Federal No Surprises Act Resources and Consumer Disclosures

The federal Consolidated Appropriations Act of 2021, more commonly known as the No Surprises Act ("NSA"), was passed by Congress. Among its requirements are steps for insurance carriers and health care providers to take that can help protect consumers from surprise medical bills beginning January 1, 2022.

The NSA also creates requirements that apply to health care providers and facilities as well as to air ambulance providers (i.e., emergency transport by helicopter), including 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.

The Massachusetts Division of Insurance ("Division") has prepared the following information to explain insurance carriers' obligations under the NSA and consumer rights and protections under the new law. Depending on the circumstances, enforcement of these federal law provisions may come from one of several federal and state regulatory entities, including but not limited to the Division, since the NSA provides for joint enforcement coordination between the relevant federal and state entities. Please note, the federal government is expected to provide ongoing guidance on the implementation of the provisions of this law.

What is a surprise medical bill?

Most consumers are enrolled in network health plans where in-network providers have agreed to accept reimbursement according to contractual rates of reimbursement. If a consumer enrolls in closed network HMO plans, they can only obtain covered services from out-of-network providers in case of emergency or when an in-network provider is not available. If a consumer enrolls in preferred provider plans (PPO plans), they have the option to obtain services from out-of-network providers but will pay higher cost-sharing (i.e., co-payment, co-insurance, and/or deductible) than if they go to an in-network provider, except in case of emergency or when an in-network provider is not available.

Surprise billing occurs when a consumer unknowingly or unexpectedly receives services from an out-of-network provider and receives a bill beyond their expected level of cost-sharing because the out-of-network provider bills the consumer for some or all of the difference between what the out-of-network provider charges and what the insurance carrier pays for the covered service.

Under the new NSA law, health care providers and certain facilities cannot bill patients for more than their in-network co-payment, co-insurance, or deductible for services provided by out-of-network providers when delivering emergency care. The NSA may also restrict health care providers and certain facilities from billing patients for more than their in-network co-payment, co-insurance, or deductible for services provided by out-of-network providers at an in-network hospital (for example, services performed by radiologists or anesthesiologists that are not in-

network for that hospital).

How are billing disputes being handled under Massachusetts law and the federal NSA?

If a consumer receives a bill for medical or mental health services that should be covered under the NSA, then they have the right to challenge the charges. The NSA establishes an arbitration process to settle disputes between out-of-network providers and insurance carriers regarding reimbursement for patient services.

The NSA also creates a dispute resolution process to determine a patient payment amount when an uninsured patient receives a bill that substantially exceeds a good faith estimate (more than $400 higher than estimated).

Consumers with questions about a surprise bill can contact the Division of Insurance by filling out a complaint form DOI Insurance Complaint Submission Form | Mass.gov, e-mailing CSSComplaints@mass.gov, or by calling **(877) 563-4467 and selecting Option 2**.

Consumers can also contact the Centers for Medicare and Medicaid Services (CMS) to learn more at https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing, or by calling **1-800-985-3059**.

Which health plans must follow the No Surprises Act?

Surprise billing protections apply if health coverage is issued through:

- An employer (including a federal, state, or local government);
- The Massachusetts Health Connector; or
- A health insurance company licensed to sell health insurance in Massachusetts.
- These protections apply whether your plan is fully insured or self-funded.

The provisions of the NSA do not specifically apply if health insurance coverage is through Medicaid (MassHealth) or Medicare, TRICARE, or if the consumer receives care through the Indian Health Services or Veterans Health Administration. However, there are also protections under other laws, including state laws, that prohibit balance billing.

What is emergency care?

Emergency care is generally considered to be care that is necessary and imminently provided such that the consumer does not have time to research and receive care from facilities and providers that are in-network with their health insurance company. Along with traditional physical emergency rooms and freestanding emergency departments, bills from emergency air ambulance services are also included under the emergency services provision. Under

Massachusetts law[1], a situation requires emergency services if a prudent layperson would consider it requires immediate attention to prevent serious injury, harm or death.

After a patient is in stable condition following an emergency, post-stabilization services provided at an out-of-network facility are not considered emergency care when certain of the following requirements are met:

- The physician declares the patient can be moved safely to an in-network facility within a reasonable travel distance using non-medical transport
- A facility is available and accepts the transfer
- The transfer will not cause unreasonable burdens to the patient
- The patient is in a condition to provide informed consent

How do Notice and Consent requirements work with regard to balance billing for out-of-hospital non-emergency care?

Under the NSA law, the consumer must provide written consent to receive non-emergency treatment from an out-of-network health care provider. The request must be in writing on a form that notifies the patient that if they sign, they may get a bill for the full charges or have to pay out-of-network cost-sharing amounts. If the patient chooses not to consent, the out-of-network provider is not required to provide any further treatment.

Consumers who belong to a fully insured health plan can only be asked to consent to out-of-network non-emergency care if the facility or provider informed the patient of the availability of a participating (and in-network) health care provider at least 72 hours prior to the service. The provider must also give the patient information in advance about what their share of the costs will be, also known as a good faith estimate.

What is a good faith estimate?

The NSA requires health carriers to provide price comparison guidance by telephone. Carriers must also make a price comparison tool available online that allows plan participants to compare the amount of cost sharing they would be responsible for paying with respect to a specific treatment or service furnished by a participating provider. If the consumer consents to receive non-emergency care from an out-of-network provider - despite knowing the anticipated costs - then the consumer is expected to pay the balance bill as well as any out-of-network co-insurance, deductibles, and co-pays. Massachusetts law already requires insurance companies to give good faith estimates for costs. The Division posts the company contact information to obtain estimates on its website: Web Transparency Chart 2019.pdf (mass.gov).

Health insurance carriers must work in coordination with health care providers and facilities to provide covered individuals with advance notification of cost estimates of items and services. The notifications will include:

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1 See M.G.L. c. 176O, §1.

- whether the provider or facility is in-network;
- information about how to locate in-network providers if the provider is out-of-network;
- the contracted rate for anticipated items or services;
- a good faith estimate of the amount the plan will pay, and the amount of any cost sharing the covered individual would be responsible for based on the procedure costs received by the provider;
- a good faith estimate of the amounts the covered individual has incurred toward any plan limits;
- whether the services are subject to any medical management techniques; and
- a disclaimer that the notification is only an estimate.

How can patients determine if a particular facility or provider is within an insurance company's network?

Under both Massachusetts law and the NSA, health insurance carriers must maintain up-to-date provider directories and reimburse members for costs resulting from any carrier error. 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:
  - 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 regulator.
- 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.

The NSA also requires that health insurance identification cards include any deductible and out-of-pocket maximum limits applicable to the plan, and the telephone number and web address through which individuals may seek additional information regarding their coverage.

What must insurance carriers do to ensure members are aware of the requirements of the NSA?

Health insurance carriers must send members a notice of their rights under the new law and include that information on their website.

Carriers may allow group health insurance issuers (ie: employer groups) to utilize the same disclosures to help their employees understand the NSA. Employers may also want to review the information available on the federal Department of Labor's website for additional information: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act

Federal law requires group health plans and health insurance issuers offering group or individual health insurance coverage to make publicly available and include on each explanation of benefits for an item or service:

- the restrictions on balance billing in certain circumstances,
- any applicable state law protections against balance billing,
- the requirements under Code section 9816, ERISA section 716, and PHS Act section 2799A-1, and
- 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

Massachusetts' current balance billing law is M. G.L. c. 176O, §6(a)(4). The NSA provides more expansive protections against balance billing than Massachusetts' law; therefore, the provisions of the NSA will expand the state law protections.

Consumers with questions regarding balance billing laws can contact:

- **CMS** https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing, or by calling **1-800-985-3059**.
- **Division of Insurance** DOI Insurance Complaint Submission Form | Mass.gov, e-mailing CSSComplaints@mass.gov, or by calling **(877) 563-4467 and selecting option 2**.