

# The COVID-19 Relief Package and the "No Surprises Act": Implications for States

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**STATE**  
Health & Value  
**STRATEGIES**  
**COVID-19**

*A grantee of the Robert Wood Johnson Foundation*

# About State Health and Value Strategies

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State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at [www.shvs.org](http://www.shvs.org).

**Questions?** Email Heather Howard at [heatherh@Princeton.edu](mailto:heatherh@Princeton.edu).

*Support for this webinar was provided by the Robert Wood Johnson Foundation.  
The views expressed here do not necessarily reflect the views of the Foundation.*

# Housekeeping Details

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All participant lines are muted. If at any time you would like to submit a question, please use the Q&A box at the bottom right of your screen.

After the webinar, the slides and a recording will be available at **[www.shvs.org](http://www.shvs.org)**.

# COVID-19 Resources for States

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State Health and Value Strategies has created an accessible one-stop source of COVID-19 information for states at [www.shvs.org/covid19/](http://www.shvs.org/covid19/). The webpage is designed to support states seeking to make coverage and essential services available to all of their residents, especially high-risk and vulnerable people, during the COVID-19 pandemic.

# About Georgetown University's Center on Health Insurance Reforms

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- A team of experts on private health insurance and health reform.
- Conduct research and policy analysis, provide technical assistance to federal and state policymakers, regulators, and consumer advocates.
- Based at Georgetown University's McCourt School of Public Policy.
- Learn more at <https://chir.georgetown.edu/>

# About Manatt Health

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Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 160 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving health care policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access, and create new ways of organizing, paying for, and delivering care. For more information, visit [www.manatt.com/ManattHealth.aspx](http://www.manatt.com/ManattHealth.aspx)

# About Jason Levitis

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Jason Levitis is principal at Levitis Strategies LLC, a healthcare consultancy focusing on the Affordable Care Act's tax provisions and state innovation waivers. He provides technical assistance to states in partnership with State Health and Value Strategies. He's also a nonresident fellow at the Brookings Institution and a senior fellow at Yale Law School's Solomon Center for Health Law and Policy. He served as Counselor and ACA Implementation Lead at the U.S. Treasury Department until January 2017.

# Agenda

- **Overview of the Consolidated Appropriations Act, 2021**
- **Summary and Implications of:**
  - The "No Surprises Act"
  - The COVID-19 Stimulus Package
  - Other Key Health Care Provisions Included in the Bill
- **Discussion**



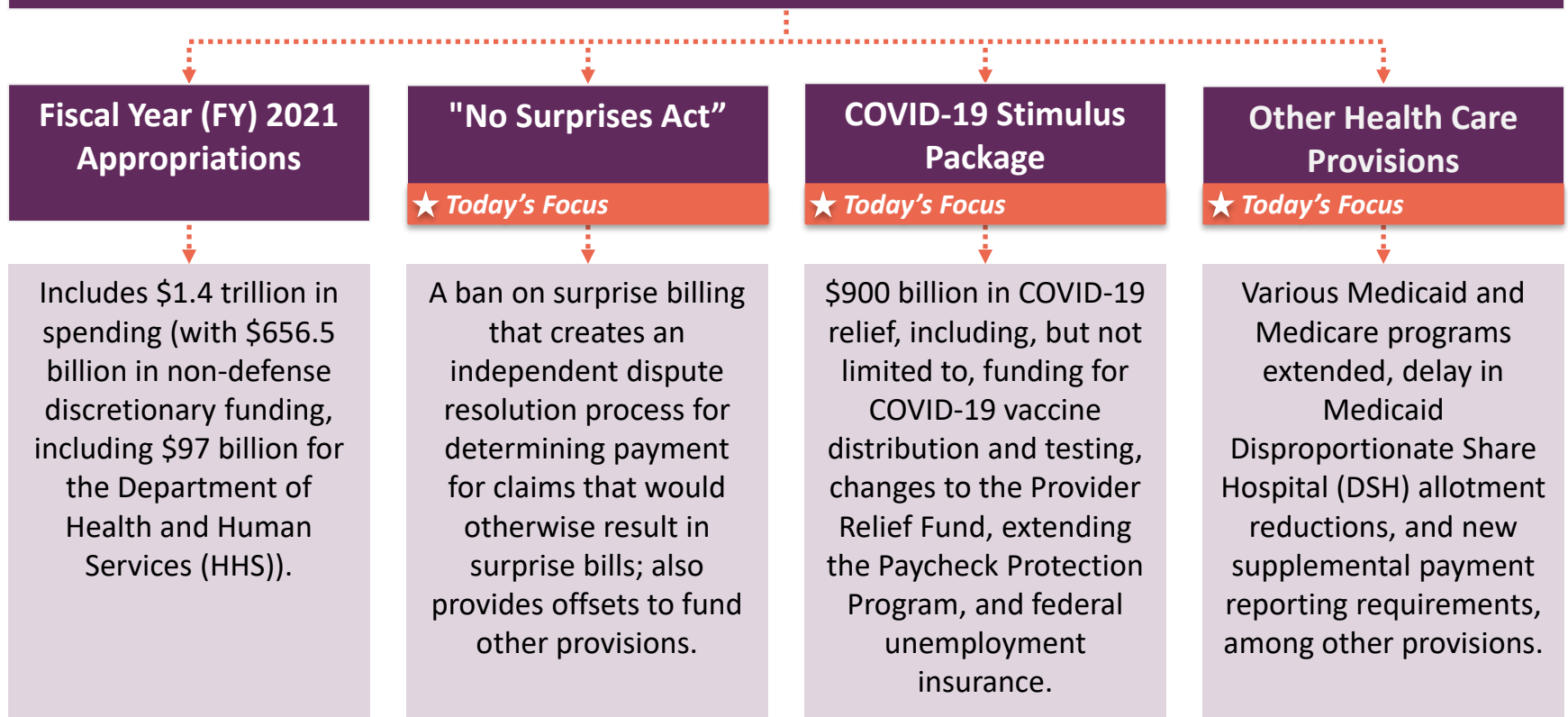


# **Overview of the Consolidated Appropriations Act, 2021**

# Level-Setting: The Consolidated Appropriations Act

*After several weeks of negotiation, President Trump signed into law on December 27, 2020 the Consolidated Appropriations Act, 2021.*

## The Consolidated Appropriations Act, 2021 (\$2.3 Trillion)



Source: H.R. 133. Available at <https://www.congress.gov/bill/116th-congress/house-bill/133>.



# The "No Surprises Act"

# Scope of Protections

- Which plans?
  - New protections for states that don't have their own balance billing laws and for the nearly 135 million in self-insured plans beyond reach of state regulators.
  - Defers, in certain circumstances, to state balance billing laws for insured plans.
- Which health care settings?
  - Non-emergency care in in-network facilities provided by out-of-network clinicians.
  - Emergency care, including air ambulances.
  - Excludes ground ambulances.
- What protections apply?
  - Patient held harmless: responsible for in-network cost-sharing only, which would count toward their in-network deductible and out-of-pocket limit.
  - Providers barred from sending a balance bill.
- Protections take effect with plan years beginning on or after 1/1/22.

## Determining Payment for Out-of-Network Care

- Health plan or insurer can, within certain timeframes, negotiate the payment amount with the provider or facility.
- Failing that, either party can request arbitration through an independent dispute resolution (IDR) entity.
- Factors for IDR entity's consideration:
  - *Must* consider insurer's median in-network rate.
  - *Can* consider various factors in determining the payment amount, including provider's level of training, experience, and quality of care; market share of the non-participating provider or facility; acuity of the patient or complexity of the services provided.
- IDR is barred from considering the provider's billed charge, usual or customary rates, and rates paid under government programs such as Medicare and Medicaid.
- The IDR must select one party's offer (called "baseball-style arbitration") and the decision would be binding on the parties.

## Waiving Protections

- Protections do not apply where a patient knowingly and voluntarily agrees to receive care from certain out-of-network providers.
- Providers can request that a patient provide a signed consent to receive *non-emergency* care from an out-of-network provider or facility.
  - Notification must generally be provided 72 hours before services are scheduled to be delivered, include good-faith cost estimate and identify available in-network options.
- Protections cannot be waived when:
  - There is no in-network provider available.
  - For urgent or unforeseen care.
  - Services are delivered by providers in designated specialties, including anesthesiology, pathology, radiology, neonatology and others that may be designated by Secretary through rulemaking.

# Enforcement

- State departments of insurance (DOIs) are the primary enforcers of provisions that apply to insurers and fully insured group health plans.
- Federal government enforces in states that fail to substantially enforce the law and for self-funded group health plans.
- With regard to provisions that apply to providers and facilities: states may enforce the provisions but the federal government will do so where a state fails to substantially enforce the law.
  - Law is silent on which state agency is responsible for enforcing provider provisions; unless addressed through rulemaking, it will be up to each state to determine responsible agency.
  - States may also notify the Secretaries of Labor, HHS and Treasury, as applicable, of any violations and actions taken.

## Considerations for States with Balance Billing Laws

- More than half of all states have enacted balance billing laws, including [17 states](#) that have comprehensive protections in law.
- State laws can be more consumer protective, as long as they don't prevent the application of federal law.
- Federal law does not preempt state payment dispute resolution laws if they rely on arbitration, a payment standard, or use a hybrid approach, as well as to states with an All Payer Model Agreement.
- Federal arbitration regime applies to DOL-regulated self-funded plans.
  - For the five states that permit self-funded plans to opt in to the state-level payment dispute process, federal rules may be needed to clarify that such programs do not conflict with the federal regime.



## Additional Provisions

- Continuity of Care: where provider contract ends, certain patients can maintain access to provider with in-network cost-sharing.
- Provider Directories: applies requirements to providers and health plans and insurers to keep provider directories current and accurate.
- Dispute Resolution for Uninsured: establishes process to contest provider charges that substantially exceed provider's good-faith estimate.
- Data Reporting and Studies to Monitor Implementation.

# Opportunities for States to Engage

- *In Rulemaking:* Secretaries of the HHS, Labor and Treasury must draft regulations to implement multiple provisions, including:
  - Creation and maintenance of the IDR system.
  - Criteria for providers who wish to bundle multiple claims for submission to the IDR.
  - Criteria for the certification of IDR entities.
  - A complaint process for patients.
- *In Implementation:*
  - States that do not currently have their own balance billing protections may want to ensure strong federal-state partnership to provide effective oversight and enforcement.
  - States that have enacted balance billing laws may want to ensure federal regulators understand how those laws operate in order to mitigate potential disruption or confusion for regulated entities and consumers.

## Opportunities for States to Engage (Continued)

- *Health Equity Considerations in Rulemaking:*
  - Ensure communications about patients' rights are understandable to all consumers, regardless of English proficiency, health literacy, or socioeconomic background.
  - When balance billing cannot be waived if no in-network provider is available, the content and delivery of patient notices and consent waivers will need attention, particularly for people who live in communities with provider shortages.
  - Ensure that the fee for the dispute resolution process for uninsured individuals is not a barrier, and that the process takes into account the significant structural inequities between the uninsured and providers.

## Opportunities for States to Engage (Continued)

- *Participate in Advisory Boards:*
  - Advisory Committee on Ground Ambulances and Patient Billing.
    - Includes a state insurance regulator representative.
    - Will make recommendations for state policymakers within their authority and for Congress.



# **The COVID-19 Stimulus Package**

# Funding for COVID-19 Vaccines and Testing

The bill allocates federal and state funding for COVID-19 vaccines, testing, and tracing:

\$ Amount	Recipient	Purpose
<b><i>Vaccines and Other Countermeasures</i></b>		
\$22.95 Billion	HHS Public Health and Social Services Emergency Fund	For the purchase of vaccines, therapeutics, diagnostics, necessary medical supplies, and medical surge capacity.
\$8.75 Billion	Centers for Disease Control and Prevention (CDC)	To plan, prepare for, promote, distribute, administer, monitor, and track coronavirus vaccines “to ensure broad-based distribution, access, and vaccine coverage” through September 30, 2024.
\$55 Million	Food and Drug Administration (FDA)	For advanced manufacturing of medical products and the development of medical countermeasures and vaccines (applicable to approximately \$40 million).
<b><i>Testing and Tracing</i></b>		
\$22.4 Billion	HHS Public Health and Social Services Emergency Fund	For COVID-19 testing and contact tracing.

*CDC must distribute at least \$4.5 billion to states, localities, territories, and tribes.*

*All \$22.4 billion must be distributed to states, localities, territories, and tribes within 21 days of the bill’s enactment.*

# Extended Deadline for Coronavirus Relief Fund

The bill extends the date – from December 30, 2020, to December 31, 2021—by which state, local, and tribal governments must incur Coronavirus Aid, Relief, and Economic Security (CARES) Act Coronavirus Relief Fund expenses.



While the extension provides some relief, it may come too late for some states to address the challenges identified in incurring expenses by the end of 2020.



The bill does not provide increased allocations for the Coronavirus Relief Fund or flexibility for states to make up for budget shortfalls and revenue losses (funds may be used only to pay for *new* expenses, those not accounted for in the most recent budget as of March 27, 2020).



States are already considering budget cutting measures, including health care program cuts, making additional state relief critical.

# Provider Relief Fund Policy Changes

The bill adds \$3 billion to the Provider Relief Fund – bringing total funding to \$178 billion – and makes targeted changes to the fund:

## Reporting Requirements

The bill modifies the way Provider Relief Fund payments may be used, offering greater flexibility to providers:

- Unwinds HHS modified definitions of “lost revenue” and reinstates June FAQs that allow recipients to use “any reasonable method” of calculating lost revenues, including comparing year-over-year actual patient care revenues or comparing 2020 budgeted revenues to 2020 actual revenues.
- For payments made to subsidiaries of a parent organization, the parent organization may transfer funds—including Targeted Distribution payments—within the “family.”

## Future Distributions

The bill:

- Specifies that HHS must distribute no less than 85% of the unallocated balance of the Provider Relief Fund and any funds that HHS recovers from providers to eligible providers based on their financial losses and changes in expenses that occurred in the third and fourth calendar-year quarters of 2020, or the first quarter of 2021.
- Ensures providers impacted by COVID-19 later in 2020 or in 2021 will receive a payment acknowledging any losses and expenses they experienced or are experiencing.

Sources: HHS, CARES Act Provider Relief Fund FAQs. Available at <https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf>; HHS, General and Targeted Distribution Post-Payment Notice of Reporting Requirements. Available at <https://www.hhs.gov/sites/default/files/post-payment-notice-of-reporting-requirements-october-2020.pdf>.



# Impact of New Direct Payments and Unemployment Benefits on Eligibility for Financial Assistance

*Unprecedented CARES Act rules apply again; states can deploy similar solutions.*

- Like the CARES Act, the relief package provides both **direct relief payments** and **supplemental unemployment (UI) benefits**.
- The rules for these new payments are **the same as under the CARES Act**:
  - The direct relief payments (generally \$600/family member, phasing out at higher incomes) are **excluded** from income for all purposes.
  - The supplemental UI payments (generally \$300/week through March 14) are **excluded** from income for Medicaid and CHIP purposes and **included** for APTC, PTC, and other tax purposes.
- As with the CARES Act, these rules may create **operational and communications challenges** for states since Medicaid and APTC normally use the same income concept.
- CARES Act responses will likely carry over – let us know if we can help.

For additional information, see [www.shvs.org/cares-act-unemployment-insurance-expansion-and-stimulus-payments-considerations-for-states](http://www.shvs.org/cares-act-unemployment-insurance-expansion-and-stimulus-payments-considerations-for-states).

## Looking Ahead

The COVID-19 stimulus agreement is also notable for provisions that are not included and which may be revisited by the Biden Administration and Congress.

- States and stakeholders have lobbied Congress to replenish the state and locality Coronavirus Relief Fund.
- States continue to seek an increase in the enhanced Federal Medical Assistance Percentages (FMAP) that applies for the duration of the public health emergency (PHE) and to extend it beyond the PHE.
- States are increasingly looking to extend coverage for postpartum women eligible for Medicaid on the basis of their pregnancy (from 60 days to 12 months).



Democrats and the incoming Biden-Harris Administration are likely to revisit COVID-19 stimulus legislation post-inauguration to address these concerns. Support for another large legislative package may be possible with Democrats in control of the presidency and both chambers of Congress.

Source: The Biden Plan to Combat COVID-19 and Prepare for Future Global Health Threats. Available at <https://joebiden.com/covid-plan/>.



## **Other Key Health Care Provisions**

# Medicaid Health Care Extenders

In addition to Medicare and public health extenders, the bill includes funding through FY 2023 for the following Medicaid programs:



## ***Money Follows the Person Rebalancing Demonstration***

- Extends funding for the demonstration (\$450 million per year through FY 2021).
- Makes minor program adjustments (e.g., application updates, new program reports).



## ***Spousal Impoverishment Protections***

- Extends through 2023 protections that allow states to disregard individuals' spousal income and assets when determining eligibility for Medicaid home and community-based services (HCBS).



## ***Community Mental Health Services Demonstration***

- Extends the program, which provides eight participating states with enhanced funding to improve behavioral health services through Certified Community Behavioral Health Clinics.

# Delay in Medicaid DSH Allotment Reductions and Supplemental Payment Reporting Requirements

## Medicaid DSH Allotment Reductions and Medicaid Shortfall and Third-Party Payments

### The Changes:

- Eliminates Medicaid DSH allotment reductions in FY 2021 and delays the remaining four years of cuts from taking effect until FY 2024.
- Modifies the maximum amount of Medicaid DSH payments an individual hospital may receive by redefining what costs are included when calculating one component of hospital-specific DSH limits—Medicaid shortfall.
  - Rather than focus on whether payments for individuals with third-party coverage should count in the hospital-specific DSH limit calculation, the bill omits from the calculation costs for Medicaid-eligible patients with third-party sources of coverage where the third-party source of coverage is the primary payer.

**The Impact:** Hospitals that treat high volumes of patients with Medicaid and third-party coverage will report less Medicaid shortfall (thereby lowering their individual hospital DSH cap), and the distribution of Medicaid DSH payments among hospitals in certain states will be impacted (in states that use calculations of uncompensated care, which includes Medicaid shortfall, to distribute payments).

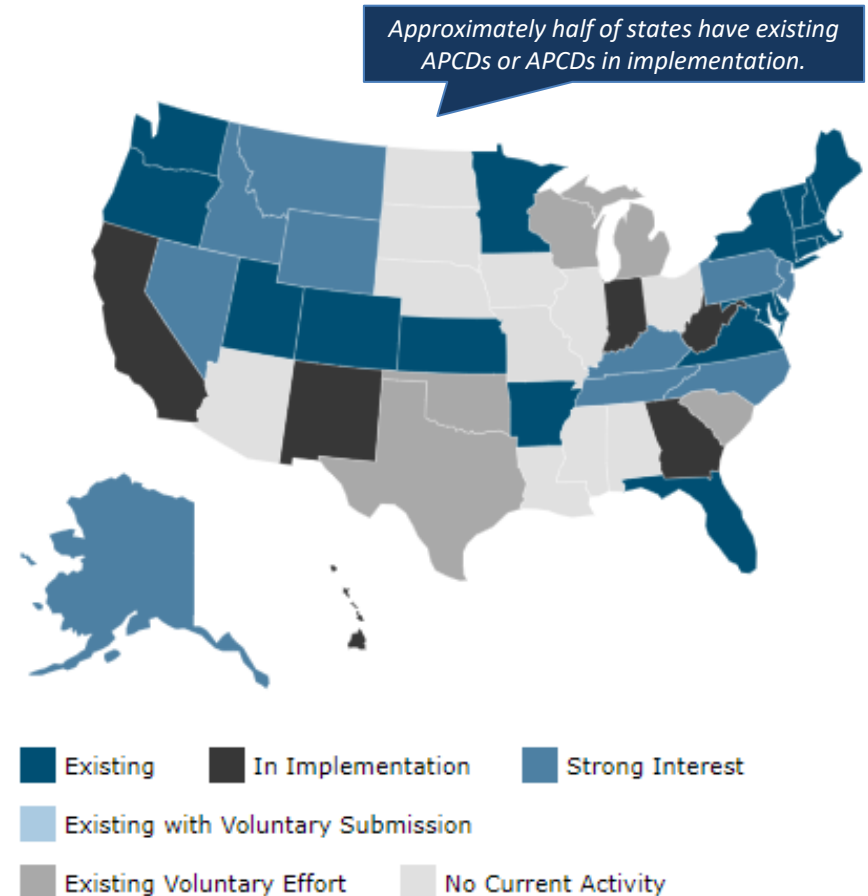
## Supplemental Payment Reporting Requirements

**The Change:** Establishes new requirements on states to report Medicaid supplemental payments (narrowly defined; e.g., does not include directed payments in managed care or DSH).

**The Impact:** Supplemental payments will remain a hot-button issue for many federal policymakers and increased transparency through required reporting may lead to future policy changes.

# Federal Support for State-Based All Payer Claims Databases (APCDs)

- Every state is entitled to \$2.5 million over three years to start or improve state-based APCDs.
- Federal regulators are charged with developing a reporting format for self-insured employers to report claims data to states that opt in.
- The bill includes requirements for APCDs to make aggregate data sets available for free and customized data sets at no cost to researchers, providers, payers and other users; and creates incentive for states to develop multi-state applications for users seeking data.



Source: APCD Council, Interactive State Report Map. Available at <https://www.apcdouncil.org/state/map>.

## Other Notable Medicaid Provisions

- **Coverage of NEMT:** Makes NEMT a mandatory benefit through statute for enrollees who lack access to regular transportation; establishes some guardrails around the new benefit (e.g., provider requirements, directing the Medicaid state plan to provide for methods and procedures to prevent unnecessary utilization); and authorizes states that utilize NEMT brokerage programs to consult stakeholders in establishing their programs.
- **Coverage for Citizens of Freely Associated States:** Eliminates the five-year bar on Medicaid eligibility for citizens of the freely associated states (i.e., Micronesia, Marshall Islands, and Palau) who are legally residing in the United States, helping to address a coverage gap exacerbated by the COVID-19 pandemic.
- **Fraud Control Unit (MFCU) Authority:** Authorizes MFCUs to investigate fraud and abuse in non-institutional settings, enhancing protections for enrollees receiving HCBS.
- **Coverage of Clinical Trials:** Covers routine items and services provided in connection with participation in a qualifying clinical trial. Investigational items and services that are not otherwise covered outside of the clinical trial are not included (but would presumably be paid as part of the trial).

# Discussion

The slides and a recording of the webinar will be available at [www.shvs.org](http://www.shvs.org) after the webinar





# Thank You

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