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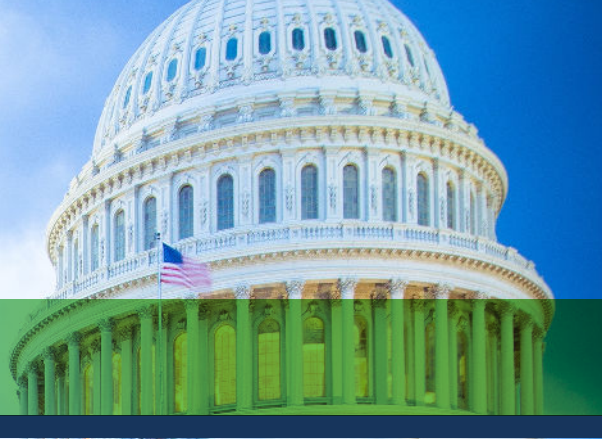


COMPLIANCE BULLETIN

NO SURPRISE BILLING: INTERIM FINAL REGULATIONS PART 1

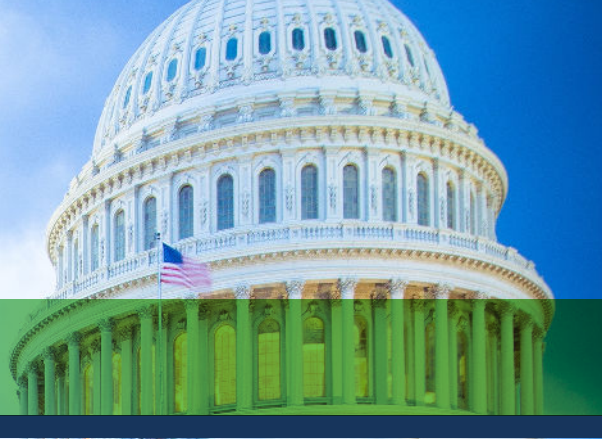
On July 1, 2021, the U.S. Departments of Health and Human Services, Labor, and Treasury, along with the Office of Personnel Management (collectively, the Departments), issued an interim final rule (IFR) to explain provisions of the No Surprises Act (the Act) that passed as part of sweeping COVID-19 relief legislation signed in December 2020. The Act and IFR aim to protect consumers from excessive out-of-pocket costs resulting from surprise and balance medical billing. This Advisor provides a high-level summary of the IFR.

Background

Under the Act, group health plans, or health insurance issuers offering group or individual health insurance coverage, that provide or cover any benefits for services in an emergency department of a hospital (including a hospital outpatient department that provides emergency services) or an independent freestanding emergency department (in-network or out-of-network, also referred to as participating and nonparticipating), must cover the emergency services with no pre-authorization and without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under the Patient Protection and Affordable Care Act (ACA), and incorporated pursuant to ERISA and the Internal Revenue Code, and other applicable cost-sharing).

If the emergency services are provided by a non-participating provider or non-participating emergency facility, the plan or issuer must cover the emergency services without imposing requirements for prior authorization or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities. Also, a plan may not apply higher cost-sharing than would apply if emergency services were provided by a participating provider or a participating emergency facility. The cost-sharing requirement is calculated as if the total amount that would have been charged for emergency services by the participating provider or participating emergency facility were equal to the recognized amount (the amount specified by state law, or a qualifying payment amount, or an amount determined under an All-Payer Model Agreement entered into by the state) for the services, plan or coverage, and year.

If a nonparticipating provider (e.g., anesthesiologist or physician) renders services at a participating facility or at a nonparticipating emergency facility, the provider may not bill beyond an allowed cost-sharing amount (based on the "recognized amount" set forth in the IFR). Further, within 30 days from when the provider transmits a bill to the plan, it must determine an initial payment amount and directly pay the provider or issue a notice of denial. If the provider disagrees with the plan's payment, the parties may begin a 30-day open negotiation period. If the parties fail to reach an agreement, the plan or provider has four days to notify the other party and the Secretary of the Department of Health and Human Services (HHS) that they are initiating the Independent Dispute Resolution (IDR) process provided for under the Act.



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Interim Final Rule

The Act directed the Departments to issue rules (in three stages) to explain how they will implement and enforce the Act. The IFR is the first set of those required rules, and it specifies that:

- Group health plans (**including grandfathered plans**) that cover emergency services must treat those services as in-network, without requiring pre-authorization, regardless of where they are provided.
- Patient cost-sharing, such as coinsurance or a deductible, cannot be higher for emergency and non-emergency services than if such services were provided by an in-network doctor, and any coinsurance or deductible must be based on in-network provider rates.
- Ancillary care (like an anesthesiologist or assistant surgeon) at an in-network facility cannot be treated as out-of-network even if provided by an out-of-network provider.
- Health care providers and facilities must give patients a plain-language consumer notice explaining that patient consent is required to receive care on an out-of-network basis before that provider can bill at the higher out-of-network rate.

The IFR provides that emergency services include certain pre-stabilization services that are provided after the patient is moved out of the emergency department and admitted to a hospital as well as certain services provided after the participant or beneficiary is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services were rendered.

The IFR also provides a complicated and detailed methodology that group health plans and health insurance issuers must use to determine the qualifying payment amount (QPA) for covered services, the information plans and issuers must share with out-of-network providers or facilities when determining the QPA, the applicable geographic regions for determining the median cost for services, and a process to receive complaints of violations of the QPA requirement.

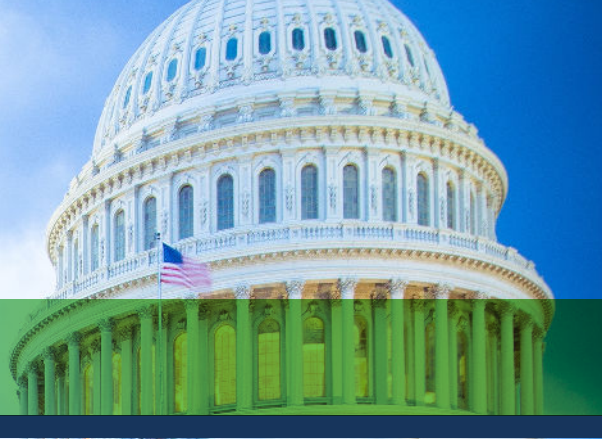
Balance Billing Prohibited

The IFR states that balance billing for the services covered by the Act is generally prohibited, and it specifically caps the allowable costs, including cost-sharing amounts, for such services at:

- An amount determined by an applicable All-Payer Model Agreement under section 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.
- If none of the three conditions above apply, an amount determined by an independent dispute resolution (IDR) entity.

The Departments intend to issue regulations soon regarding IDR entities and the IDR process.

The median contracted rate for an item or service is generally calculated 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.



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

Scope

The IFR will apply to all group health plans other than:

- Excepted benefits (e.g., limited-scope dental and vision plans)
- Short-term, limited-duration insurance (STLDI)
- Health reimbursement arrangements (HRA) or other account-based group health plans
- Retiree-only plans

ACA Patient Protections

The IFR extends certain patient protection provisions to grandfathered plans. Specifically, the IFR provides that participants in a plan that requires designating a primary care physician (PCP) be allowed to designate any participating provider as PCP. Additionally, the IFR provides that a participant may name a pediatrician as the PCP for a child beneficiary and prohibits a plan from requiring pre-authorization or PCP referral for treatment or care from any participating provider of gynecological or obstetric care. The IFR provides sample language for plans to include in summary plan descriptions (SPDs) or other explanations of plan terms and conditions.

Effective Date

The IFR will take effect 60 days after being published in the Federal Register and will apply to group and individual health plans beginning with plan years that start on or after January 1, 2022. The Departments have invited interested parties to submit public comments through September 7, 2021. Any Final Rule issued after the comment period should track the IFR closely, but the Departments have specifically sought comment on the method for calculating the QPA, so we expect the Departments ultimately could modify the calculus for these amounts.

Next Steps

For fully insured plans, carriers will be responsible for ensuring compliance with these new rules, and no direct action is needed at this time. Self-funded plan sponsors, however, are legally responsible for ensuring compliance. For Innovative's self-funded clients, we will be working closely with your third party administrators in the coming months to ensure the plan is in compliance and that plan participants receive any notifications. If you have any questions, please contact your account team or email us at icomply@ibpllc.com.

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