



The No Surprises Act

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Disclaimer

The following material was prepared by the Commonwealth of Pennsylvania's Insurance Department, based on the law, regulations, and guidance available as of December 1, 2021. For further details, please refer to the No Surprises Act and its regulations in their entirety.

The really important things to you...

- ▶ The Disclosure requirement applies to all “health care providers.”
- ▶ The Provider Directory requirement applies to all “health care providers.” (Applicable only to providers who are in network for major medical insurance policies.)
- ▶ The Good Faith Estimate requirement applies to all “health care providers.”

Which Facilities and Services must follow the No Surprises Act?



Emergency Air
Ambulance Services



Emergency
Facility/Provider
Services



Emergency Ground
Ambulance Services
*This is deferred for
further Study



Non-Emergency Services
in connection to a visit
at the facility

- Facilities
Include at least:
- Hospital
 - Hospital
Outpatient
Department
 - Ambulatory
Surgical
Center

Which Health Plans Must Follow the No Surprises Act?

Surprise billing protections apply if you get your coverage through:

- Your employer (including a federal, state, or local government)
 - Our state-based Marketplace, Pennie
 - Directly through an individual market health insurance company.
- ❖ The Act does not apply to people with coverage through programs such as Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE. These programs have other balance billing protections.

What about those with other health plans?

Participants in the following plans do not have the balance billing protections:

- ▶ Indemnity or excepted benefit plan enrollees
 - ▶ It is not “individual market” coverage
 - ▶ It does not typically have a network
- ▶ Short-term limited duration plan enrollees
 - ▶ It is not “individual market” coverage
- ▶ Healthcare sharing ministry or Amish participants
 - ▶ It is not “individual market” coverage
- ▶ Individuals with no health care coverage at all

What if an individual is uninsured?

- Individuals who pay for health care services themselves will get bills from all providers.
- Providers are required to provide a good faith estimate upon request or upon scheduling an item or service.

What is a good faith estimate?

- At this time, the regulations have been finalized so that at least uninsured/self-pay Patients will get a timely good faith estimate.
- Timing:
 - A good faith estimate must be provided at least 72 hours (3 days) before a service is furnished.
 - If a service is scheduled within 3 days, the good faith estimate must be given at least 3 hours ahead of time.
- The Act does require that a good faith estimate be provided to a Patient's Plan in advance of a service. However, due to the technological challenges of effecting this provision, the federal government is currently taking a non-enforcement approach to this provision, as is Pennsylvania.
- Providers are encouraged to coordinate with Co-Providers to present a single good faith estimate, but HHS is exercising enforcement discretion/flexibility to allow for the technological coordination this may require.



Providers

Facilities, Health
Care Practitioners, Air
Ambulance Service



Which Providers May Not Balance Bill?

- Emergency room providers
- Anesthesiologists
- Pathologists
- Radiologists
- Neonatologists
- Assistant surgeons
- Hospitalists
- Intensivists
- Diagnostic services (incl. radiology and laboratory)
 - Does not include “advanced diagnostic laboratory tests” as identified by HHS
- Other specialty items or services as identified by HHS
- Any service provided by an out-of-network provider if no in-network provider was available at the facility
- Urgent services that arise during a service for which notice & consent was provided

What about Provider Directories?

- Providers and Facilities:
 - Must have a business process to give provider directory and network information to Plans any time there is a material change.
 - May by contract impose on Plans the duty to keep directory current in event of contract termination.
 - If a Provider/Facility bills patient more than in-network cost-sharing amount, and Patient pays, the Provider/Facility must reimburse Patient plus interest.

What about Continuity of Care?

- Providers and Facilities:
 - If a contract with a Plan terminates so that the Provider/Facility is no longer in-network,
 - And if the Patient is a “continuing care patient”, i.e., being treated for a “serious and complex condition” (scheduled nonelective surgery, pregnancy, terminal illness),
 - Then the Provider/Facility must:
 - Accept payment, including cost-sharing, calculated on an in-network basis for duration of continuity of care situation

If a Provider has a complaint about a Plan, where should the Provider go?

- The Provider should contact the Pennsylvania Insurance Department (PID). The PID has a process set up to quickly review the complaint and make sure it is handled in the best way possible.
- The Provider may also go to HHS, which is establishing a complaint process, with acknowledgement of the complaint possibly taking 60 days from receipt.

If a Provider has a complaint about a Patient, where should the Provider go?

- It is possible the Patient may not understand the Act, so the Provider is encouraged to contact the PID in these situations.
- If the Provider is confident that the Patient does understand the Act, the Provider should handle this as they did before the Act, but with the understanding that in the case of a surprise medical bill, the Provider may not collect from the Patient more than the in-network cost-sharing.

Provider and Facility Disclosure Requirements

- The No Surprises Act requires certain health care providers and facilities to provide patients with a one-page disclosure notice on:
 - The requirements and prohibitions applicable to the provider or facility regarding balance billing.
 - Any applicable state balance billing prohibitions or limitations.
 - How to contact appropriate state and federal agencies if the patient believes the provider or facility has violated the requirements described in the notice.
- This information must be publicly available from the provider or facility, too.
- PID has a Model Notice available for use in PA
- <https://www.cms.gov/nosurprises/Policies-and-Resources/Overview-of-rules-fact-sheets>



Provider Notice and Consent Requirements

For those Providers not prohibited from balance billing, they may do so if:

- The Provider gives notice and get written consent from the patient.
- Given at least 3 days before service, and not later than 1 business day after scheduling, or 3 business days after scheduling if scheduled at least 10 days in advance.
 - May not be used in an emergency situation.
- The Notice and Consent must be on a separate document, using the HHS form.
- The signed Consent must be retained for 7 years, and a copy given to the patient.

What must the Notice and Consent Explain?

- That the Provider does not participate with the Consumer's healthcare coverage plan (the Plan).
- The good faith estimated amount the Provider may charge the person for all services that would reasonably be included.
 - Include related services expected to be provided by another provider or facility, with expected billing and diagnostic codes
- Notice that the service might need to be authorized or otherwise approved by the Healthcare Plan.
- Clearly state that signing the Notice is **optional**; a person does not have to consent.
- Clearly state that the person may get the service from an available in-network Provider.

How will the Provider receive payment?

- First, confirm the Patient's coverage. If it is individual or group coverage subject to the Act, then ...
- If an out-of-network Provider furnishes a surprise medical service:
 - The Provider may collect cost-sharing from the Patient.
 - The amount of the cost-sharing must be at the in-network level.
 - The Provider must bill the Patient's Plan for all remaining charges.
 - The Plan must pay the Qualifying Payment Amount (QPA).
 - If the Provider is not satisfied with the QPA, the Provider and the Plan may negotiate, either directly or through the federally administered Independent Dispute Resolution Process.

How will the Provider receive payment from the uninsured/self-pay individual?

- If the individual is uninsured or self-pay, then ...
 - The Provider may bill the Patient.
- ▶ If the individual has a dispute with a Provider:
 - ▶ They may use a Patient Provider Dispute Resolution Process that the federal government (HHS) is setting up.
 - ▶ The Patient Provider Dispute Resolution Process uses a Selected Dispute Resolution (SDR) entity to decide the claim.
 - ▶ To be eligible to use this SDR process, the total charges must be at least \$400 more than the good faith estimate.
 - ▶ The uninsured Patient must access the process within 120 days of receiving their first bill.
 - ▶ The uninsured Patient will need to pay a small administrative fee to start the process. This fee is expected to be no more than \$25, which will be refunded if the Patient wins.

Enforcement

For concerns related to the No Surprises Act:

- Contact the PID at www.insurance.pa.gov/nosurprises
 - The PID is the Commonwealth agency coordinating enforcement with state agencies that have oversight over Providers, including Facilities. The PID has a process set up to quickly review the complaint and make sure it is handled in the best way possible.
 - The PID has oversight over insurance companies.
 - The PID will work collaboratively with other state agencies to coordinate enforcement efforts as necessary.
- You may use the federal complaint process, though response time will likely be delayed.

State Oversight Authority

- General Standard: State law applies unless it “prevents the application” of the federal law.
- PA state agencies will exercise their responsibilities to protect Pennsylvanians primarily through laws regulating:
 - Insurance
 - Professional conduct
 - Licensure

Reporting to the Insurance Department

- ▶ When a State Agency receives a call related to balance billing and the No Surprises Act, they can visit our webpage for the guidance needed to assist the Patient.
- ▶ Included on the page is a No Surprises Act Referral Form with necessary questions to ask while the Patient is on the phone.
- ▶ Once the information is received, the State Agency may complete the form and the PID will review and follow-up as appropriate.

Once a Complaint is Received....

- ▶ It will be assigned to a consumer services representative and uploaded for tracking
 - ▶ The complaint will be marked as "No Surprises"
- ▶ The representative will complete outreach to obtain necessary information
- ▶ The outreach will potentially be to:
 - ▶ Patient,
 - ▶ Provider,
 - ▶ Health Plan
- ▶ The representative will work with the other state agencies if determined in the investigation their regulated entity may have acted inappropriately

Coordination with Federal Enforcement

- PA will collaborate with federal agencies to coordinate enforcement efforts as necessary and appropriate:
 - HHS (for insurance plans and providers/facilities)
 - DOL (for self-funded plans)
 - Office of Personnel Management (for Federal Employee Health Benefit Plan)
- The Federal government will enforce if the state is unable to or lacks authority.
 - The Federal government and state government will collaborate to enforce where appropriate.

Our Webpage

- ▶ www.insurance.pa.gov/nosurprises
- ▶ The webpage includes:
 - ▶ A description of the No Surprises Act.
 - ▶ Information related to Patient, Provider and Health Plan roles.
 - ▶ A link to the reporting form.

The PA Insurance Department Is Here to Help

- ▶ To learn more about the No Surprises Act or to submit a complaint form visit www.insurance.pa.gov/nosurprises
- ▶ You can also call our Consumer Services Bureau at 1-877-881-6388.