No Surprises Act Overview

Presentation to the House Committee on Health Care
January 20, 2021

VERMONT
DEPARTMENT OF FINANCIAL REGULATION

What is a Surprise Medical Bill?

Surprise medical bills, also known as "balance bills," happen when patients unknowingly receive care from providers that do not participate in their health plan.

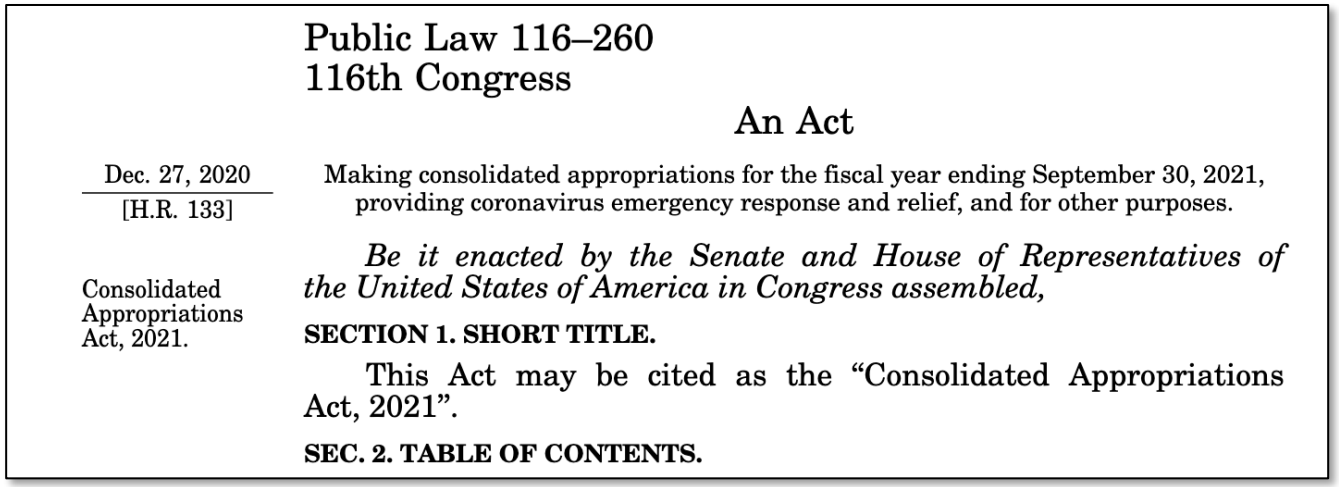
For instance, a patient may go to an in-network hospital for a surgery, but then get billed by an out-of-network anesthesiologist on the surgical team.

In these cases, the out-of-network provider may bill the patient for up to the full charge for the service.

Both Medicare and Medicaid prohibit providers from balance billing beneficiaries.*

*Except in certain limited circumstances. See **33 V.S.A. § 6503**

What is the No Surprises Act?



Public Law 116–260
116th Congress

An Act

Dec. 27, 2020
[H.R. 133]

Making consolidated appropriations for the fiscal year ending September 30, 2021, providing coronavirus emergency response and relief, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Consolidated Appropriations Act, 2021.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Consolidated Appropriations Act, 2021".

SEC. 2. TABLE OF CONTENTS.

The No Surprises Act (NSA) is a measure included in the Consolidated Appropriations Act, 2021 (CAA), an omnibus bill which also provided funding for the federal government and stimulus relief for the COVID-19 pandemic.

On December 27, 2020, CAA was signed into law.

The NSA went into effect on January 1, 2022.

What does the NSA do?

No Surprises Act.

TITLE I—NO SURPRISES ACT

42 USC 201 note.

SEC. 101. SHORT TITLE.

This title may be cited as the "No Surprises Act".

SEC. 102. HEALTH INSURANCE REQUIREMENTS REGARDING SURPRISE MEDICAL BILLING.

(a) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—

At a high level, the NSA adds four key consumer protections:

- Requires health plans to cover emergency services and out-of-network providers at in-network hospitals and facilities;
- Forbids out-of-network providers from billing patients beyond applicable in-network cost-sharing unless the patient gives written consent;
- Creates an independent dispute resolution process for providers and and health plans to resolve reimbursement disputes without patient involvement; and
- Requires health plans and providers to provide advance information about how much services will cost and how they will be covered.

Health Plan Coverage Requirements

- Applies to:
  - fully-insured plans,
  - Qualified Health Plans (QHPs),
  - and self-insured plans (including plans governed by the Employee Retirement Income Security Act of 1974).
- Health plans are required to cover the following services with in-network cost-sharing:
  - Emergency services; and
    - Includes post-emergency stabilization services;
    - Patients must receive written notice and give written consent to be transferred.
  - Non-emergency services performed by non-participating providers at in-network facilities;
    - Includes treatment, equipment and devices, telemedicine services, imaging and lab services, and preoperative and postoperative services;
    - Patients may give written consent for out-of-network care in certain circumstances.
- Health plans are required to provide transitional coverage for up to 90 days when a participating provider leaves the network.
- In-network cost sharing for out-of-network services is based on a "recognized amount," based on the median in-network payment for similar services under the plan.
- Provider reimbursement for out-of-network services is based on either an agreed-upon rate or through an independent dispute resolution process if the plan and provider cannot agree on a rate.

Dispute Resolution Process

The NSA defines a process through which out-of-network reimbursement is determined:

- First, the provider may accept the health plan's initial reimbursement offer;
- Second, the provider and health plan may negotiate a mutually-acceptable rate during a 30-day period beginning the day the provider receives initial payment or payment denial from the health plan.
- Finally, the provider and health plan may bring a reimbursement dispute to a new independent dispute resolution (IDR) process under the NSA.
    - The IDR process can be triggered by either party after the 30-day negotiation period;
    - IDR entities are chosen jointly by providers and health plans from a list of entities approved by the federal government;
    - Each party submits a final offer, and the IDR entity chooses the most reasonable offer ("baseball-style" arbitration) based on the following factors:
        - Provider's level of training and experience and scope of services provided;
        - Quality and outcomes of the provider;
        - Provider's or health plan's market share;
        - Patient acuity;
        - If applicable, past contracted rates between the parties.
    - Once the IDR entity makes a decision, the health plan must reimburse the provider within 30 days.
    - Party that submits the losing bid is responsible for the costs of the IDR process.

Provider Requirements

Under the NSA, out-of-network providers are prohibited from billing patients for more than applicable in-network cost sharing unless the patient has consented in writing to receiving out-of-network services. A penalty of up to $10,000 for each violation can apply.

- If a patient is insured, the provider must first submit its out-of-network bill to the patient's health plan;
- The health plan then has 30 days to inform the provider what the applicable in-network cost-sharing amount for the claim will be, based on the "qualifying payment amount (QPA)," which is defined as the median of contracted rates recognized by the insurer for similar services in the same specialty and geographic region;
- The health plan then sends an initial payment to the provider and a notice to the patient advising that the claim has been processed and indicating the applicable in-network cost-sharing amount;
- The provider can the bill the patient for no more than the in-network cost sharing amount;

Providers may seek written patient consent to waive their rights under the NSA and may refuse care if consent is denied. Notice and consent waivers are not permitted for the following services:

- Emergency services;
- Unforeseen urgent medical needs arising when non-emergent care is given;
- "Ancillary Services[,]" defined as item and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Services provided by assistant surgeons, hospitalists, and intensivists;
- "Diagnostic services[,]" including radiology and lab services;
- Services provided when there is not an in-network provider who can provide that service in an in-network facility.

Disclosure Requirements

"(f) ADVANCED EXPLANATION OF BENEFITS.—

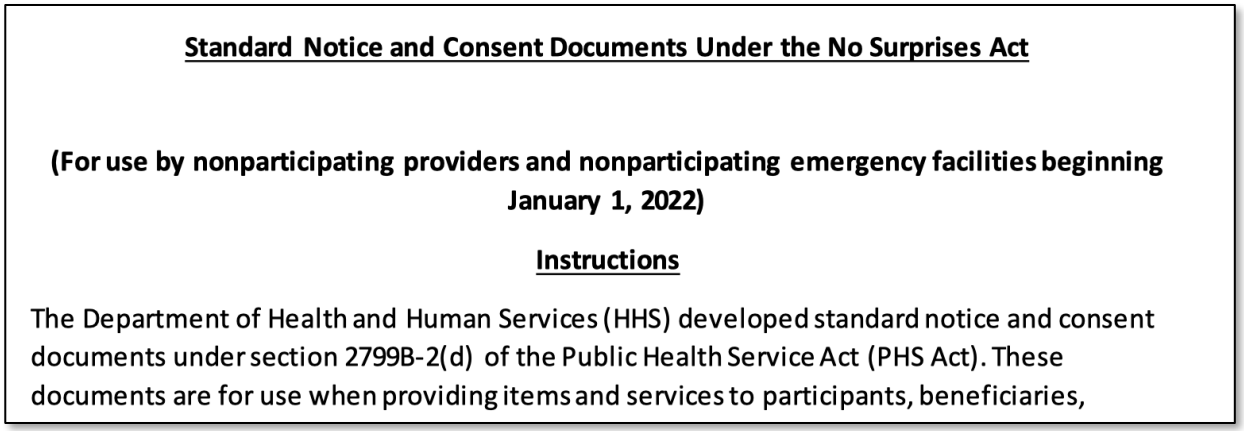
"(1) IN GENERAL.—For plan years beginning on or after January 1, 2022, each group health plan shall, with respect to a notification submitted under section 2799B–6 of the Public Health Service Act by a health care provider or health care

Effective date.
Deadlines.
Notification.
Estimates.

Under the NSA, health plans are required to help patients get advance information about how services will be covered and work to make prices more transparent by requiring:

- Provision of advance information how services will be covered. For scheduled services patients can submit advanced explanation of benefit requests, which health plans must provide within three days, including:
    - Whether the provider/facility participates in-network;
    - A good faith estimate of what the plan will pay and what the patient's out-of-pocket costs will be.
- Establishment of a verification process to update provider directory information at least every 90 days. Health plans must also respond within 1 business day to requests about whether a given provider is in-network. The response is binding on the plan.
- Disclosure to consumers prior to plan selection of direct and indirect compensation paid to insurance brokers for enrollment.

Identification of Surprise Bills



Standard Notice and Consent Documents Under the No Surprises Act

(For use by nonparticipating providers and nonparticipating emergency facilities beginning January 1, 2022)

Instructions

The Department of Health and Human Services (HHS) developed standard notice and consent documents under section 2799B-2(d) of the Public Health Service Act (PHS Act). These documents are for use when providing items and services to participants, beneficiaries,

The NSA places the burden on health plans and providers to identify protected claims.

Health plans and providers must notify consumers of their surprise medical bill protections. Providers must additionally post a one-page disclosure notice developed by the federal government summarizing surprise billing protections on their website and give the disclosure to each patient receiving services covered under the NSA.

If the health plan and provider fail to identify a surprise bill, the patient must seek relief from the plan. If the plan incorrectly denies coverage or applies out-of-network cost-sharing to a protected claim, patients may seek external review.

Enforcement

Under the NSA, states have a primary role in enforcement against health plans and providers, even when the patient is covered by a health plan regulated by the federal government.

The federal government has offered states, including Vermont, collaborative enforcement agreements (CEAs), to accomplish enforcement of the NSA. Under a CEA, the states perform the following compliance functions:

- Policy form review;
- Investigations;
- Market conduct examinations; and
- Consumer assistance.

The federal government will undertake formal enforcement only if the states are unable to obtain voluntary compliance.

In Vermont, DFR has pursued a CEA covering all provisions of the NSA except those relating to air ambulance providers.