Compliance FAQ

August 31, 2021

The No Surprises Act Frequently Asked Questions

This FAQ summarizes the provisions of The No Surprises Act (NSA) released by the Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury (the Departments).

Summary of Federal Legislation

What is the purpose of the federal legislation enacted by the No Surprises Act (NSA)?

The goal of the NSA is to make health care information accessible to consumers and overall enhance consumer protection in the healthcare market place.

What are the new requirements of the NSA that affect group health plans?

Payment Amounts Effective January 1, 2022:

The bulk of the No Surprises Act is a legislative effort aimed to prevent surprise medical bills. Surprise medical bills occur when a patient receives a bill for the difference between the out-of-network (OON) provider's fee and the amount covered by the patient's health insurance, after co-pays and deductible. This situation could arise in an emergency when the patient has no ability to select the emergency room, treating physicians, or ambulance providers. Surprise medical bills might also arise when a patient receives planned care from an in-network (INN) provider (often, a hospital or ambulatory care facility), but other treating providers brought in to participate in the patient's care are not in the same network. These can include anesthesiologists, radiologists, pathologists, surgical assistants, and others.

Applies to:

1. emergency services provided by non-participating providers at participating facilities;
2. non-emergency services performed by non-participating providers during a visit at certain participating facilities;
3. air ambulance services. Concerning ambulance providers, the No Surprises Act imp-acts air ambulance only, ground ambulance in not part of this protection.

The law establishes maximum patient out-of-pocket amounts, which generally cannot be more than the in-network amount that would have been charged to the patient had the services been provided by a participating provider or facility, and establishes a qualifying payment amount that must be paid to the provider. The qualifying payment amount is the median of contracted rates for similar services in a particular geographic area adjusted by the consumer price index to minimize the influence of high outlier rates. The law also prohibits balance billing, but creates an advance beneficiary notice (ABN)-like process applicable to services furnished by non-participating providers at participating facilities to permit providers to balance bill under certain circumstances.

Additionally, the law establishes an Independent Dispute Resolution (IDR) process for plans and providers to negotiate the rate that will be paid to the non-participating provider or facility if the parties cannot agree.

Prohibition on Surprise Medical Bills Requirement.

What is the purpose of this requirement?

To prohibit surprise out-of-network billing for healthcare consumers.

Will consumers/patients receive a balance bill anymore?

No, for the majority of instances. The law establishes maximum patient out-of-pocket amounts, which generally cannot be more than the amount that would have been charged to the patient had the services been provided by a participating provider or facility. If a patient/consumer however decides to sign a waiver with a provider who is out of network in a nonemergency setting, and agrees to be balance billed, the patient/consumer will be balanced billed. In this situation, the out-of-network provider can ask the patient for written consent to send a balance bill, but the provider must provide a notice including details such as a good faith estimate of the charges, the fact that the provider or facility does not participate in the patient's health plan, and a list of in-network physicians or facilities where the patient can receive care instead. The law also bars specialties with a history of balance billing from using these waivers.

What specialists are barred from using these wavier?

Ancillary services and providers such as anesthesiologist, radiologist and pathologist cannot issue notice and consent forms.

How does the out of network provider get paid in an emergency situation?

The provider and the plan work out the payment without the patient/consumer being involved. If an agreement cannot be reached by the two parties, a IDR process begins using a federally approved IDR arbitration firm. The arbitration is "baseball style", the appointed IDR arbitration firm has final say and the loser pays the IDR arbitration firm fee and payment in question.

What is HPI doing to meet the payment amount requirements of the NSA?

HPI will configure our client's plans so that members only pay the INN cost share amounts for the services covered by the NSA. In addition, HPI's external vendor partner, Zelis, that works in payer/provider negotiations and prices OON claims for our clients' plans will be pricing the applicable OON claims in accordance with the median contracted rate requirements in order for HPI to administer plans in compliance. Zelis will also provide all needed backup pricing information to support IDR if applicable; however, the goal is for Zelis to negotiate with the provider to accept payment and avoid the need for IDR.

Will HPI have a system ready for January 1, 2022?

Yes.

Will there be a cost impact to clients?

There will be no additional costs for our clients associated with pricing the OON claims. As specified in the No Surprises Act, if a claim goes to IDR, the costs of arbitration would be charged to the client's plan if the plan loses in IDR.

Other requirements of the NSA. Most requirements are effective January 1, 2022; however, pursuant to an FAQ issued by Departments of Labor, HHS, and the Treasury (the Departments) on August 20, 2021, the Departments will defer enforcement of certain requirements as noted below.

- Plan ID Cards: Effective for plan year start dates on or after January 1, 2022. Plan ID cards (digital and physical cards) must have in clear writing:
  - In-network and out-of-network deductibles,
  - In-network and out-of-network out-of-pocket limits
  - and consumer assistance information (phone number and website).
- Advanced EOBs: Pursuant to the Departments' August 20, 2021 FAQ, enforcement is deferred until further federal guidance is issued. Previously Effective January 1, 2022.
  - This new form is required to provide information on the estimated costs of procedures and services, especially the additional costs of non-participating providers. The request for an Advanced EOB may be made by the participant or their representative and must include the billing and diagnostic codes for the anticipated services. The Advanced EOB must then be provided within one business day of request for scheduled procedures (three business days if the request is made at least 10 business days before the scheduled procedure).
- Price Comparison Tool: Pursuant to the Departments' August 20, 2021 FAQ, enforcement of the price comparison tool will be deferred to January 1, 2023 to align with the Transparency Tool requirements of the Transparency in Coverage Final Rule. However, the Price Comparison Tool may be rescinded pending rulemaking by the Departments to determine if the requirements of the Transparency Tool satisfy the Price Comparison Tool. Previously Effective January 1, 2022.
  - Plans are required to create and maintain a web-based price comparison tool for use by plan participants. The tool must include out-of-pocket cost comparisons for various services by an INN provider or facility for a specific geographic region and plan year. This is a general comparison tool only. It is not the full plan specific estimates required under the full Transparency Tool.
- Continuity of Care: Pursuant to the Departments' August 20, 2021 FAQ, the effective date of the Rule is delayed until further rulemaking is issued with an applicable effective date. However, plans must still use a good faith, reasonable interpretation of the rules to begin implementation. Previously Effective January 1, 2022.
  - Group health plans and insurers are required to allow "continuing care" patients, including those in an active course of treatment or who have a life-threatening illness, to continue to see their provider with in-network cost-sharing if the provider's contract is terminated. These protections apply for a continuing care patient for up to 90 days.

- Provider Directory Requirements: Effective January 1, 2022
  - Plans must ensure provider directories are current and accurate, with regular verification of provider contract status and updates required at least once every 90 days. Providers are required to submit regular updates to group health plans and insurers to assist with their verification and update process, including notice of material changes to their provider directory information.
  - If a member receives services from a provider who was out of network but the member was told the provider was in network (due to the directory not being updated on time or other error), the member can only be charged the in-network cost share amounts.
- Model EOB Notice: Effective January 1, 2022
  - Plans must post on a public website and include on each EOB for services subject to the No Surprises Act:
    - the restrictions on balance billing in certain circumstances;
    - any applicable state law protections against balance billing;
    - the requirements under the No Surprises Act; 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. A Model Notice has been issued.

What is HPI doing to meet these additional requirements?

- Plan ID cards:
  - HPI will re-issue all existing clients' ID cards starting with plan year start dates January 1, 2022 and after to include all required information. New clients on or after January 1, 2022 will also receive our new ID cards including all required information.
- Advanced EOBs:
  - HPI is waiting on further federal guidance pursuant to the Departments' August 20, 2021 FAQ.
- Price Comparison Tool:
  - HPI is waiting on further federal guidance pursuant to the Departments' August 20, 2021 FAQ.
- Continuity of Care:
  - HPI will administer the Continuity of Care requirements for our clients' applicable members in accordance with the Rule.
- Provider Directory Requirements:
  - HPI's network partners will update and maintain their provider directories in accordance with the requirements of the Rule. Links to our clients' networks and provider directories are posted on our website. HPI will also apply the in-network cost share amount in accordance with the Rule as applicable.
- Model EOB Notice:
  - HPI will issue the Model Notice with EOBs and we will post the Notice on our public website.

Will HPI have a systems/requirements ready for January 1, 2022?

Yes unless otherwise noted above pursuant to the Departments' August 20, 2021 FAQ.

Will there be a cost impact to clients?

No, assuming the Price Comparison Tool is rescinded.

How to Contact HPI

Where can clients obtain more information?

Please reach out to your Account Managers for assistance.