Interplay of the Federal No Surprises Act and Texas State Specific Balance Billing Law

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WHO WE ARE?

GetixHealth provides personalized revenue cycle services to healthcare providers, including health systems, hospitals, and physician groups. Our experienced team improves revenue cycle efficiency, reduces costs, and increases cash flow, resulting in higher profitability for your organization.

Our Solutions:

- Patient Access
- Eligibility & Enrollment
- Workers' Compensation
- Insurance Resolution
- Coding & Chart Audit
- Self Pay Patient Billing
- Professional RCM Services

ABOUT COMPANY

Since our start in 1992, GetixHealth has grown into a leading healthcare partner, actively managing the revenue cycle for over 400 providers and 15,000 physicians.

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Medical Billing Challenges

- ❑ $88 Billion in Medical Debt on Consumer Credit Records as of June 2021
- ❑ 58% of all third-party debt collection tradelines were for medical debt
- ❑ Medical bill amounts can be unpredictable and often vary widely based on patient and provider characteristics.

What is Surprise Billing (Balance Billing)?

Surprise Billing occurs when a patient receives medical care from out-of-network providers, resulting in unexpected, often high bills beyond what insurance covers.

The No Surprises Act in the United States addresses and aims to prevent surprise billing, protecting patients from excessive healthcare costs in certain situations.

70% of Physicians

Approximately 70 percent of physicians bill 2 percent or fewer of their claims out-of-network (OON).

5% of Physicians

A small share of physicians, just over 5 percent, account for the majority of their claims being billed out-of-network.

High OON Specialties:

The specialties with the highest rates of OON billing are psychiatry, emergency medicine, pathology, anesthesiology, and pain medicine. On average, they bill over 4 percent of their claims out-of-network.

Service Location Impact

Emergency Department claims have a 13% OON likelihood, Ambulatory Surgery Centers have an 8% likelihood, while office visits have a lower 4% OON likelihood.

The Road to No Surprises Act: Balance Billing Laws Over Time

- **Early 2000s:** States begin to introduce their own balance billing laws, addressing the issue of surprise medical bills at the state level. These laws vary significantly from state to state.
- **2010:** The Affordable Care Act (ACA) is enacted, including provisions that limit balance billing for emergency services and certain out-of-network care, but these protections had limitations.
- **2014:** New York State passes one of the first comprehensive balance billing laws, providing strong patient protections.
- **2015:** A study by Consumers Union (now Consumer Reports) highlights the prevalence and impact of surprise medical bills, drawing national attention to the issue.
- **2016-2017:** Bipartisan efforts in Congress to address balance billing gain momentum, but comprehensive federal legislation remains elusive.
- **2018:** Several states take action to strengthen their balance billing laws, and public awareness of the issue continues to grow.
- **2019:** Congress holds hearings on surprise billing, with both the House and Senate exploring legislative solutions.
- **December 2019:** The No Surprises Act is included in a federal spending package as part of the Consolidated Appropriations Act, marking a significant step towards comprehensive federal legislation.
- **December 2020:** The No Surprises Act is officially signed into law as part of the Consolidated Appropriations Act, 2021, providing robust patient protections against surprise medical bills and establishing a framework for resolving payment disputes between providers and insurers.
- **2022:** The No Surprises Act's provisions take effect, providing relief to millions of Americans from unexpected and excessive healthcare costs.

The Road to No Surprises Act: Balancing Billing Laws Over Time

The Road to No Surprises Act: Balancing Billing Laws Over Time

“We're already preventing insurance companies from sending surprise medical bills, stopping 1 million surprise bills a month.”

Remarks of President Joe Biden – State of the Union Address, February 2023

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Summary of the Federal No Surprises Act

NSA High Level Goals

PROTECTIONS AGAINST SURPRISE BILLING

Prohibits providers and facilities from "balance billing" in certain situations.

NSA protects patients from the financial burden of surprise medical bills resulting from out-of-network care in situations where they have limited control over provider choices, such as emergencies or care received at in-network facilities.

Billing and Reimbursement Rules

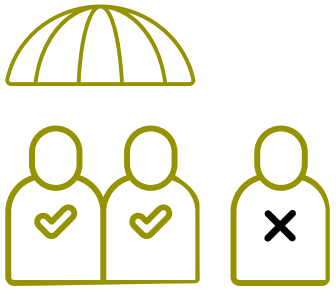
Regulates the billing procedures, the billing rate that must be used to determine cost-sharing amounts, and the out-of-network provider reimbursement rate.

Independent Dispute Resolution Process

Creates a patient-provider dispute resolution process for uninsured (or self-pay) individuals to contest charges that are "substantially in excess" of the good faith estimate.

Services Covered

Emergency Services



Out of Network Provider

Air Ambulatory Services

How NSA goes beyond the ACA provisions ?

- **Comprehensive Protection:** The No Surprises Act provides more comprehensive protection against surprise billing by addressing both emergency and non-emergency situations, whereas the ACA primarily focused on emergency care.
- **Prohibition of Balance Billing:** While the ACA included some protections against balance billing, the No Surprises Act goes further by explicitly prohibiting balance billing for emergency services and certain non-emergency services provided by out-of-network providers.
- **Patient Cost-Sharing:** The No Surprises Act establishes clear rules for patient cost-sharing, ensuring that patients are responsible for in-network rates in cases of surprise billing. The ACA did not provide such clear guidelines.
- **Advance Cost Estimates:** Under the No Surprises Act, healthcare providers and facilities are required to provide patients with cost estimates for non-emergency services in advance. This transparency empowers patients to make informed decisions about their care, a provision not found in the ACA.
- **Independent Dispute Resolution (IDR):** The No Surprises Act introduces an IDR process to resolve payment disputes between providers and insurers, ensuring that disputes are resolved fairly and without imposing undue financial burdens on patients. This mechanism was not part of the ACA.
- **Broader Applicability:** The No Surprises Act extends its protections to a wider range of healthcare settings, including ambulatory surgery centers (ASCs), whereas the ACA primarily focused on emergency services provided by in-network facilities.
- **Enhanced Enforcement:** The No Surprises Act includes provisions for stronger enforcement and penalties for non-compliance, encouraging healthcare providers and insurers to adhere to the new rules.

Covered Emergency Services

The emergency services subject to the NSA include not only the immediate treatment of an emergency medical condition, but also medical screening and other ancillary services to stabilize a patient, as well as post-stabilization services, regardless of whether the services are furnished within an emergency department.

Prudent Layperson Standard for Determining Emergency Medical Condition

The statute establishes a prudent layperson standard to determine whether an individual is suffering an emergency medical condition. This determination is based on whether a medical condition manifests itself by acute symptoms of sufficient severity (including severe pain). The test is whether a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in specified provisions of the Social Security Act (SSA).

Knowledge Check

Zoe is a 26-year-old female with Marketplace coverage. She works as a teacher and has an average knowledge of health and medicine. She has severe pain, swelling and redness on her right calf, and becomes concerned that this may be dangerous. So, she travels to the local hospital emergency department that is in her health plan's network. She has a venous ultrasound. The radiologist, who is out-of-network, reads the ultrasound, which shows a deep vein thrombosis. Zoe is started on medication and discharged from the emergency department.

Do the NSA's balance billing protections related to emergency services apply to the radiologist?

Yes, it would. Zoe sought care for a medical condition that, using reasonable layperson judgment, she thought was an emergency medical condition that needed immediate medical attention to avoid serious jeopardy, impairment, or dysfunction. Per the No Surprises Act, out-of-network providers are banned from balance billing for emergency services provided for emergency medical conditions. Emergency services include ancillary services available to the emergency department to evaluate whether an emergency medical condition exists, such as services of a radiologist who reads an imaging study.

Knowledge Check

Carol is a 58-year old female with Marketplace coverage. Over 2 days, she develops worsening abdominal pain, nausea, and constipation, which prompts her to call 911 for medical assistance. She is driven by ground ambulance transport to her local in-network emergency department for exam and treatment.

How much can the ambulance provider bill Carol under the NSA rules?

The ambulance provider isn't banned from balance billing under the No Surprises Act because it is a ground ambulance provider. Note: Air ambulance service providers, but not ground ambulance service providers, are banned from balance billing under the No Surprises Act. As such no restrictions are placed on the amount the ambulance provider can bill an individual under the No Surprises Act.

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Billing and Reimbursement Rules For Providers and Payors

Provider Responsibilities

1 **Good Faith Estimates**

Provide Good Faith Estimates for un-insured or self-pay patients for scheduled services

You have the right to receive a "Good Faith Estimate" explaining how much your health care will cost

- Under the law, health care providers need to give patients who don't have certain types of health care coverage or who are not using certain types of health care coverage an estimate of their bill for health care items and services before those items or services are provided.
- You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- If you schedule a health care item or service at least 3 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.
- If you receive a bill that is at least $400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.

Provider Responsibilities

1 Good Faith Estimates

Provide Good Faith Estimates for un-insured or self-pay patients for scheduled services

2 Notice of Rights

Provide notice of rights to consumers: single page notice and website

3 Consent Forms

Consent forms allow claim to be processed as OON with higher patient out of pocket. Guidelines include:

- Must be provided 72 hours BEFORE services are rendered in non-emergent situation and within 3 hours in emergent situation.
- Allowed for ED AFTER patient stabilized
- Must be a separate document from all other consent paperwork

Knowledge Check

Shawn is a 35-year-old male who has insurance through the Marketplace. He is playing soccer and sustains a knee injury, which is later diagnosed as a torn ACL. He is advised by his friends to go to a specific orthopedist who has an excellent reputation. His surgery is scheduled at an in-network ambulatory surgical center a week in advance. One day before his surgery, he gets an email with the written notice and consent documents, informing him that the orthopedist is out of-of-network and requesting that he consent to waive his balance billing protections under the No Surprises Act in order to be treated by the orthopedist. Shawn signs the consent to waive balance billing protections, as he would like to see this specific provider for his knee surgery. Several weeks after his surgery, Shawn gets a balance bill from his orthopedist.

Did the orthopedist comply with requirements of the No Surprises Act?

No, the provider violated No Surprises Act requirements related to when notice and consent documents must be provided to individuals. Since Shawn scheduled his surgery more than 72 hours in advance, written notice and consent must be provided to the individual no later than 72 hours before the date of the appointment. In this case, the provider sent notice and consent documents one day before the appointment. Because all requirements related to using notice-and-consent exceptions were not met, the orthopedic surgeon is banned from balance billing Shawn for services provided as part of the surgery even though he signed the consent form.

Payor Responsibilities

1. Prompt payment requirement (within 30 days for clean claims)
2. All ED and Air Ambulance Services must be automatically processed in-network.
3. Out of Network reimbursed at qualifying rate without prior authorization
4. Disclosures on ID cards
5. Advanced EOB (deferred)
6. Payment made to Provider not to Patient
7. Regularly update provider directories

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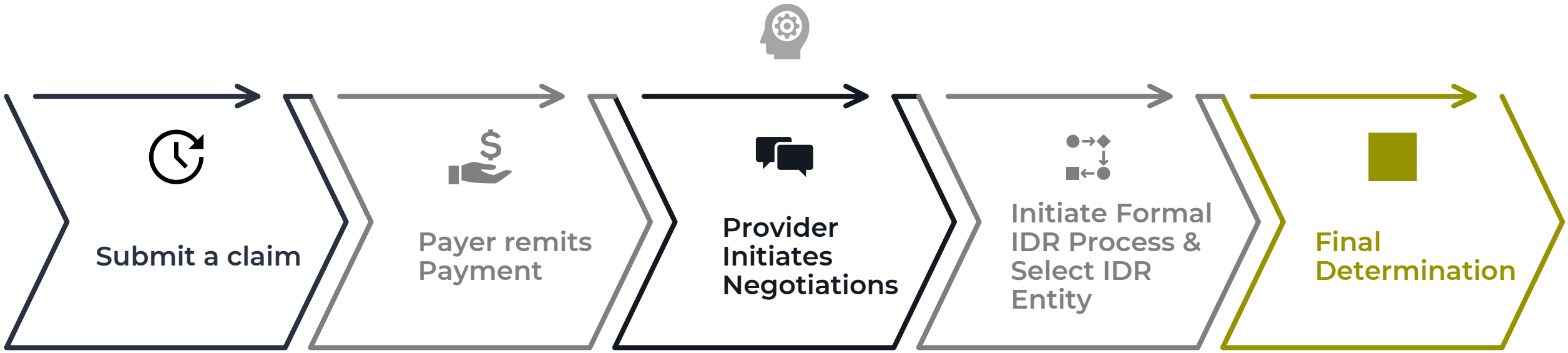
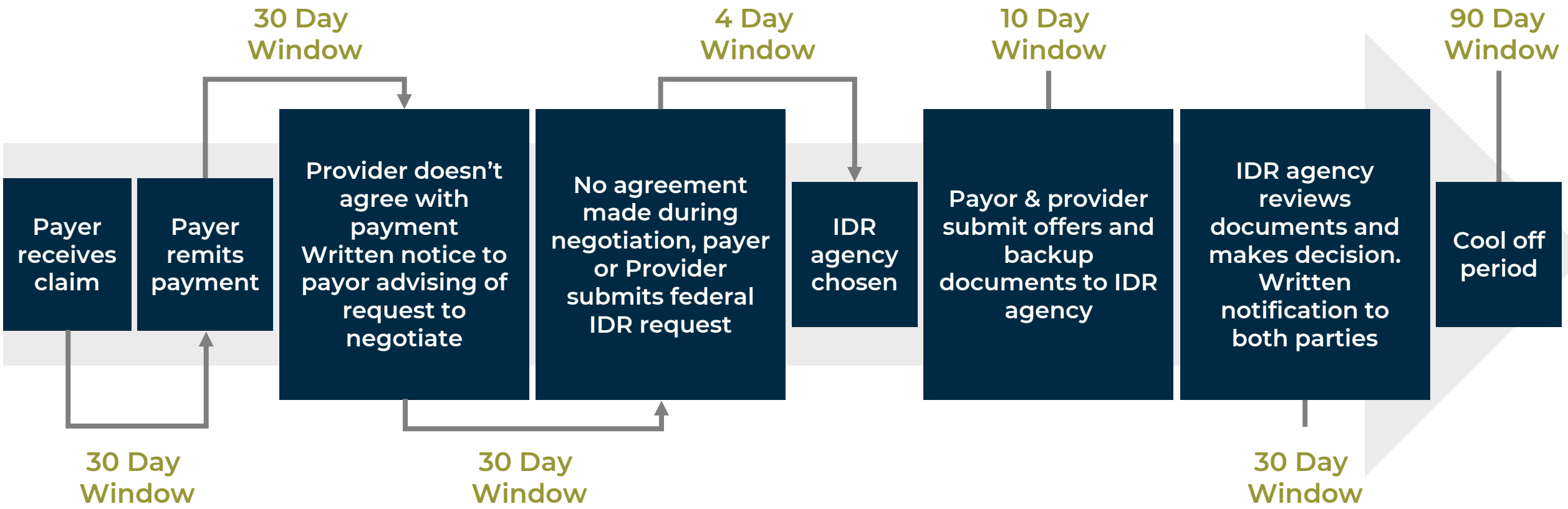
Independent Dispute Resolution Process

Federal IDR Process Timeline



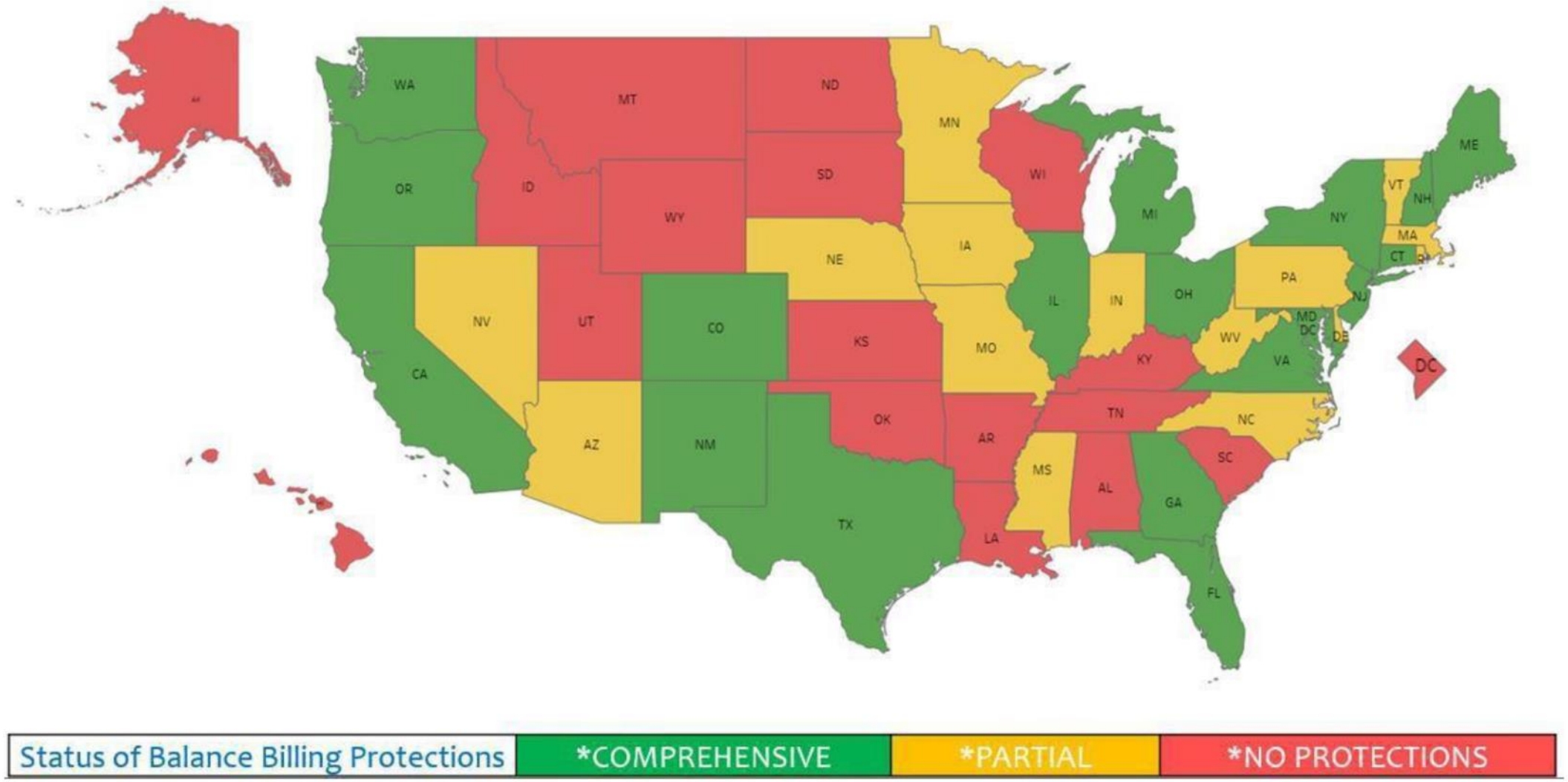
Federal IDR Process Timeline

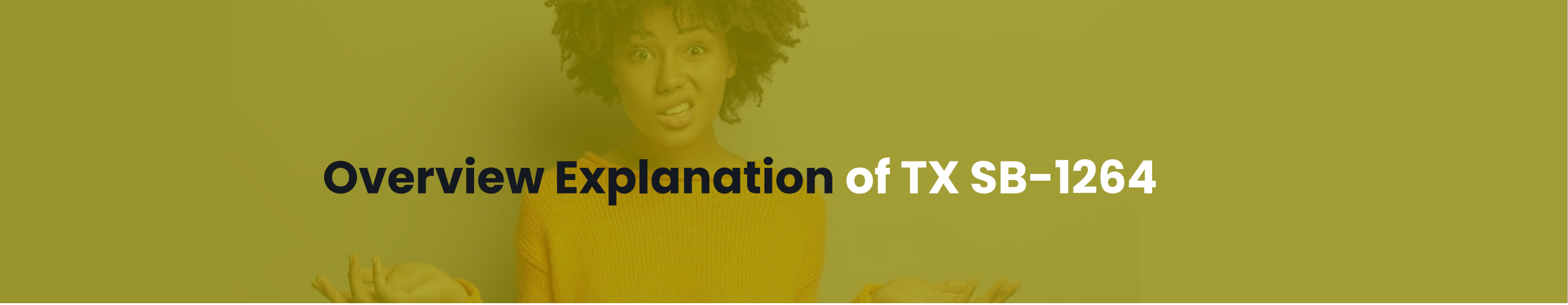


The Federal IDR Process does not apply:

- To items and services payable by Medicare, Medicaid, the Children's Health Insurance Program, or TRICARE
- In cases where a specified state law (SSL) or All-Payer Model Agreement (APMA) under Section 1115A of the Social Security Act provides a method for determining the total amount payable under a group health plan or group or individual health insurance coverage with respect to the OON items and services furnished by the provider or facility.

Figure 2-1 – State Surprise Billing Protections Prior to NSA, 2021





Overview Explanation of TX SB-1264

Plans not regulated by TDI

Starting January 1, 2022, the federal No Surprises Act will protect Texas consumers with health plans not regulated by the state from surprise bills for:

- Air ambulance services.
- Emergency care.
- Care provided at in-network facilities when the patient didn't have a choice of doctors.

Plans regulated by TDI

Texas and federal laws protect Texas consumers with state-regulated health plans from surprise bills.

- Federal law bans balance bills for air ambulance services received on or after January 1, 2022.
- State law bans balance bills for the following received on or after January 1, 2020:
  - Emergency care.
  - Care provided at in-network facilities when the patient didn't have a choice of doctors.

State law authorizes arbitration (for doctors) and mediation (for facilities) to resolve payment disputes in those cases.

The law carves out a narrow exception when a consumer chooses an out-of-network doctor or provider at an in-network facility.

Comparison between Federal and Texas State Provisions

Federal Provisions

- ✓ All commercial insurance plans – incl. self funded
- ✓ Non emergent/specific emergency and air ambulance services (pro & tech)
- ✓ Payment determined as median rate from 2019 reimbursement data
- ✓ Consent process
- ✓ Formal dispute process for providers & patients
- ✓ Good Faith Estimate requirement (uninsured)
- ✓ Consumer notification requirement

Texas Provisions

- ✓ Arbitration Process for provider-related disputes
- ✓ Mediation Process for facility-related disputes
- ✓ The state's IDR process involves multiple state agencies
- ✓ Texas has not entered a CEO to pursue voluntary enforcement for federal IDR cases
- ✓ Bans balance bills: (1) in emergencies; (2) when the patient didn't have a choice of doctors for medical services, or for (3) air ambulance services.
- ✓ Only applies to state-regulated plans.

OMB Control No. 1210-0169
Expiration Date: 11/30/2025

Information on the Parties and Item(s) and/or Service(s)

[*Enter name of party initiating negotiations*] is initiating an open negotiation period with [*enter name of the non-initiating party*] for the out-of-network rate of the following item(s) and/or service(s). To negotiate, please contact me (the representative of the initiating party) at the e-mail address or telephone number below:

Item(s) and/or service(s) [insert additional rows as appropriate]

	Description of item(s) and/or service(s)	Claim Number	Name of provider, facility, or provider of air ambulance services, and National Provider Identifier (NPI)	Date provided	Service code	Initial payment *(if no initial payment amount, write N/A)*	Offer for total out-of-network rate (including any cost sharing)
1.							
2.							
3.							
4.							
5.							

Signature _____ Date _____

Print Name _____ Relationship to person(s) or entity listed above

Mailing Address _____ Telephone number _____

Email Address _____

Please keep a copy of this notice for your records.

KEY TAKEAWAYS

01

Review 835 reason/remark code mapping, flagging remittance codes associated with NSA payments.

02

If system indicator or agency will be utilized, develop reports to track volume of accounts, payer information, reimbursement, and date of claim submission to ensure timely payment of claims.

03

If IDR process will be utilized, develop reporting to track all accounts going through IDR process. Be sure to track the date account(s) enter IDR process and outcomes.

04

Implement and monitor a weekly denial report to ensure payers aren't blanket denying out of network claims.

05

Monitor reimbursement percentages closely for both in and out of network payers to ensure consistent cash flow.

Takeaways for Collectors

01

Create a Good Faith Reliance Upon Information Provided by the Creditor

02

Crucial Conversations with Clients

03

Establish Safeguard Policies and Procedures as to Medical Debt

- Validation Notice and Disputes/Requests for Validation
- Credit Report Furnishing; and
- Reasonable Investigations

04

Training

Q & A

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THANK YOU!

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