No Surprises Act Regulations

Prohibition on Surprise Bills & Balance Billing

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On July 13, 2021, the Departments of Treasury, Labor, and Health and Human Services (the "Departments") published Interim Final regulations entitled "Requirements Related to Surprise Billing; Part One" ("Regulations") which go into effect on September 13, 2021. The Regulations implement provisions of the No Surprises Act which, effective plan years beginning on or after January 1, 2022, protect plan participants from surprise bills and balance billing. The No Surprises Act applies to employer-sponsored group health plans, including self-funded plans, fully insured plans, and grandfathered plans. It does not apply to HRA plans (or other account-based plans), voluntary dental and vision plans administered under a separate policy or agreement, or retiree-only plans.

Employers and plan sponsors will need to review and amend their plans and policies to ensure compliance with the No Surprises Act.

The Regulations are summarized in the chart below.

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Overview of the Prohibitions on Surprise Bills and Balance Billing

Under the No Surprises Act:

- *Emergency Services* are services to check for an emergency medical condition and to treat a participant to keep an emergency medical condition from getting worse in either a licensed hospital's emergency room or a free-standing emergency department. The Regulations *include* covered benefits furnished by an out-of-network facility or provider (regardless of the department of the hospital in which such items or services are furnished) after the participant is stabilized and as part of outpatient observation or an inpatient or outpatient stay.

- *In-Network Facility/Provider* means a health care facility/provider that has a contract with a health care plan to provide health care services.

- *Out-of-Network Facility/Provider* means a health care facility/provider that does not have a contract with a health care plan to provide health care services.

- *Cost Sharing* means the amount the participant must pay for services (sometimes called "out-of-pocket costs"), including but not limited to copayments, deductibles, and coinsurance.

Surprise Bills

Surprise billing occurs when a participant unknowingly receives emergency or non-emergency services from (1) out-of-network facilities/providers, (2) out-of-network providers at in-network facilities, or (3) out-of-network air ambulances (under certain conditions) and then receives a bill that is not fully covered by their plan, resulting in unforeseen costs to the participant. For example, in an emergency when the participant has no ability to select the facility/provider rendering services, or when a participant receives care at an in-network facility but is treated by an out-of-network physician.

Overview of the Prohibitions on Surprise Bills and Balance Billing

The Regulations also provide guidance regarding the prohibition on balance billing, which occurs when an out-of-network health care facility/provider bills a participant for the balance remaining on the bill that the participant’s plan doesn't cover. For example, if an out-of-network provider’s bill is $200 and the plan pays $110, the provider may bill the participant for the remaining $90.

Out-of-Network Emergency Facilities and Providers

No Surprise Bills Guidance

Coverage of Emergency Services. If a plan provides or covers emergency services in a hospital or independent freestanding emergency department, the services must be provided without requiring prior authorization, and without regard to whether the facility/provider is in- or out-of-network. If emergency services are provided by an out-of-network facility/provider, the plan:

- Can't impose any administrative requirement or limitation on the participant that is more restrictive than the ones that apply to in-network emergency facilities/providers.
- Can't impose cost-sharing requirements on the participant that are greater than the requirements that apply to in-network facilities/providers.
- Can't limit what constitutes an emergency medical decision based solely on diagnostic codes.
- Must calculate the cost-sharing requirement as if the total amount that would have been charged by an in-network facility or provider were equal to the recognized amount for such services (using any method permitted under the Regulations).
- Must count any participant cost-sharing payments toward any in-network deductible or in-network out-of-pocket maximums.
- Can't take into regard any other term or condition of the plan coverage other than coordination of benefits, an affiliation or waiting period, or applicable cost-sharing.

Out-of-Network Emergency Facilities and Providers

No Balance Billing Guidance

Out-of-network emergency facilities and providers cannot balance bill a participant for any amount in excess of their cost-sharing requirement for emergency services.

Balance billing *is* allowed *if all of the following conditions are satisfied*:

- The attending emergency physician or treating provider determines that the participant is able to travel using non-medical or non-emergency transportation to an in-network provider within a reasonable traveling distance;
- The emergency facility or provider meets statutory notice and consent criteria, as well as any prohibitions imposed by state law;
- The participant can understand the notice and provide informed consent to the out-of-network services under applicable state law; and
- The emergency facility or provider satisfies any additional requirements or prohibitions under state law.

An out-of-network facility/provider will always be prohibited from balance billing participants for services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is provided, regardless of whether the notice and consent requirements are satisfied.

Non-Emergency Services Furnished by Out-of-Network Providers at In-Network Facilities

No Surprise Bills Guidance

If items or services are provided or covered by a plan (other than emergency services), they must be covered when furnished by an out-of-network provider during a visit to an in-network facility. The plan:

- Can't impose a cost-sharing requirement on the participant that is greater than the cost-sharing requirement that would apply if the items or services had been furnished by an in-network provider.
- Must calculate the cost-sharing requirements as if the total amount that would have been charged by such in-network provider were equal to the recognized amount for the items and services (using any method permitted under the Regulations).
- Must count any participant cost-sharing payments toward any in-network deductible or in-network out-of-pocket maximums.
- Can't take into regard any other plan term or condition other than the exclusion or coordination of benefits, an affiliation or waiting period, or applicable cost-sharing.

No Balance Billing Guidance

- An out-of-network provider furnishing services at an in-network facility cannot balance bill a participant for any amount in excess of the cost-sharing requirement for emergency services unless the notice and consent criteria set forth above are satisfied.
- An out-of-network provider will always be prohibited from balance billing participants for (1) services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is provided, and (2) for ancillary services regardless of whether the notice and consent requirements are satisfied. Ancillary services include, but are not limited to, anesthesiology and diagnostic services.

Out-of-Network Air Ambulance Service Providers

If a plan provides or covers any benefits for air ambulance services, the plan must cover out-of-network air ambulance services.

- The cost-sharing requirements must be the same that would apply to an in-network air ambulance service.
- The cost-sharing requirement must be calculated as if the total amount that would have been charged for the services by an in-network air ambulance service were equal to the lesser of the "qualifying payment amount" OR (using any method permitted under the Regulations).
- The plan must count any participant cost-sharing payments toward any in-network deductible or in-network out-of-pocket maximums as if the air ambulance service was an in-network provider.

No Balance Billing Guidance

- An out-of-network air ambulance service provider cannot balance bill a participant in excess of the plan's cost-sharing requirements.

Payment, Claims, and Complaints

Payment By Plan to Health Care Facility, Health Care Provider, or Air Ambulance Service Provider

In general, a plan has 30 days from after the bill for services is sent by a health care facility, health care provider or air ambulance service provider to determine whether the services are covered, and to send either an initial payment or a notice of denial.

Resolving Payment Disputes Between the Plan and a Health Care Facility, Health Care Provider or Air Ambulance Service Provider

A health care facility, health care provider or air ambulance service provider may initiate negotiations with the plan to contest payment for services within 30 days of receiving initial payment. Open negotiation will last 30 days. If there is no resolution either party can initiate an independent review process (IDR) within four (4) days after the end of the open negotiation period using an IDR entity certified by the Departments. The Departments have not yet issued guidance regarding the IDR process.

Participant Claims and Appeals

The External Review process now applies to denials concerning emergency services or air ambulance services covered by the No Surprises Act.

Department of Labor Complaint Process

The Department of Labor has the authority to receive, resolve and investigate complaints that a health care facility, health care provider, or an air ambulance service provider is not complying with the prohibition on surprise bills and balance billing requirements.