Legislative Update:
No Surprises Act

MURRAY GROUP

Interim Final Rules | July 30, 2021

July 1, 2021, HHS, the DOL and the Treasury Department released interim final rules implementing the No Surprises Act (the Act) that was part of the CAA passed by Congress in late 2020.[1]

The interim final rules are generally applicable to group health plans and health insurance issuers for plan and policy years beginning on or after January 1, 2022. **Employers who self-insure their health plans, as well as those covered by fully insured plans, should be aware of how the No Surprises Act will affect their plan(s).**

The No Surprises Act also includes **price transparency requirements,** which will affect group health plans. Murray Group will provide specific guidance on this topic as they develop.

What is considered a "Surprise Medical Bill"?

The Act addresses situations wherein a person covered by a health plan receives services from providers who are not in the plan's network. In those circumstances, the out-of-network provider may bill the patient the difference between the amount the provider charges for the service and the amount the health plan will pay for that service, a practice called "balance billing."

An in-network hospital still might have out-of-network providers, and patients may have little or no choice when it comes to who provides their care. For non-emergency care, an individual might choose an in-network facility or an in-network provider but not know that a provider involved in their care (for example, an anesthesiologist or radiologist) is an out-of-network provider.

In most cases, out-of-network cost sharing and surprise bills usually do not count toward a person's deductible and maximum out-of-pocket limit. Individuals with surprise bills may have to spend more out-of-pocket because they have to pay their out-of-network cost sharing and surprise billing amounts regardless of whether they have met their deductible and maximum out-of-pocket limits.

The Act and the interim rules include protections that address some of these circumstances.

[1] An interim final rule is a rule that an agency promulgates when it finds that it has good cause to issue a final rule without first issuing a proposed rule. Although interim rules are often effective as of the date of their publication, they will have a comment period after which the interim rule may be amended in response to public comments. In this case, the interim final rules are effective 60 days from the date they are published in the Federal Register. Public comments may be submitted until 9/7/2021.

Plan Coverage Requirements:

The protections in this rule apply to most emergency services, air ambulance services from out-of-network providers, and non-emergency care from out-of-network providers at certain in-network facilities, including in-network hospitals and ambulatory surgical centers. *Note: Ground ambulance services are not addressed in the interim final rules.*

This rule also protects people from excessive out-of-pocket costs by limiting cost sharing for out-of-network services to in-network levels, requiring cost sharing for these services to count toward any in-network deductibles and out-of-pocket maximums, and prohibiting balance billing under certain circumstances.

If a plan or coverage provides benefits for emergency services, it requires emergency services to be covered:

- Without any prior authorization (i.e., approval beforehand).
- Regardless of whether the provider is an in-network provider or an in-network emergency facility.
- Regardless of any other term or condition of the plan or coverage other than the exclusion or coordination of benefits, or a permitted affiliation or waiting period.

Note that in cases where the plan must pay the bill before the participant meets their deductible, the plan must pay the provider or facility the difference between the out-of-network rate and the cost-sharing amount (the latter of which in this case would equal the amount of either the billed charge or the qualifying payment amount, which is generally the plan's median contracted rate), even in cases where the participant has not satisfied their deductible.

In an example provided in the interim rules, an individual is enrolled in a high deductible health plan with a $1,500 deductible and has not yet accumulated any costs towards the deductible at the time the individual receives emergency services at an out-of-network facility. The plan determines that the recognized amount for the services is $1,000. Because the individual has not satisfied the deductible, the individual's cost-sharing amount is $1,000, which accumulates towards the deductible. The out-of-network rate is subsequently determined to be $1,500. Under the requirements of the statute and these interim final rules, the plan is required to pay the difference between the out-of-network rate and the cost-sharing amount. Therefore, the plan pays $500 for the emergency services, even though the individual has not satisfied the deductible. The individual's out-of-pocket costs are limited to the amount of cost sharing originally calculated using the recognized amount (that is, $1,000). Even though such payments would normally cause a high deductible health plan to lose its status, the Act states that a plan shall not fail to be treated as a high deductible health plan by reason of providing benefits pursuant to the Act.

Specifically, the consumer cost-sharing amount must be calculated based on all-payer models (if applicable), state law requirements, or if the former do not apply, the lesser amount of either the billed charge or the qualifying payment amount.

Additionally, this rule requires certain health care providers and facilities to furnish patients with a one-page notice on:

- The requirements and prohibitions applicable to the provider or facility regarding balance billing.
- Any applicable state balance billing prohibitions or limitations.
- How to contact appropriate state and federal agencies if the patient believes the provider or facility has violated the requirements described in the notice.

Determining the Amount Plans Pay Out-of-Network Providers

The rules also provide plans with three methods of determining the amount they must pay out-of-network providers who provide services to their participants. As described above, the plan must first look to the applicable All-Payer Model Agreement and, if no such agreement exists, to applicable state law. If neither option is available, then the plan and the out-of-network provider must come to an agreement regarding the price. If they cannot agree, then they go through an informal dispute resolution process (IDR) to determine the amount. The agencies plan to issue additional rules describing the IDR at a future date. To prevent billing disputes between providers and insurers, the interim final rule requires plans to make an initial out-of-network payment (or send a notice denying payment) within 30 calendar days after a clean claim is submitted for emergency services or non-emergency services performed by nonparticipating providers at participating facilities. The initial payment should reflect the amount that the plan intends to be payment in full; it is not intended to be a first installment. While the interim final rule did not provide guidance on the dollar amount of the initial payment, the agencies requested comments on whether and how the rate should be set in the future, and noted that some states already set standards for minimum initial payment amounts, which should be followed.

More to Come…

The No Surprises Act also implements **other price transparency requirements,** which will affect group health plans. Look for more guidance from Murray Group on this topic as we gather more details.

Interim Final Rules:

https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i

Other Sources:

https://www.kff.org/private-insurance/issue-brief/ground-ambulance-rides-and-potential-for-surprise-billing/

http://www.benefits-partners.com/tools-and-resources/federal-update.aspx