The No Surprises Act

April 2024

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Disclaimer

The following material was prepared by the Commonwealth of Pennsylvania's Insurance Department, based on the law, regulations, and guidance available as of November 1, 2021. For further details, please refer to the No Surprises Act and its regulations in their entirety.

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Which Facilities and Services must follow the No Surprises Act?

Emergency Air Ambulance Services

Emergency Facility/Provider Services

Emergency Ground Ambulance Services
*This is deferred for further Study

Non-Emergency Services in connection to a visit at the facility

Facilities Include at least:

- Hospital
- Hospital Outpatient Department
- Ambulatory Surgery Center

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Which Health Plans Must Follow the No Surprises Act?

Surprise billing protections apply if you get your coverage through:

- Your employer (including a federal, state, or local government)
- Our state-based Marketplace, Pennie
- Directly through an individual market health insurance company.

- The Act does not apply to people with coverage through programs such as Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE. These programs do not allow balance billing.

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What about those with other health plans?

Participants in the following plans do not have the balance billing protections:

- Indemnity or excepted benefit plan enrollees
  - It is not “individual market” coverage
  - It does not typically have a network
- Short-term limited duration plan enrollees
  - It is not “individual market” coverage
- Healthcare sharing ministry or Amish participants
  - It is not “individual market” coverage
- Individuals with no health care coverage at all

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What if an individual is uninsured?

- Individuals who pay for health care services themselves will get bills from all providers.
- Providers are required to provide a good faith estimate upon request or upon scheduling an item or service.

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Providers

Facilities, Health Care Practitioners, Air Ambulance Service

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Which Providers May Not Balance Bill?

- Emergency room providers
- Anesthesiologists
- Pathologists
- Radiologists
- Neonatologists
- Assistant surgeons
- Hospitalists
- Intensivists
- Diagnostic services (incl. radiology and laboratory)
  - Does not include "advanced diagnostic laboratory tests" as identified by HHS
- Other specialty items or services as identified by HHS
- Any service provided by an out-of-network provider if no in-network provider was available at the facility
- Urgent services that arise during a service for which notice & consent was provided

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What about Provider Directories?

- Providers and Facilities:
  - Must have business process to give provider directory and network information to Plans any time there is a material change.
  - May by contract impose on Plans the duty to keep directory current in event of contract termination.
  - If Provider/Facility bills patient more than in-network cost-sharing amount, and Patient pays, Provider/Facility must reimburse Patient plus interest.

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What about Continuity of Care?

- Providers and Facilities:
  - If contract with a Plan terminates so that the Provider/Facility is no longer in-network,
  - And if the Patient is a “continuing care patient”, i.e., being treated for a “serious and complex condition” (scheduled nonelective surgery, pregnancy, terminal Illness),
  - Then the Provider/Facility must:
    - Accept payment, including cost-sharing, calculated on an in-network basis for duration of continuity of care situation

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If a Provider has a complaint about a Plan, where should the Provider go?

- The Provider should contact the Pennsylvania Insurance Department (PID). The PID has a process set up to quickly review the complaint and make sure it is handled in the best way possible.

- The Provider may also go to HHS, which is establishing a complaint process, with acknowledgement of the complaint possibly taking 60 days from receipt.

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If a Provider has a complaint about a Patient, where should the Provider go?

- It is possible the Patient may not understand the Act, so the Provider is encouraged to contact the PID in these situations.

- If the Provider is confident that the Patient does understand the Act, the Provider should handle this as they did before the Act, but with the understanding that in the case of a surprise medical bill, the Provider may not collect from the Patient more than the in-network cost-sharing.

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Provider and Facility Disclosure Requirements

- The No Surprises Act requires certain health care providers and facilities to provide patients with a one-page disclosure notice on:
  - The requirements and prohibitions applicable to the provider or facility regarding balance billing.
  - Any applicable state balance billing prohibitions or limitations.
  - How to contact appropriate state and federal agencies if the patient believes the provider or facility has violated the requirements described in the notice.
- This information must be publicly available from the provider or facility, too.
- https://www.cms.gov/nosurprises/Policies-and-Resources/Overview-of-rules-fact-sheets

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Provider Notice and Consent Requirements

For those Providers not prohibited from balance billing, they may do so if:

- The Provider gives notice and get written consent from the patient.
- Given at least 3 days before service, and not later than 1 business day after scheduling, or 3 business days after scheduling if scheduled at least 10 days in advance.
  - May not be used in an emergency situation.
- The Notice and Consent must be on a separate document, using the HHS form.
- The signed Consent must be retained for 7 years, and a copy given to the patient.

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What must the Notice of Consent Explain?

- That the Provider does not participate with the Consumer's healthcare coverage plan (the Plan).
- The good faith estimated amount the Provider may charge the person for all services that would reasonably be included.
  - Include related services expected to be provided by another provider or facility, with expected billing and diagnostic codes
- Notice that the service might need to be authorized or otherwise approved by the Healthcare Plan.
- Clearly state that signing the Notice is **optional**; a person does not have to consent.
- Clearly state that the person may get the service from an available in-network Provider.

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How will the Provider receive payment?

- First, confirm the Patient's coverage. If it is individual or group coverage subject to the Act, then …
- If an out-of-network Provider furnishes a surprise medical service:
  - The Provider may collect cost-sharing from the Patient.
    - The amount of the cost-sharing must be at the in-network level.
  - The Provider must bill the Patient's Plan for all remaining charges.
    - The Plan must pay the Qualifying Payment Amount (QPA).
    - If the Provider is not satisfied with the QPA, the Provider and the Plan may negotiate, either directly or through the federally administered Independent Dispute Resolution Process.

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How will the Provider receive payment from the uninsured/self-pay individual?

- If the individual is uninsured or self-pay, then …
  - The Provider may bill the Patient.
- If the individual has a dispute with a Provider:
  - They may use a Patient Provider Dispute Resolution Process that the federal government (HHS) is setting up.
  - The Patient Provider Dispute Resolution Process uses a Selected Dispute Resolution (SDR) entity to decide the claim.
  - To be eligible to use this SDR process, the total charges must be at least $400 more than the good faith estimate.
  - The uninsured patient must access the process within 120 days of receiving their first bill.
  - The uninsured patient will need to pay a small administrative fee to start the process. This fee is expected to be no more than $25, which will be refunded if the patient wins.

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Enforcement

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State Oversight Authority

- General Standard: State law applies unless it "prevents the application" of the federal law.
- PA state agencies will exercise their responsibilities to protect Pennsylvanians primarily through insurance, professional conduct, and licensure laws.
- PA will collaborate with federal agencies to coordinate enforcement efforts as necessary and appropriate:
  - HHS (for insurance plans and providers/facilities)
  - DOL (for self-funded plans)
  - Office of Personnel Management (for Federal Employee Health Benefit Plan)

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For concerns related to the No Surprises Act:

- Contact the PID at a future vanity URL.
  - The PID is the Commonwealth agency coordinating enforcement with state agencies that have oversight over Providers, including Facilities. The PID has a process set up to quickly review the complaint and make sure it is handled in the best way possible.
  - The PID will work collaboratively with other state agencies to coordinate enforcement efforts as necessary
- Use the federal complaint process, though response time will likely be delayed.
- The Federal government will enforce if the state is unable to or lacks authority.
  - The Federal government and state government will collaborate to enforce where appropriate.

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Once a Complaint is Received....

- It will be assigned to a consumer services representative and uploaded for tracking
  - The complaint will be marked as "No Surprises"
- The representative will complete outreach to obtain necessary information
- The outreach will potentially be to:
  - Patient,
  - Provider,
  - Health Plan
- The representative will work with the other state agencies if determined in the investigation their regulated entity may have acted inappropriately

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How is it going?

- Pennsylvania Insurance Department is the lead agency for NSA enforcement in Pennsylvania:
  - Executive Order 2021-08 (December 20, 2021)
    - Other agencies (DOS, DOH, OAG) have been very cooperative

- Early Education (i.e., even before the NSA took effect):
  - In anticipation of NSA taking effect, PID presented webinars to provider licensing boards, hospital and medical associations, etc.
  - Those educational efforts were well-received, and may have prevented some complaints

  - Insurance Department NSA webpage
    - FAQs
    - Overview for Consumers
    - Overview for Health Plans
    - Overview for Providers
    - Model Disclosure Notices

- Statistics:
  - 2022 – 39 complaints
  - 2023 – 214 complaints

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What are some challenges we've experienced?

- Self-funded plans seem to have difficulty understanding the applicability of the NSA to them
- Efforts to get provider responses to inquiries are sometimes difficult. Provider bills often include only the billing department phone number, rather than the provider's office; the billing department declines to provide information to avoid any HIPAA violations.
- Out of state insurers or providers are sometimes reluctant to respond.

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What are some successes we've had so far?

- Notable Successes, including where the coverage is self-funded (outside of PID jurisdiction) or relates to coverage issued in another jurisdiction - PID has been able to assist through informal mediation with provider and insurer/issuer
  - On a self-funded plan, negotiation with a provider resulted in a consumer's recovery of over $17,000
  - Emergency services provided in PA to a NJ insured; PID was able to get ER provider to remove balance bill for over $20,000
  - Urgent care sent lab specimen to the local hospital rather than participating lab; hospital billed a NY insured. PID coordinated with NY DOI to recover consumer's cost share. Reaching many more consumers, the hospital also created a brochure for consumers regarding the NSA.

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Questions to Ask Your Members:

- Do you need more detail about the federal No Surprise Act?
- Do you need additional guidance from the Insurance Department?
- Do you know that you may not balance bill in relation to the No Surprises Act?
- Do you know you may not send consumers to collections in relation to the No Surprises Act?
- Do you need links to the federal model notices?

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The PA Insurance Department Is Here to Help

- To learn more about the No Surprises Act or to submit a complaint form visit www.insurance.pa.gov/nosurprises
- You can also call our Consumer Services Bureau at 1-877-881-6388.

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