INFORMATIONAL BULLETIN TO HEALTH CARE PROVIDERS AND FACILITIES ON REQUIREMENTS UNDER THE FEDERAL NO SURPRISES ACT

To: Health Care Providers and Facilities

From: State Corporation Commission Bureau of Insurance

Date: April 15, 2022

Subject: Federal No Surprises Act (NSA) Health Care Provider, Health Care Facility and Provider of Air Ambulance Services Requirements

The purpose of this communication is to provide information on requirements in the federal No Surprises Act (NSA) that apply to health care providers and facilities and providers of air ambulance services for plans starting in 2022.

The State Corporation Commission Bureau of Insurance (SCC BOI) provides this information to educate stakeholders about new protections applicable to health insurance enrollees in Virginia. Depending on circumstances, enforcement of these federal law provisions and similar state laws may come from one of several federal and state regulatory entities, including but not limited to the SCC BOI. Under this framework, SCC BOI intends to continue its responsibilities and commitment to protect consumers, including receiving complaints from consumers on issues related to the NSA. These complaints may concern health care providers and facilities and may be referred, as appropriate, to other state or federal agencies for investigation and enforcement.

Background

As part of the Consolidated Appropriations Act of 2021, on Dec. 27, 2020, the U.S. Congress enacted legislation, the federal No Surprises Act (NSA), which contains many provisions to help protect consumers from surprise bills for plans starting in 2022. The provisions in the NSA create requirements that apply to health care providers and facilities and providers of air ambulance services, such as cost-sharing rules, prohibitions on balance billing for certain items and services, notice and consent requirements and requirements related to disclosures about balance billing protections.

These health care provider and facility and provider of air ambulance services requirements generally apply to items and services provided to individuals enrolled in group health plans or group or individual health insurance coverage, including Federal Employees Health Benefits (FEHB) plans. The NSA's requirements related to the good faith estimates and patient-provider dispute resolution process also apply to individuals with no health insurance coverage and individuals choosing not to use their health insurance coverage.

Health Care Provider and Facility and Provider of Air Ambulance Services Requirements that Apply to Plans Starting in 2022

Health care providers and facilities and providers of air ambulance services:

- May not balance bill for out of network emergency services (Public Health Service Act (PHS Act) section 2799B-1; 45 C.F.R. section 149.410).
- May not balance bill for non-emergency services by nonparticipating providers at certain participating health care facilities, unless notice and consent was given in some circumstances (PHS Act section 2799B-2; 45 C.F.R. section 149.420).
- Shall disclose patient protections against balance billing (PHS Act section 2799B-3; 45 C.F.R. section 149.430)
- May not balance bill for air ambulance services by nonparticipating air ambulance providers (PHS Act section 2799B-5; 45 C.F.R. section 149.440)
- Shall provide a good faith estimate in advance of scheduled services, or upon request (PHS Act section 2799B-6; 45 C.F.R. section 149.610 (for uninsured or self-pay individuals)
- Shall submit accurate information for provider directories and reimburse enrollees for amounts paid in excess of the in-network cost-share (PHS Act section 2799B-9)

Summary of Major NSA Health Care Provider and Facility and Provider of Air Ambulance Services Requirements

1) No balance billing for out-of-network emergency services

Nonparticipating providers and *nonparticipating emergency facilities*:

- Cannot bill or hold liable enrollees in group health plans or group or individual health insurance coverage who received *emergency services* at an emergency department of a hospital or an independent freestanding emergency department for a payment amount greater than the in-network *cost-sharing requirement* for such services.

- Post-stabilization services are considered *emergency services*, and are therefore subject to this prohibition, unless notice and consent requirements are met.

2) Exceptions to no balance billing for out-of-network emergency services—notice and consent

Nonparticipating providers and facilities may balance bill for post-stabilization services only if the following conditions have been met:

- The attending emergency physician or treating provider determines the enrollee: 1) can travel using nonmedical transportation to an available *participating provider or participating health care facility* located within a reasonable travel distance, taking into account the individual's medical condition; and 2) is in a condition to receive notice and provide informed consent;

- The *nonparticipating provider* or non-participating facility provides the beneficiary, enrollee or participant with a written notice and obtains consent as outlined in the NSA's regulation and guidance; **and**

- The provider or facility satisfies any additional state law requirements, such as the post-stabilization services are not considered non-emergency surgical or ancillary services provided in an in-network facility.

Even if all of the conditions above are met:

- With respect to both emergency and non-emergency services, a provider or facility cannot balance bill for items or services furnished because 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.

3) No balance billing for non-emergency services by nonparticipating providers at certain participating health care facilities

Nonparticipating providers of non-emergency services at a participating health care facility:

- Cannot bill or hold liable enrollees in group health plans or group or individual health insurance coverage, including FEHB plans, who received covered non-emergency services with respect to a visit at a participating health care facility from a nonparticipating provider for a payment amount greater than the in-network cost-sharing requirement for such services, unless notice and consent requirements are met.

- ***Note:*** The exception for notice and consent requirements does not apply to the following list of ancillary services, for which the prohibition against balance billing remains applicable:
  a. Items and services related to emergency medicine, anesthesiology, pathology, radiology and neonatology;
  b. Items and services provided by assistant surgeons, hospitalists, and intensivists;
  c. Diagnostic services, including radiology and laboratory services; and
  d. Items and services provided by a nonparticipating provider if there is no participating provider who can provide such item or service at such facility.

- Providers must be aware that they are prohibited from waiving or asking an enrollee covered under Virginia law to waive their protections for nonemergency surgical or ancillary services provided in a participating facility.

4) Disclose patient protections against balance billing

- A provider or facility must disclose to an enrollee information regarding federal and, if applicable, state 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 enrollee in a timeframe and manner consistent with state and federal regulations.

5) No balance billing for air ambulance services by nonparticipating air ambulance providers

- Providers of air ambulance services cannot bill or hold liable enrollees who received covered air ambulance services from a nonparticipating air ambulance provider for a payment amount greater than the in-network cost-sharing requirement for such services.

6) Provide a good faith estimate of the expected charges in advance of scheduled services, or upon request, to uninsured or self-pay individuals.

- Upon an individual's scheduling of items or services, or upon request, a provider or facility must ask if the individual is enrolled in a health benefit plan or health insurance coverage.

- For individuals without health insurance coverage or individuals who do not plan to file a claim for the item or service, starting Jan. 1, 2022, the provider or facility must give the individual a good faith estimate of the expected charges for furnishing the scheduled item or service and any items or services reasonably expected to be provided in conjunction with those items and services, including those provided by another provider or facility. In addition, the good faith estimate provided directly to these individuals must include information related to the patient-provider dispute resolution process that is used to determine the appropriate payment amount when the difference between the good faith estimate provided and a bill the individual receives following the provision of the item or service satisfies the dollar threshold established in federal regulation to be eligible to use the process.

- For individuals with health insurance coverage and who plan to submit a claim for the item or service to the plan or issuer, once federal regulations are finalized, the provider or facility must provide to the individual's plan or issuer a good faith estimate of the expected charges for furnishing the scheduled item or service and any items or services reasonably expected to be provided in conjunction with those items and services, including those provided by another provider or facility, with the expected billing and diagnostic codes for these items and services.

7) Submit accurate information for provider directories and reimburse enrollees for errors

Any health care provider or health care facility that has or has had a contractual relationship with a health benefit plan or health insurance 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: a) at the beginning of the network agreement with a plan or issuer, b) at the time of termination of

a network agreement with a plan or issuer; c) when there are material changes to the content of the provider directory information of the provider or facility; d) upon request by the plan or issuer; and e) at any other time determined appropriate by the provider, facility or the U.S. Department of Health and Human Services (HHS).

Reimburse beneficiaries, enrollees or participants who relied on an incorrect provider directory and paid a provider bill in excess of the in-network cost-sharing amount (i.e., the difference between the patient's in-network cost-sharing and the amount that the patient paid the provider previously).

8) **Use independent dispute resolution or other available methods to resolve out-of-network bills**

- In Virginia, some health care items and services are subject to balance billing protections established under state law. When such laws apply, providers and facilities will continue to use Virginia's process for resolving disputes with payers related to out-of-network payment amounts (see attached chart).

- For items and services to which state law does not apply (see attached chart), the NSA establishes an independent dispute resolution process that providers, facilities, and air ambulance providers can use in the case of certain out-of-network claims when open negotiations do not result in an agreed-upon payment amount.

- Providers, facilities and air ambulance providers will be required to meet deadlines, attest to no conflicts of interest, choose a certified independent dispute resolution entity, submit a payment offer and provide additional information if needed. More information on the federal independent dispute resolution process is expected to be added to the Centers for Medicare & Medicaid Services No Surprises Act home page - https://www.cms.gov/nosurprises.

Guidance and Technical Resources

- Centers for Medicare & Medicaid Services No Surprises Act Home Page
  - Provider Requirements and Resources Page
- Overview of NSA Rules and Fact Sheets
- Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process Under No Surprises (Download Fee Information) (PDF)
- Standard notice & consent forms for nonparticipating providers & emergency facilities regarding consumer consent on balance billing protections (Download Surprise Billing Protection Form) (PDF)
- Model disclosure notice on patient protections against surprise billing for providers, facilities, health plans and insurers (Download Patient Rights & Protections Against Surprise Medical Bills) (PDF)
- Paperwork Reduction Act (PRA) model notices and information collection requirements for the Federal Independent Dispute Resolution Process (Download Model Notices and Information Requirements)

- Paperwork Reduction Act (PRA) model notices and information collection requirements for the good-faith estimate and patient-provider payment dispute resolution (Download Model Notices and Information Requirements)
- Requirements for including federal agency contact information and website URL on certain documents (Download Memo of Requirements for Plans, Providers and Facilities) (PDF)