COMPLIANCE ALERT

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Agencies Release First Rule on the No Surprises Act

On July 13, 2021, the DOL, HHS, and IRS released a joint Interim Final Rule implementing specified provisions of the No Surprises Act, a new law included within the Consolidated Appropriations Act, 2021. The No Surprises Act addresses, among other things, a prohibition on surprise billing, which impacts emergency room parity rules previously implemented under the Affordable Care Act ("ACA") and ACA provisions related to provider choice.

The Interim Final Rules will be finalized on September 13, 2021 and apply for plan years beginning on or after January 1, 2022.

Background

ACA Provider Choice and Emergency Services Requirements

Under §2719A of the ACA, most group health plans that require designation of a participating primary care provider must permit the participant or beneficiary to designate an available, participating primary care provider of their choice, and must inform participants of their ability to make a designation or, if they don't, a primary care provider will be designated for them. A participant can designate a pediatric primary care provider for children, and the notice must inform participants and beneficiaries that they do not need prior authorization from the plan to access participating Ob-Gyn providers, though prior authorization may be required for certain services and providers may have to comply with any referral processes. The ACA did not extend these requirements to "excepted benefits" such as stand-alone dental or vision plans, and grandfathered health plans were exempt from complying.

Additionally, §2719A of the PHSA requires emergency services to be provided:

1. Without prior authorization (whether they are provided by an in-network or out-of-network provider);
2. Without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services; and
3. Without imposing administrative requirements or limitations on the coverage that are more restrictive than those that apply to in-network providers when emergency services are provided out-of-network.

The ACA also required compliance with certain cost-sharing requirements for out-of-network emergency services, though providers could still balance bill (after the plan made a reasonable payment meeting certain minimum payment standards). Like the provider choice provision, the emergency services requirements also did not apply to grandfathered health plans.

The No Surprises Act

Among other things, the No Surprises Act sunsets §2719A of the ACA effective January 1, 2022 and replaces it with new emergency services requirements for group health plans

(under §2799A-1 and 2799A-2 of the PHSA), and recodifies the provider choice provisions (under §2799A-7 of the PHSA). Further, the No Surprises Act extends the recodified provider choice requirements and the new emergency care provisions to all group health plans, among other plans, except those plans consisting of excepted benefits. Thus, all non-excepted group health plans – fully-insured, self-funded, grandfathered, and non-grandfathered must comply with these requirements.

The new emergency services requirements protect individuals from surprise medical bills by requiring all non-excepted group health plans and issuers that cover hospital emergency room services or emergency services provided in a freestanding, independent emergency department, to cover services without imposing any prior authorization or limitation on coverage regardless of whether the provider is a participating provider or emergency facility.

Essentially, all emergency services must be covered in the same manner regardless of whether they are provided by an in-network or out-of-network provider or facility. Further, any participant cost sharing requirements for out-of-network emergency services providers or facilities must be the same as cost-sharing requirements for in-network emergency services providers or facilities and must be counted towards any applicable in-network deductible or OOP maximums under the plan.

Similarly, the No Surprises Act requires group health plans and issuers to cover non-emergency services provided by out-of-network providers working at in-network facilities, as well as air ambulance services provided by out-of-network providers, using the same general approach as emergency services described above.

As described above, balance billing is prohibited in many situations, such as for emergency services and certain ancillary services connected to non-emergency care at in-network facilities, such as anesthesiology services or radiology services provided by out-of-network providers contracted by the in-network facility.

In other non-emergency situations balance billing may be permitted if the non-participating facility or provider meets certain, stringent advance notice and consent requirements under §2799A-2(d) of the PHSA. For the notice, the provider must provide participants, beneficiaries, or enrollees a written or electronic notice at least 72 hours before the appointment (or the date the appointment is made if it is less than 72 hours before the appointment), containing the following information:

- That the provider or facility is non-participating/OON under the plan;
- A good faith estimate of charges for the items or services needed/involved, including that the estimate or consent does not constitute a contract with respect to the charges estimated for the items or services provided;
- If the facility is in-network, but the provider providing services at the facility is not, then a list of any participating providers at the facility who are able to furnish the necessary items or services, and that the participant can be referred, at their option, to a participating provider; and
- Whether prior authorization or other care management limits are required before a participant can receive items or services from the non-participating provider.

The notice must clearly state that consent to receive items or services from a non-participating provider is optional, and that the participant can seek treatment or care from a participating provider or facility instead that would have more favorable cost sharing. The notice must be available in the 15 most common languages in the geographic region of the applicable facility or provider.

The consent must be written in clear, understandable language, and indicate that the participant, beneficiary or enrollee has been:

- Provided with the above written notice in the form selected by the participant (written or electronic).
- Informed that payments made towards the service or item may not accrue towards meeting any cost sharing limitations under their medical coverage, including that it may not apply towards the in-network deductible under the plan, if any.

The consent form must include the date the participant, enrollee, or beneficiary received the notice, and the date they signed the consent. A signed copy of the consent must be provided to the participant, beneficiary, or enrollee.

The No Surprises Act instructed the DOL, IRS, and HHS to develop rules by July 1, 2021, that include the methodology the group health plan can use to determine the qualifying payment amount, information the group health plan must share with the nonparticipating provider or facility, geographic regions, and a process to receive complaints of violations. The Interim Final Rule fulfills that requirement.

Interim Final Rules

Among other things, the Interim Final Rule defines "emergency medical condition" and "emergency services" similar to how those terms are defined under the Emergency Medical Treatment and Labor Act ("EMTALA"); however, the definition of "emergency services" includes pre-stabilization services provided after a patient is moved out of the emergency department and admitted to a hospital such that these services are protected under the No Surprises Act. "Emergency services" also include certain post-stabilization services. Further, according to the preamble to the regulations, defining "emergency medical condition" consistent with EMTALA ensures that group health plans or issuers must cover emergency services without limiting what constitutes an emergency medical condition solely based on diagnosis codes.

The Interim Final Rules specify the methodologies that group health plans can use to determine cost-sharing amounts for (1) out-of-network emergency facilities, (2) out-of-network emergency providers, and (3) certain non-emergency services furnished by out-of-network providers at certain in-network facilities. Specifically, the Interim final Rules require that cost sharing amount be calculated by using:

- An amount determined by an applicable All-Payer Model Agreement under §1115A of the Social Security Act.
- If there is no such applicable All-Payer Model Agreement, an amount determined under a specified state law.
- If neither of the above apply, the lesser amount of either the billed charge or the qualifying payment amount, which is generally the plan's or issuer's median contracted rate.

The regulations provide guidance for determining the median contracted rate.

Cost sharing amounts for out-of-network air ambulance services must be calculated using the lesser of the billed charge or the plan's or issuer's qualifying payment amount, and the requirement must be the same as if services were provided by an in-network air ambulance provider.

Rates for out-of-network providers (including any cost sharing) must be based on:

- An amount determined by an applicable All-Payer Model Agreement under §1115A of the Social Security Act.
- If there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law.
- If there is no such applicable All-Payer Model Agreement or specified state law, an amount agreed upon by the plan or issuer and the provider or facility.
- If none of the three conditions above apply, an amount determined by an independent dispute resolution entity.

Regulations related to the independent dispute resolution process and entities have not been issued; however, the agencies indicated that they intend to release the regulations soon.

Additionally, certain health care providers and facilities, as well as health plans and health issuers are required to make a notice publicly available, post on a website (for health plans, that would be a website of the plan), and provide individuals a notice about:

- the restrictions on balance billing in certain circumstances,
- any applicable state law protections against balance billing, and
- information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing

Health plans and issuers are also required include the above information on each EOB containing an item or service for which the No Surprises Act applies. The agencies released a model notice for health plans and issuers.

What Does This Mean for Employers?

Employers sponsoring non-excepted group health plans should work with their carriers or third party administrators to ensure their plan is prepared to comply with the No Surprises Act beginning with their 2022 plan year, including any disclosure requirements on EOBs, and to ensure any plan materials and SPDs are updated, as necessary. Further, employers should prepare to comply with the applicable notice requirements by either using or tailoring, as applicable, the Model Notice provided by the agencies. Finally, employers with grandfathered health plans should ensure they comply with the ACA's provider choice requirements beginning in 2022 and update their SPDs and/or wrap documents to include the required provider choice notice.

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