No Surprises Act Overview and FAQ

On Dec. 27, 2020, Congress passed, and President Trump signed, the No Surprises Act as part of the Appropriations bill. The No Surprises Act, which is a law not guidance, goes into effect for plan or policy years beginning on or after Jan. 1, 2022.

The surprise billing legislation establishes federal standards to protect patients from balance billing for defined items and services provided by specified doctors, hospitals and air ambulance carriers on an out-of-network basis. The federal law applies to individual, small group, and large group fully insured markets and self-insured group plans including grandfathered and transitional relief plans. The legislation caps patient cost-sharing for out-of-network items and services at in-network levels and requires providers to work with insurers and health plans to negotiate remaining bills. If the insurer/health plan and the provider are unable to reach agreement, an Independent Dispute Resolution (IDR) process, sometimes called arbitration, was established to determine the reimbursement amount.

There are federal rules and processes yet to be developed, and questions about scope and applicability as it relates to state laws still to be answered. We will continue to update our customers as more is known.

What is the benefit of the No Surprises law? New 2/17

Consumers will be protected from surprise medical bills when they receive out-of-network care in both emergency and nonemergency settings; the protections extend to out-of-network emergency air ambulances. As a result, patients will be protected from surprise bills in situations where they have little or no control over who provides their care.

However, patients are not protected from balance billing where they have a choice of services including where services are provided by an out-of-network provider at an out-of-network facility or place of service. In addition, it does not protect patients from balance billing for ground ambulance services.

How does No Surprises help protect a consumer? New 2/17

Patients are protected from surprise medical bills for nonemergency services provided at an in-network facility but by an out-of-network provider.

For example, today a patient might receive a surprise bill from a nonemergency out-of-network provider that provides ancillary services, such as those delivered by a radiologist, anesthesiologist, or pathologist, or a medical professional that provides specialty services needed to respond to unexpected complications, such as those delivered by a neonatologist or cardiologist.

Under the law, beginning plan or policy years on and after January 1, 2022, consumers will be protected from surprise medical bills in situations where they have little or no control over who provides their care and they have not signed a statement acknowledging that they are aware the additional charges.

For ancillary services no balance bill is ever allowed. However, there is an exception for certain non-ancillary services at an in-network facility where the provider informs the patient in advance that they are out-of-network and gives them an estimate of the charges.

Which plans are included, and which plans are excluded from the No Surprise Law? New 2/17

The federal law applies to individual, small group, and large group fully insured markets and self-insured group plans including grandfathered plans and transitional relief plans. Coverage offered through an Exchange and for federal employees through the Federal Employees Health Benefits Program is also covered by the surprise billing law.

Excepted benefits and short-term limited duration insurance are excluded.

What are some of the key features that are in the No Surprises law? New 2/19

The No Surprises Act is a law establishing federal standards to resolve surprise bills for the fully insured individual, small group, and large group markets and for self-insured group plans including grandfathered and transitional relief plans for plan and policy years beginning on and after January 1, 2022. The law applies to emergency services at out-of-network (OON) hospitals and free-standing emergency facilities, OON providers at in-network (INN) facilities, and OON air ambulance carriers.

The No Surprises Act establishes an Independent Dispute Resolution (IDR) process, also referred to as arbitration, to resolve disputes between OON providers and insurers/health plans and prohibits balance billing by OON providers with certain exceptions. The law does not apply if the member chooses to receive items and services from an OON provider.

The Departments of Health and Human Services, Labor, and the Treasury will clarify some of important provisions of the No Surprises Act though rulemaking later this year.

Are there different requirements or approaches for UMR? New 2/17

The self-funded medical benefit plans for UMR are also covered.

How does the No Surprises Act work if member has a high deductible plan with an HSA? New 2/17

An individual shall not be disqualified from contributing to a health savings account because the individual receives out-of-network benefits covered by the surprise billing provisions.

Also, a high deductible health plan is not disqualified from being used in conjunction with a health savings account because it provides coverage for out-of-network benefits covered by the surprise billing provisions.

If a plan year starts on Dec. 1, 2021 will the No Surprises Act impact them on 1/1/22 or on renewal 12/1/22? New 2/22

The law is effective for policy and plan years on or after January 1, 2022. Therefore, if a plan renews during 2022, No Surprise Act will go in on the renewal date.

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How does the No Surprises Act work if member has a high deductible plan with an HSA? New 2/22

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What providers and facilities does the No Surprise Act apply to? New 2/25

No Surprises Act applies to three types of health care providers and facilities:

1. OON emergency covered items and services at a hospital or independent, free standing facility.
2. Covered medical items and services performed by an OON provider at an INN facility.
3. OON emergency air ambulance items and services.

How are emergency services handled? New 2/25

Under No Surprises Act, like the ACA, emergency services are defined as those a prudent layperson would consider an emergency. This includes coverage for items and services such as medical screening and ancillary services routinely available to evaluate the emergency medical condition to stabilize the patient and transfer them to an INN facility or home.

The Act also includes additional services provided by an out-of-network provider or facility as part of an out-patient observation or inpatient or out-patient stay with respect to the emergency services visit if the benefits would be otherwise covered.

If the provider determines there is not an emergency and the patient may be balanced bill, then

- The provider or facility must determine the individual can travel using nonmedical transportation or nonemergency medical transportation.
- The provider must furnish the notice that the additional items/services are out-of-network and the cost and receive acknowledgement.
- The individual must be in a condition to acknowledge the notice.

What is a qualifying payment amount? New 2/25

Member cost-sharing and IDR determinations are based in part on the "qualifying payment amount".

- Qualifying payment amount is the median contract rate for the item or service. The qualifying payment amount is established for all OON coverage offered by an insurer in the specified market and for all plans of a group plan sponsor.
- The amount is determined based on the individual, small or large group insured market and self-insured market with some variations by geography. The NAIC will be consulted on the establishment of geographic regions.

- The median contract rate is determined based on the amount paid by the insurer/health plan for a covered OON item or service on January 1, 2019. A cost-of-living adjustment is applied using the Consumer Price Index for all Urban Consumers (CPI-U).

  A methodology, yet to be established, will determine the median contract rate in cases where the items and services are newly covered by an insurer/health plan or where there is a new insurer/health plan in that market.

How are prior authorization, coverage limits, and member cost-sharing treated for OON services subject to the No Surprises Act? New 2/22

Insurers/health plan are prohibited from requiring prior authorization for OON emergency services and may not apply coverage limitations for OON emergency services that are more restrictive than those for INN services.

Insurers/health plans cannot apply cost sharing for OON covered items and services that is greater than cost-sharing applied to INN covered items and services (e.g., 10% coinsurance for same INN and OON covered items and services). All OON cost-sharing must be counted toward any INN deductible and cost-sharing limits.

What do payers have to do when they receive a bill for OON services covered by the No Surprises Act? New 2/22

Insurers/health plans have 30 days after they receive a bill to either pay the "out-of-network rate" directly to the provider or deny the claim. The out-of-network rate is the difference between the member's cost-sharing amount and the following:

- If the insurer/health plan and OON item or service is covered by a state law that establishes the reimbursement rate, that rate will apply.
- If the state does not have an applicable law, either the amount agreed to by the insurers/health plan and provider or the amount set by the IDR process.
- If the state has an All-Payer Model Agreement, the reimbursement is set by that agreement.

Who can request an Independent Dispute Resolution (IDR)? New 2/22

Either an insurer/health plan or a provider may request independent dispute resolution. There is a 30-day negotiation period to resolve disputes over reimbursement for OON covered items and services. The negotiation period starts after the provider receives payment or a claim

denial as discussed above. Four days after the end of the 30-day negotiation period, either the insurer/health plan or the provider can request an IDR.

How does the IDR process work? New 2/22

The law includes a measure to have insurers/health plans and providers first try to resolve any payment differences through negotiation on their own. If negotiation does not work, either party may request IDR process, which is a form of arbitration.

- Both the insurer/health plan and the provider will submit an offer along with any documentation supporting their position to the IDR entity, which will choose between them.
- In choosing either the insurer/health plan or provider offer, the IDR can consider certain factors such as the median contracted rate for the disputed items and services, the provider's market share, the provider's training and qualifications, and the severity of the patient's condition.
- When making a decision, the IDR entity cannot consider government program rates (Medicare, Medicaid, Tricare), provider billed charges or usual and customary charges.

Who are the IDR entities/arbitrators? New 2/22

They have not been announced yet. We expect this to be finalized and communicated before Dec. 27, 2021.

Can the health plan choose who they want or do not want as IDR? New 2/22

The law allows payer and provider to pick and agree on the IDR entity, otherwise HHS will choose.

How are IDR entities compensated? New 2/22

Whoever's offer is not selected pays the IDR entity. Other litigation costs such as negotiation or administration costs would be paid by the party incurring them.

Is there a minimum threshold requirement to request dispute resolution? New 2/22

There is no minimum claim threshold.

Can claims be batched when requesting dispute resolution? New 2/22

Claims that are related to the original OON covered items and services that were furnished by the same provider within a 30-day period may be combined for purposes of dispute resolution.

Does the No Surprises Act prohibit balance billing? New 2/22

Yes, in certain cases it may. OON providers are prohibited from balance billing members for emergency services. OON providers at INN facilities are prohibited from balance billing members with certain exceptions.

OON providers of ancillary services at an INN facility are prohibited from balance billing members. Ancillary services are defined by the No Surprises Act as those related to emergency medicine, anesthesiology, pathology, radiology, neonatology, and laboratory and in situations where an INN provider is not available at the INN facility to provide the services.

An OON provider at an INN facility may balance bill members if they are not providing ancillary services and if they give advance notice to the member that the covered item or service is OON and the estimated cost. The member must acknowledge that they received the notice.

Can ancillary providers balance bill? New 2/22

No. An OON ancillary provider providing services at INN facility cannot balance bill.

Which providers are considered ancillary? New 2/17

Ancillary services are defined by the No Surprises Act as those related to emergency medicine, such as RAPL (radiology, anesthesiology, pathology, lab) neonatology, and laboratory and specialty services needed to respond to unexpected complications such as those delivered by a neonatologist or cardiologist and also in situations where an INN provider is not available at the INN facility to provide the services. Ancillary providers may not balance bill ever.

What notice or acknowledgements are required for non ancillary provider to balance bill? New 2/17

OON providers of “non-ancillary” services at INN facilities must provide notice to members in order to balance bill for OON items/services.

If the member schedules an appoint at the INN facility at least 72 hours in advance the notice must be provided no later than 72 hours in advance. If the member schedules the appointment within 72 hours the notice must be provided when the appointment is made.

The notice must disclose that the item/service is not covered, the estimated charges for the item/service, that the member is not obligated to use an OON provider for the item/service, and whether there are INN providers at the facility who can provide the item/service.

The member must sign an acknowledgement that they received the notice and understand that any cost-sharing will be applied toward their OON deductible and cost-sharing limits. By receiving the acknowledgement, the member has not agreed that they will pay those estimated charges.

What are timing requirements before going to IDR/arbitration? New 2/22

1. Provider submits bill to insurer/health plan for OON service.
2. No later than 30 days after bill submission–Insurer/plan makes payment to the provider or facility or denies claim.
3. 30-day negotiation period after payment/ claim denial.

   Insurer/plan negotiates with provider if there is a disagreement about the reimbursement amount.
4. 4 days after end of negotiation period–either insurer/health plan or provider may request IDR by submitting notice to HHS and other party.

   HHS or parties select IDR entity.

   Insurer/health plan and the provider can continue negotiation during IDR
5. 10 days after IDR entity selection insurer/health plan and provider submit offer and supporting documentation to IDR entity.
6. 30 days after IDR entity selection–IDR entity chooses insurer/health plan or provider offer and notifies parties.
7. Any payments must be made no later than 30 days after IDR decision.

How does the balance billing notice provision work? New 2/22

OON providers at INN facilities that are providing “non-ancillary services” must provide advance notice to members that the services are OON and a good faith estimate of the cost. If the member makes an appointment for the OON services at least 72 hours in advance, the notice must be provided no later than 72 hours before the date of service. If the member schedules

the appointment within 72 hours of the date of service, the notice must be provided on the date of service.

The notice may be in writing or electronic at the option of the member. The notice must include the following information:

- That the provider is out-of-network.
- Good faith estimates of the cost for any items and services.
- Consent to obtain OON items and services is voluntary.
- That the member may choose to receive the items or services from an INN provider.
- If applicable, identify INN providers at the facility who can provide the items or services.
- Information about whether prior authorization may be required.

The member must sign an acknowledgement that they received the notice and understand that any cost-sharing will apply to the member's OON deductible and cost-sharing limits and that they will be responsible for any balance bill

Will the law apply if a member chooses to use an out-of-network provider? New 2/22

No. The No Surprises Act does not impact claims related to members who choose to use OON providers. Balance billing may continue with those claims.

Does the federal No Surprises Act pre-empt state surprise billing laws? New 2/22

The law may not pre-empt state surprise billing laws that establish a process for determining OON reimbursement for covered items and services for insurers subject to the state's law.

What insurer and health plan responsibilities are included in the No Surprises Act? New 2/22

The insurer and health plan have certain responsibilities if a member gets out-of-network notice from a provider prior to service, including:

- Include INN and OON deductibles and the INN and OON out-of-pocket max on the ID Card.
- Count all cost-share toward plan deductible and out-of-pocket max unless the member agreed to receive out-of-network care.
- Cap member cost-share at the plan's network cost-share level.
- Provide estimate of cost of care and member cost-share if member chooses to go out-of-network.
- Provide information to members on how to receive the items and services in-network.

Are there requirements that must be included on ID cards? New 2/22

Yes. Insurers and health plans must include the INN and OON deductibles and out-of-pocket max on the member's ID Card.

When will insurers and health plans receive more information to assist in implementing the No Surprises law? Update 2/22

The Departments of Health and Human Services, Labor, and the Treasury will clarify certain provisions of the No Surprises Act though rulemaking later this year.

The No Surprises Act requires the federal regulatory agencies – the Departments of Health and Human Services, Labor, and the Treasury – to provide additional guidance through rulemaking:

- By July 1, 2021, the methodology for determining the "qualifying amount" used for calculating member cost-sharing and as part of the Independent Dispute Resolution (IDR) process.
- By Oct. 1, 2021, procedures for conducting audits of health insurance and group health plans for compliance with the No Surprises Act.
- By Dec. 27, 2021, the process for IDR including certification of IDR entities.

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Are there CAPS on consumer cost share at plans INN amount? New 2/22

The member cost share will be based on either state reimbursement methodology or par median amounts and determined by the member's benefit plan costs share (copayment, deductible, coinsurance).

What are provider responsibilities? New 2/22

Beginning January 1, 2022, providers and facilities must post and provide on any websites, and provide to any patients with coverage under an insurer/plan a notice of the following:

- The balance billing prohibitions under the No Surprises Act.
- Any applicable state requirements with respect to balance billing.

Information on contacting any applicable state or federal regulatory agency if the individual believes the provider or facility has violated balance billing restrictions.

How is the No Surprises Act enforced? Are there penalties? New 2/17

Insurer and health plans: provisions applicable to insurers and health plans are enforced by the applicable federal agency (the Departments of Health and Human Services, Labor, and the Treasury).

Providers and facilities: provisions applicable to health care providers and facilities are enforced by the Department of Health and Human Services which may impose fines of up to $10,000 per violation.

States: provisions applicable to providers and facilities (including air ambulance) may be enforced by the states.