No Surprises Act

What you need to know about upcoming changes in the health insurance industry.

In late December 2020, Congress passed the Consolidated Appropriations Act (CAA). It contains significant COVID-19 relief measures and also includes numerous additional legislative items impacting other sectors, such as the healthcare and health insurance industries.

One of the most notable items in the CAA relates to surprise billing. Surprise bills arise when a patient receives care at an in-network facility by an out-of-network provider; or when a patient receives emergency services, without having a say in where they are treated under such emergency conditions. Surprise bills are often shockingly expensive. The No Surprises Act will require health plans to implement several changes which apply to individual and group health plans (grandfathered and non-grandfathered).

While many of the regulatory details are not yet available, Blue Cross and Blue Shield of Kansas (BCBSKS) has multiple interdisciplinary committees meeting to begin the work of how BCBSKS will implement these new changes. They are required to be implemented by Jan. 1, 2022.

While regulators are still working out the final details, below you will find a brief description of key points of the No Surprises Act and the CAA.

Balance Billing: Surprise bills must be covered at in-network rates.

Health plans must negotiate surprise medical bills on behalf of patients who receive emergency services rendered by out-of-network providers/facilities, air ambulance services, and services provided by out-of-network providers at in-network hospitals or facilities. The new law lifts the burden off patients so they are held harmless and not balance billed for provider charges that exceed the in-network rate.

Health plans must keep their provider directories up to date, and verify they are accurate every 90 days.

Additionally, carriers must also establish a "response protocol" system, allowing them to respond to covered individuals, within a newly required one-business-day timeframe, when asked whether a provider or facility is considered "in-network."

2022 Jan. 1

Changes go into effect Jan. 1, 2022.

Health plans must provide price comparison tools to consumers.

These tools, which must be available by phone and internet, allow covered individuals and in-network providers to compare expected cost-sharing amounts for covered services.

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Health plans must provide advanced Explanation of Benefits (EOBs) to consumers upon request, and to consumers proactively before scheduled care.

Health plans must provide advanced EOBs explaining benefits and estimates of cost-sharing before scheduled care. They must furnish such good-faith estimates, within three business days, of what the plan will pay and what the patient cost might be for covered services (whether the provider is in-network or out-of-network). For services scheduled within 10 days, the advanced EOB must be distributed within one business day.

Providers must also furnish good-faith estimates of expected charges for services — including related billing and diagnostic codes in advance of a service.

Providers are also expected to furnish charges for services that are reasonably expected alongside the scheduled services.

Health plans must notify individuals when a provider/facility leaves its network and must provide related transitional continuity of care to patients in some circumstances.

For patients receiving certain types of ongoing care from affected providers or facilities, health plans must provide up to 90-days of transitional coverage (or until treatment ends) by those providers, at in-network rates. Such transitional coverage is generally available for patients being treated for serious/complex health conditions, inpatient care, non-elective surgery, pregnancy and terminal illness.

Carriers must update and re-release physical and digital ID cards.

For plan years beginning January 2022 or later, these cards must list plan deductibles and out-of-pocket maximum limits.

Health plans must make available in-network negotiated rates and out-of-pocket (OOP) costs.

The in-network negotiated rates with providers will be available in regularly updated, machine-readable files located on bcbsks.com. Personalized OOP cost information will be made available, upon request. The OOP cost information will be made available in two waves – an initial list of 500 services for plan years that begin on or after Jan. 1, 2022, and the remainder of all items and services for plan years that begin on or after Jan. 1, 2023.

Health plans must update some pharmacy reporting procedures.

Health plans are required to report on pharmacy benefits and drug costs. Plans will be required to annually report a number of plan details to the Departments of Health and Human Services, Labor and the United States Treasury.

Health plans will be required to strengthen parity in mental health and substance use disorder benefits.

Under the new requirements, individual and group health plans, including self-funded group health plans, must conduct and document a comparative analysis of their non-quantitative treatment limits (processes, strategies, standards, or other criteria that limit the scope or duration of benefits for services provided under the plan) for mental health and medical surgical benefits. The new mental health parity requirements went into effect on February 10, 2021. BCBSKS will continue to review and document this information for our health plans to ensure we are complying with the new guidelines.

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