, and the losing party is responsible for paying associated costs. When the difference between the two final offers is less than $750, the carrier will reimburse the provider directly as long as the provider's charges don't exceed 80th percentile of charges for that service in a benchmarking database. A provider can dispute more than one bill with same carrier for the same service as long as the total of bills exceeds $750.
Citation(s)	Me. Rev. Stat. tit. 22, § 1718-D Me. Rev. Stat. tit. 24-A, § 4301-A

OON Balance Billing State Laws for NSA Deference to State Law Requirements: Massachusetts

Topic	Details
Service Types Impacted	Both emergency and non-emergency services rendered by OON professionals at INN facilities. The protections do not apply to services at OON facilities, in instances where enrollees consented to OON services, enrollees of self-funded plans, and ground ambulance services. "Emergency medical condition" is a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of a member or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B). An "attending physician" is the emergency physician or consultant physician who actively treats the emergency medical condition of a member at an emergency facility.
Calculation of Reasonable Amount	An HMO must provide or arrange for indemnity payments to a member or provider for a reasonable amount charged for the cost of emergency medical services by a provider who is not normally affiliated with the HMO when the member requires services for an emergency medical condition. If a PPO enrollee receives Emergency Care and cannot reasonably reach a Preferred Provider, payment for such care will be made at the same level and in the same manner as if the Covered Person had been treated by a Preferred Provider.
Providers Impacted	The Massachusetts statutes do not specifically delineate the types of providers/physicians/facilities affected, but in general the language would be applicable to any licensed medical worker or facility rendering care to an OON patient.
Facilities Impacted	The Massachusetts statutes do not specifically delineate the types of providers/physicians/facilities affected, but in general the language would be applicable to any licensed medical worker or facility rendering care to an OON patient.
Patient Refund Obligations	Massachusetts is silent on the matter of patient refunds for overpayments/credit balances. Rules regarding this matter will be subject to future regulations promulgated under the No Surprises Act by the Secretary of HHS, along with the Secretaries of Treasury and Labor as applicable. An update will be provided at that time.
Payor Obligations Under the Law(s)	Payors must hold HMO and PPO enrollees harmless for amounts beyond INN level of cost-sharing. A "carrier" is an insurance company authorized to provide accident and health insurance under chapter 175, a nonprofit hospital service corporation authorized under chapter 176 A, or a nonprofit medical service corporation authorized under chapter 176B.
Patient Considerations Under the Law(s)	Protections for non-emergency or emergency services will not apply if an INN provider is available and enrollee has "reasonable opportunity" to choose to have the service performed by a network provider.
Disputes	The statutes do not provide a specific process for resolution of disputes.
Citation(s)	Mass. Gen. Laws Ann. ch. 176G, § 5 Mass. Gen. Laws Ann. ch. 176G, § 1 211 Mass. Code Regs. 51.05 Mass. Gen. Laws Ann. ch. 176O, § 6

OON Balance Billing State Laws for NSA Deference to State Law Requirements: **Missouri** (page 1 of 2)

Topic	Details
Service Types Impacted	Treatment of "emergency medical condition[s]," which are defined as the sudden and unexpected onset of a health condition with symptoms of sufficient severity, regardless of the final diagnosis that is given, that would lead a prudent lay person, to believe that immediate medical care is required, which may include, but shall not be limited to: (a) Placing the person's health in significant jeopardy; (b) Serious impairment to a bodily function; (c) Serious dysfunction of any bodily organ or part; (d) Inadequately controlled pain; or (e) With respect to a pregnant woman who is having contractions: a. That there is inadequate time to effect a safe transfer to another hospital before delivery; or b. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child. "Unanticipated out-of-network care" means health care services received by a patient in an in-network facility from an out-of-network health care professional from the time the patient presents with an emergency medical condition until the time the patient is discharged.
Calculation of Reasonable Amount	Not specified unless the health care professional participates in one or more of the carrier's commercial networks, then the offer of reimbursement for unanticipated out-of-network care shall be the amount from the network which has the highest reimbursement.
Providers Impacted	When unanticipated out-of-network care is provided, the health care professional may bill a patient for no more than the patient's cost-sharing requirements. Health care professionals shall send any claim for charges incurred for unanticipated out-of-network care to the patient's health carrier within 180 days of the delivery of the unanticipated out-of-network care. "Health care professional," a physician or other health care practitioner licensed, accredited or certified by the state of Missouri to perform specified health services consistent with state law.
Facilities Impacted	"Facility," is any institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.
Patient Refund Obligations	Missouri is silent on the matter of patient refunds for overpayments/credit balances. Rules regarding this matter will be subject to future regulations promulgated under the No Surprises Act by the Secretary of HHS, along with the Secretaries of Treasury and Labor as applicable. An update will be provided at that time.
Topic	**Details**

OON Balance Billing State Laws for NSA Deference to State Law Requirements: **Missouri** (page 2 of 2)

Payor Obligations Under the Law(s)	Within 45 processing days of receiving the health care professional's claim, the health carrier shall offer to pay the health care professional a reasonable reimbursement for unanticipated out-of-network care based on the health care professional's services. The in-network deductible and out-of-pocket maximum cost-sharing requirements shall apply to the claim for the unanticipated out-of-network care. The patient's health carrier shall inform the health care professional of its enrollee's cost-sharing requirements within 45 processing days of receiving a claim from the health care professional for services provided.
Patient Considerations Under the Law(s)	Cost sharing as if unanticipated out-of-network care was provided in-network.
Disputes	If the health care professional declines the health carrier's initial offer of reimbursement, the health carrier and health care professional shall have 60 days from the date of the initial offer of reimbursement to negotiate in good faith to attempt to determine the reimbursement for the unanticipated out-of-network care. If the health carrier and health care professional do not agree to a reimbursement amount by the end of the 60-day negotiation period, the dispute shall be resolved through an arbitration process as specified in subsection 4 of this section. To initiate arbitration proceedings, either party must provide written notification to the director and the other party within 120 days of the end of the negotiation period, indicating their intent to arbitrate the matter and notifying the director of the billed amount and the date and amount of the final offer by each party. A claim for unanticipated out-of-network care may be resolved between the parties at any point prior to the commencement of the arbitration proceedings. Claims may be combined for purposes of arbitration, but only to the extent the claims represent similar circumstances and services provided by the same health care professional, and the parties attempted to resolve the dispute in accordance with the law. External arbitration begins with the director randomly selecting an arbitrator for the case. The director shall specify the criteria for an approved arbitrator or entity by rule. The arbitrator shall determine a dollar amount due to the provider between 120% of the Medicare-allowed amount and the 70th percentile of the usual and customary rate for the unanticipated out-of-network care, as determined by benchmarks from independent nonprofit organizations that are not affiliated with insurance carriers or provider organizations. When determining a reasonable reimbursement rate, the arbitrator shall consider the following factors if the health care professional believes the payment offered for the unanticipated out-of-network care does not properly recognize the health care professional's training, education, or experience; the nature of the service provided; the health care professional's usual charge for comparable services provided; the circumstances and complexity of the particular case, including the time and place the services were provided; and the average contracted rate for comparable services provided in the same geographic area. The arbitrator's decision is final and binding on the parties. The costs of arbitration shall be shared equally between the parties.
Citation(s)	MO ST § 376.690 20 CSR 400-14.100

OON Balance Billing State Laws for NSA Deference to State Law Requirements: New Hampshire

Topic	Details
Service Types Impacted	Patient protections apply to services provided by health care providers performing anesthesiology, radiology, emergency medicine, or pathology services if the service is performed at an INN facility.
Calculation of Reasonable Amount	Per the statute, fees for health care services submitted to a payor shall be limited to a commercially reasonable value, based on payments for similar services from New Hampshire insurance carriers to New Hampshire providers.
Providers Impacted	New Hampshire includes any health care provider performing anesthesiology, radiology, emergency medicine, or pathology services performed at a hospital or ambulatory surgical center that is INN. OON providers may not bill patients for any amount beyond INN level of cost-sharing.
Facilities Impacted	This statute does not specifically contemplate facilities and speaks specifically to individual providers.
Patient Refund Obligations	New Hampshire is silent on the matter of patient refunds for overpayments/credit balances. Rules regarding this matter will be subject to future regulations promulgated under the No Surprises Act by the Secretary of HHS, along with the Secretaries of Treasury and Labor as applicable. An update will be provided at that time.
Payor Obligations Under the Law(s)	Must remit a commercially reasonable payment.
Patient Considerations Under the Law(s)	No obligations under § 329:31-b.
Disputes	In the event of a dispute between payor and provider, the state Insurance Commissioner will have jurisdiction to determine if the fee is commercially reasonable. The department of insurance may require mediation prior to a decision.
Citation(s)	NH Rev Stat § 329:31-b

OON Balance Billing State Laws for NSA Deference to State Law Requirements: New Jersey

Topic	Details | Please Note: the New Jersey legislation is particularly broad.
Service Types Impacted	New Jersey's law contemplates all "emergency and urgent care services" including, but not limited to, those found in N.J.A.C. 11:24-5.3, which governs HMOs. This would include: medical and psychiatric care, coverage for trauma services at any designated Level I or II trauma centers as medically necessary, medically necessary care for emergent injuries or illness, including prehospital care. New Jersey's law also includes non-emergency/pre-scheduled services rendered by OON providers and/or at OON facilities.Services such as anesthesiology, laboratory, pathology, radiology, and/or assistant surgeon services are also affected by this law. "Inadvertent out-of-network services" includes laboratory testing ordered by an INN health care provider and performed by an OON bio-analytical laboratory
Calculation of Reasonable Amount	The payment amount is either the billed amount or agreed upon final payment amount. See "disputes."
Providers Impacted	New Jersey includes both individual professionals and facilities as "providers." Health care professionals under this law are any individual, acting within the scope of his or her licensure or certification, who provides a covered service defined by a health benefits plan. A professional must disclose their network status when scheduling non-emergency services. Further, a professional must provide notice that includes INN/OON status, (upon request) the CPT codes that will be associated with the prospective care, the financial responsibility associated with the care, and advise the patient to contact the carrier for further consultation on costs. OON professionals may not bill patients for any amount beyond INN level of cost sharing.
Facilities Impacted	New Jersey includes any health care facility that is a general acute hospital, satellite emergency department, hospital based off-site ambulatory care facility in which ambulatory surgical cases are performed, and/or ambulatory surgery facilities. When pre-scheduling services, a facility must disclose to the patient the facility's INN/OON status, advise the patient to check with the physician arranging the services as to whether they are INN or OON, advise the patient regarding their financial responsibility for services at an INN or OON depending on what the case may be. A facility may not bill for emergency services (as defined by EMTALA) for an OON patient at a rate greater than INN for medically necessary services.
Patient Refund Obligations	New Jersey is silent on the matter of patient refunds for overpayments/credit balances. Rules regarding this matter will be subject to future regulations promulgated under the No Surprises Act by the Secretary of HHS, along with the Secretaries of Treasury and Labor as applicable. An update will be provided at that time.
Payor Obligations Under the Law(s)	Payors must hold patients harmless for amounts beyond INN level of cost-sharing.
Patient Considerations Under the Law(s)	Patients in self-funded plans must opt-in to these protections. Otherwise, those enrolled in HMOs, PPOs, EPOs, and POSs are covered for emergency services. Patient is not covered by this law if they knowingly consent to OON services where same services are available INN.
Disputes	If a patient receives emergent medically necessary services at an OON facility, and the facility and payor cannot agree on the appropriate reimbursement, the payor, facility, or patient may initiate binding arbitration proceedings. Payor has 20-days within receipt of bill to notify provider that they consider the claims excessive. After notice, the parties have 30-days to negotiate a settlement. If none is reached, payor must remit the final offer. If a dispute remains, then provider, payor, or patient may initiate arbitration proceedings.
Citation(s)	NJ P.L.2018, C.32

OON Balance Billing State Laws for NSA Deference to State Law Requirements: **New York** (page 1 of 2)

Topic	Details
Service Types Impacted	New York's laws cover emergency services, which means, with respect to an emergency condition: (1) a medical screening examination as required under section 1867 of the social security act, 42 U.S.C. § 1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (2) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of the social security act, 42 U.S.C. § 1395dd, to stabilize the patient. Non-emergency services rendered by a non-par physician at a par hospital or ambulatory surgical center, where a par physician is unavailable or a non-par physician renders services without the insured's knowledge, or unforeseen medical services arise at the time the health care services are rendered. Non-emergency services rendered by a non-par provider, where the services were referred by a par physician to a non-par provider without explicit written consent of the insured acknowledging that the par physician is referring the insured to a non-par provider and that the referral may result in costs not covered by the health care plan.
Calculation of Reasonable Amount	Health plan is required to pay the provider the billed amount or attempt to negotiate reimbursement with the provider.
Providers Impacted	Providers must hold insureds who sign an assignment of benefits harmless for any billed amounts in excess of the insured's INN cost sharing. However, this law does not apply to medical services where physician fees are subject to schedules or other monetary limitations, including workers' compensation law and article fifty-one of New York's insurance law.
Facilities Impacted	Emergency Department of hospitals, including ancillary services routinely available to the Emergency Department to evaluate an emergency medical condition; Hospitals; Ambulatory Surgical Centers.
Patient Refund Obligations	New York is silent on the matter of patient refunds for overpayments/credit balances. Rules regarding this matter will be subject to future regulations promulgated under the No Surprises Act by the Secretary of HHS, along with the Secretaries of Treasury and Labor as applicable. An update will be provided at that time.
Payor Obligations Under the Law(s)	Health Plans (HMOs or insurers subject to NY law) must hold insured harmless from bills for OON emergency services, or for inpatient services that follow an ED visit, that are more than the insured's INN cost sharing.
Patient Considerations Under the Law(s)	Cost Sharing, including co-pay, co-insurance, and deductible, as if INN.

OON Balance Billing State Laws for NSA Deference to State Law Requirements: **New York** (page 2 of 2)

Topic	Details
Disputes	**IDR Entity Reviews**. Disputes are reviewed by independent dispute resolution entities (IDRE). Decisions will be made by a reviewer with training and experience in health care billing, reimbursement, and usual and customary charges in consultation with a licensed doctor in active practice in the same or similar specialty as the doctor providing the service that is the subject of the dispute. **30 Day Timeframe**. The IDRE will make a determination within 30 days of receipt of the dispute. Parties to the dispute must submit all necessary information with their IDR application and immediately when contacted by the IDRE, or the information will not be considered. **IDRE Determines the Fee**. For disputes involving HMO or insurance coverage, the IDRE chooses either the non-participating provider bill or the health plan payment. For disputes submitted by uninsured patients, or patients with employer or union self-insured coverage, the IDRE determines the fee. **IDRE Considers These Factors When Making a Determination:** • Whether there is a gross disparity between the fee charged by the provider and (1) fees paid to the provider for the same services provided to other patients in health care plans in which the provider is non-participating, and (2) the fees paid by the health plan to reimburse similarly qualified out-of-network providers for the same services in the same region; • The provider's training, education, experience, and usual charge for comparable services when the provider does not participate with the patient's health plan; • In the case of a hospital, the teaching status, scope of services, and case mix; • The circumstances and complexity of the case; • Patient characteristics; and • For physician services, the usual and customary cost of the service. **IDRE may direct a good faith negotiation for settlement.** In cases when settlement is likely, or if the health plan's payment and the provider's fee are unreasonably far apart, the IDRE may direct the parties to negotiate. **Review is Binding.** The review is binding and admissible in court.
Citation(s)	N.Y. Fin. Serv. § 601 et seq. NY DFS Surprise Medical Bills and Emergency Services NY DFS Surprise Medical Bills and Emergency Services NY DFS Independent Dispute Resolution for Emergency Physician and Hospital Services Including Inpatient Services Following an Emergency Room Visit Q&A Guidance NY DFS Out-of-Network Guidance NY DFS Out-of-Network Law FAQs

OON Balance Billing State Laws for NSA Deference to State Law Requirements: **Texas** (page 1 of 2)

Topic	Details | **Please Note: the Texas legislation is particularly broad.**
Service Types Impacted	Emergency Services; and Non-emergency services provided at INN facilities when the patient did not have a choice of providers.
Calculation of Reasonable Amount	The usual and customary rate or at an agreed rate, meaning the relevant allowable amount as described by the applicable master benefit plan document or policy.

Providers Impacted	Providers covered by the law include:
	• Diagnostic imaging providers;
	• Emergency care providers;
	• Facility-based providers; and
	• Laboratory service providers
	Providers must hold enrollees harmless for any amounts in excess of their INN cost sharing, including copays, coinsurance, and deductibles. Balance billing prohibition applies to HMO, EPO and PPO enrollees.
	Protections do not apply to non-emergency services if the enrollee "elects" to receive services from an out-of-network provider and all the following are met:
	• Enrollee had meaningful choice and was not just assigned a provider;
	• Enrollee was not coerced by policies like cancellation fees;
	• Enrollee received disclosure and notice 10 days prior to the service and signed it, and which written disclosure:
	  • Explains that the physician or provider does not have a contract with the enrollee's health benefit plan;
	  • Discloses projected amounts for which the enrollee may be responsible; and
	  • Discloses the circumstances under which the enrollee would be responsible for those amounts.

Facilities Impacted	The Texas law is particularly broad and contemplates a wide array of care and facilities. The provisions of this law regarding emergency care affect services originated in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility following treatment or stabilization of an emergency medical condition. In addition to those providing emergency care, this law also affects laboratory service facilities and more widely covers any facility providing non-emergency care.

OON Balance Billing State Laws for NSA Deference to State Law Requirements: Texas (page 2 of 2)

Topic	Details | Please Note: the Texas legislation is particularly broad.
Patient Refund Obligations	It is already established law in Texas that a physician, hospital, or other health care provider that receives an overpayment from an enrollee must refund the amount of the overpayment to the enrollee not later than the 30th day after the date the physician, hospital, or health care provider determines that an overpayment has been made. See Texas Insurance Code § 1661.005, Texas Health & Safety Code § 324.101, and Texas Occupations Code § 101.352.
Payor Obligations Under the Law(s)	Payors must hold enrollees harmless for amounts beyond in-network levels of cost sharing only applies to HMO and EPO enrollee, but not PPO enrollees. There must be balance billing prohibition disclosures in the EOB. Remit payment on the 30th day after receipt of a clean, electronic claim, or on the 45th day for clean, nonelectronic claims.
Patient Considerations Under the Law(s)	Cost sharing, including copayment, coinsurance, and deductible under their health plan as if the services were provided INN.
Disputes	For out-of-network providers, the state provides a binding arbitration process. Within 90 days of the provider receiving an initial payment from an insurer, the provider or insurer may request arbitration if there is a further charge billed by the provider and unpaid by the insurer, and the claim is for emergency care, a health care or medical service or supply provided by a facility-based provider in a facility that is a participating provider, an out-of-network laboratory service, or an out-of-network diagnostic imaging service. All parties are required to participate in an informal settlement teleconference within 30 days of requesting arbitration. Within 51 days of requesting arbitration, an arbitrator is to provide a binding decision by picking either the billed charge or the insurer's final offer amount. The state provides a list of 10 factors that an arbitrator must consider in making a determination, including: the level of training and experience of the provider; the circumstances and complexity of the case; the 80th percentile of all billed charges for the service as performed by a provider in the same or similar specialty and provided in the same geographic area as reporting by a state-selected benchmarking database; and the 50th percentile of rates for the service paid to participating providers in the same or similar specialty and provided in the same geographic area as reported in the state-selected benchmarking database. For out-of-network facilities, the state provides a non-binding mediation process for claims involving emergency care, an out-of-network laboratory or diagnostic imaging service. If the parties do not reach an agreement at the end of the mediation, either party is allowed to file a civil action within 45 days of the mediator submitting a report to the Department of Insurance.
Citation(s)	2019 Tex. Sess. Law Serv. Ch. 1342 (S.B. 1264) TDI How Texas Protects Consumers from Surprise Medical Bills TDI Balance Billing: Health Care Provider Resources TDI What Doctors Should Know About the State's New Surprise Billing Law FAQ

OON Balance Billing State Laws for NSA Deference to State Law Requirements: **Virginia** (page 1 of 2)

Topic	Details | **Please Note: the Virginia legislation is particularly broad.**
Service Types Impacted	Emergency services provided to an enrollee; or Nonemergency services provided to an enrollee at an in-network facility if the nonemergency services involve surgical or ancillary services provided by an out-of-network provider. "Surgical or ancillary services" means any professional services, including surgery, anesthesiology, pathology, radiology, or hospitalist services and laboratory services.
Calculation of Reasonable Amount	A "commercially reasonable amount" is based on payment for the same or similar services provide in a similar geographic area. Review the State Corporation Commission data set available at the link in the citation below.
Providers Impacted	Providers must ensure enrollee is not balance billed or otherwise subject to attempts to collect any amount greater than their INN cost sharing as set forth by the payor in the EOB. Within 30 business days of receipt of overpayment must refund payment, payment must be remitted back with interest beginning the 31st business day. Providers are not precluded from collecting a past due balance on a cost-sharing requirement with interest. A health care provider shall provide a notice of consumer rights upon request and post the notice on its website, along with a list of carrier provider networks with which it contracts. If no website is available, a health care provider shall provide to each consumer a list of carrier provider networks with which it contracts and the notice of consumer rights.
Facilities Impacted	A health care facility shall provide the notice of consumer rights to an enrollee at the time any non-emergency service is scheduled and also with the bill. A health care facility shall provide the notice of consumer rights to an enrollee with any bill for an emergency service. The notice may be provided electronically. However, a posted notice on a website will not satisfy this requirement. The Virginia legislation does not offer much delineation between facilities and individual providers.
Patient Refund Obligations	If the enrollee pays the out-of-network provider an amount that exceeds the amount determined as their in-network cost sharing requirement, the provider shall refund the excess amount to the enrollee within 30 business days of receipt. The provider shall pay the enrollee interest computed daily at the legal rate of interest stated in § 6.2-301 beginning on the first calendar day after the 30 business days for any unrefunded payments.

OON Balance Billing State Laws for NSA Deference to State Law Requirements: **Virginia** (page 2 of 2)

Topic	Details | **Please Note: the Virginia legislation is particularly broad.**
Payor Obligations Under the Law(s)	Treat any cost-sharing requirement falling under this law as if the health care services were provided INN and shall apply any cost sharing amounts paid by the enrollee toward their INN maximum out-of-pocket payment obligation. Within 30 calendar days of receipt of clean claim must pay or make offer of payment of a "commercially reasonable amount" directly to the provider. Carrier shall provide an EOB to the enrollee and OON provider that reflects the cost-sharing requirement. Carriers shall make available through electronic and other methods of communication generally used by a provider to verify enrollee eligibility and benefits information regarding whether an enrollee's health plan is subject to this balance billing law. Balances owed to Providers shall be subject to resolution through "good faith negotiations" or arbitration and are the sole responsibility of the payor unless otherwise prohibited under state or federal law.
Patient Considerations Under the Law(s)	The patient shall not be required to pay an amount greater than what he/she would pay under the in-network cost-sharing requirement specified in the enrollee's or applicable group health plan contract. The enrollee's obligation shall be determined using the carrier's median in-network contracted rate for the same or similar service in the same or similar geographical area. The enrollee's obligation when they are in a health benefit plan that uses no median INN contract rate for the services provided is determined by VA Code Ann. § 38.2-3407.3, which indicates that the amount payable may be a percentage of the costs of services as set forth in the enrollee's policy or the payor's "pre-established allowed amount to calculate the amount payable by the insured for services."
Disputes	Within 30 calendar days after receipt of payment or payment notification, the provider shall dispute the payor's initial offer. After a provider disputes the payment or offer the payor and provider shall have 30 calendar days from the initial offer to negotiate in good faith. If the payor and provider do not agree to a commercially reasonable payment amount within 30 calendar days and either party chooses to pursue further action to resolve the dispute, the dispute shall be resolved through arbitration. Arbitration is initiated by either party providing written notification to the State Corporation Commission no later than 10 calendar days following completion of the period of good faith negotiation, and such notification must state the initiating party's final offer to settle. Additional rules and timeframes then follow to complete the arbitration process. The SCC sets fixed fees for the costs of arbitration and the fees are divided equally between the parties. The Payor must remit payment for services under this law directly to the Provider.
Citation(s)	VA Code Ann. § 38.2-3445.01 et seq. 14 VAC 5-405-10 – 14 VAC 5-405-90 https://scc.virginia.gov/pages/Balance-Billing-(1)

OON Balance Billing State Laws for NSA Deference to State Law Requirements: **Ohio** (page 1 of 3)

Topic	Details | Legislation Enacted, Effective January 2022
Service Types Impacted	**The regulations implementing this new legislation have not yet been drafted, so additional detail on impacted service types will be provided in the future. This law will not go into effect until early 2022.** This will cover emergency services, as defined by EMTALA, including medical screening examinations, treatment needed to stabilize an emergency medical condition, and appropriate transfers undertaken prior to an emergency medical condition being stabilized. "Unanticipated out-of-network care" means health care services, including clinical laboratory services, that are covered under a health benefit plan and that are provided by an out-of-network provider when either of the following conditions applies: • The covered person did not have the ability to request such services from an in-network provider. • The services provided were emergency services.
Calculation of Reasonable Amount	**Reimbursement Amount:** Unless the provider wants to negotiate reimbursement, the reimbursement to be paid is the greatest of the following amounts: • The amount negotiated with INN providers for the service in question in that geographic region under that health benefit plan • The amount for the service calculated using the same method the health benefit plan generally uses to determine payments for OON services, such as UCR • The amount that would be paid under Medicare.
Providers Impacted	**A provider shall not balance bill a covered person for:** • Unanticipated OON care at an INN facility in OH • Emergency services provided at an OON emergency facility in OH • Applies to both OON facility and OON provider • Clinical lab services provided in OH in connection with unanticipated OON care at an INN facility or emergency services provided to a covered person at an OON emergency facility, including OON provider **For health care services *other than those described above* that are covered but provided to a covered person by an OON provider at an INN facility, both of the following apply:** For services provided in OH, the provider shall not balance bill unless all of the following conditions are met: • Provider informs the covered person that the provider is OON • Provider provides with covered person with a good faith estimate of the cost of services with a disclaimer that the patient is not required to obtain health care services from that provider. • Covered person affirmatively consents to receive the services. The health plan issuer may reimburse the provider at either the INN or OON rate as described in the covered person's health benefit plan.

OON Balance Billing State Laws for NSA Deference to State Law Requirements: **Ohio** (page 2 of 3)

Topic	Details | Legislation Enacted, Effective January 2022
Facilities Impacted	As currently written, this will affect facilities that provide emergency medical services as well as facilities providing clinical laboratory services.
Patient Refund Obligations	Currently silent but regulations have not yet been drafted and published.
Payor Obligations Under the Law(s)	**Health plan issuer shall reimburse:** OON provider for unanticipated OON care when the services are provided to a covered person at an INN facility, and the services would be covered if provided by an INN provider. Both of the following for emergency services provided to a covered person at an OON emergency facility: • An OON provider • The OON emergency facility Both of the following for emergency services provided to a covered person at an OON ambulance: • An OON provider • The OON ambulance Any OON provider and any OON facility that provided clinical laboratory services in connection with the care described above.
Patient Considerations Under the Law(s)	**Cost sharing:** no greater than if the services were INN

OON Balance Billing State Laws for NSA Deference to State Law Requirements: **Ohio** (page 3 of 3)

Topic	Details | Legislation Enacted, Effective January 2022
Disputes	**Provider Acceptance or Not of Reimbursement** The provider, facility, emergency facility, or ambulance must timely notify the health plan issuer of its acceptance of the reimbursement, or seek to negotiate reimbursement. Timely has not yet been established – it is left to ODI to establish and they have not yet issued the accompanying regulations (forthcoming in 2021). **Negotiating Reimbursement** Provider must notify health plan issuer of wish to negotiate. Notification must be timely as determined by regulations not yet published. Health plan issuer shall negotiate in good faith. **Negotiation** to last for 30 days **Arbitration** After 30 days of negotiation, if at an impasse, the provider sends a request for arbitration to the superintendent of insurance and notifies the health plan issuer of its request. Eligibility for arbitration: • Service in question was provided not more than one year prior to the request. The billed amount exceeds $750, except that claims may be bundled up to 15 claims that involve the same or similar services provided under similar circumstances • Each party submits its final offer to the arbitrator, along with any evidence. Arbitrator shall consider all the following factors: • INN rates that other health benefit plans reimburse that provider for the service in question for that geographic area • INN rates that the health benefit plan reimburses that provider for the service in question for that geographic area • If the parties had any contractual relationship in the previous 6 years, any INN reimbursement rates previously agreed upon • The results of a previous arbitration between the parties Non-prevailing party pays 70% of arbitrator's fees, prevailing party pays 30%.
Citation(s)	Ohio House Bill 388 *Regulations not yet published, and this law does not go into effect until 9 months following the effective date of the section (April 12, 2021), which appears to be January 12, 2022.*

References & Sources

[1] Sec. 102 and Sec. 104 of the Act to be inserted into Title XXVII of the Public Health Services Act (PHSA) at Sec. 2799A-1 and Sec. 2799B-2.

[2] Beth Fuchs and Jack Hoadley, Summary of the No Surprises Act (H.R. 133, P.L. 116-260), COMMONWEALTH FUND (updated Jan. 19, 2021), https://www.commonwealthfund.org/sites/default/files/2021-01/Surprise_Billing_Law_Summary_v2_UPDATED_01-19-2021.pdf.

[3] Not later than 90 after enactment of this law, the Secretaries of Labor, HHS, and Treasury will be required to establish an advisory committee to review options similar to this law for ground ambulance services. (Page 1707).

[4] Sec. 102 and Sec. 103 of the Act; Sec. 2799A-1(b); Sec. 9822(d); Sec. 103(b) of the PHSA.

[5] APPLICATION TO FEHB.—Section 8902 of title 5, United States Code, is amended by adding at the end the following new subsection: "Each contract under this chapter shall require the carrier to comply with requirements described in the provisions of sections 2799A–1, 2799A–2, and 2799A–7 of the Public Health Service Act, sections 716, 717, and 722 of the Employee Retirement Income Security Act of 1974, and sections 9816, 9817, and 9822 of the Internal Revenue Code of 1986 (as applicable) in the same manner as such provisions apply to a group health plan or health insurance issuer offering group or individual health insurance coverage, as described in such sections. The provisions of sections 2799B–1, 2799B–2, 2799B–3, and 2799B–5 of the Public Health Service Act shall apply to a health care provider and facility and an air ambulance provider described in such respective sections with respect to an enrollee in a health benefits plan under this chapter in the same manner as such provisions apply to such a provider and facility with respect to an enrollee in a group health plan or group or individual health insurance coverage offered by a health insurance issuer, as described in such sections." (Page 1616)

[6] Section 1251(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18011(a)) is amended by adding at the end the following: "(5) APPLICATION OF ADDITIONAL PROVISIONS.—Sections 2799A–1, 2799A–2, and 2799A–7 of the Public Health Service Act shall apply to grandfathered health plans for plan years beginning on or after January 1, 2022.".

[7] Sec. 102 of the Act; Sec. 2799A-1(3)(3) and Sec. 2799B-1(f)(1) of the PHSA.

[8] Sec. 102 and Sec. 104 of the Act; Sec. 2799A-1(b)(2) and Sec. 2799B-2(f)(3) of the PHSA.

[9] "Hospitals" constitutes those as defined under 42 U.S.C. 1861(e), available at, https://www.ssa.gov/OP_Home/ssact/title18/1861.htm (last visited April 7, 2021).

[10] Sec. 116 of the Act; Sec. 2799B-9(b).

[11] Sec. 104 of the Act; Sec. 2799B-2 of the PHSA.

[12] Sec. 104 of the Act; Sec. 2799B-2 of the PHSA.

[13] Sec. 104 of the Act; Sec. 2799B–3 of the PHSA.

[14] Sec. 104 of the Act; Sec. 2799B–4 of the PHSA.

[15] The applicable Secretary/federal agency may be the Secretary of Labor, Secretary of Health and Human Services, or the Secretary of the Treasury. Page 1648

[16] The Secretary to whom an alleged violation is reported to will only issue a penalty if a State has failed to enforce the requirements under the Act. The applicable provisions of the Social Security Act will result in a monetary penalty or assessment.

[17] Sec. 104 of the Act; Sec. 2799B-4 of the PHSA.

[18] Sec. 116 of the Act; Sec. 2799B-9 of the PHSA.

[19] Section 2799A–5(a)(1) of the PHSA, Section 720(a)(1) of ERISA, or Section 9820(a)(1) of the Internal Revenue Code, as applicable.

[20] Sec. 116 of the Act; Sec. 2799B-9 of the PHSA.

[21] Unless the state has applicable laws regarding the OON rates. new secs. 2799A-1(c)(1) of the PHS Act, 716(c)(1) of ERISA; 9816(c)(1) of IRC.

[22] See exceptions in Paragraphs (1) through (4) of section 10(a) of title 9, United States Code – 9 U.S.C. §10(a)(1)-(4)

[23] Applicable to items or services furnished to patients of a group health plan or group or individual health insurance coverage offered by a health insurance issuer.

[24] The most simple definition of a "qualifying payment amount" is defined as "[f]or an item or service furnished during 2022, the median of the contracted rates [. . .] as the total maximum payment [. . .] under such plans or coverage […] on January 31, 2019, for the same or a similar item or service provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished[. . .] increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021. . ."

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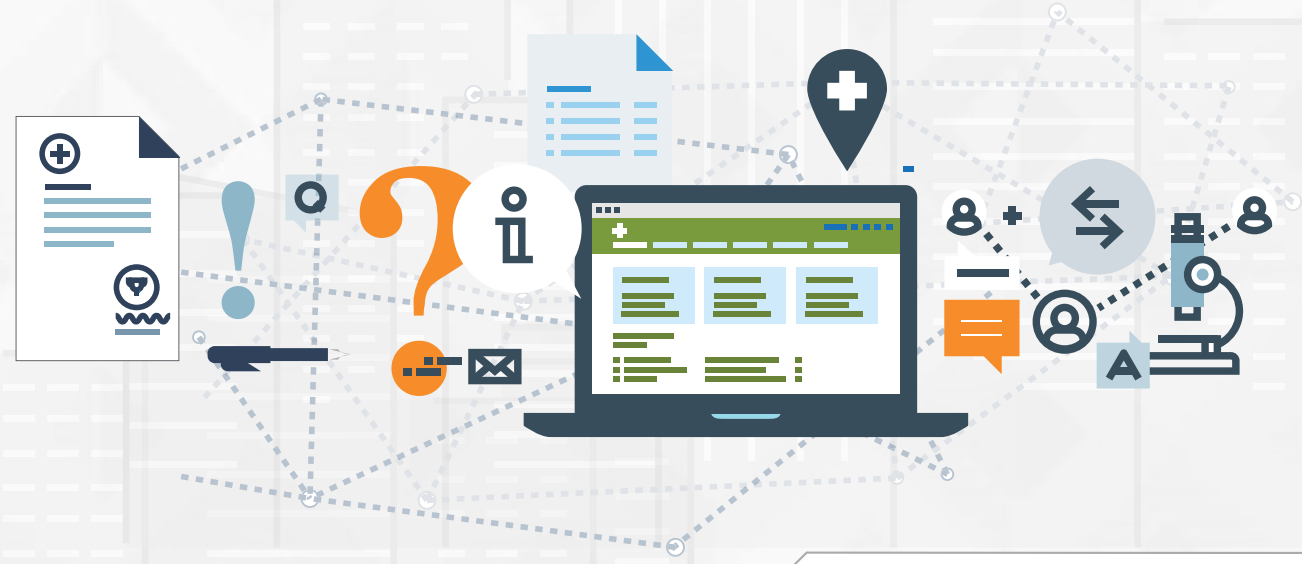

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