

Let's Break Down the **No** **Surprises Act**



A riveting ebook by **rivet**

Even before the public health emergency, two-thirds of Americans were worried about being able to afford an unexpected medical bill, and 78% of people supported legislation to protect against surprise medical bills.

A recent report from the Department of Health and Human Services (HHS) found that millions of Americans with private health insurance experience some kind of surprise medical billing.

In fact, the HHS found surprise medical bills to be quite commonplace, seeing that “privately-insured patients can average more than \$1,200 for services provided by anesthesiologists, \$2,600 for surgical assistants, and \$750 for childbirth-related care.”

Health and Human Services Secretary Xavier Becerra commented about the report, “Today’s report shows that despite some state efforts to tackle surprise medical bills, patients continue to experience exorbitant medical expenses due to lack of transparency and rules. The Biden-Harris Administration will continue implementing federal regulations from the No Surprises Act to not only protect the patients but also curb rising costs in health care.”

Now signed into law, the No Surprises Act is part of the Consolidated Appropriations Act of 2021 (H.R. 133; Division BB – Private Health Insurance and Public Health Provisions).

The No Surprises Act addresses surprise medical billing issues at the federal level, establishing patient protections against surprise medical bills along with other provisions (e.g., transparency). Most of the legislation will go into effect on Jan. 1, 2022. The Departments of the HHS, Treasury, and Labor will issue regulations and guidance to implement a number of provisions.

Key points of the No Surprises Act

- ⊕ Both providers and health plans must assist patients in accessing health care cost information (“good faith estimates”).
- ⊕ Patients are protected from receiving surprise medical bills from gaps in coverage for EMS (including air ambulances) and certain services provided by out-of-network providers at in-network facilities.
- ⊕ Providers and insurers have access to an independent dispute resolution (IDR) process to settle reimbursement disputes.
- ⊕ Patients can be held liable only for their in-network cost-sharing amount, though providers and insurers have the opportunity to negotiate reimbursement. No benchmark reimbursement amount will be set



Fair and honest “good faith” cost estimates

This section of the No Surprises Act establishes new stipulations for health plans offering group and individual health insurance coverage to send patients “Advanced Explanations of Benefits” (EOB) prior to scheduled care or upon patient request prior to scheduling. The Advanced EOB requirement is triggered by the provider sending a good faith estimate, as stipulated in Section 112 of this legislation, to the plan. A patient can request an Advanced EOB from their health plan, if desired.

Information Needed for an Advanced EOB

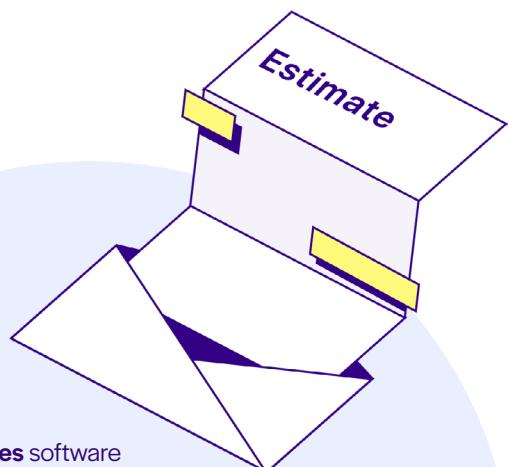
- If the patient’s provider, facility or service are in-network, based on the patient’s health plan.**
 - If provider and facility are in-network, the contracted rate for the item or service (based on the diagnostic codes) must be included.
 - If a provider or facility is out-of-network, a description of how to obtain in-network provider information must be included.
- A good faith estimate of the following items:**
 - expected charges and probable billing and diagnostic codes
 - the plan’s payment responsibility
 - the patient’s expected cost-sharing amount (based on the notification date and not on the date of service)
 - and the amount the patient has incurred toward meeting their financial responsibility limits (e.g., deductible and out-of-pocket maximums).
- A disclaimer describing that coverage for the item or service is subject to a certain medical management technique (e.g., prior auth) as appropriate.**
- A disclaimer describing that all info included in the notice is an estimate and is subject to change. The estimate must be based on the information known at the time of scheduling or requesting the information.**
- Any other info or disclaimers determined to be appropriate for this notice by the health plan.**

Health plans need to share this information by mail or electronically (based on patient preference) within three business days of receiving a request, or if notice of service being scheduled (at least 10 business days after notice).

If the service is scheduled for less than 10 days after notice, the health plan will need to provide information within one business day.

The patient-provider dispute resolution process will be established by Jan. 1, 2022, “to adjudicate any disputes over pricing for uninsured patients that receive a substantially higher bill than the ‘good faith estimate’ provided prior to service,” paraphrased the American Hospital Association.

Though providers are only federally required to offer good faith estimates to self-pay individuals, many price transparency changes have been made to individual states. See your state’s website for local price transparency guidelines. For information about Hospital Transparency guidelines, [see this article](#).



Rivet’s Estimates software offers accurate good faith estimates that you can send to patients via HIPAA-compliant text and/or email, or print out the estimate right in your office. Patients will see their deductible/out-of-pocket maximum met, diagnostic codes, their financial responsibility and their plan’s financial responsibility, prior authorization flags, customized disclaimers, and more.

[Learn more about Estimates here.](#)

*Summarized from the [AHA](#)

Coverage for out-of-network providers at in-network facilities

Health insurers are required to cover out-of-network emergency services and certain non-emergency services performed by out-of-network providers at in-network facilities. No prior authorization is necessary for emergency services.

“Emergency services” include post-stabilization services, unless certain conditions are met. Those conditions include ability to transfer the individual or the provider has met the notice and consent requirements established in this legislation.

Notice and Consent Process Requirements

If all of the following requirements are met, a patient may be billed the out-of-network costs associated with their visit:

- Written notice and consent must be received within 72 hours of the item or service being delivered or, if the item or service is scheduled within that time frame, at the time the appointment is made.**
- Notice must be in paper or electronic form as selected by the patient.**
- Notice must contain the following info at minimum:**
 - notification that the provider is out-of-network
 - a good faith estimate of charges
 - a list of in-network providers at the facility that the patient can be referred, if facility is in-network
 - info on any prior auth or other care management requirements
 - and a clear statement that consent is optional and the patient could opt for an in-network provider.

* This process may NOT be used for services such as emergency services, certain ancillary services, and items or services that are delivered as a result of an unforeseen urgent medical need that arises during a procedure for which notice and consent was received.



Some ancillary services do not apply to the Notice and Consent option. Patients receiving the following non emergency ancillary items and services may not be billed beyond their in-network cost-sharing amount:

- | | |
|--------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Emergency medicine | <input checked="" type="checkbox"/> Radiology |
| <input checked="" type="checkbox"/> Anesthesiology | <input checked="" type="checkbox"/> Neonatology |
| <input checked="" type="checkbox"/> Pathology | <input checked="" type="checkbox"/> Diagnostic services
(including radiology and laboratory services) |

An out-of-network provider cannot use the notice and consent process if there is an in-network provider available to render the item or service at the facility.

For example of the coverage for out-of-network providers at in-network facilities: Bob's child, Jane, obtained a serious injury. He rushed her to their in-network hospital for an ER visit. The only surgeon available to offer lifesaving care was an out-of-network provider. The new No Surprises Act establishes that Jane's care be billed as in-network, unless notice and consent requirements were met.

This act states that provisions apply to comprehensive individual and group health plans and establishes a process that insurers must follow to calculate a patient's cost-sharing obligation. It also specifies the amount insurers must reimburse out-of-network providers and establishes a federal oversight audit procedure for this provision.

Health plans must pay or issue payment denial notice to the provider within 30 calendar days after receiving the bill from the provider. Any patient cost-sharing will count toward the patient's deductible and/or out-of-pocket cost-sharing maximum as if services were provided in-network.

Cost-sharing for out-of-network providers at in-network facilities is determined, in part, by two new concepts: recognized amount and qualifying payment amount.

The qualifying payment amount (QPA) is used for determining the patient cost-sharing amount unless another state law or policy applies. QPA is generally the plan or issuer's median contracted rate for the same or similar service in the specific geographic area.

When another state law or policy applies (i.e., state surprise billing law or an all-payer rate setting model as in Maryland) it is called the recognized amount. This amount will be used in lieu of QPA, if applicable.

This legislation also protects patients with certain circumstances of non-emergency services performed by out-of-network providers at in-network facilities. Under these circumstances, health plans must observe patient cost-sharing as if they were in-network and compensate as previously talked about.

Reimbursement disputes

For reimbursement disputes, see Section 103 of the No Surprises Act, which talks about a negotiation period and independent dispute resolution (IDR) process. Publicly accessible information on the IDR process will be available on a quarterly basis.

Reimbursement disputes will undergo a negotiation period and IDR process like the one spoken of previously. This legislation does not apply to ground ambulances.

[Click here](#) to read more about the IDR process.

Miscellaneous parts of the No Surprises Act

Surprise air ambulance bills

An air ambulance service is defined as emergency transport using helicopter or airplane. Under this part of the No Surprises Act, patients are required to pay only the in-network cost-sharing amount for out-of-network air ambulances. Cost-sharing under these circumstances will count toward their deductible.

As of Jan. 1, 2022, out-of-network air ambulance providers are barred from sending patients balance bills for more than the in-network cost-sharing amount.

Health plan price comparison tool

Health plans must maintain online price comparison tools so that patients can compare expected out-of-pocket costs for items and services across multiple providers. Price comparisons must also be available over the phone. Health plans need to be prepared with price comparison tools for plan years beginning on or after Jan. 1, 2022.

Transparency on insurance ID cards

In Section 107 of the No Surprises Act, health plans offering group and individual health insurance coverage are required to include the following information on insurance identification cards for plan years beginning on or after Jan. 1, 2022:

- All plan deductibles, including in-network and out-of-network deductible amounts (as applicable).
- Maximum limits on out-of-pocket costs for both in-network and out-of-network out-of-pocket cost limits (as applicable).

A phone number and web address for consumer assistance information, like info on in-network providers.

Ensuring care for women and children

Under this legislation:

- Pediatricians must be able to serve as a child's primary care provider.
- Enrollees must be able to access obstetrical and gynecological care without a plan-instituted approval process.

Ensuring coverage for continuing care patients

Section 113 of this law ensures services are not hindered for enrollees of health plans when the plans' provider network changes.

Health plans are required to timely notify continuing care patients if in-network status of providers and facilities changes. Qualifying patients will have up to 90 days of continued coverage at in-network cost sharing as they transition to an in-network provider.

Continuing care patients include those who are:

- undergoing a course of treatment for a serious or complex condition
- undergoing institutional or inpatient care
- scheduled to undergo non-elective surgery including post-operative care
- pregnant and undergoing treatment
- terminally ill and receiving services

Provider directory information

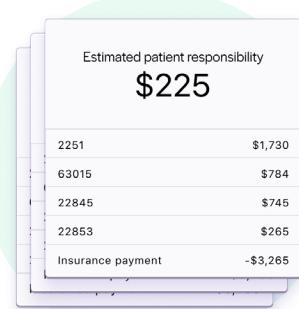
Health plans are required to establish a verification process to ensure in-network provider directories are accurate, full of needed information, and publicly accessible.

**Note: Grants for state “all payer claims databases” and implementation funding were also part of the No Surprises Act.
See more info [here](#).*



EHRs can be so useful for your practice, but you probably need more than an EHR to know what's happening with your claims. With Rivet, you can analyze claims, manage denials and underpayments and provide accurate patient cost estimates.

Go to rivethehealth.com for more information.



Date	Procedure	Allowed	Variance
3/30/2020	92014	\$115.10	\$46.19
3/24/2020	92134	\$41.92	\$17.11
3/19/2020	92134		
3/15/2020	92134	Expected Charged	Actual \$32.00 \$32.00
3/15/2020	92134	CO-45	-\$3.17 -\$12.11
	Total	\$28.33	\$19.49

Ron Swanson

Insurance	Payer	Subscriber	Balance	Deductible	Out-of-pocket
	Aetna	80510239	\$1,498	\$3,182	\$8,996

Demographic:

- DOB: 03/10/1951
- Phone: (505)555-1234
- Address: 123 fake St, Seattle, WA
- Email: ron@swanson.gov

Encounters:

Date	Balance	Status
03/01/2020	\$1,498	Billed
03/02/2020	\$129	Paid
03/04/2020	\$482	Paid
03/05/2020	\$91	Paid
03/06/2020	\$64	Paid
03/07/2020	\$287	Paid

History:

- 3/10/2020 Paper statement sent
- 3/11/2020 Email sent
- 3/12/2020 New encounter
- 3/13/2020 Statement paid
- 3/14/2020 Payment received
- 3/15/2020 Paper statement sent
- 3/16/2020 Email sent
- 3/17/2020 SMS sent
- 3/18/2020 Payment received
- 3/19/2020 New encounter
- 3/20/2020 Payment received

Estimates

Rivet Estimates is an eligibility and cost estimate tool that offers you:

- ✓ Eligibility checks
- ✓ Cost estimates
- ✓ Up-front patient payments
- ✓ Payer contract management

Underpayments

Rivet Underpayments is a claim underpayments detection tool that offers you:

- ✓ Payer contract analysis
- ✓ Claim payments auditing
- ✓ Underpayments analysis
- ✓ Underpaid claims delegation
- ✓ Claims analytics

Denials

Rivet Denials is a denials management tool that offers you:

- ✓ A collaborative database
- ✓ Intelligent worklists
- ✓ Automated forms and letters
- ✓ A comprehensive claim view
- ✓ Claims analytics

"Rivet has driven up revenue massively. It paid for itself in less than a month."

The biggest thing is that we're getting paid what we're supposed to and Rivet helps with that."

— Jennifer Davison, CEO of VERO Orthopaedics

Find out more at rivethehealth.com.