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TAKING THE SURPRISE OUT OF THE NO SURPRISES ACT

by | **Caroline Pieper**

Many employers and health plan sponsors are struggling to navigate the complex requirements and practical implications of the No Surprises Act. The author reviews the key provisions of the law and offers 11 action steps plan sponsors can take now.

The cost of health care is on the rise, and patients across the United States are more frequently experiencing a bit of shock when their medical bills arrive in their mailbox. Even before the COVID-19 pandemic, rising health care costs were top of mind for many, including lawmakers.

Many states have passed restrictions or prohibitions on surprise billing, which often occurs when patients receive emergency or out-of-network care and the providers bill the difference between their billed charges and the amount paid by the patient's health plan. This is also referred to as *balance billing*, and the costs are usually both significant and unexpected. It often occurs in emergency care but can occur in nonemergency situations—for example, when an individual is unknowingly treated by an out-of-network provider at an in-network facility.

As other price transparency rules and legislation relating to welfare plans started flooding in during recent years, Congress passed legislation addressing the balance-billing issue at the federal level. On December 27, 2020, the No Surprises Act (NSA) was signed into law as part of the Consolidated Appropriations Act of 2021 (CAA). It is one of the many recent targeted efforts to increase price transparency in the health care world and reduce sticker shock when individuals are paying for care.

The law went into effect January 1, 2022 and aims to reduce surprise billing experienced by patients when they unwillingly or unintentionally receive services from an out-of-network provider. Since the initial passage of NSA, regulations and guidance have been released attempting to clarify the rules for plans, issuers and providers, and a number of court cases have been filed.

With the vast array of recent legislation impacting health and welfare plans, many employers are struggling to navigate the complex requirements being imposed as well as the practical implications of NSA. This article will review some of the key provisions of the law related to surprise billing, cost sharing and dispute resolution between providers and plans, and it will provide a list of action steps for health plan sponsors.

takeaways

- The No Surprises Act (NSA) took effect January 1, 2022 and aims to reduce surprise billing experienced by patients when they unwillingly or unintentionally receive health care services from an out-of-network provider.
- Generally, NSA applies to group health plans that provide coverage for emergency services, including both nongrandfathered and grandfathered plans under the Patient Protection and Affordable Care Act (ACA).
- Under NSA, cost sharing for emergency care and out-of-network services provided at in-network facilities must be the same as in-network cost sharing (based on the "recognized amount") and must count toward in-network deductibles and out-of-pocket maximums.
- NSA lays out specific procedures for providers to follow in objecting to payment amounts and outlines mandatory procedures for negotiating and settling payment disputes with health plans. A binding independent dispute resolution (IDR) process is available to plans and providers for determining an out-of-network rate for services.
- Additional guidance is expected from federal agencies relating to NSA and implementation of its new rules. Employers should keep a close eye on the headlines and court decisions in order to ensure continued compliance.

What Types of Health Plans Are Subject to NSA?

Generally, NSA applies to insured and self-insured group health plans that provide coverage for emergency services, including both nongrandfathered and grandfathered plans under the Patient Protection and Affordable Care Act (ACA). However, group health plans constituting "excepted benefit" plans, health reimbursement arrangements, account-based group health plans and short-term limited duration insurance plans are not required to comply. NSA also applies to providers and health plan issuers.

Emergency Care and Out-of-Network Air Ambulance Services

Under NSA, health plans must cover "emergency services" (including post-emergency stabilization services and out-of-network air ambulance services) without prior authorization, regardless of network status, without limiting the definition of *emergency medical condition* to those based only on diagnosis codes and regardless of any other plan provision (other than those related to an exclusion, coordination of benefits or permissible waiting period). Out-of-network emergency care requirements and limits cannot be more restrictive than those applicable to in-network care.

In addition, certain cost-sharing requirements are imposed on out-of-network emergency care. These provisions require health plans to pay claims at certain minimum levels of coverage and provide patient cost sharing equal to in-network levels. The cost-sharing requirements are discussed in greater detail below.

Nonemergency Care From Out-of-Network Providers at In-Network Facilities

The emergency care rules described above also apply if a patient receives covered benefits under a plan from an out-of-network provider at an in-network facility, unless certain notice and consent requirements are satisfied by the provider. Where a patient receives *nonemergency care and/or post-stabilization services,* balance billing may generally occur after notice and consent are provided and obtained by the provider. However, even if a provider issues notice and obtains consent, balance billing is still prohibited for certain types of nonemergency services, such as ancillary services relating to emergency care, diagnostic services and services provided by out-of-network providers when no in-network providers are available to provide care at the facility.

It is important to note that emergency care and air ambulance services cannot be balance billed *even if the provider gives notice and obtains consent.* Rather, balance billing may occur after notice and consent *only* for certain types of nonemergency care and post-stabilization.

Cost-Sharing Requirements

Although ACA already provides financial protection against excessive cost sharing by requiring minimum levels of coverage for emergencies and other situations, NSA expands the scope of these protections and also adds a prohibition against balance billing. Under NSA, cost sharing for emergency care and out-of-network services provided at in-network facilities must be the same as in-network cost sharing (based on the "recognized amount") and must count toward in-network deductibles and out-of-pocket maximums. The *recognized amount* is the lesser of billed charges or (1) the All-Payer Model Agreement of the Social Security Act (SSA), (2) applicable state law where the SSA All-Payer Model Agreement does not apply or (3) the *qualifying payment amount (QPA)* (the lesser of the median contract rate for the plan in the applicable geographic region or the provider's billed charge).

For purposes of self-funded group health plans, the QPA is likely the applicable standard unless the plan has decided to opt in to applicable state law. For fully insured plans, the applicable standard is likely state law. If the QPA is the recognized amount for a certain claim, the plan must provide a disclosure to the provider indicating the QPA, information on the independent dispute resolution (IDR) process, contact information for the plan and a statement certifying that the QPA was calculated in accordance with NSA.

Payment Disputes and the Independent Dispute Resolution Process

NSA lays out specific procedures for providers to follow in objecting to payment amounts and outlines mandatory procedures for negotiating and settling payment disputes with health plans. A binding IDR process is available to plans and providers for determining an out-of-network rate for services covered by NSA once the parties have openly negotiated with each other for 30 days.

The plan or provider must affirmatively initiate the IDR process. If the process is utilized by the parties to determine a payment rate, the IDR entity will consider the QPA, services provided, historical contracts, the training and experience of the provider, and the market share of the plan and provider. The parties may jointly select a certified IDR entity within three business days after the initiation of the IDR process; if an IDR entity is not selected on a timely basis, an IDR entity will be selected for the parties and assigned no later than six business days after the IDR process has been initiated. The DOL, HHS and IRS maintain a list of certified IDR entities online and, in April 2022, released the *Federal Independent Dispute Resolution (IDR) Process Guidance for Disputing Parties* for certified IDR entities to follow in administering the IDR process.[1] Several lawsuits have been filed by providers over the payment dispute process, and one court has vacated part of a prior interim federal rule requiring IDR entities to give deference to the QPA (removing the presumption in favor of the QPA during an arbitration).

Although the IDR process does not replace the ACA external review requirements (which are used to resolve disputes between plans and individuals over adverse benefit determinations), it is possible for a dispute to go through both the IDR process and the external

review process. For example, a claim initially denied but later required to be covered as a result of the external review process might subsequently go through the IDR process in order to determine the payment amount.

Publicly Available Notice

NSA requires plans and providers to post a publicly available notice regarding the various balance-billing protections under the law. The notice should be posted on a public website of the plan and included on each explanation of benefits for an item or service to which the NSA requirements apply. A model notice has been made available by the agencies.

Enforcement of NSA

In order to enforce the rules under NSA, agencies can rely on enforcement mechanisms under the Employee Retirement Income Security Act of 1974 (ERISA), the Internal Revenue Code and the Public Health Service Act. In addition, the agencies may increase enforcement mechanisms available to them through future rulemaking.

Future Guidance Expected

Additional guidance is expected from the agencies relating to NSA and implementation of its new rules. Employers and plan sponsors should keep a close eye on the headlines and court decisions in order to ensure continued compliance. In addition, employers should not forget about other ongoing price transparency efforts including, but not limited to, additional price transparency requirements within CAA (such as an advance explanation of benefits and a price comparison tool) and the transparency in coverage regulations requiring health plans to disclose in-network provider negotiated rates, historical out-of-network allowed amounts for providers, and in-network negotiated rates and historical net prices for covered prescription drugs.

Recommended Action Steps for Health Plan Sponsors

Health plan sponsors should consider the following steps to work toward compliance with NSA.

1. Review and update the definition of emergency services under the plan to ensure the scope of the definition complies with NSA. Emergency care now encompasses a much broader scope of services—including some services not typically thought of as emergency care (such as some poststabilization services)—and likely requires a plan amendment.
2. Review and update cost-sharing provisions under the plan, taking into consideration the requirement that cost sharing for emergency care and out-of-network services at in-network facilities must be the same as in-network cost sharing.
3. Review processes for calculating in-network accumulators (e.g., deductibles and out-of-pocket maximums) in light of the requirement that cost sharing for emergency care and out-of-network services at in-network facilities must count toward in-network deductibles and out-of-pocket maximums.
4. Analyze and update standards reviewing emergency care claims so as not to run afoul of the requirement that claims not be denied automatically based solely on diagnosis codes.
5. If the plan is a self-funded group health plan, decide whether to opt in to state law or rely on the QPA for purposes of setting the "recognized amount." If the QPA will be utilized, determine what the median contract rate will be based on.
6. Draft a publicly available notice (keeping in mind that the agencies have developed a model notice) discussing the protections under NSA, and determine how the public notice will be made available for the plan. Consider whether it should be included in the plan's summary plan description(s) (SPD(s)) or other plan-related materials (e.g., explanation of benefits, open enrollment materials, etc.).
7. Connect with third-party administrators and insurance carriers regarding delegation of and responsibility for handling payment disputes and the IDR process. This may include reviewing and negotiating service agreements with plan service providers to determine whether and how they will implement compliance with the IDR requirements on behalf of the plan.
8. Consult with legal counsel to determine whether the plan and/or SPD should be updated to reflect or describe the payment dispute and IDR process.
9. Monitor guidance issued by the agencies and court rulings relating to NSA and other ongoing price transparency efforts.
10. Periodically and consistently review and update provider network directories so that plan participants are

aware of which providers are considered in network. Carriers should make these changes, but plan sponsors should monitor carriers and update contracts to ensure directories are kept up to date.

11. Review and update ongoing fiduciary compliance efforts relating to the plan, including establishing a fiduciary committee, adopting or revising policies and procedures for the fiduciary committee, and monitoring plan service providers.

Editor's note: Benefits Magazine is in production several weeks before publication. The status of federal regulations and other guidance related to NSA was current at the time of writing. More guidance may have been published or may be forthcoming in the months following the finalization of this article.

bio

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Endnote

1. *Federal Independent Dispute Resolution (IDR) Process Guidance for Disputing Parties.* www.cms.gov/files/document/federal-independent-dispute-resolution-guidance-disputing-parties.pdf.

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