Understanding the Requirements for Health Care Providers and Facilities under the No Surprises Act

The Alaska Division of Insurance seeks to educate stakeholders about new protections applicable to health insurance enrollees in Alaska. 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 Alaska Division of Insurance. Under this framework, the Division intends to continue its responsibilities and commitment to protect consumers, including receiving complaints from consumers and provider on issues related to the No Surprises Act (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.

Need-to-know information for health care providers, facilities and providers of air ambulance services starting in 2022

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

Nonparticipating providers and nonparticipating emergency facilities:

- Cannot bill or hold liable enrollees in both insured and self-funded plans 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 either non-emergency medical transportation or 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.

Even if all 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 both insured and self-funded plans, 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.

4) Disclose patient protections against balance billing

- A provider or facility must disclose to an enrollee information regarding federal 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.

Notice and Consent forms can be found on the CMS website at this link.

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 (GFE) 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 estimates 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 or for those states that have a balance billing law, the dollar threshold amount and payment methodology found in that state law or regulation] to be eligible to use the process.

What triggers the obligation to provide a GFE?
A patient may request a GFE prior to scheduling care. Further, convening providers are required to treat any discussion with or inquiry from an uninsured patient regarding costs to be a request for a GFE. Further, the convening provider or facility is required to provide a GFE when a service is scheduled.

How soon should the GFE be provided?
Within one business day of a service being scheduled or a GFE requested, the convening provider or facility is required to request estimates from each co-provider or co-facility expected to provide services in connection with the convening provider's or facility's services. When a service has been scheduled, the GFE is to be provided not later than one business day after the date of scheduling if the service is scheduled at least three business days before the service, and within three business days of scheduling if the service is scheduled at least 10 business days in advance. If a GFE is requested before the service is scheduled, the GFE is due within three business days. Once the service is scheduled, a new GFE must be provided.

Note, for the 2022 calendar year, HHS will not enforce the requirement that the convening provider's or facility's GFE incorporate estimates from the co-providers or co-facilities. Patients would be free to request estimates directly from co-providers and co-facilities, and those providers and facilities would be required to provide a GFE directly to the patient.

What happens when the elements of the GFE change before the service is finished?
The convening provider or facility must update the GFE at least one business day before the service if it learns of or anticipates any changes to the scope of the prior GFE. If any providers represented in the GFE change within one business day prior to the scheduled service, the replacement providers must accept the GFE as their own GFE.

Can the provider furnish a single GFE for the recurring services?
The convening provider or facility may provide a single GFE for recurring services, as long as the GFE is updated at least every 12 months.

What is the required content of the GFE?
HHS is publishing a template GFE, although providers and facilities are not required to use that template. The GFE is required to include:

1. The patient's name and date of birth
2. A description of the primary item or service in "clear and understandable language" and, if applicable, the date of scheduled service
3. The items or services expected to be provided in conjunction with primary service, grouped by provider or facility, with their diagnosis code, procedure code and expected charge
4. The name of and identifying information for each provider or facility
5. The items or services that require separate scheduling and that will be estimated in a separate GFE
6. Various required disclaimers

How must the GFE be furnished to a patient?
The GFE must be provided either in writing or electronically, as requested by the patient. An electronic GFE must be provided in a manner such that the patient can both save and print it.

- 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 Alaska, 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 Alaska's process for resolving disputes with payers related to out-of-network payment amounts. For patients with fully insured plans, health care providers and insurance companies can use the provider complaint process available at the Alaska Division of Insurance to ensure the bill has been paid in compliance with applicable state law. You can reach the Alaska Division of Insurance at (907) 269-7900 or visit our website at insurance.alaska.gov. The Division's provider complaint process is available here.

- For items and services to which state law does not apply, 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.
    - Consumers can agree in advance to be treated by an out-of-network provider in some situations, such as when they choose an out-of-network surgeon knowing the cost will be higher. The provider must give consumers information in advance about what their share of the costs will be. If a consumer opts for this, they are expected to pay the balance bill as well as out-of-network coinsurance, deductibles, and copays.

Exceptions to the protections under the No Surprises Act

- For vision, dental-only plans, or other limited benefit plans, the new billing protections established by the No Surprises Act generally don't apply to services these plans cover. But if a patient's health plan includes dental or vision benefits, these protections could apply to any dental or vision services covered by the health plan.
- The balance billing protections in the No Surprises Act generally don't apply to ground ambulance services.
- Some health insurance coverage programs already have protections against high medical bills. Patients are already protected against surprise medical billing if you have coverage through Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE. The new No Surprises Act rules don't apply to these programs.
- Providers and payers of self-funded plans will be able to use negotiation and federal independent dispute resolution process to resolve payment disagreements. Consumers will not be impacted by such negotiations.

What else should I know?

- A patient who receives a surprise bill can file an appeal with their insurance company or may ask for an external review of the company's decision. You also can file a complaint with the Alaska Division of Insurance or the federal Department of Health and Human Services (HHS). You can reach the Alaska Division of Insurance at (907) 269-7900 or complete a complaint online: https://www.commerce.alaska.gov/web/ins/Consumers/Complaints.aspx
- An independent dispute resolution (IDR) process, is available to settle bills if the health plan is **self-funded**. The IDR process is through the federal HHS at this website: https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing. You may also call the No Surprises Help Desk at 1-800-985-3059. You are also welcome to reach out to the Alaska Division of Insurance with questions (907) 269-7900 or email at insurance@alaska.gov.
- Providers serving patients with self-funded plans should use the federal complaint process available at this website: https://www.cms.gov/nosurprises/policies-and-resources/providers-submit-a-billing-complaint.
- A dispute resolution process is available for individuals who are uninsured, in certain circumstances, such as when the actual charges are much higher than the estimated charges. For more information on this federal process please visit: https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing.

- You can get more information about filing a complaint with the Alaska Division of Insurance by calling (907)269-7900. You may also reach out to the No Surprises Help Desk by calling 1-800-985-3059 with questions.

Additional Resources:

- Provider Requirements and Resources - Centers for Medicare and Medicaid Services
- No Surprises Act Good Faith Estimates and Patient-Provider Dispute Resolution - CMS presentation
- Model Disclosure Notice Regarding Patient Protections Against Surprise Billing
- NSA toolkit for physicians from the American Medical Association January 2022
- Standard notice and consent forms nonparticipating providers emergency facilities - CMS guidance