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First Guidance on Surprise Medical Billing Issued

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On July 13, 2021, the Departments of Health and Human Services ("HHS"), Labor ("DOL"), and the Treasury (collectively, "the Departments") jointly published an interim final rule implementing provisions of the No Surprises Act ("NSA"). This is the first set of regulations to address the NSA ("Part I Regulations"); additional rules are forthcoming, including guidance on the Independent Dispute Resolution ("IDR") process.

Briefly, as it relates to group health plans, the regulations:

- Include protections to limit out-of-network ("OON") cost-sharing and "balance billing" as they relate to emergency services, OON providers of air ambulance services, and non-emergency services performed by OON providers at in-network facilities (with limited exceptions).

- Prescribe a formula to determine a participant's cost-sharing for these services and how much the plan will pay to the provider for these services. Generally, this will be the lesser of a Qualified Payment Amount ("QPA") or the provider's billed charge, unless a state law or the All-Payer Model Agreement applies.

- Describe new notification obligations, including posting information about the surprise medical bill protections on the plan's website as well as including such information in the Explanations of Benefits ("EOBs") issued with respect to these services.

These rules take effect for plan years beginning on or after January 1, 2022, and apply to all group health plans (including grandfathered plans), except:

- Excepted benefits (e.g., dental and vision plans);

- Short-term limited duration insurance;

- HRAs and other account-based plans; and

- Retiree plans (plans with fewer than 2 participants who are current employees).

For fully insured group health plans, the carrier will be responsible for compliance.

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For self-funded group health plans, the plan sponsor is responsible and will need to work closely with third-party administrators ("TPAs") to comply with these rules. TPAs will likely need to update plan documents to reflect the changes required under the NSA and could pass additional administrative costs on to plan sponsors.

The following highlights some of the additional details from these rules. It will be important to discuss implementation and compliance with TPAs. The Departments request comments on numerous aspects of the rule by September 7, 2021.

Background

As previously reported, with respect to group health plans (and health insurance carriers), the NSA provides protection as it relates to OON cost-sharing and "balance billing" with respect to:

- Emergency services;
- Non-emergency services delivered by OON providers at in-network facilities, and
- OON air ambulance services.

"Balance billing" refers to the practice of an OON provider billing a patient the difference between (1) the provider's billed charges and (2) the amount collected from the plan (or carrier) plus any amounts previously collected from the patient (e.g., copays, coinsurance, or amounts paid toward the deductible).

The law also establishes a pathway for resolving payer-provider payment disputes using negotiation and arbitration. If entities are unable to come to an agreement, the IDR process requires each party to submit a final payment offer and the arbiter will select one of these offers as the final payment amount. The arbitrator's decision is final and generally may not be appealed.

Generally, the requirements of the NSA apply to the items and services described above unless the state has an "All-Payer Model Agreement" ("APMA") (used by Maryland, Pennsylvania and Vermont) or state balance billing law (including Delaware, Massachusetts and Pennsylvania that applies.

In general, self-funded ERISA group health plans will be subject to the requirements of the NSA (versus state law or APMA). However, where state law allows, a plan sponsor may voluntarily "opt-in" to a state's balance billing protections that provide a method for determining the cost-sharing amount or total amount payable under such a plan (versus the NSA). Currently four states – Nevada, New Jersey, Virginia and Washington – provide such an option. A plan that opts in to such a state law must do so for all items and services to which the state law applies.

Self-funded plans that opt-in to the state law must prominently display in their plan materials describing the coverage of OON items and services a statement that the plan has opted into a specified state law, identify the state (or states), and include a general description of the items and services provided by OON facilities and providers that are covered by the specified state law.

Interim Final Rules

General Requirements

With respect to OON emergency services, non-emergency services furnished by an OON provider in an in-network facility and OON air ambulance services, the NSA requires the services be provided:

- without cost-sharing requirements that are greater than those that would apply if the services were provided in-network;

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- by calculating cost-sharing requirements as if the total amount that would have been charged for the services were equal to the "recognized amount" for such services; and

- by counting any cost-sharing payments toward any in-network deductible or out-of-pocket maximum ("OOPM") (including the annual limit on cost-sharing).

Emergency Services

If a group health plan provides coverage for emergency services in a hospital's emergency department (or an independent free-standing emergency department), the coverage must be provided:

- without any prior authorization;

- regardless of whether the provider furnishing the emergency services is an in-network provider (or facility);

- without limiting what constitutes an emergency medical condition solely based on diagnosis codes; and

- without regard to any other term or condition of coverage, other than:
  - an exclusion or coordination of benefit;
  - a waiting period; or
  - applicable cost-sharing.

The Departments are concerned that some plans (and carriers) currently deny coverage of certain services provided in the hospital's emergency department by determining whether the care involves an emergency medical condition based solely on the final diagnosis code. The interim final rules clarify that all pertinent documentation must be considered and should focus on the presenting symptoms and not final diagnosis when evaluating claims for emergency services.

The regulations further clarify that:

- Post-stabilization services are considered emergency services subject to the NSA unless certain conditions are satisfied.

- A plan that covers emergency services is prohibited from denying benefits to a participant with an emergency medical condition that receives emergency services based on a general plan exclusion.

Notice & Consent Exception for Non-Ancillary Services

In the case of non-emergency, non-ancillary services performed by an OON provider at certain in-network facilities, an exception to the prohibition on surprise medical billing may be permissible when the provider gives the patient advance oral and written notification and receives the patient's signed consent. The rules provide the specific content, method and timing of the notice and consent communications and provides substantial detail on each of these components.

This exception does not apply to ancillary services. For this purpose, ancillary services include items and services:

- related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;

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- provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services;

- that are diagnostic, including radiology and laboratory services; and

- provided by an OON provider, only if there is no in-network provider who can furnish such item or service at such facility.

In addition, the exception does not apply for items or services furnished because of unforeseen, urgent medical needs that arise at the time a service is furnished for which an OON provider otherwise satisfied the notice and consent requirements.

Cost-Sharing Calculations

Cost-sharing is what the participant or beneficiary must pay for a covered item or service under the terms of the group health plan (e.g., copayments, coinsurance, and amounts paid towards deductibles). Generally, cost-sharing does not include premium payments, balance billing by OON providers, or the cost of items or services that are not covered under the plan.

The participant's cost-sharing for OON emergency services and for non-emergency services furnished by an OON provider in an in-network facility is calculated based on the "recognized amount" for such services. Unless the APMA or a state law applies, the recognized amount is the lesser of the "Qualified Payment Amount" ("QPA"), or the amount billed by the provider or facility. If the APMA or state law applies, the recognized amount is determined by the APMA or specified state law.

With respect to OON air ambulance providers, APMA and state laws generally do not apply. Cost-sharing is determined based on the lesser of the QPA or the billed amount.

Qualified Payment Amount

The QPA is the median of the contracted rates for a particular item or service plus an inflation adjustment. The rules around calculating the QPA are complicated and described in much detail in the regulations, including various special rules that apply (e.g., related to anesthesiology, new plans, and limited data). Briefly, the QPA is determined by:

1. Calculating a median contracted rate by arranging in order from least to greatest the contracted rates of all group health plans of the plan sponsor in the same insurance market for the same or similar item or service that is provided by a provider in the same or similar specialty or facility of the same or similar facility type and provided in the geographic region in which the item or service is furnished and selecting the middle number.

2. Adding an inflation adjustment (to be announced by the Departments annually).

Notably, for self-funded plans, the regulations define the "insurance market" as all self-insured group health plans of the plan sponsor or, at the option of the plan sponsor, all self-insured group health plans administered by the same entity that is responsible for calculating the QPA on behalf of the plan (in most cases, the TPA).

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Plan/Provider Payment Process

The plan will determine whether the services are covered by the plan. Within 30 days of receipt of a "clean claim,"[1] the plan must send the provider an initial payment or notice of denial of the payment. The total amount paid by a plan for items and services is referred to as the "OON Rate." Assuming APMA and state laws do not apply, the plan must make a total payment equal to one of the following amounts, less any cost sharing from the participant, beneficiary, or enrollee:

- if the plan and the provider or facility have agreed on a payment amount, the agreed-on amount; or

- if the parties (plan and provider) enter into the IDR process and do not agree on a payment amount before the date when the IDR entity makes a determination of the amount, the amount determined by the IDR entity.

If the APMA or state law applies, then the OON rates is determined by the APMA or specified state law.

If the payment is disputed, an IDR process will begin after a 30-day window for open negotiation. The regulations addressing the IDR process and IDR entities will be issued in later rulemaking.

Group Health Plan Disclosures

Group health plans (and health insurance carriers) must make publicly available, post on a public website of the plan or issuer and include on each EOB for an item or service with respect to which the NSA applies a notice of the protections under the NSA. If a state balance billing law applies, this must be included in the notice. A model notice may be found at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act.

Employer Action

Employers should review these requirements with their carriers and TPAs for compliance effective with the first plan year that begins on or after January 1, 2022. As most of these requirements are functions of claim payment and adjudication, it will be important that vendors can support the changes required by the NSA. Self-funded health plans will want to ensure TPAs can meet these new requirements.

We expect additional guidance on the NSA, including the IDR process.

1. For this purpose, a "clean claim" means the plan received the information necessary to adjudicate a claim for payment for such services.

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