Summarizing the No Surprises Act

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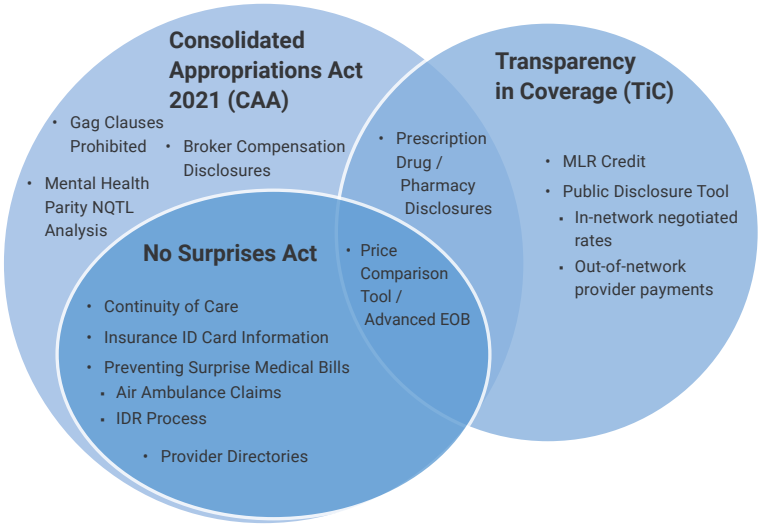
Questions: Which provisions of the No Surprises Act affect group health plan sponsors, and what do we need to do to comply? How do these rules fit into the larger picture of the recent healthcare transparency laws?

Summary:

Healthcare transparency has been a growing priority in recent years for legislators and consumer advocates alike. The No Surprises Act—several key provisions went into effect at the beginning of 2022—was a culmination of efforts designed to increase transparency around the costs of health care services. It has several key compliance requirements affecting group health plan sponsors as well as health care providers, insurers and consumers.

The diagram on the right is a visual overview of how the No Surprises Act fits into the larger scheme of recent transparency legislation.



Detail:

The No Surprises Act was signed into law on December 20, 2020, as part of the Consolidated Appropriations Act.[1] The primary purpose of the Act was to address surprise billing, commonly referred to as "balance billing." Surprise billing occurs when patients unexpectedly receive care from out-of-network providers. It typically occurs (1) when medical services are performed at an in-network facility by an out-of-network provider; or (2) when emergency medical services are performed by an out-of-network provider. The No Surprises Act provides patient rights and protections against these surprise medical bills and includes the following requirements:

- Limits on cost-sharing to in-network amounts for out-of-network emergency care; ancillary services provided by certain out-of-network providers at in-network facilities; and out-of-network air ambulance services;
- Disclosures about billing protections;
- Enhanced health plan identification (ID) cards;
- Maintenance of accurate provider directories;
- Continuity of care when providers or facilities move out of network;
- Creation of a federal independent dispute resolution (IDR) process to address conflicts about final payment amounts that arise between providers, insurers and consumers;
- Advanced Explanation of Benefits (EOB) providing a good faith estimate of a patient's cost-sharing upon request and before scheduled care;
- Creation and maintenance of a price-comparison tool; and
- Description of cost-sharing guidelines and reporting on emergency air ambulance services.

Given the complexity involved in complying with the various requirements of the No Surprises Act, the enforcement agencies – the Departments of Labor, Health and Human Services and Treasury (collectively "agencies") - have responded by issuing regulations and delaying enforcement of certain provisions pending further guidance. Several provisions became effective before additional agency guidance could be issued. For these provisions, the agencies have said that affected entities are expected to comply based on a good faith, reasonable interpretation of the law.

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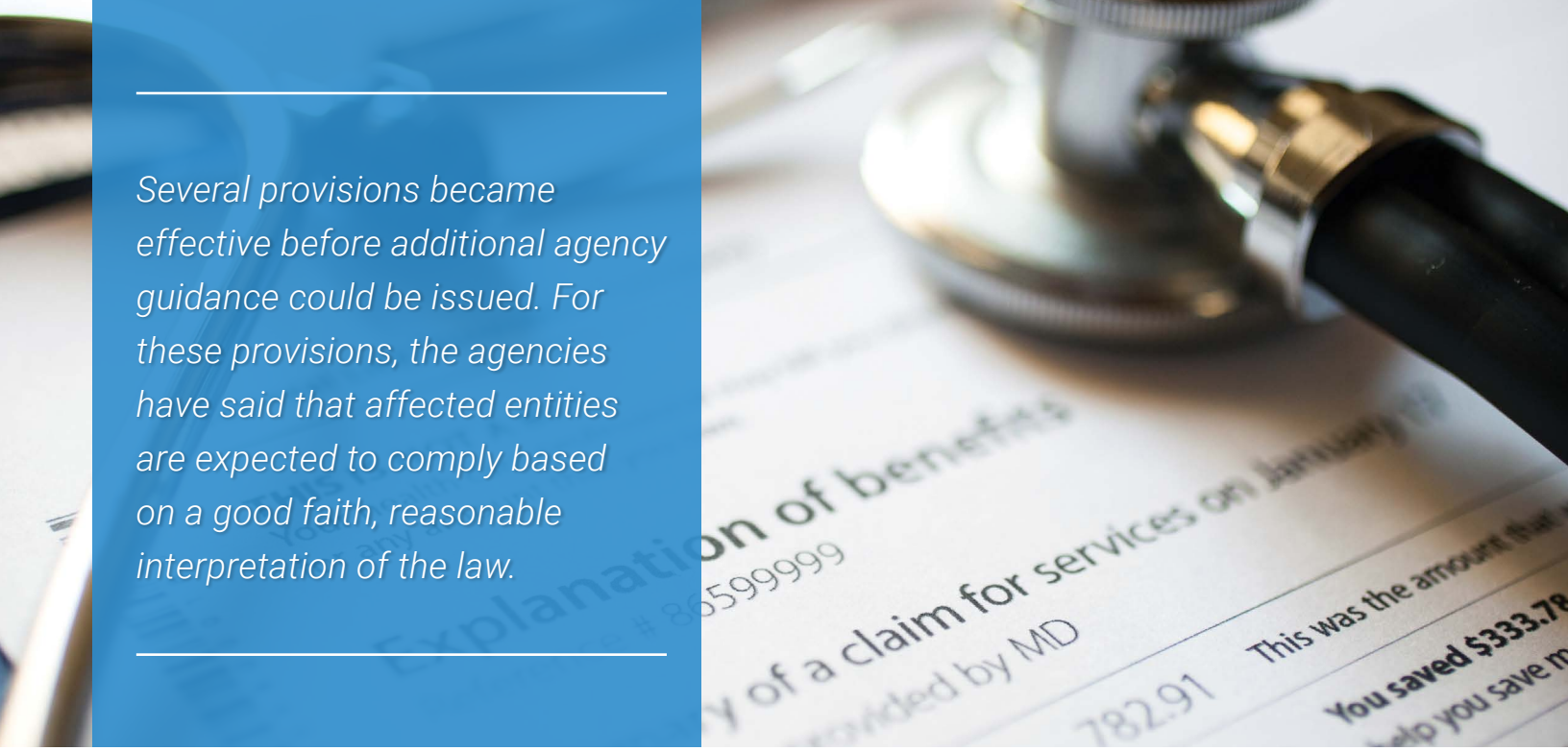

Preventing Surprise Medical Bills
Effective 1/1/2022

Under the No Surprises Act, plans must limit cost-sharing to in-network amounts (and providers may not balance bill) for out-of-network emergency care; ancillary services provided by certain out-of-network providers at in-network facilities; and out-of-network air ambulance services.

Emergency Services

In July 2021, the agencies released an interim final rule, "Requirements Related to Surprise Billing; Part I"[2] requiring group health plans to treat emergency services provided by out-of-network providers or facilities as in-network for purposes of cost-sharing. In addition, the rule prohibits plans from automatically denying coverage for services obtained in an emergency room simply based on diagnostic codes. Instead it defines an emergency medical condition based on the standard of what a "prudent layperson" (in this case someone with an average knowledge of health and medicine) would find, rather than what a medical professional would consider, to be an emergency. The rule also states that a plan that covers emergency services cannot deny benefits to participants for a condition for which emergency treatment is sought based on a general plan exclusion. For example, if a plan has a general exclusion for dependent maternity care, the plan could not deny a claim for emergency coverage when a pregnant participant seeks emergency care simply based on the exclusion for dependent maternity care.

Ancillary Services Provided by Out-of-Network Providers at In-Network Facilities

The agencies' rule also bans charging out-of-network rates for ancillary care obtained at an in-network hospital or ambulatory surgical center. It is not uncommon for a patient to seek services from an in-network facility but receive medical care at that facility from an out-of-network provider. Ancillary medical services that can often result in balance billing include services performed by anesthesiologists, pathologists, laboratory technicians, radiologists, neonatologists, assistant surgeons and ER doctors. The No Surprises Act protects patients from unexpected medical bills for these services by providers not chosen by the patient.

Air Ambulance Bills and Reporting of Air Ambulance Services

Bills for air ambulance services can be shockingly high. Costs for air ambulance services by helicopter averaged over $30,000 in 2020.[3]

The No Surprises Act effectively bans surprise billing for air ambulance services. And cost-sharing rates for out-of-network emergency air ambulance services will now be similar to in-network rates. The air ambulance surprise billing requirements are very similar to the out-of-network pricing requirements in the Independent Dispute Resolution (IDR) provisions discussed below. The agencies also issued a notice of proposed rule-making in September of 2021 to implement reporting requirements regarding these services.[4] The reporting rules, which have not been finalized, would require health plans, issuers, and providers of air ambulance services to submit data for each air ambulance claim and transport.

Billing Protection Disclosure Requirements
Effective 1/1/2022

The No Surprises Act requires group health plans to provide participants with a notice that summarizes the above surprise billing protections and provides contact information where participants can obtain more information and/or file a complaint. The notice is intended to provide consumers with information about balance billing, their protections against receiving balance bills for emergency services, and, if applicable, what additional state protections may apply. The agencies provided a model notice that plan sponsors can use,[5] and the Centers for Medicare and Medicaid Services (CMS) later issued a memo with the required federal contact information.[6] The model notice also provides instructions for plan sponsors on how to distribute this information, such as posting it on the plan's public website and including it with all EOBs containing out-of-network claims.

Enhanced ID Cards
Effective 1/1/2022

The No Surprises Act requirement that plans provide enhanced ID cards is part of a larger goal to increase coverage transparency. Specifically, the law requires that group health plan ID cards disclose in- and out-of-network deductibles; any applicable out-of-pocket maximum, both in- and out-of-network; and a telephone number and website for additional information and assistance. Many, if not most, insurers are providing these updates on their clients' behalf. However, as the responsibility ultimately lies with the plan sponsor, groups should confirm that their carrier and/or third party administer will be making these updates accordingly.

Provider Directories
Effective 1/1/2022

The No Surprises Act also requires health plans to establish a database containing a list of providers and facilities that have contracted with the plan to provide services, to establish a verification process to ensure that the database is accurate and publicly available to covered individuals, and to have a response protocol for individuals who inquire about a provider's status as in- or out-of-network. In addition, plans must not charge participants who rely on an inaccurate database when obtaining services from an out-of-network facility or provider more than the in-network cost-sharing amount. While the agencies have indicated that additional guidance is forthcoming, compliance based on a good faith, reasonable interpretation of the law is expected as of January 1, 2022. Most insurers already maintain and provide provider and facility directories, but this provision places the burden of compliance on group health plans.

Continuity of Care
Effective 1/1/2022

The No Surprises Act continuity of care provision requires plans to ensure that individuals receiving treatment for a complex condition (defined as a "continuing care patient") from a provider or facility whose network relationship is terminated receive timely notification of the change in network status. The provision also allows them up to ninety days to continue to receive care at in-network costs.

The law defines a "continuing care patient" as an individual who:

> is undergoing a course of treatment for a serious and complex condition from the provider or facility; is undergoing a course of institutional or inpatient care from the provider or facility; is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility to such a surgery; is pregnant and is undergoing a course of treatment for the pregnancy from the provider or facility; or is or was determined to be terminally ill . . . and is receiving treatment for such illness from such provider or facility.

Continuing care patients also may elect not to receive continued transitional care from such providers, and therefore immediately seek care from an in-network provider or facility.

Independent Dispute Resolution (IDR)
Effective 1/1/2022

In order to help effectively eliminate surprise bills for out-of-network services, the implementing regulations describe four ways to determine out-of-network payment when an out-of-network provider charges a higher amount than the plan is willing to pay:

1. payment as established by an applicable All-Payer Model Agreement[7] with CMS to test and operate systems of all-payer payment reform;
2. if there is no applicable All-Payer Model Agreement, the amount determined by an applicable state law (referred to as a specified state law);
3. if there is no applicable All-Payer Model Agreement or specified state law, an amount agreed upon by the provider and payer; or
4. if none of the above apply, an amount determined by a certified IDR entity.

The agencies released regulations relating to this IDR process as an interim final rule on October 7, 2021.[8] In addition to the interim final rule, the Department of Health and Human Services (HHS) also published a brief on November 22, 2021, discussing the background of the rule and highlighting outstanding questions, such as how often

the IDR process will be used.[9] At this point, it is unclear how frequently this process will be necessary and which entities will be certified as IDR providers.

Advanced EOBs

Enforcement delayed pending further guidance

The No Surprises Act requires that plans provide participants with an Advanced EOB via mail or electronically when the plan receives a "good faith estimate" of an item or service the participant scheduled at least three business days in advance. This Advanced EOB must contain the following information in clear and understandable language:

1. the network status of the provider or facility;
2. the contracted rate for the item or service, or if the provider or facility is not a participating provider or facility, a description of how the individual can obtain information on providers and facilities that are participating;
3. the good faith estimate received from the provider;
4. a good faith estimate of the amount the plan or coverage is responsible for paying, and the amount of any cost-sharing for which the individual would be responsible for paying with respect to the good faith estimate received from the provider; and
5. disclaimers indicating whether coverage is subject to any medical management techniques.[10]

The Advanced EOB must also notify the participant that the information is only an estimate based on the item and services requested or expected to be provided at the time of scheduling. In response to feedback about the logistical challenges of complying with the above, the agencies announced in August of 2021 that they would delay enforcement of these provisions until further rule-making is released.

Price-Comparison Tool

Effective 1/1/2023

To increase transparency related to the costs of health care services, the No Surprises Act also requires that plans or issuers providing group health insurance maintain price comparison information that is available to participants by phone and electronically. Given that these requirements largely overlap with other provisions set forth by the Transparency in Coverage rules,[11] the agencies have announced that they will defer enforcement of the price comparison tool requirements until January 1, 2023.

Conclusion:

It is clear that the agencies are still ironing out the enforcement details for several of the provisions above. However, the increased focus on transparency in health coverage is likely here to stay. Group health plan sponsors should familiarize themselves with the law and existing guidance and stay alert for updates and additional guidance on how to comply with the provisions of the No Surprises Act affecting plan sponsors.

References

1 - H.R. 133, Consolidated Appropriations Act, 2021, https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf

2 - Requirements Related to Surprise Billing; Part I, https://www.cms.gov/files/document/cms-9909-ifc-surprise-billing-disclaimer-50.pdf.

3 - Air Ambulance Services in the U.S., FAIR Health White Paper, September 2021, https://s3.amazonaws.com/media2.fairhealth.org/whitepaper/asset/Air%20Ambulance%20Services%20in%20the%20United%20States%20-%20A%20Study%20of%20Private%20and%20Medicare%20Claims%20-%20A%20FAIR%20Health%20White%20Paper.pdf

4 - Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement, https://www.federalregister.gov/documents/2021/09/16/2021-19797/requirements-related-to-air-ambulance-services-agent-and-broker-disclosures-and-provider-enforcement.

5 - Requirements Related to Surprise Billing, Part I, "Model Notice," https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act.

6 - Memo on No Surprises Act Phone Number and Website URL Requirements, CMS.gov, https://www.cms.gov/files/document/memo-no-surprises-act-phone-number-and-website-url-clean-508-mm2.pdf.

7 - All-Payer Model Agreements are agreements between a state and the federal government that sets forth a process for determining payment amounts that providers and facilities must accept as final. Currently only two states, Maryland and Vermont, have such agreements with CMS. Vermont All-Payer Model, https://innovation.cms.gov/innovation-models/vermont-all-payer-aco-model; Maryland All-Payer Model, https://innovation.cms.gov/innovation-models/maryland-all-payer-model.

8 - Requirements Related to Surprise Medical Billing; Part II, https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii

9 - Evidence on Surprise Billing: Protecting Consumers with the No Surprises Act, https://aspe.hhs.gov/sites/default/files/documents/acfa063998d25b3b4eb82ae159163575/no-surprises-act-brief.pdf.

10 - FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021, Implementation Part 49, https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf.

11 - Transparency in Coverage Final Rule, https://www.federalregister.gov/documents/2020/11/12/2020-24591/transparency-in-coverage.

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