New Hampshire Insurance Department

2021 Federal No Surprises Act Frequently Asked Questions

State of New Hampshire
Insurance Department

21 South Fruit Street, Suite 14
Concord, NH 03301
603-271-2261

Purpose: The purpose of this FAQ is to provide consumers, health care providers, facilities and providers of air ambulance services information on requirements in the federal No Surprises Act (NSA) that apply starting Jan. 1, 2022. The New Hampshire Insurance Department (NHID) provides this information to educate stakeholders about new protections applicable to health insurance enrollees in New Hampshire.

Background: As part of the Consolidated Appropriations Act of 2021, on Dec. 27, 2020, the U.S. Congress enacted legislation, the federal NSA, which contains many provisions to help protect consumers from surprise bills starting Jan. 1, 2022. The provisions in the NSA create requirements that apply to health care providers and facilities and providers of air ambulance services, such as 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 health care provider, facility and provider of air ambulance services 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 Benefit plans. The NSA's requirements related to the patient-provider dispute resolution process also apply to individuals with no health insurance coverage.

Table of Contents:

SECTION I:

FREQUENTLY ASKED QUESTIONS (FAQ) FOR HEALTH CARE CONSUMERS UNDER THE FEDERAL NO SURPRISES ACT

Frequently Asked Questions:

1. What is balance billing?

Balance billing happens when a health care provider (a doctor, for example) bills a patient after the patient's health insurance company has paid its share of the bill. The balance bill is for the difference between the provider's charge and the price the insurance company set, after the patient has paid any copays, coinsurance or deductibles.

Balance billing can happen when a patient receives covered health care services from an out-of-network provider or an out-of-network facility (a hospital, for example). In-network providers agree with an insurance company to accept the insurance payment in full, and do not balance bill. Out-of-network providers do not have this same agreement with insurers.

Some health plans, such as Preferred Provider Organization (PPO) or Point of Service (POS) plans, include some coverage for out-of-network care, but the provider may still balance bill the patient if state or federal protections do not apply. Other plans do not include coverage for out-of-network services and the patient is responsible for all of the costs of out-of-network care. Medicare and Medicaid have their own protections against balance billing.

2. What is surprise billing?

Surprise billing happens when a patient receives an unexpected balance bill after they receive care from an out-of-network provider or at an out-of-network facility, such as a hospital. It can happen for both emergency and non-emergency care. Typically, patients do not know the provider or facility is out-of-network until they receive the bill.

Some states have laws or regulations that protect patients against surprise billing. However, state laws generally do not apply to self-insured health plans, and most people who get coverage through an employer are in self-insured health plans. Now, a new federal law protects consumers in self-insured health plans as well as consumers in states that do not have their own protections.

3. What protections are in place?

A new federal law, the No Surprises Act, protects you from:

- Surprise bills for covered emergency out-of-network services, including air ambulance services (but not ground ambulance services), and
- Surprise bills for covered non-emergency services at an in-network facility.

The law applies to health insurance plans starting January 1, 2022. It applies to the self-insured health plans that employers offer as well as fully-insured plans from health insurance companies.

- An emergency facility (such as a hospital or freestanding emergency room (ER)) and professional emergency provider (such as a doctor) may not bill you more than your in-network coinsurance, copays, or deductibles for emergency services, even if the facility or provider is out-of-network.
- If your health plan requires you to pay copays, coinsurance, and/or deductibles for in-network care, you are responsible for those costs.
- The new law also protects you when you receive non-emergency services from out-of-network providers (such as an anesthesiologist) at in-network facilities. An out-of-network provider may not bill you more than your in-network copays, coinsurance, or deductibles for covered services performed at an in-network facility.
    - You can never be asked to waive your protections and agree to pay more for out-of-network care at an in-network facility for care related to emergency medicine, anesthesiology, pathology, radiology or neonatology—or for services provided by assistant surgeons, hospitalists (doctors who focus on care of hospitalized patients), and intensivists (doctors who care for patients needing intensive care), or for diagnostic services including radiology and lab services.
    - You still can agree in advance to be treated by an out-of-network provider in some situations, such as when you choose an out-of-network surgeon knowing the cost will be higher. The provider must give you information in advance about what your share of the costs will be. If you did chose the out-of-network provider knowing the anticipated costs, you would be expected to pay the balance bill as well as your out-of-network coinsurance, deductibles and copays.

4. What else should I know?

- Your health plan and the facilities and providers that serve you must send you a notice of your rights under the new law.

- If you have received a surprise bill that you think is not allowed under the new law, you can file an appeal with your insurance company or ask for an external review of the company's decision. You also can file a complaint with the New Hampshire Insurance Department or the federal Department of Health and Human Services.
- There are processes available under the New Hampshire law as well as the federal law to assist providers and insurance companies in settling disputes about your bill without putting you in the middle. There is also a federal dispute resolution process available for individuals who are uninsured, in certain circumstances, such as when the actual charges are much higher than the estimated charges.
- Other protections in the new law require insurance companies to keep their provider directories updated. The insurance company also must also limit your copays, coinsurance or deductibles to in-network amounts if you rely on inaccurate information in a provider directory.

5. What are some examples of balance billing and how this new law will work?

Example #1: Deion fell off a ladder, hitting his head and breaking his arm. He was taken to the nearest emergency room. He needed covered imaging and radiology services as well as surgery. Now bills are starting to come in. What is he responsible for paying? How can he get help if he's receiving bills that do not match the explanation of benefits (EOB) from his health insurance plan?

For emergency care he received, Deion is only responsible for paying his in-network deductibles, copays and coinsurance, even if health care providers who were not in his plan network treated him, or he was taken to a facility that was out-of-network. If the bills do not match his explanation of benefits (EOB), Deion can call his health insurer first. If he isn't satisfied with the insurer's response, he can contact the New Hampshire Insurance Department.

If Deion is admitted to the hospital after he receives care in the emergency room, he should know that any out-of-network health care providers at the facility may ask him to consent to continuing care and to agree to pay higher amounts. They can only ask for his consent to receive out-of-network care once he is stabilized, able to understand the information about his care and out-of-pocket costs, and it is safe to travel to an in-network facility using non-medical transportation. If those conditions are met, Deion can decide if he wants to continue with the out-of-network provider, or travel to a provider who participates in his health plan's network. If he stays with the out-of-

network provider and consents to out-of-network billing, he'll be responsible for any out-of-network deductibles, copays, or coinsurance. He'll also be responsible for the amount the provider charges that is more than what the insurance company pays (the balance bill).

Example #2: Elena is scheduled for a biopsy, a service that her health plan covers. Her hospital and surgeon are in-network with her health plan, but the hospital uses anesthesiologists and pathologists that are not in-network. Does this mean everything will be covered as in-network, or could Elena have some unexpected charges?

Surgery for a biopsy can involve health care providers that you do not get to choose, such as an anesthesiologist and a pathologist. Under New Hampshire's current balance billing law, the out-of-network anesthesiologist and pathologist that assisted with Elena's care at an in-network facility are prevented from billing Elena any amount over her plan's cost sharing.

Example #3: Hannah is admitted to an in-network hospital. While in the in-network hospital, Hannah receives treatment from an Intensivist that is out-of-network. Starting in 2022, when Hannah receives care at an in-network facility, all of her out-of-pocket costs will be at the in-network rate. That includes the costs for any out-of-network providers she didn't choose who participate in her care.

SECTION II:

FREQUENTLY ASKED QUESTIONS (FAQ) FOR HEALTH CARE PROVIDERS AND FACILITIES ON REQUIREMENTS UNDER THE FEDERAL NO SURPRISES ACT

Frequently Asked Questions:

1. What NSA Health Care Provider and Facility Requirements will begin to apply starting Jan. 1, 2022?

For health care providers and facilities and providers of air ambulance services, the following requirements will be in effect:

- Providers and facilities shall not balance bill the patient for out-of-network emergency services[1].
- Nonparticipating providers shall not balance bill for non-emergency services provided at participating health care facilities, unless the patient is provided with adequate notice and consents in writing to be balance billed[2]. Nonparticipating providers are prohibited from balance billing for ancillary services.
- Health care providers and facilities must disclose patient protections against balance billing[3].
- Nonparticipating air ambulance providers may not balance bill for air ambulance services[4].
- Health care providers and facilities are expected to make good faith efforts to comply with the law. Further, they shall provide a good faith estimate in advance of scheduled services, or upon request[5].

2. What does no balance billing for out-of-network emergency services mean?

Nonparticipating providers and nonparticipating emergency facilities cannot bill or hold liable enrollees in group health plans or individual health insurance plan 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.

---

[1] Public Health Services Act (PHSA) section 2799B-1; 45 C.F.R. section 149.410.
[2] PHS Act section 2799B-2; 45 C.F.R. section 149.420.
[3] PHS Act section 2799B-3; 45 C.F.R. section 149.430.
[4] PHS Act section 2799B-5; 45 C.F.R. section 149.440.
[5] PHS Act section 2799B-6; 45 C.F.R. section 149.610 (for uninsured or self-pay individuals).

Post-stabilization services are considered emergency services, and are therefore subject to this prohibition, unless certain conditions are met.

3. What are the exceptions to no balance billing for out-of-network post-stabilization emergency services?

Nonparticipating providers and facilities may balance bill for post-stabilization services only if the following conditions are met:

- The treating provider determines the patient is able to travel using nonmedical transportation to an available participating provider within a reasonable travel distance;
- The provider or facility providing post-stabilization services satisfies the notice and consent requirements; and
- The individual or individual's authorized representative is in a condition to provide informed consent in accordance with state law.

4. Can nonparticipating providers balance bill for non-emergency services at participating health care facilities?

No. 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 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. A standard notice and consent form can be found at https://www.cms.gov/files/document/standard-notice-consent-forms-nonparticipating-providers-emergency-facilities-regarding-consumer.pdf.

5. How do providers adequately satisfy the disclosure of patient protections against balance billing?

A provider or facility must disclose to an enrollee information regarding federal and state balance billing protections and how to report violations. A model disclosure notice can be viewed at https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf.

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.

6. Does NSA apply to air ambulatory providers?

Yes. 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.

7. Does NSA apply to ground ambulatory providers?

No. There is currently no prohibition against balance billing by either the state of federal government for ground ambulatory providers.

8. What are the NSA requirements for providers to provide a good faith estimate of the expected charges in advance of scheduled services?

There are four predominant requirements to satisfy the NSA's good faith estimate provision:

- 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 plan or insurer is responsible for determining coverage and cost-sharing amounts.
- 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.
- Under the NSA, 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 to be eligible to use the process.
- The standard notice and consent form found at https://www.cms.gov/files/document/standard-notice-consent-forms-

nonparticipating-providers-emergency-facilities-regarding-consumer.pdf includes an estimate template.

9. What are the NSA's requirements for provider directories and reimbursement to enrollees?

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)[6].
- Reimburse beneficiaries, enrollees or participants with interest any amount paid to a provider based on a provider bill at was in excess of the in-network cost-sharing amount.[7]

10. How does the NSA differ from New Hampshire's balance billing law?

In short, New Hampshire's current balance billing law is narrower in scope than the NSA. During the 2018 session, the New Hampshire Legislature and Governor Chris Sununu acted to prohibit out-of-network anesthesiologists, pathologists, radiologists and emergency physicians from balance billing a commercially insured patient when the care was provided at an in-network hospital. However, those were the only providers that New Hampshire's law prohibited from balanced billing.

The NSA expands the prohibition against balance billing to all emergency care, out-of-network providers at in-network facilities and air ambulatory providers. Therefore, because the federal law provides greater protections against balance billing than New Hampshire law, the provisions of the NSA will expand the protections under state law.

11. Who is enforcing the NSA, the State of New Hampshire or the federal government?

It is important for providers to remember that regardless of which provision of the NSA is implicated or whether the state or federal government is the enforcing

[6] PHS Act section 2799B-9.
[7] PHS Act section 2799B-9.

entity, patients are removed from payment disputes between a provider or health care facility and their health plan and must not be balance billed.

Providers that engage in balance billing may be subject to disciplinary action by their respective state licensing board or by the Centers for Medicare & Medicaid Services (CMS) if the federal government determines that the state is failing to enforce the requirements or lacks the necessary authority.

For the following provisions, NHID will ONLY enforce when the circumstance involves emergency and pathology, as well as radiology and anesthesiology for in-network facilities in the state in non-emergency cases. In all other cases, the federal Centers for Medicaid and Medicare Services (CMS) will enforce:

- Limitations on Out-of-Pocket Costs for Out-of-Network Emergency Services; Cost-Sharing and Out-of-Network Payment Amounts; Emergency Services Definition and Non-Emergency Services Provided by an Out-of-Network Provider at an In-Network Facility; Consumer Protections related to Price Transparency and Other Information.
- Independent dispute resolution for issuers and providers. Determination of payment through APCD, state law, or independent dispute resolution process.
- Balance Billing – both emergency and non-emergency.
- Patient disclosure.

For the following provisions, until NHID has the statutory authority to enforce, only CMS will enforce the following:

- Group health insurance issuers must apply the same surprise billing requirements that to out-of-network air ambulance services, if the plan or issuer provides coverage of air ambulance services by an in-network provider.
- Air Ambulance balance billing and independent dispute resolution process.
- Provision of Information.
- Uninsured patient independent dispute resolution process.

12. How do providers bill and handle billing disputes with insurers under New Hampshire law and the federal NSA?

Under New Hampshire's balance billing law, the healthcare provider or facility is entitled to payment of the commercially reasonable value.

In the event of a dispute about the value, the New Hampshire Insurance Commissioner has exclusive jurisdiction to determine whether the charge is commercially reasonable and either party may request a hearing.

Under the NSA, the healthcare provider or facility is entitled to payment of the out-of-network amount. There is a presumption that the qualifying payment amount (QPA) is appropriate out-of-network rate. The QPA is generally the plan or issuer's median contracted rate for the same or similar service in the specific geographic area. If there is disagreement that the QPA is the appropriate rate, a 30-day open negotiation period may be initiated. If no agreement is reached, either party may initiate the federal independent dispute resolution (IDR) process.

Both parties must pay an administrative fee ($50 each for 2022), and the non-prevailing party is responsible for the certified independent dispute resolution entity fee for the use of this process. The IRD entity must begin with the presumption that the QPA is the appropriate amount. For the IRD entity to deviate from the offer closest to the QPA, information submitted must clearly demonstrate that the value of the item or service is materially different from the QPA. Neither party may submit information about usual or customary charges, the amount that would have been billed by the provider or facility in the absence of the federal rules about surprise billing, or the reimbursement rates payable to a public payer. The IDR's decision is not subject to judicial review.