The No Surprises Act

December 2021

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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.

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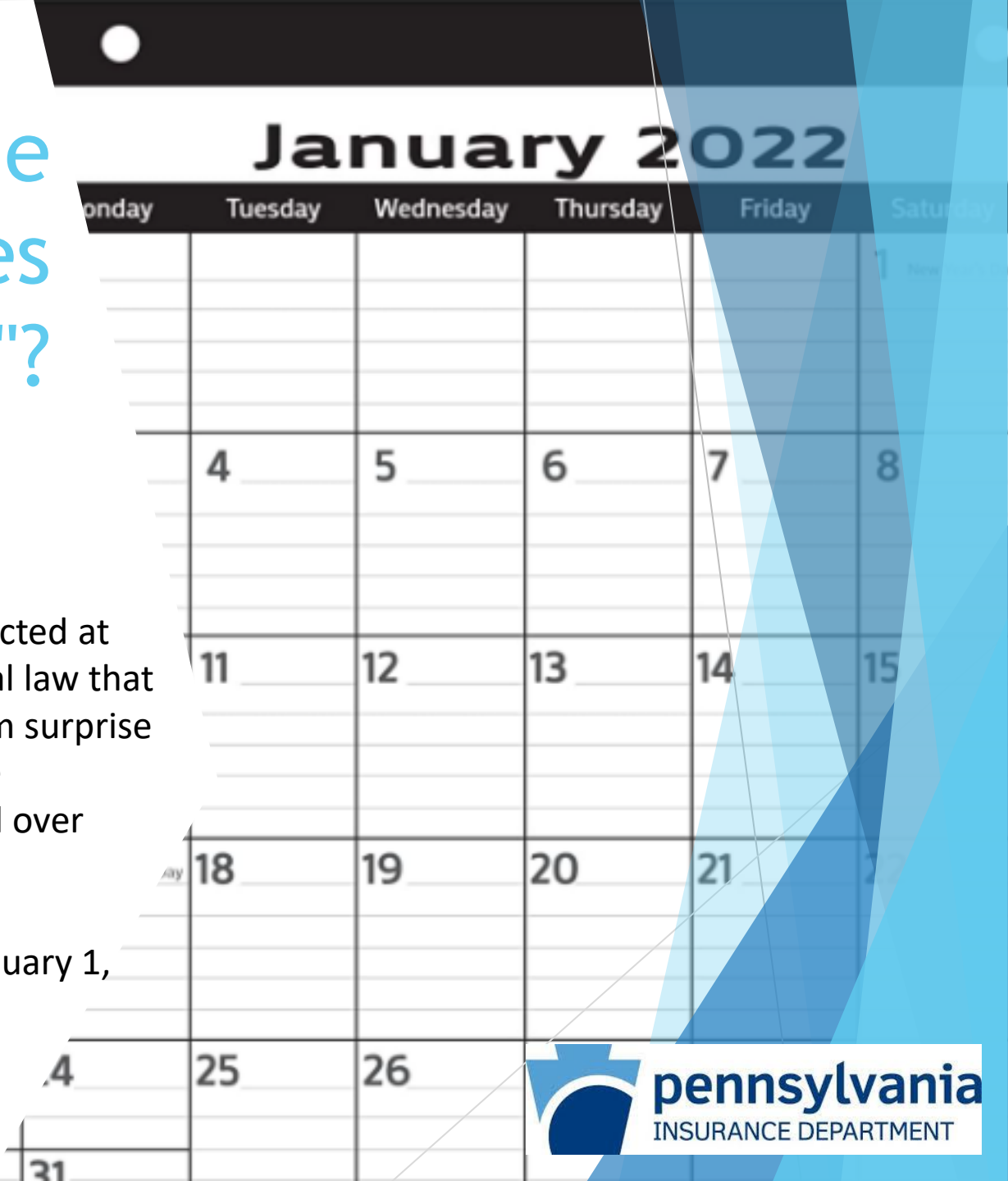
What is the "No Surprises Act"?



The No Surprises Act (NSA), enacted at the very end of 2020, is a federal law that seeks to protect consumers from surprise medical bills in situations where patients have little or no control over who provides their care.

This new law takes effect on January 1, 2022.

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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:

- Hospitals
- Hospital Outpatient Departments
- Ambulatory Surgical Centers

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What does the "No Surprises Act" do?

If a health plan covers any benefits for emergency services, including air ambulance, the No Surprises Act requires emergency services to be covered:

- Without any prior authorization.
- Regardless of whether a provider or facility is in-network.

If a health plan covers any benefits for non-emergency services related to a visit in an in-network facility, the No Surprises Act requires that patients are protected when they have little or no control over who provides their care.

- Certain ancillary providers, such as labs or doctors involved in a surgery that the patient does not select, may not balance bill under any circumstance.
- Cost-sharing for care by those ancillary providers is treated as in-network.

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What does the "No Surprises Act" do? Cont...

- The No Surprises Act protects people:
  - From unexpected bills for emergency services, air ambulance services, and certain non-emergency services related to a visit to a facility.
    - Non-emergency services for some ancillary care (like an anesthesiologist or assistant surgeon) at an in-network facility is treated as in-network in all circumstances
    - Other non-emergency services may only be billed as out-of-network with advance notice and consent from the patient
  - Limits high out-of-network cost sharing in these situations:
    - Patient cost-sharing, such as coinsurance or a deductible, cannot be higher than if such services were provided by an in-network doctor, and any cost-sharing must be based on in-network provider rates.

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What does the "No Surprises Act" do? Cont...

- The No Surprises Act also requires certain health care providers and facilities to provide patients with a one-page 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.

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Which Health Plans Must Follow the No Surprises Act?

Surprise billing protections apply if the consumer gets coverage through:

- Their 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.

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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

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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

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Health Plans

Insurance Companies, Self-funded Plans, Federal Employees Health Benefit Plan

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If a Health Plan receives a bill from an out-of-network Provider...

- If a Health Plan receives a bill from an out-of-network Provider for a service subject to the Act, the Plan must pay the Provider rather than the Patient
  - The Plan must pay the Provider directly.
- A Plan may not require that an emergency service be subject to prior authorization.
- A Plan may not make a decision on coverage of an emergency service based on the diagnosis code after the Patient is evaluated by the Provider.
  - An emergency service is determined from the Patient's perspective when they present to the Provider: whether a prudent person with average knowledge would reasonably expect that without immediate care, they would be placing their health (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or serious impairment to bodily functions, or serious dysfunction of a bodily organ or part.
  - Emergency services also include appropriate emergency room screening and post-stabilization services, as long as the post-stabilization services are covered by the Patient's Plan.

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If a Health Plan receives a bill from an out-of-network Provider...

- A Plan must pay the full amount of a Provider's bill for a surprise medical service -
  - If the service is covered, a Plan must pay an initial amount within 30 days.
  - The regulations provide detailed rules about payment amounts, depending on whether the service was an emergency service, a non-emergency service, or an air ambulance service.
- The Patient is responsible for cost-sharing for a surprise medical bill -
  - The Patient is responsible for the in-network cost-sharing amount for the bill.
  - The Provider must bill the Patient's Plan for all remaining charges.

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What if a Health Plan receives a bill but thinks the service was not protected by the Act?

- The Plan may deny the bill, which will trigger the start of a 30-day period during which the Provider may trigger the 30-day open negotiation period.
- In addition, a Provider may work with a Patient to follow the Plan's adverse benefit determination processes. A Plan will in most cases need to provide an External Review process if the Plan claims that the Act does not give the Patient protection from a surprise medical bill.

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Cost Sharing

The Plan must credit the Patent's cost-sharing payment for the surprise medical service against the Patient's in-network deductible and maximum out-of-pocket expense calculation?

- The Patient is to be treated as they would if the Provider had been in-network.

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Is the Health Plan Required to provide in-network cost-sharing information to the Provider?

- The Plan should provide the cost-sharing information, because the Patient may not be required to pay the Provider more than the appropriate cost-sharing as if the Patient had gone to an in-network provider.
  - The amount of cost-sharing is based on the “recognized amount”, which is the lesser of the QPA or the billed charges.

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What if the Provider did not get Consent to balance bill and is not satisfied with the Qualifying Payment Amount (QPA)?

The Provider and Plan have 30 business days to trigger an open negotiation period, beginning on the day the Provider gets the initial (QPA) payment or a denial of payment.

- A form developed by HHS must be used.

- The open negotiation period lasts for 30 days, beginning when the notice of triggering it is sent.
- If the Provider and Healthcare Plan do not reach an agreement, either party may trigger an IDR process.
- The IDR process must be triggered in the 4 days beginning on the 31st day after the open negotiation period was triggered (i.e., the 4 days after the open negotiation period).
  - A form developed by HHS must be used.
- The parties each submit an administrative fee (to be determined by HHS) at the beginning of the IDR process, and the prevailing party will have it refunded.

- HHS has an extensive process laid out for the IDR process.
  - It is baseball-style; each party submits an offer, with additional information.
  - The IDR entity will pick the offer closest to the QPA unless credible information demonstrates that the other offer best represents the value of the service.
  - The IDR entity will provide a written decision.

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Additional IDR Questions...

- Batching similar claims for the IDR process is permitted if the claims:
  - Involve the same Provider and same Plan
  - Are for the same or similar services
  - Are furnished within a 30-day period
    - If a prior IDR decision was rendered on like claims, there is a 90-day suspension period before the 30-day period may begin
- The IDR determination is not appealable.

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Will the Health Plan get a good faith estimate of any anticipated charge by the Provider?

- 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.
  - Technology permitting, a good faith estimate must be provided at least 72 hours (3 days) before a service is furnished.
  - Technology permitting, if a service is scheduled within 3 days, the good faith estimate must be given at least 3 hours ahead of time.
- At this time, the regulations have been finalized so that **at least uninsured/self-pay Patients** will get a timely good faith estimate.
- 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.

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Where to go with questions under the Act?

- Contact the PID @ www.insurance.pa.gov/nosurprises
  - The PID is the Commonwealth agency coordinating enforcement with state agencies that have oversight over Providers. The PID has a process set up to quickly review the complaint and make sure it is handled in the best way possible.
  - The Plan may also file a complaint about a Provider with HHS, with acknowledgement of the complaint possibly taking 60 days from receipt.
- 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.

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What if a Health Plan has a complaint against a Provider?

- The Plan 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 Plan may also go to HHS, which is establishing a complaint process, with acknowledgement of the complaint possibly taking 60 days from receipt.

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What about Continuity of Care?

- Health Plan
  - If a contract 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 Plan must:
    - Provide the Patient with the ability to elect transitional care
    - Permit the Patient to continue care on in-network basis for 90 days or until the Patient is no longer a continuing care patient.

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What about Provider Directories?

- Health Plans:
  - Must have verification process for provider directory database at least every 90 days, and within 2 days of receipt of information from provider/facility
  - Must respond to enrollee inquiry within 1 business day
  - Print directory must reference database
- Providers/Facilities:
  - Must have process to provide timely provider directory information to health plans

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Enforcement

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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.

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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

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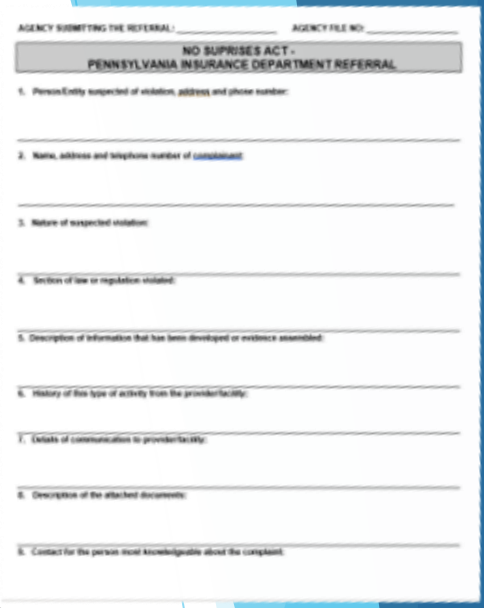
Reporting to the Insurance Department


AGENCY SUBMITTING THE REFERRAL: _____ AGENCY FILE NO: _____

NO SUPRISES ACT -
PENNSYLVANIA INSURANCE DEPARTMENT REFERRAL

1. Person/Entity suspected of violation, address and phone number:

2. Name, address and telephone number of complainant:

3. Nature of suspected violation:

4. Section of law or regulation violated:

5. Description of information that has been developed or evidence assembled:

6. History of this type of activity from the provider/facility:

7. Details of communication to provider/facility:

8. Description of the attached documents:

9. Contact for the person most knowledgeable about the complaint:

- 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 forward the document to (RA Account in development) for the PID to review and follow-up as appropriate.

** *The form is in the process of being finalized*

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Once the Complaint is Received....

- The reporting form 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

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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 is currently in development. The page will include:
  - A description of the No Surprises Act.
  - Information related to Patient, Provider and Health Plan roles.
  - A link to the reporting form.

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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.

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