No Surprises Act

2021 Montana Healthcare Conference

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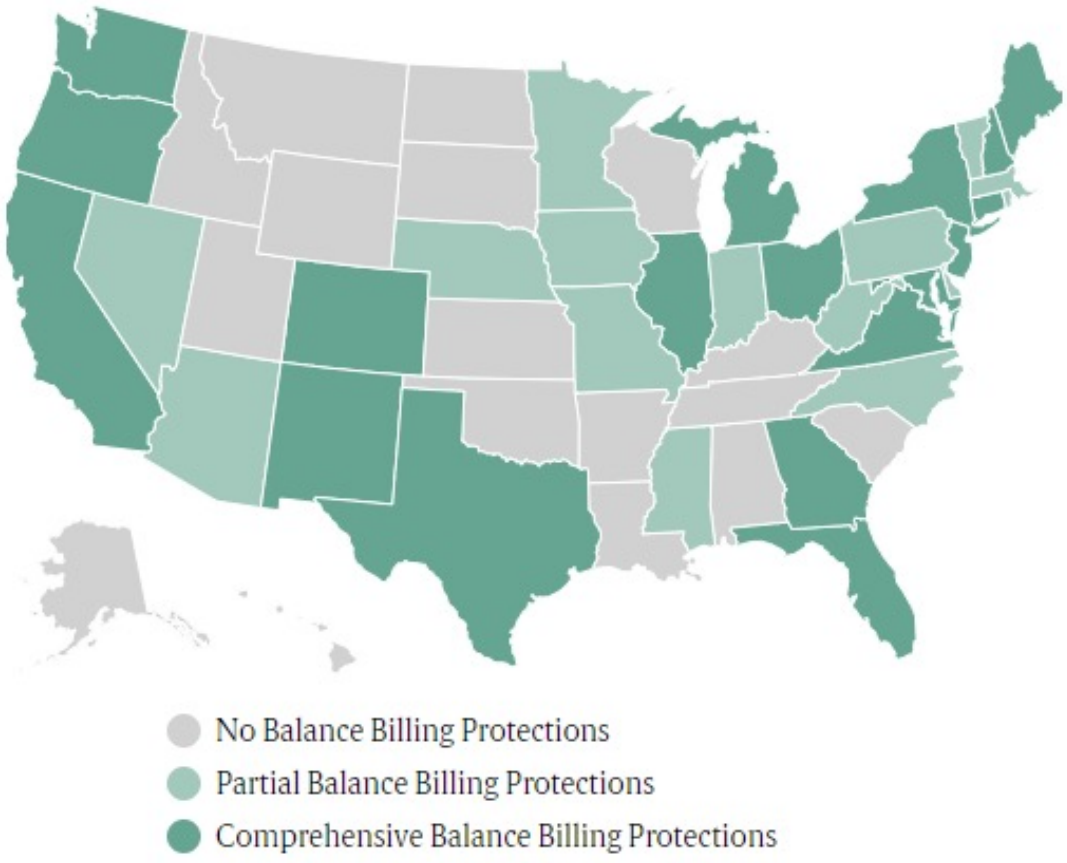
PYA

State Balance Billing Protections



https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections

No Surprises Act

- Federal legislation to address surprise billing
  - Individual unable to exercise choice over facility/provider and thus receives services from out-of-network (OON) facility/provider
- Included in Consolidated Appropriations Act
  - Follows years of work devising and debating such legislation and its intended/unintended consequences
- Effective January 1, 2022 (with some limited exceptions)

Application

- Healthcare Entities
  - Facilities (hospitals, CAHs, freestanding EDs, ASCs)
  - Providers furnishing services at a facility (not outside)
  - Air ambulance (not ground, at least for now)
- Health insurance issuers offering group or individual health insurance coverage
  - Group coverage includes both insured and self-insured plans, ERISA plans, non-federal government plans, church plans, traditional indemnity plans (**not** Medicaid MCOs or MA plans)
  - Individual coverage includes exchange and non-exchange plans, student health insurance coverage (**not** health reimbursement arrangements, short-term limited-duration insurance, or retiree-only plans)

Surprise Billing for Emergency Services

- Includes emergency services furnished at OON facility AND emergency services furnished by OON provider at in-network facility
  - Apply “prudent layperson” standard to determine what constitutes emergency services
  - Includes necessary post-stabilization services (admission, observation) as determined by treating physician
  - Plan cannot require prior authorization nor limit coverage for emergency services to certain diagnosis codes

Surprise Billing for Non-Emergency Services

- Ancillary services furnished by OON provider at in-network facility
  - Emergency medicine, anesthesia, pathology, radiology, neonatology
  - Assistant surgeon, hospitalist, and intensivist items and services
  - Diagnostic services, including radiology and laboratory services
  - Items or services provided by OON provider if there are no in-network providers who can furnish the item or services at the facility
  - Items or services that result from unforeseen, urgent medical needs that arise when item or service is furnished.
- All other services furnished by OON provider at in-network facility absent prior notice and written consent

Note: NSA does not apply to non-emergency services furnished at OON facility.

Advance Notice/Consent

- Utilize HHS Standard Notice and Consent documents
  - Do not modify except to complete bracketed information and as necessary to reflect applicable state law; provide appropriate translations/interpreters
  - Complete “Estimate of what you could pay” and “More details about your estimate” before giving to patient
  - Must be provided separately; not included with other documents
  - Provide signed copy to patient/representative in manner requested
- Timing
  - If service scheduled at least 72 hours in advance, must provide notice at least 72 hours in advance (?)
  - If service scheduled less than 72 hours in advance, must provide notice day of appointment, but not less than 3 hours before providing the service
- Plan must be notified and receive copy of signed consent

Standard Notice and Consent

Surprise Billing Protection Form

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan.

Getting care from this provider or facility could cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

You **shouldn't** sign this form if you **didn't** have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

See the next page for your cost estimate.

Estimate of what you could pay

Patient name:_____

Out-of-network provider(s) or facility name:_____

_____

Total cost estimate of what you may be asked to pay:	

► **Review your detailed estimate.** See Page 4 for a cost estimate for each item or service you'll get.

► **Call your health plan.** Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.

► **Questions about this notice and estimate?** Call [*Enter contact information for a representative of the provider or facility to explain the documents and estimates to the individual, and answer any questions, as necessary.]*

► **Questions about your rights?** Contact [*contact information for appropriate federal or state agency]*

Prior authorization or other care management limitations

[*Enter either (1) specific information about prior authorization or other care management limitations that are or may be required by the individual's health plan or coverage, and the implications of those limitations for the individual's ability to receive coverage for those items or services, or (2) include the following general statement:*

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.]

[*In the case where this notice is being provided for post-stabilization services by a nonparticipating provider within a participating emergency facility, include the language immediately below and enter a list of any participating providers at the facility that are able to furnish the items or services described in this notice]*

Understanding your options

You can also get the items or services described in this notice from these providers who are in-network with your health plan:

More information about your rights and protections

Visit [*website*] for more information about your rights under federal law.

https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780

Standard Notice and Consent

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.

With my signature, I am saying that I agree to get the items or services from (select all that apply):

☐ [*doctor's or provider's name*] [*If consent is for multiple doctors or providers, provide a separate check box for each doctor or provider*]

☐ [*facility name*]

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on [*enter date of notice*] explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You **don't** have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

_____ or _____

Patient's signature — Guardian/authorized representative's signature

_____ _____

Print name of patient — Print name of guardian/authorized representative

_____ _____

Date and time of signature — Date and time of signature

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.

More details about your estimate

Patient name: _____

Out-of-network provider(s) or facility name: _____

_____

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This means that **the final cost of services may be different than this estimate**.

Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.

[*Enter the good faith estimated cost for the items and services that would be furnished by the listed provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services. Assume no coverage would be provided for any of the items and services.*].

[*Populate the table below with each item and service, date of service, and estimated cost. Add additional rows if necessary. The total amount on page 2 must be equal to the total of each of the cost estimates included in the table.*]

Date of service	Service code	Description	Estimated amount to be billed
		Total estimate of what you may owe:	

Consumer Protections

- Cost sharing limited to in-network cost-sharing amount
  - State law or All-Payer Model Agreement
  - Qualifying payment amount (QPA)
  - Plan's 2019 median in-network rate paid for specific service indexed for subsequent years, with special rules for new plans and services with no established rates in 2019
- Consumer complaints process and appeals rights
- Facilities/providers must notify patients of cost-sharing protections (model notice)
  - Post prominently at physical location
  - Post on website (link from homepage)
  - Given to each insured patient to whom services provided at facility (by facility and providers?) in manner requested by patient no later than time at which request for payment made (or claim submitted, if no request)

Model Notice

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language as appropriate*]

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language regarding applicable state law requirements as appropriate*]

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact [*applicable contact information for entity responsible for enforcing the federal and/or state balance or surprise billing protection laws*].

Visit [*website*] for more information about your rights under federal law.
[*If applicable, insert:* Visit [*website*] for more information about your rights under [state laws].]

https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780

Out-of-Network Payments

- OON facility/provider “shall not bill, and shall not hold patients liable” for more than in-network cost sharing amount
- If state law or All-Payer Model Agreement governs, parties must adhere to those requirements
- If no such requirements, plan has 30 days to send initial payment (or notice of denial of payment based on non-coverage)
  - No minimum standard for initial payment (such as QPA)
  - Facility/provider may initiate 30-day negotiation period
  - Facility/provider may then force independent dispute resolution (IDR) process, requiring each side to submit last best offer
  - IDR entity selects between the two offers based on specified factors (not including facility/provider charges nor Medicare/Medicaid rates), with loser paying administrative costs
  - IDR implementing regulations expected by end of year

Good Faith Estimates

- Facilities/providers must share “good faith estimates” of total expected charges for scheduled items/services (including any expected ancillary services) with plan (if patient is insured) or individual (if patient is uninsured)
  - Notice must include expected billing and diagnostic codes for all items and services to be provided.
  - Requirement applies whenever items or services are scheduled at least three days in advance or when requested by a patient
- Implementing regulations for providing estimates to uninsured individuals to be published before 01/01/2021
- Effective date for insured individuals delayed pending future publication of implementing regulations

Advanced Explanation of Benefits

- Based on facility's/provider's good faith estimate, health plan must issue advanced explanation of benefits
  - Network status of facility/provider
  - Contracted rate for item/service or, if facility/provider is OON, description of how individual can obtain information on network facilities/providers
  - Good faith estimate received from facility/provider
  - Good faith estimate of amount plan is responsible for paying and amount individual is responsible for paying
- Effective date delayed pending future publication of implementing regulations

Continuity of Care

- Following discontinuation of facility/provider network status, plan must continue coverage for that provider for up to 90 days for patients who are -
  - Undergoing a course of treatment for a serious or complex condition
  - Undergoing institutional or inpatient care
  - Scheduled to undergo non-elective surgery (including postoperative care)
  - Pregnant and undergoing treatment
  - Terminally ill and receiving services
- Implementing regulations will not be published prior to 01/01/2022; plans must comply based on good faith reading of statutory requirements

Provider Directories

- Health plan provider directory requirements
  - Verification process to ensure accurate provider directories
  - Response protocol for individuals inquiring about provider's network status
  - Publicly accessible provider database
- Implementing regulations will not be published prior to 01/01/2022; plans must comply based on good faith reading of statutory requirements
- Plan is deemed to comply so long as it does not penalize any covered person who relies on inaccurate information

Plan Disclosures – Balance Billing

- Plan must post on its public website and include on plan communications (including EOBs) similar notices regarding balance billing protections
- Implementing regulations will not be published prior to January 1, 2022; plans must comply based on good faith reading of statutory requirements (e.g., reference to facility/provider model disclosure forms)

Between Now and January 1…

- Compliance with notice requirements
- Revenue cycle
- Hospital-based physicians
- Managed care negotiations

Transparency in Coverage

- By January 1, 2022, plans must issue ID cards with any applicable deductibles, any applicable out-of-pocket maximum limitations, and telephone number and website address for individuals to seek consumer assistance
- By July 1, 2022, plans must disclose on public website in-network provider rates for covered items and services and OON allowed amounts and billed charges for covered items and services in machine-readable formats
- By January 1, 2023, plans must post self-service price comparison tool for cost-sharing liability