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BULLETIN NO. 2022-01

TO: Health Care Providers and Facilities

FROM: Jim L. Ridling
Commissioner of Insurance JSR

DATE: January 27, 2022

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

EFFECTIVE: Immediately

The purpose of this Bulletin is to provide guidance on several requirements outlined in the federal No Surprises Act (NSA) which apply to both health care providers and facilities effective January 1, 2022.

The Alabama Department of Insurance (ALDOI) provides this guidance to inform stakeholders about current new protections applicable to health insurance enrollees in Alabama. Depending on the circumstances, enforcement of these new federal laws and similar state laws may come from one of several federal or state regulatory entities, including but not limited to the Alabama Department of Insurance. Under this framework, the ALDOI remains steadfast in our commitment and responsibility to protect the interests of consumers, by serving as a resource center to receive NSA related complaints from consumers. 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

On December 27, 2020, as part of the Consolidated Appropriations Act of 2021, the U.S. Congress enacted the federal No Surprises Act (NSA), which contains many provisions to help protect consumers from surprise bills starting January 1, 2022. The provisions in the NSA create requirements that apply to health care providers and facilities as well as the providers of air ambulance services. These requirements also include 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 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 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 Requirements and Provider of Air Ambulance Services Requirements that Apply to Plans Starting January 1, 2022

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

- May not balance bill for out of network emergency services (Public Health Services Act (PHSA) 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).
- Once applicable rules are in place, 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 errors (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 that 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.

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 by 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 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 as outlined by regulation.

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 changes 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.

- If the individual has such coverage and plans to submit a claim for the item or service to the plan or issuer, 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.

- The good faith estimate must include expected charges for the items or services that are reasonably expected to be provided together with the primary item or service, including items or services that may be provided by other providers and facilities.

- For individuals without health insurance coverage or individuals who do not plan to file a claim for the item or service, the provider or facility must provide this notification to the individual. 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.

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.

- 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.

JLR/WR/bc