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Don’t be surprised by the No Surprises Act:

New requirements for group health plans are effective for plan years starting on or after Jan. 1, 2022

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The No Surprises Act protects health plan participants from unexpected, or "surprise," medical bills from out-of-network providers and facilities in certain situations. In these cases, participants pay only in-network cost-sharing, the health care provider is prohibited from balance billing the participant for any additional amount, and a new dispute resolution process applies to resolve the remaining bill between the plan and provider. Federal regulators have issued regulations on some but not all of these requirements. This advisory provides an overview of key requirements for group health plans.

The No Surprises Act includes important new protections for individuals. Along with these protections come new requirements for group health plans. Employer plan sponsors should take steps now to ensure that their insurer or third-party administrator will be compliant.

Plans subject to the No Surprises Act

In general, the No Surprises Act applies to all group health plans, including:

- Large- and small-group plans.
- Self-insured and fully insured plans.
- Private sector and public sector plans.
- Grandfathered plans and “grandmothered” plans (also called transitional plans).

The following plans are exempt from the new requirements:

- Excepted benefit plans (including dental, vision, accident, disability, specified disease and hospital indemnity excepted benefit plans).
- Retiree-only plans (meaning plans with fewer than two active employees participating).
- Health reimbursement arrangements (HRAs) and other account-based plans, such as health flexible spending arrangements (FSAs) and health savings accounts (HSAs).
- Short-term limited duration insurance (STLDI).

Note regarding grandfathered plans:

Grandfathered plans are not subject to the emergency services requirements that were included in the Affordable Care Act (ACA) but **are** subject to the new requirements in the No Surprises Act. Grandfathered plans also are not subject to the ACA external review requirements but **are** subject to the new external review requirements relating to the surprise billing protections. Further, the No Surprises Act recodifies the ACA protections regarding choice of health care provider and extends these provisions to grandfathered plans.

Basic requirements

The surprise billing provisions apply in three situations:

- Emergency services furnished by out-of-network providers or facilities.
- Nonemergency services provided by out-of-network providers at an in-network facility, unless notice and consent requirements have been satisfied.
- Air ambulance services.

In each of these situations, covered services must be provided by the plan:

- Without imposing cost-sharing requirements greater than those imposed with respect to in-network services (e.g., if the plan imposes 20% coinsurance on in-network emergency services, no more than a 20% coinsurance rate can be imposed on out-of-network emergency services).
- By determining the amount of cost-sharing. This is done by using the recognized amount, defined below, as the amount charged by the provider.
  - For air ambulance services, cost-sharing is determined based on the lesser of billed charges or the qualifying payment amount defined below.
- By counting any cost-sharing payments toward any in-network deductible or in-network out-of-pocket maximum in the same manner as if the services were provided in-network.

Requirements based on type of service

Specific requirements based on the type of service are outlined below.

Emergency Services

Trigger for requirements

The emergency services requirements apply to a group health plan if the plan covers any services in an emergency department of a hospital or emergency services in an independent free-standing emergency department, which is a health care facility that is geographically separate, distinct and licensed separately from a hospital under applicable state law. Urgent care facilities that are licensed under state law to provide emergency care are included in this definition.

Covered services

"Prudent layperson" standard: The surprise billing provisions apply when an average person (a prudent layperson) would think that they have a medical emergency, not based on whether a medical professional or a health plan or insurer would determine there is a medical emergency.

Site of care: Emergency services include services provided in a hospital or at an independent, free-standing emergency department.

Scope of emergency services: In general, emergency services include:

- A medical screening examination within the capability of the hospital emergency department or independent free-standing emergency department.
- Other services provided until the patient is stabilized, regardless of the department in which the services are furnished.
- Post-stabilization services covered under the plan and provided by an out-of-network provider (regardless of the department in which the services are furnished), subject to a notice and consent exception.
- Under the exception, post-stabilization services are not subject to the balance billing provisions if:
  - The attending health care provider determines that the individual is able to travel using nonmedical or nonemergency transportation to an available in-network provider located within a reasonable travel distance, considering the individual's medical condition.
  - The health care provider or facility satisfies notice and consent requirements as detailed in regulations.

Additional requirements

Emergency services must be covered:

- Without any prior authorization, even if the services are provided out of network.
- Without regard to whether the health care provider or facility is in network or out of network.
- If the services are provided by an out-of-network health care provider or facility, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements imposed on in-network services.
- Without limiting what constitutes an emergency medical condition solely on the basis of diagnostic codes.
- Without regard to any other term or condition of the coverage other than the exclusion or coordination of benefits (to the extent consistent with the definition of emergency services), an affiliation or waiting period, or permitted cost-sharing.

Nonemergency services performed by out-of-network providers at in-network facilities

Trigger for requirements

These provisions apply with respect to nonemergency services performed by out-of-network providers at an in-network facility. Thus, these nonemergency requirements do not apply to a plan that does not have any in-network facilities. The provisions do apply, however, to a plan that has in-network facilities even if the plan does not have a network of providers.

Required services

In order for the surprise billing protections to apply to a particular nonemergency item or service, the following conditions apply:

- The plan must otherwise cover the item or service in question. For example, the provisions would not apply to a nonemergency procedure that is not otherwise covered by the plan.
- The provisions generally do not apply where the provider has met notice and consent requirements as detailed in regulations.
- There are two situations in which the surprise billing provisions apply to nonemergency services regardless of whether consent has been obtained:

- Ancillary services, defined as:
  - Items and services related to emergency medicine, anesthesiology, pathology, radiology and neonatology.
  - Items and services provided by assistant surgeons, hospitalists and intensivists.
  - Diagnostic services, including radiology and laboratory services.
  - Items and services provided by an out-of-network provider if there is no in-network provider who can furnish such items or services at the facility.
- Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.

Air ambulance services

Trigger for requirements

If a plan covers any benefits for air ambulance services, the plan must cover out-of-network air ambulance services, even if there are no in-network air ambulance providers, as is often the case.

Covered services

Air ambulance services are transportation by a fixed-wing aircraft that is certified as a fixed-wing air ambulance or by a helicopter that is certified as an ambulance, including services and supplies as may be medically necessary.

Calculation of participant cost-sharing, including the recognized amount and qualifying payment amount

Emergency services and nonemergency services at an in-network facility

As noted above, cost-sharing for emergency services and nonemergency services by an out-of-network provider at an in-network facility subject to the surprise billing protections must be no greater than the cost-sharing that applies in network, and the amount used to determine cost-sharing must be based on the recognized amount. For example, if a plan imposes 10% coinsurance for emergency services at an in-network facility, then cost-sharing for emergency services at an out-of-network facility would be 10% of the recognized amount for the services.

The recognized amount is one of the following mutually exclusive methods, in order of priority:

- The amount determined under an applicable All-Payer Model Agreement between a state and the federal Centers for Medicare and Medicaid Services (Maryland and Vermont are examples of states with such agreements).
- If there is no applicable All-Payer Model Agreement, the amount determined under an applicable specified state law, which is a state law that applies to the plan, the health care provider or facility, and the service in question.
    - State insurance laws generally do not apply to self-insured plans covered by the Employee Retirement Income Security Act (ERISA). However, such plans may opt in to a specified state law for purposes of determining the recognized amount, if permitted under the state law.
- If neither of the above applies, the lesser of billed charges or the qualifying payment amount.

The qualifying payment amount is the method that will be used most often, particularly for self-insured ERISA-covered plans. The details of how the qualifying payment amount is determined are complicated. In general terms, the qualifying payment amount for 2022 (when the No Surprises Act first takes effect) is the median of the plan's contracted rate on Jan. 31, 2019, for the same or similar item or service provided by the health care provider or facility in that specialty, in the same geographic region, in the same market. For fully insured plans, the individual market, the large-group market and the small-group market are treated as separate markets. For self-insured group health plans, the sponsor has the option of calculating the qualifying payment amount based on all plans of the same sponsor or all self-insured group health plans administered by the same third-party administrator (or other entity) that is responsible for calculating the qualifying payment amount on behalf of the plan. In the rare situation when there is insufficient data on which to determine the qualifying payment amount based on contracted rates, the qualifying payment amount is determined using an eligible database described in regulations. Data is insufficient if there are less than three contracted rates for the item or service.

Air ambulance services

For air ambulance services, cost-sharing is determined using the lesser of the qualifying payment amount or billed charges rather than the recognized amount. This reflects the fact that All-Payer Model Agreements and state balance billing laws generally do not apply to air ambulance services. There are also some special rules for calculating the qualifying payment amount for air ambulance services, including when reimbursement is based on air mileage.

Group health plans are required to report information on air ambulance services to federal regulators for calendar year 2022 (due by March 31, 2023) and calendar year 2023 (due by March 30, 2024). Providers of air ambulance services are also subject to reporting requirements.

Resolving the bill between the provider and the group health plan

By limiting the amount that a health plan participant has to pay for covered services, the No Surprises Act removes the participant from the determination of the final amount to be paid to the provider or facility. For self-insured plans and, in many cases, fully insured plans, the bill will be resolved either through negotiation between the plan and provider or, if that fails, through a federal independent dispute resolution (IDR) process. Recently issued regulations provide details on the IDR process. For fully insured plans, the state law provides for resolution of the bill, so state law will apply rather than the IDR process. If permitted under the state law, ERISA-covered self-funded plans may opt in to the resolution process. Finally, if there is an applicable All-Payer Model Agreement, the final payment would be determined under that agreement rather than the IDR process or state law.

Other requirements

The No Surprises Act includes a variety of other new requirements for group health plans, including a variety of transparency requirements (e.g., new requirements for ID cards, provider directories and cost-comparison tools), reporting requirements, external review requirements for claims subject to the surprise billing rules and a continuity of care requirement when a provider's network status changes. These provisions are generally effective for plan years starting on or after Jan. 1, 2022, but some have different effective dates. Certain requirements have been delayed until further regulations are issued, including the requirement that plans provide an Advanced Explanation of Benefits. Other provisions will take effect before regulations are issued. In such cases, plans are to use a reasonable, good faith interpretation of the statutory provisions in implementing the provisions. An FAQ issued by the federal regulators Aug. 20 provides additional information on delays and good-faith compliance.

Conclusion

Plan sponsors (and their insurers and administrators) have a lot to do to be ready to implement the requirements of the No Surprises Act for plan years starting in or after 2021. Federal regulators have provided guidance on some but not all provisions. Employers should consult with their own advisors as to additional details and how the provisions will impact their plans.

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