Ballard Spahr LLP

No Surprises Rules

Background. Sometimes, individuals, even those covered by a health plan or other health insurance, are surprised by the bills they receive from out-of-network providers. In addition to the larger amounts in cost-sharing (deductible, copayment, or coinsurance) that apply out-of-network, these bills often include the amount that the out-of-network provider charges for the services rendered in excess of the amount that the plan will allow to be considered as the value of the services (the allowed amount).

> **Example.** Suppose an out-of-network provider charges an individual $15,000 for a medical procedure, but the allowed amount for the procedure under the individual's health plan is only $5,000, and the plan pays 70% of that amount (assuming any deductible has already been met). The plan pays $3,500. The enrollee is responsible for the remaining $1,500 in coinsurance plus the $10,000 differential between the provider's charge and the plan's allowed amount.

This practice is known as balance billing. It can lead to disputes between plan sponsors and insurers, on one side, and providers, on the other. It can also lead to significant financial hardship for individuals.

New Rule. The Consolidated Appropriations Act, 2021 (CAA) sets forth requirements (No Surprises Rules) that apply to individuals who receive care from an out-of-network provider in situations where the individual has little or no choice about the use of an out-of-network provider. Specifically, the No Surprises Rules apply when an out-of-network provider furnishes the following:

- Emergency services,
- Services for an individual who is an inpatient at an in-network facility, or
- Air ambulance services.

Emergency Services. For these purposes, emergency services generally refer to care provided in a hospital emergency department or an independent, freestanding emergency department to evaluate and stabilize a patient. In certain situations, care provided after admission to a hospital may continue to be treated as emergency services. Coverage for emergency services must be provided without prior authorization or similar conditions, and plans may not impose administrative requirements on an out-of-network provider for emergency services that plans do not impose on in-network providers. However, a plan's exclusions, coordination of benefits provisions, waiting period rules, and cost-sharing requirements will still apply.

The Responsibility of Individuals. When the No Surprises Rules apply, an individual will generally be required to pay only the applicable cost-sharing amount that would be required if the provider were in-network.

Example. If a plan requires an enrollee to pay 10% of the cost of services in-network and 30% out-of-network, the employee will need to pay only 10% of the appropriate charge for emergency services at an out-of-network hospital.

The No Surprises Rules also address the appropriate charge to which the in-network percentage will apply. Except in the relatively unusual situations when an All-Payor Model Agreement or a specified state law applies, the charge will be based on the Qualifying Payment Amount (QPA) or, if less, the actual billed charge. The QPA is the median of all the rates that the plan (technically, this must be based on all plans of the applicable plan sponsor or, alternatively, all plans administered by the applicable insurer or vendor) or the insurer has negotiated with in-network providers for an item or service in the relevant insurance market and geographic area.

Example. If a plan sponsor has one plan, and the plan's network includes 10 providers that provide a particular service in a geographic area (five of whom have agreed to fees of $4,000 for the service and five of whom have agreed to fees of $6,000 for the service), the QPA for the service in that area would be $5,000. If a plan enrollee receives the service as an emergency service and the in-network co-insurance rate for emergency care is 10%, the enrollee would be required to pay $500.

The No Surprises Rules prohibit the provider from balance billing the individual, even if the provider views the QPA as inadequate for the service rendered.

The Responsibility of Plans/Insurers. The No Surprises Rules also set forth a process and standards for determining the plan's responsibility for payment in these situations. The process is subject to very specific timing, notification, and other requirements. It begins with a plan or insurer initially determining and paying the amount of benefits due for the out-of-network item or service. The provider (and even the plan or insurer) may dispute that amount by initiating a period for open negotiation. If the parties do not agree on an amount by the end of that period, either of them may submit the matter for resolution through an independent dispute resolution (IDR) process that entails the selection of an entity to resolve the dispute and the submission by each party of an offer as to the amount of benefits that should be paid for the service, along with appropriate substantiating information.

The IDR entity must choose one of the two offers and is required to select the offer closer to the QPA unless credible evidence clearly demonstrates that the other offer is more appropriate. The IDR entity may take a number of factors into account in making its determination, including the acuity of the individual's condition, the complexity of the treatment, and the training and experience of the provider. The IDR entity may not take into account the usual, customary, and reasonable charge for the service or item, the amount that the provider would ordinarily have billed, or the amount that would have been paid under Medicare or Medicaid. The covered IDR entity's determination is generally final and binding, although in certain circumstances it may be subject to external review.

The parties may continue to negotiate during the IDR process, and if they reach agreement before the covered IDR entity makes a decision, the agreed-upon amount will apply.

The No Surprises Rules remove certain situations from this process. In particular, an out-of-network provider rendering services to an individual who is an inpatient at an in-network facility may balance bill the individual for services if the individual knowingly and voluntarily waives the protection offered by the No Surprises Rules. To obtain this waiver, the provider must meet specific requirements for providing notice and obtaining the individual's consent, and the waiver will be valid only if the individual is in a condition to make an informed, voluntary decision. In these situations, the ordinary claim and appeal procedures will apply.

Disclosure of Requirements. Plans and health insurers must prepare plain language descriptions of the prohibition on balance billing under state and federal law, other No Surprises Rules, and contact information for federal and state agencies (to report a violation of the No Surprises Rules), make that information available, post that information on a public website, and include that information on explanations of benefits.

Coordination with State Law. Certain states have processes in place for addressing surprise medical bills that will apply to insurers and may allow self-funded plans to opt in. The new rules allow plans to continue to opt into applicable state processes.

External Review. The external review process established under the Affordable Care Act must be made available for adverse benefit determinations that involve consideration of whether a plan or insurer has not complied with the No Surprises Rules. For example, if there is a dispute over whether care actually qualifies as an emergency service, a determination that the service did not qualify as an emergency may be submitted for external review. In these situations, the external review will apply even to grandfathered plans, which ordinarily are exempt from this process.

Air Ambulance Services. The rules for air ambulances are similar to the rules for other out-of-network providers, with some differences and additional reporting requirements.

Additional Requirements to Avoid Surprises. In a further effort to prevent surprises, the CAA includes provisions requiring plans, insurers, and health care providers to disclose financial information. These rules apply in all situations, not only those covered by the No Surprises Rules described above. When an individual schedules a procedure, providers are required to furnish a good faith estimate of their expected charges for the procedure to the group health plan or insurer (if the individual has no coverage or does not intend to file a claim, the provider must furnish the estimate directly to the individual). Upon receiving the good faith estimate, the plan or insurer must provide the individual with an Advanced Explanation of Benefits (EOB) that includes the provider's good faith estimate, the amount that the plan will pay, the cost-sharing amount that the individual will need to pay, the extent to which the individual has met any applicable deductible or out-of-pocket maximum, and certain other information relevant to the individual's benefits and the expense.

Citations. ERISA sections 716, 717, 720(c), and 723; Internal Revenue Code sections 9816, 9817, 9820(c), and 9823; Public Health Services Act sections 2799A-1, 2799A-2, 2799A-5(c), 2799A-8, and 2799B-1 through B-7; 29 CFR 2590.715-2719 et seq.; 29 CFR 2590.716-1 et seq.; 29 CFR 2590.717-1 and 2590.717-2; 26 CFR 54.9815-2719T, 54.9816-1T, 54.9816-2T, 54.9816-8T, 54.9817-1T, and 54.9817-2T; 45 CFR 147.136, 149.10 et seq., 149.110 et seq., 149.410 et seq., and 45 CFR 149.510 et seq., and 45 CFR 149.610 et seq.

Effective Date. Plan years beginning on or after January 1, 2022.

Enforcement. For health plans that are subject to ERISA, the Department of Labor and plan participants and beneficiaries may enforce compliance with these rules. Plans not subject to ERISA may be subject to enforcement by the Department of Health and Human Services. HHS shares responsibility for enforcement against insurers with state agencies. In addition, the Internal Revenue Service may impose an excise tax of $100 per day per affected individual under section 4980D of the Code for any failure to comply. The Departments will establish a complaint process for individuals to submit complaints related to the No Surprises Rules.

The Departments have announced that they will not enforce the CAA rules on the provision of good faith estimates to plans and insurers or the provision of Advanced EOBs by plans or insurers until further guidance is issued (but there will be no delay in enforcement for the provision of good faith estimates by providers to individuals who do not have or do not intend to submit claims to insurance).

Plan Considerations. Plan sponsors will need to rely on their vendors to comply with these requirements and should be addressing these matters with their insurers or claims administrators. Sponsors of self-funded plans, in particular, should review their contracts with claims administrators with regard to the new requirements. Plan sponsors may also evaluate how their plan enrollees will learn about their rights under the new rules.

In states that have implemented their own rules to prevent surprise medical bills, insured plans must still comply with those rules. Self-funded plans, which may choose to follow those rules, should consider the extent to which state rules offer any advantages.

Although the Departments have announced a delay in their enforcement of the good faith estimate and Advanced EOB requirements, the rules themselves will become effective as of the first day of the plan year beginning in 2022. Plan sponsors may seek information from vendors as to how they will act in the interim period between when the rules formally become effective and the date that government enforcement begins.

There will be certain fees that apply to the IDR process, but the fee for the covered IDR entity will be returned if the plan prevails.

The regulations that set the rules for determining a plan's payment responsibility have provoked an outcry from the provider community, which will make efforts to change the rules set forth in the regulations.

Recommended Steps. Plan sponsors should consider the following actions:

- Confirm that claims administrators and insurers are prepared to process applicable claims and appeals in accordance with the No Surprises Rules and revise vendor contracts as appropriate.
- Confirm that claims administrators and insurers are prepared to make required information about the No Surprises Rules available, post it on an appropriate website, and include it in explanations of benefits, when applicable.
- Inquire whether claims administrators and insurers are taking any interim steps to be able to respond to inquiries from enrollees prior to the issuance of guidance on Advanced EOBs.
- Evaluate the new federal rules against any state rules that may apply.
- Revise plan documents and summary plan descriptions, as appropriate, to account for the emergency service rules, payment provisions, and external review opportunities.
- Determine whether to make a plain language description of the No Surprises Rules available through a link to the insurers or vendor's website, through physical posting, or other means. Confirm that the insurer or vendor will place it in EOBs. Use the government model, as appropriate.
- Confirm that claims administrators and insurers are able to meet reporting requirements for air ambulance services.
- Watch for further developments, including guidance on the Advanced EOBs and how the concerns raised by the provider community play out.

Lawyers at Ballard Spahr are working with the new rules and are prepared to assist you with questions you may have. Please contact Edward Leeds or Jessica DuBois.

Contacts

Edward I. Leeds
Counsel, Philadelphia
leeds@ballardspahr.com
215.864.8419

Jessica M. DuBois
Associate, Minneapolis
duboisj@ballardspahr.com
612.371.2416