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Oregon Department of Consumer and Business Services
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TO: Health Care Providers and Facilities

DATE: January 13, 2022

SUBJECT: Federal No Surprises Act (NSA) health care provider, health care facility, and air ambulance provider requirements

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The purpose of this bulletin is to provide information on requirements in the federal No Surprises Act that apply to health care providers and facilities and providers of air ambulance services starting Jan. 1, 2022. The division is providing this information to educate stakeholders about new protections applicable to consumers in Oregon.

Background

Surprise billing, sometimes also called balance billing, is a situation when a health care provider bills a patient after the patient's health insurance company has paid its share of the bill per a consumer's benefits. The balance bill is the difference between the provider's charges, what the insurance carrier paid for the services, and the patient cost sharing (co-pay, co-insurance, or deductible) as required by the plan.

On Dec. 27, 2020, as part of the Consolidated Appropriations Act of 2021, the U.S. Congress enacted the No Surprises Act (NSA), which contains many provisions to help protect consumers from surprise medical bills starting in 2022. The provisions in the act create requirements that apply to health care providers, facilities, and providers of air ambulance services. The requirements 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.

The NSA's 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. Requirements related to good faith estimates and patient-provider dispute resolution processes also apply to individuals with no health insurance coverage and individuals choosing not to use their health insurance coverage.

Oregon's balance billing law, ORS 743B.287, prohibits an out-of-network provider at an in-network facility from billing a patient for more than the patient's in-network cost-sharing responsibility, subject to certain specified exceptions. It also requires health insurers to reimburse these providers at a set rate based on data from the state's All Payer All Claims database. This reimbursement methodology sunset on Jan. 2, 2022. However, the state law prohibition on balance billing under ORS 743B.287 remain in effect.

Requirements for health care providers, facilities, and air ambulance providers

Health care providers and facilities and providers of air ambulance services:[1]

- May not balance bill a consumer for out-of-network emergency services;
- May not balance bill a consumer for nonemergency services by out-of-network providers at certain in-network health care facilities, unless notice and consent was given in some circumstances;
- May not balance bill a consumer for air ambulance services by out-of-network air ambulance providers;
- Shall disclose patient protections to a consumer about the prohibition on balance billing;
- Shall provide a good faith estimate to a consumer in advance of scheduled services and also when request by the consumer; and
- Shall submit accurate information to insurers for provider directories and reimburse consumers for errors.

Summary of major NSA requirements for health care providers, health care facilities, and air ambulance providers

1) **Prohibits balance billing for out-of-network emergency services**

   Out-of-network providers and out-of-network emergency facilities cannot bill or hold liable consumers 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) **Required notice and consent for exceptions to balance billing prohibition**

   Out-of-network 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 nonmedical transportation to an available in-network provider or in-network 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;

[1] See Public Health Service Act (PHS Act) section 2799B-1; 45 C.F.R. section 149.410-440; PHS Act section 2799B-6; 45 C.F.R. section 149.610; and PHS Act section 2799B-9.

- The out-of-network provider or out-of-network facility provides the consumer 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.[2]

Even if all of the conditions above are met, with respect to both emergency and nonemergency 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 out-of-network provider or facility previously satisfied the notice and consent criteria.

3) Prohibits balance billing for nonemergency services by out-of-network providers at certain in-network health care facilities

Out-of-network providers of nonemergency services at an in-network health care facility cannot bill or hold liable consumers who received covered nonemergency services during a visit at an in-network health care facility from an out-of-network 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 an out-of-network provider if there is no in-network provider who can provide such item or service at such facility.

4) Disclosure of patient protections from balance billing

A provider or facility must disclose to a consumer information regarding the federal 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, and provide a one-page notice to the consumer.

5) Prohibits balance billing for air ambulance services by out-of-network air ambulance providers

Providers of air ambulance services cannot bill or hold liable consumers who received covered air ambulance services from an out-of-network 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 charges in advance of scheduled services, or upon request, to uninsured or self-pay individuals.

[2] See e.g., ORS 677.097 for informed consent and ORS 127.507 on capacity to make health care decisions.

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 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. 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 exceeds $400 in difference.

- For more information on the good faith estimates for uninsured or self-pay patients, see the following FAQ: Good Faith Estimates FAQ 12.21.2021 FINAL (cms.gov).

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. Implementation of these requirements have been delayed until federal regulations can be issued.

7) Submit accurate information for provider directories and reimburse enrollees for errors

Any health care provider or health care facility that has or 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 (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 (IDR) or other available methods to resolve out-of-network bills**

Insurers, providers, and facilities will be required to use the voluntary negotiation and IDR process as outlined in federal rule for any disputed claims subject to the act. Information on Oregon's state methodology, which sunsets on Jan. 2, 2022, will remain available for insurers, providers, and facilities to use during the voluntary negotiation or to reference, as it is helpful to determining the payment amount.[3]

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 more 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.

Consumer complaint contacts

Complaints regarding the No Surprises Act will be received by DFR and the U.S. Department of Health and Human Services (HHS), depending on the entity subject to the consumer's complaint.

Insurer complaints:

DFR will receive consumer complaints related to an insurer and the No Surprises Act. Consumers can file a complaint online or contact the division to speak with a consumer advocate by:

- Phone: 888-877-4894 (toll-free)
- Email: DFR.InsuranceHelp@dcbs.oregon.gov

Provider and facility complaints:

HHS, in coordination with the Department of the Treasury, Department of Labor and the Office of Personnel Management, will operate a telephone line with functionality for individuals to submit complaints regarding potential violations of the No Surprises Act. HHS will route complaints to the appropriate federal agency by:

- Website: https://www.cms.gov/nosurprises/consumers
- Phone: 800-985-3059 (toll-free)

Resources and guidance on implementation

The following resources are provided as references to the law's requirements and model notices, forms, and templates that may be useful for implementation of the law:

[3] See OARs 836-053-1600 to 836-053-1615 and DFR's out-of-network calculators for non-anesthesia-related procedures and anesthesia procedures.

- Centers for Medicare & Medicaid Services No Surprises Act Home Page
  Provider Requirements and Resources Page

- Overview of No Surprises Act Rules and Fact Sheets

- Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process Under No Surprises (Download Fee Information) (PDF)

- Standard notice & consent forms for nonparticipating providers and emergency facilities regarding consumer consent on balance billing protections (Download Surprise Billing Protection Form) (PDF)

- Model disclosure notice on patient protections against surprise billing for providers, facilities, health plans, and insurers (Download Patient Rights & Protections Against Surprise Medical Bills) (PDF)

- Paperwork Reduction Act (PRA) model notices and information collection requirements for the Federal Independent Dispute Resolution Process (Download Model Notices and Information Requirements)

- Paperwork Reduction Act (PRA) model notices and information collection requirements for the good faith estimate and patient-provider payment dispute resolution (Download Model Notices and Information Requirements)

- Requirements for including federal agency contact information and website URL on certain documents (Download Memo of Requirements for Plans, Providers and Facilities) (PDF)

1/13/2022

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Date