# The "No Surprises Act" and How it Impacts Chiropractic

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On January 1, 2022, The Consolidated Appropriations Act of 2021 will become effective. Why is this important information for Chiropractors? Because within this act, is a section (Private Health Insurance and Public Health Provisions – Division BB) that will affect chiropractic along with the entire medical profession. This is where the guidelines for the "NO SURPRISES ACT" (Title I and Transparency – Title II) can be found. This article explains the Act and how it will impact a Chiropractic Office?

## Who does the Act affect?

This Act was established in order to protect the patient, the facility or provider and the insurance companies.

- First, it protects the patient against "Surprise Billing", also known as Balance Billing.
- Next, it protects the facility/provider from any repercussions when a Good Faith Estimate along with Communication regarding the process, services and charges is established.
- Lastly, it protects the Insurance Companies through an Independent Dispute Resolution (IDR) process regarding settlements.

## What is Balance Billing?

Prior to this Act, laws regarding Balance Billing existed at a state level, but only in some states. Wisconsin was not one of those states. This Act now changes this and will cover all states.

Patients being seen in an emergency situation, run the risk of being treated by an out of network provider. This can happen simply because the care is urgent and, in an emergency, it is likely that the patients insurance information was not obtained prior to treatment in order to conduct a verification of benefits. It is also a possibility that even though the patient is being treated at an in-network facility, such as a hospital, the rendering provider could be out of network with their insurance carrier.

When these types of events occur, the patient can be left with very high costs. Whether in or out of network, once the insurance responds to the charges, the patient has typically been responsible for all unpaid services. This Balance Billing can come at a surprise to the patient because it was never discussed with the patient that the rendering provider was out of network or that services were non covered. Often times these services are much higher than if the patient had been seen by an in-network provider.

## What does the "No Surprises Act" do?

This Act protects the patient, provider/facility, and insurance company.

**FOR THE PATIENT:** Regardless of how the beneficiary obtains coverage (employer, Marketplace, or individual health plan), this act will ensure that, emergency services, even if they are provided out-of-network, must be covered at an in-network rate without requiring prior authorization. It will also prevent balance billing and out of network cost sharing for both emergency and non-emergency services. Meaning the patient's cost should not be more than what the service would have been if provided by an in-network provider. This applies to coinsurances and deductibles as well. Services provided by an anesthesiologist or assistant surgeon (ancillary care) are also included in this act.

**FOR THE FACILITY/PROVIDER:** Whether the patient is insured or uninsured, the services and cost of those services are to be discussed. The act requires that providers and facilities communicate to the patient, in a comprehensive manner, what services will be rendered, the cost of those services, insurance participation and what the patients expected cost would be. This is a "Good Faith Estimate", and it must be provided within (1) the required time frame (see below), (2) an itemized list of the services, charges and expected coverage must be offered to the patient, (3) the services and cost must be explained to the patient (over the phone or in person) along with either a paper or electronic estimate or provide the estimate in a way that is accessible to the patient and HIPAA compliant. The patient's consent is required in order to have the out of network care provided. If this consent is obtained, prior to the services, then the provider can bill the patient.

## The 72-hour notice

If the patient schedules care 72 hours or more prior to the date the care is to be rendered, the "Good Faith Estimate" must be disclosed no less than 72 hours prior to the appointment. If an appointment is scheduled with less than 72 hours before being rendered, the "Good Faith Estimate" must be provided on the date of the appointment and at least 3 hours prior to the appointment. The provider must inform the patient of the services to be rendered, the cost (in and out of network), and expected insurance participation as well as what the patient will be expected to pay.

▶ **Remember, this does not do away with the patients responsibility to pay for a co-pay or co-insurance.** This act only prevents patients from unexpected fees for services and costs that are not explained to them prior to treatment and that have not been consented to.

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### There are three ways to provide the patient with the disclosure information regarding the No Surprises Act.

1. **Post In Your Clinic:** Providers are required to have this information posted in a central location wherever services are being rendered (waiting area, treatment room, Notice of Privacy Practices, etc.)
2. **Share On Your Website** It must be able to be located on the website (if one is available) and it must be searchable and without cost or a required login.
3. **Provide a Paper Copy:** Patients must be given the disclosure information in a one-page notice. Using at least 12-point font and may be double-sided.

The 72-hour notice cannot be applied to certain types of services that are out-of-network when performed at an in-network office. For example: ancillary services(anesthesia), diagnostic services(radiology/labs) or any other services that the Secretary of Health and Human Services (HHS) may identify.

Violations to this law, meaning that balance billing has occurred, are likely to incur penalties up to $10,000.00 per violation from the HHS.

## FOR THE INSURANCE COMPANY/CARRIER

This Act also provides protection for the Insurance Companies and the relationship with both their beneficiaries and the providers.

Within 30 days of billing, private health plan carriers would have to pay a portion of out of network charges whether the services were pre-authorized or not if that carrier typically covers emergency services. Also applicable to non-emergency services that are out-of-network if they were performed at a hospital or facility that is in-network. Determination of the amount that the plan must pay to the out of network provider in this 30-day time frame, is based upon the same or similar service and the in-network payment for those services. If Excluded/Non-Covered services are being provided, the health plan can deny the services based upon the benefit plan when the services are billed within the 30-day window. This helps prevent any "partial payments" for the health plan.

Upon receiving the health plan's partial payment or denial letter, an out-of-network provider and health plan have 30 days to try to negotiate a resolution of any dispute. If the dispute is not resolved within this time frame, the provider then has a tight window from the end of the 30-day negotiation period – to initiate an appeal using an Independent Dispute Resolution (IDR) process established under the new federal law.

### The IDR Process:

- Creates an independent review and expedited arbitration process.
- Within three days of initiating the IDR process, both parties must select a certified IDR entity to decide their dispute.
- Within 10 days of selecting the IDR entity, both the provider and the health plan must submit "final offers" to the IDR entity. Including any supporting materials required by the IDR entity that either party believes to be pertinent to their dispute.
- The IDR entity will review the information submitted and make a determination.
- The offer that is not selected must pay the costs of the IDR, which are expected to range from approximately $500 to $2,000 in most cases.
- Once a decision has been made, the balance due must be paid within 30 days.

When deciding which "final offer" to accept, the IDR entity must consider a benchmark known as the "qualifying payment amount" (QPA) for the services at issue. As of January 1, 2022, the QPs for various services are expected to be set at amounts that represent the median of the contracted (in-network) rates that the health plan paid for such services in the relevant market as of January 31, 2019, with an upward adjustment based on the Consumer Price Index for urban consumers (CPIU). For 2023 and subsequent years, the QPAs for existing health plans will continue to be adjusted upward based on the CPIU. For new health plans formed after January 31, 2019, the QPAs may be calculated based on a different methodology approved by HHS, or pursuant to a database that HHS may set up in accordance with the Act. The law mandates that an IDR entity consider the QPA when evaluating and deciding which of the competing 'final offers" to approve. But there are other factors that IDR entities are also directed to consider, including the provider's training, experience, and outcome measurements; the complexity of the case; the provider's teaching status; and any contracting rate history between the parties over the prior four years.

## Steps to prepare you for January 1, 2022:

The Act requires that, effective January 1, 2022, providers must have processes in place to ensure they are regularly supplying updated provider information to health plans for use in directories that are made available to help patients identify in-network providers.

1. Create and have in written format, your policies, and procedures for this Act and train your staff so they are prepared to implement this process in the new year.
2. Create your forms for the Good Faith Estimate, Insurance Verification, and Consent, if you do not already have these forms available in your office. Also have the disclosure notifications in place.

Please keep in mind that this law is new and the details are still unfolding and will continue to do so even after the implementation date. WCA will keep you aware of details as they are released. If you have any additional questions, contact wcahelpdesk@wichiro.org or 608.256.7023.