No Surprises Act

Kimberly S. Cammarata
Assistant Attorney General
September 8, 2022

Health Education and Advocacy Unit

No Surprises Act - Overview

- Protects consumers from surprise medical bills.
- Offers price transparency for consumers.
- Improves provider directories.
- Ensures continuity of care.

No Surprises Act - Overview

- Because it is a federal law, the requirements apply to most individual and group health plans, and the FEHBP, unlike state laws that only apply to state-regulated plans.
- The requirements do not apply to Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or Tricare.

No Surprises Act - Overview

Provider and facility requirements that applied as of January 1, 2022

- No balance billing for out-of-network emergency services. (PHSA 2799B-1; 45 CFR 149.410)
- No balance billing for non-emergency services by nonparticipating providers at certain participating health care facilities, unless notice and consent requirements are met (in limited circumstances). (PHSA 2799B-2; 45 CFR 149.420)
- Disclose patient protections against balance billing. (PHSA 2799B-3; 45 CFR 149.430)

No Surprises Act - Overview

- No balance billing for air ambulance services by nonparticipating air ambulance providers. (PHSA 2799B-5: 45 CFR 149.440)
- Provide good faith estimate in advance of scheduled services, or upon request (currently for uninsured or self-pay individuals). (PHSA 2499B-6; 45 CFR 149.610)
- Ensure continuity of care when a provider's network status changes. (PHSA 2799B-8)
- Improve provider directories and reimburse enrollees for errors. (PHSA 2799B-9)

Surprise Billing Examples – HEAU cases

- A consumer went to the emergency room of an in-network hospital with severe stomach pain. She needed an appendectomy. While being wheeled into surgery, an out-of-network, on-call surgeon told the patient that he was an out-of-network provider and that she would be responsible for his $15,000 bill. She was later balance billed $16,156.

- Another consumer gave birth at an in-network hospital and later received a $36,000 bill for neonatology services provided to her newborn infant by an out-of-network neonatologist.

Balance Billing

Balance billing is billing the patient for the difference between the provider's charge and the amount the health plan pays plus the patient's cost-share amount.

Surprise billing is an unexpected balance bill, often from a provider the consumer didn't get to choose. This can happen when the consumer can't control who is involved in their care—like when they have an emergency or when they schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

Balance Billing Protections

Under the No Surprises Act, health plans are required to apply in-network cost-sharing terms, and out-of-network providers, facilities, or providers of air ambulance services are prohibited from billing patients more than the in-network cost sharing amounts ("balance billing") when:

1. A person gets covered emergency services from an out-of-network provider or out-of-network emergency facility;
2. A person gets covered non-emergency services from an out-of-network provider delivered as part of a visit to an in-network health care facility; or
3. A person gets covered air ambulance services provided by an out-of-network provider of air ambulance services.

Determining Patient Cost Share

When balance billing is banned under the No Surprises Act, health plans must calculate the patient's in-network cost sharing amount based on the "recognized amount" as specified in regulations. This amount can be set by:

1. All-payer model agreement (if applicable to plan and provider);
2. Specified state law (if applicable to plan and provider); or
3. Lesser of:

   a) billed charges, or

   b) **Qualifying Payment Amount**

Determining Patient Cost Share

- The Qualifying Payment amount is defined in regulation and is generally the plan or issuer's median contracted rate for the item or service in the geographic area where the item or service was delivered from January 31, 2019, indexed for inflation.

- For Air Ambulance services, the all-payer and specified state law provisions do not apply.

Determining Provider Reimbursement

After an out-of-network provider, facility, or provider of air ambulance services furnishes items or services to an individual, the out-of-network provider or facility receives an initial payment from the health plan or issuer. However, the final payment they receive from the plan will be determined by:

- An all-payer model agreement
- State law
- Initial plan payment accepted as payment in full
- Negotiated amount
- Federal IDR process-determined amount

More information about the IDR process can be found at: https://www.cms.gov/nosurprises/plans-and-issuers-requirements-and-resources

Emergency Services

- Out-of-network providers and out-of-network emergency facilities can't balance bill an individual who gets covered emergency services for an emergency medical condition.
- Certain post-stabilization services are considered emergency services and subject to the balance billing prohibition, unless certain notice and consent requirements are met.

Emergency Services

Providers

Physicians and other health care providers acting within their scope of practice under applicable state law.

Out-of-Network Facility

1. Emergency departments of a hospital, defined as hospital outpatient departments that provide emergency services.
2. Hospitals, regardless of the department, when providing post-stabilization services.
3. Independent, freestanding emergency departments, defined as health care facilities that:

    Are geographically separate and distinct and licensed separately from a hospital under applicable state law; and

    Provide any emergency services.

Emergency Services

Under the No Surprises Act, balance billing isn't allowed for emergency services when an individual gets care for an emergency medical condition, using a *"prudent layperson"* definition, and not based solely on the diagnosis codes:

- A person, who has average knowledge of health and medicine, experiences a medical condition (including a mental health condition or substance use disorder) that is so severe they believe:
  - They need immediate medical care; and
  - Failing to get immediate medical care could:
    * Result in their health or the health of their unborn child being in serious jeopardy; or
    * Result in serious impairment to bodily functions; or
    * Lead to serious dysfunction of any bodily organ or part.

Emergency Services – Post-Stabilization

- Post-stabilization services are covered services that are provided after the individual is stabilized, as part of an outpatient observation, or an inpatient or outpatient stay related to the emergency visit (regardless of the department of the hospital).
- Post-stabilization care is considered emergency care until the treating provider determines that:
  - the patient can travel safely to an available in-network facility;
  - using non-medical transport or non-emergency medical transport;
  - within a reasonable travel distance; and
  - taking into consideration the individual's medical condition.

Emergency Services – Post-Stabilization

- In limited circumstances, emergency facilities and some out-of-network providers can use the No Surprises Act's notice-and-consent exceptions to obtain voluntary consent from an individual to waive the balance billing protections for certain post-stabilization services. CMS has model forms on their website. The patient must be able to understand the consent form and waiver.

- HMO members and PPO/EPO members in Maryland-regulated plans receiving care from on-call or hospital-based physicians who accept an assignment of benefits cannot be asked to waive their balance-billing protections.

Air Ambulance Services

Out-of-network air ambulance service providers cannot balance bill for the following air ambulance services, including medical supplies and services provided in transport:

1. Medical transport by helicopter ("rotary wing" ambulance); and
2. Medical transport by airplane ("fixed wing" ambulance).

This applies when air ambulance services are covered under the in-network terms of an individual's health plan/coverage, even if there are no in-network air ambulance service providers within an individual's plan/coverage.

Air ambulance service providers may NEVER seek an individual's consent to waive No Surprises Act protections for these services through notice-and-consent exceptions.

The No Surprises Act does not apply to ground ambulance services, but Maryland law offers some balance billing protections.

Non-Emergency Services

Out-of-network providers can't balance bill for non-emergency items and services that are part of a visit at an in-network health care facility, except in limited circumstances where the notice-and-consent exceptions apply.

Out-of-network providers

Physicians and other health care providers acting within their scope of practice under applicable state law.

In-Network Facility

- Hospitals (including critical access hospitals);
- Hospital outpatient departments; or
- Ambulatory surgical centers.

To be considered an in-network health care facility, a facility must be in-network or have a single case agreement with a health plan or issuer for a specific individual.

Scope of Non-Emergency Services

Non-Emergency Services include:

1. Equipment and devices;
2. Imaging services;
3. Telemedicine services;
4. Lab services; and
5. Preoperative services and postoperative services.

- These items or services don't need to happen physically within the in-network health care facility to be treated as part of a visit (e.g., offsite laboratory services).
- The No Surprises Act's ban on balance billing for non-emergency services only applies to covered services. If a non-emergency service is not covered under the in-network benefits and terms of coverage under an individual's health plan, then the No Surprises Act's rules on balance billing do not apply.

Waiver of Balance Billing Protections

- The No Surprises Act balance billing protections can be waived by patients in some limited circumstances, but only when the Act's Notice and Consent requirements are met.
- Non-participating providers and facilities may balance bill for post-stabilization services only if all the following conditions have been met:

  - the patient can travel safely to an available in-network facility;
  - using non-medical transport or nonemergency medical transport;
  - within a reasonable travel distance; and
  - taking into consideration the individual's medical condition.

Waiver of Balance Billing Protections

- The nonparticipating provider or facility provides a written notice, including cost estimate, and obtains consent that includes certain content and within a specific timeframe and format outlined in regulation and guidance.

CMS provides a template for the notice and consent forms. Forms were recently updated.

https://www.cms.gov/files/document/standard-notice-consent-forms-nonparticipating-providers-emergency-facilities-regarding-consumer.pdf

- The provider or facility satisfies any additional state law requirements.

Waiver of Balance Billing Protections

The Balance Billing protections can never be waived for *Ancillary Services*.

The No Surprises Act defines ancillary services as:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, provided by either a physician or non-physician practitioner;
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services; and
- Items and services provided by an out-of-network provider when there is no in-network provider who can provide the item or service at the in-network health care facility.

- A provider or facility cannot balance bill for items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the nonparticipating provider or facility previously satisfied the notice and consent criteria.
- Note that this applies to both emergency and non-emergency services.

MD-Specific Balance Billing Protections

- **HMOs:** Consumers enrolled in a Health Maintenance Organization (HMO) governed by Maryland law generally may not be balance billed for services covered by their plan, including ground ambulance services.
- **PPOs or EPOs**: Consumers enrolled in a PPO or EPO governed by Maryland law may not be balance billed by a hospital-based or on-call physician that accepts an assignment of benefits and is paid directly by the PPO or EPO. These providers can't ask consumers to waive their balance billing protections.
- **Ground Ambulance:** An ambulance service provider operated by a local government, who accepts an assignment of benefits from a plan governed by Maryland law, may not balance bill the consumer.

Balance Billing Disclosure Requirements

- A provider or facility must disclose to any participant, beneficiary, or enrollee in a group health plan or group or individual health insurance coverage to whom the provider or facility furnishes items and services information regarding federal and state (if applicable) balance billing protections and how to report violations.
- Providers or facilities must post this information prominently at the location of the facility, post it on a public website (if applicable), and provide it to the participant, beneficiary, or enrollee in a timeframe and manner outlined in regulations.
- HHS issued a model notice that providers and facilities can choose to use.
- HEAU and MIA developed state-specific language to assist providers and facilities in satisfying this requirement. This language will be updated to incorporate recent updates.

Balance Billing Disclosure Requirements

- Plans and issuers must make publicly available, post on a public website of the plan or issuer, and include on each explanation of benefits for an item or service with respect to which balance billing protections apply, information in plain language on:

  (1) the restrictions on balance billing in certain circumstances;

  (2) any applicable state law protections against balance billing;

  (3) the requirements under Code section 9816, ERISA section 716, and PHS Act section 2799A–1; and

  (4) information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing.

Appeal Rights for Consumers

Consumers can appeal the following decisions made by their health plan:

- Refusing to pay all or part of a claim (like a health service, treatment, or prescription drug)
- Termination of coverage
- Eligibility determinations
- Rescissions
- Application of out-of-network cost-sharing (copay, coinsurance, or deductible) instead of in-network cost-sharing
- Mental health parity application

Coverage decisions that involve whether a health plan is complying with the surprise billing and cost-sharing protections under the No Surprises Act protections are eligible for external review.

Good Faith Estimates of Planned

- As of January 1, 2022, health care providers and facilities are required to provide a good faith estimate of expected charges to **uninsured consumers** or to insured consumers if they don't plan to have their health plan help cover the costs **(self-paying individuals).**

- Consumers with health insurance will be able to get estimates from their health plans in the future, but the No Surprises Act requirement to provide the estimates has been delayed.

Good Faith Estimates of Planned Treatment

- The good faith estimate must include:
  - A list of items and services that the scheduling provider or facility reasonably expects to provide the patient for that period of care.
  - **Beginning in 2023, a list of items and services and their associated costs that can be reasonably expected to be given to the patient by another provider or facility involved in their care (a co-provider or co-facility).** For example, a surgeon would include anesthesia in the estimate for a knee replacement surgery.
  - Applicable diagnosis and service codes.
  - Expected charges or costs associated with each item or service.
  - A notification that if the billed charges are higher than the good faith estimate, the consumer can ask their provider or facility to update the bill to match the good faith estimate, ask to negotiate the bill, or ask if there is financial assistance available.

If Billed More than Good Faith Estimate

- The HEAU can mediate good faith estimate billing disputes.
- If an uninsured or self-pay consumer gets a bill that is **at least $400 more** than the total expected charges (for that provider or facility) on the good faith estimate, there is a new federal patient-provider dispute resolution (PPDR) process available.
- Under the PPDR process, consumers can request a payment review and decision from an independent company, referred to as Selected Dispute Resolution (SDR) entities.
- The SDR entity will decide what amount consumers must pay if their bill is at least $400 more for any provider or facility than their good faith estimate from that provider or facility.

Health Insurance ID Cards

- Starting in 2022, new pricing information will be shown on any physical or electronic plan or insurance identification (ID) cards including:
    - Applicable deductibles.
    - Applicable out-of-pocket maximum limits.
    - A telephone number and website for consumers to get assistance.

  Additional information may be provided on a health plan's website that can be accessed through a QR Code on a physical ID card, or through a hyperlink on a digital ID card.

Continuity of Care

- Health plans that began on or after January 1, 2022, must allow a continuing care patient to continue receiving care from a provider or facility whose contract ended and the provider or facility is now out-of-network.
- The consumer's health plan must treat the provider or facility as if they were still in-network for 90 days, or until the consumer is no longer a continuing care patient, whichever comes first.

Continuity of Care

A health care provider or facility that ends a contractual relationship with a plan or issuer and has a continuing care patient must, generally:

A. Accept payment from the plan or issuer (and cost-sharing payments) for a continuing care patient at the previously agreed to payment amount for up to 90 days after the date on which the patient was notified of the change in the provider's network status.

B. Not balance bill the continuing care patient.

C. Continue to adhere to all policies, procedures and quality standards imposed by the plan or issuer for such items or services as if the contract were still in place.

Continuity of Care

- A continuing care patient would be an individual who:
  - is undergoing a course of treatment for a serious and complex condition from the provider or facility;
  - is undergoing a course of institutional or inpatient care from the provider or facility;
  - is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
  - is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
  - is or was determined to be terminally ill and is receiving treatment for such illness from such provider or facility.

Provider Directory

Any health care provider or health care facility that has or has had a contractual relationship with a plan or issuer to provide items or services under such plan or insurance coverage must submit provider directory information to a plan or issuer, at a minimum:

- At the beginning of the network agreement with a plan or issuer;
- At the time of termination of a network agreement with a plan or issuer;
- When there are material changes to the content of the provider directory information of the provider or facility;
- Upon request by the plan or issuer; and
- At any other time determined appropriate by the provider, facility, or HHS

Provider Directory

Under the No Surprises Act, if an individual relies on incorrect provider directory information and, as a result, receives items or services from an out-of-network provider or out-of-network health care facility:

1. Their plan or issuer must:
   - Limit cost-sharing to in-network terms that would apply had items or services been furnished by an in-network provider; and
   - Apply the deductible or out-of-pocket maximums as if the provider or health care facility were in-network.
2. Their provider or health care facility must not bill an individual more than their in-network cost-sharing.

HEAU Assistance – No Surprises Act

The HEAU can assist consumers who:

- Receive a surprise medical bill that they believe is incorrect;
- Believe that their health plan has improperly processed their claim;
- Believe a waiver of balance billing protections should not apply;
- Receive a bill that is higher than the good faith estimate given to them before their planned treatment;
- Need help negotiating a payment plan if the SDR disagrees with the consumer;
- Relied on incorrect provider directory information; and
- Believe that they have a continuing care case, and their health plan disagrees.

HEAU Contact

Health Education and Advocacy Unit
Office of the Attorney General
200 St Paul Place, 16th Floor
Baltimore, Maryland 21202
Phone: (410) 528-1840 or toll-free 1 (877) 261-8807
En español: 410-230-1712
Fax: (410) 576-6571
heau@oag.state.md.us

File a complaint online:
https://www.marylandattorneygeneral.gov/Pages/CPD/HEAU/ComplaintChooser.aspx

Questions

Kimberly S. Cammarata

Assistant Attorney General

Director, Health Education and Advocacy Unit

kcammarata@oag.state.md.us

Many of the slides contained herein were copied from a CMS presentation.

The information provided is intended only to be a general, informal summary based on current policy.

Public Comment