No Surprises Act FAQs

EPIC Special Compliance Webinar
September 30, 2021

Consolidated Appropriations Act of 2020

No Surprises Act Prohibition on Balance Billing FAQs

General Information

1. **What is the No Surprises Act prohibition on balance billing?**
   The No Surprises Act (NSA) is part of the Consolidated Appropriations Act (CAA), signed into law on December 27, 2021. It prohibits "surprise" balance bills for certain out-of-network items and services so that patients are only responsible for their usual in-network cost sharing amounts. On July 1, 2021, the Department of Labor (DOL), the Treasury department, and the Department of Health and Human Services (HHS) released update guidance on the No Surprises Act in the form of Interim Final Rules.

2. **What plans are covered by the No Surprises Act?**
   The No Surprises Act (NSA) applies to both fully insured and self-funded health plans. Many states currently have balance billing laws. In those states, the state law will apply to the fully insured plan. The federal law will apply to fully insured plans in states without a balance billing law and to self-funded ERISA plans. Self-funded plans have the option to opt-in to many state balance billing laws.

3. **When does the No Surprises Act go into effect?**
   The No Surprises Act (NSA) goes into effect for plan years beginning in January 2022.

4. **Are amendments to Plan Documents or Summary Plan Descriptions (SPD) required?**
   Yes. Third Party Administrators (TPAs) should provide updated provisions that describe the new requirements and processes for the No Surprises Act that will be incorporated into Plan Documents and SPDs. We encourage plan sponsors to reach out to their TPAs to review sample amendments.

Covered Items and Services

1. **What items and services does the No Surprises Act cover?**
   The No Surprises Act (NSA) covers out-of-network emergency room care, certain non-emergency care provided by an out-of-network provider at an in-network facility, and out-of-network air ambulance charges.

2. **What items and services are included as emergency services?**
   Under the No Surprises Act (NSA) whether a service is an emergency service is based on a reasonable prudent person standard and cannot be denied based on billing codes. The NSA applies to services rendered in both hospital emergency departments and free-standing emergency facilities but does not apply to urgent care facilities. In addition, "post stabilization" services will be covered as emergency services unless four conditions are met. First, the

attending physician must determine that the individual is able to travel using non-medical transportation for a reasonable distance to a provider that is in network. Second, the provider must satisfy notice and consent requirements which allow a patient to opt-out of certain NSA protections. Third, the individual must be in a condition to provide informed voluntary consent. Finally, the provider must satisfy any other applicable state law requirements.

3. What is a post-stabilization service?

The Interim Final Rules define post-stabilization as any additional services rendered after a patient is stabilized as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the other emergency services are furnished.

4. When can a plan participant be balance billed for a post-stabilization service?

For notice and consent to be permitted for post-stabilization services the following conditions must apply:

1) Written notice must be provided to the individual.
2) Notice must be provided no later than 72 hours prior to the date of service (with limited exceptions).
3) Voluntary consent is given by the individual or the individual's authorized representative.
4) A signed copy of the notice is given to the individual for their records.

5. Are items and services that are excluded by the plan now covered because of the No Surprises Act (NSA)?

No. The NSA applies to certain out-of-network items and services but does not apply to items or services that are excluded from the plan.

Payment Calculation

1. How is the plan participant's cost-sharing amount determined?

In-network plan provisions (deductible, coinsurance, out-of-pocket maximum) will be applied to what is called the "Recognized Amount." For self-insured plans, the "Recognized Amount" is the lesser of the billed charges or the "Qualified Payment Amount (QPA)." The QPA is the median contracted rate for similar items/services in the same insurance market by a provider in the same specialty and provided in the same geographic region, adjusted for inflation. For fully insured plans, the "Recognized Amount" could be determined by state law instead of the QPA/median contracted rate.

2. How is the cost to the plan determined?

For fully insured plans, some states will have laws that determine the appropriate provider fees. For self-insured plans and fully-insured plans not affected by specific state laws governing provider payments, the total provider fees will need to be negotiated with the provider or determined by an Independent Dispute Resolution (IDR) arbitration process. The plan will be responsible for paying the total provider fees less any previous plan or participant payments.

3. **How is the cost of an air ambulance determined if there is no in-network air ambulance covered by the plan?**
   We are waiting for additional guidance from the departments on this issue, but we anticipate that the in-network "contracted" rates for air ambulance services will be based on the median contracted rates by mile of transport within a geographic region, and there is no differentiation between rotator and fixed wing aircraft in this determination.

4. **Who is responsible for determining the qualified payment amount (QPA)?**
   The plan will need to rely on the carrier or TPA will need to calculate the qualified payment amount, based on the plan's contracted rates for various items and professional services.

5. **When is the qualified payment amount disclosure (QPA) provided?**
   The QPA disclosure is provided with the explanation of benefits (EOB).

6. **Is the out-of-network payment still based on usual customary reasonable charges but paid at the same percent?**
   No. The out-of-network payment will be based on negotiations with the provider or by the Independent Dispute Resolution (IDR) arbitration process. Usual and customary charges might be a factor in the provider negotiations but are not a determinative factor in the final required payment amount.

7. **How are plans without a network, such as those using reference-based pricing (RBP) handled?**
   The current guidelines address only in-network cost sharing. We hope that the Departments will release additional guidance on how to handle RBP claims in the near future.

8. **Will payments made in these specific circumstances count toward the in-network or out-of-network cost-sharing?**
   Yes. Payments made by the plan participant and the plan will count toward the in-network deductible and out-of-pocket maximum limits.

9. **Is there any potential impact on an out-of-network shared savings arrangement?**
   The impact is unclear at this point. It is possible that these No Surprises Act services will need to be excluded from out-of-network shared savings arrangements. With the Independent Dispute Resolution (IDR) arbitration process in the picture, it is difficult to see how shared savings amounts would be accurately measured for these services. This will be better understood when we have more information on the IDR process, and how the process works in actual practice.

10. **What is the impact on HSA eligibility?**
    When the plan pays its share of the out-of-network costs to the provider, there may be times when the plan pays for a plan participant's medical costs before the plan participant has met their deductible. In these cases, the amount the plan pays will not affect the plan participant's HSA eligibility.

Notice and Consent

1. **Are there situations where the plan participant can be balance billed for out-of-network services?**

   Yes. First, remember that the No Surprises Act (NSA) only applies to out-of-network emergency services, non-emergency services provided by an out-of-network provider at an in-network facility, and out-of-network air ambulance charges. Other out-of-network items and services are still subject to out-of-network cost-sharing and may incur balance bills. Also, there are limited circumstances under the NSA when a plan participant may receive notice from the provider and give their consent to be balance billed. Note that notice and consent does not apply to emergency services or air ambulance services. Further, it does not apply to does not apply to ancillary services, which are services such as anesthesiology, pathology, radiology. It also does not apply to items and services provided by an out-of-network provider in circumstances where there is no in-network provider available to provide the service or items or services furnished as a result of unforeseen, urgent medical needs that arise after the out-of-network provider has obtained consent.

2. **What happens if a patient does sign the consent or notice and consent requirements are not satisfied?**

   In the limited cases when notice and consent is available, all the requirements must be satisfied before the provider can balance bill the plan participant. Should the requirements not be satisfied then the out-of-network charges will be adjudicated according to the same method as claims that are not eligible for notice and consent.

3. **Are there notice requirements for carriers and plan sponsors?**

   Yes. The Departments developed a No Surprises Act (NSA) model notice for plans and issuers to use in order to disclose information on the federal surprise billing requirements and applicable state laws. The notice also includes information about contacting appropriate agencies if a plan participant believes a provider or facility has violated the prohibition against balance billing. The NSA model notice must be included on a public website such as the carrier's or Third Party Administrator's (TPA's) website. Employers that have a benefits portal or intranet are also encouraged to post the notice electronically until we receive further guidance on model notice distribution. Further the notice must be provided with a plan participant's explanation of benefits (EOB) which will be provided by the carrier or TPA. Pending additional guidance, it is encouraged that employers either include the notice or a brief summary of the NSA with other legal notices in their legal notice packets/open enrollment materials. There are no specific requirements for how the notice should be distributed so the conservative approach to distribution is to follow other ERISA requirements for document distribution according to the Department of Labor (DOL) safe harbor guidelines.

EPIC Employee Benefits Compliance Services

For further information on this or any other topics, please contact your EPIC benefits consulting team.