No Surprises Act Guidance – Part 1

The Departments of the Treasury, Labor, and Health and Human Services (the Departments) issued the first *Interim Final Regulation* (IFR) in a series of regulations implementing the surprise medical billing provisions of the Consolidated Appropriations Act, 2021 (CAA). (This portion of the CAA is also referred to as the "No Surprises Act" or NSA.) The NSA is intended to protect participants, beneficiaries, and enrollees in group health plans (and group and individual health insurance coverage) from "surprise" balance billing when they receive specified emergency care (generally from out-of-network providers or facilities). Balance billing refers to the practice of out-of-network providers billing patients for the difference between (1) the provider's billed charges, and (2) the amount collected from the plan or insurer plus the amount collected from the patient in the form of cost sharing (such as a copayment, coinsurance, or amounts paid toward a deductible).

The 411-page IFR, which was released on July 1, provides initial guidance on cost-sharing amounts for patients, plan/insurer payments to out-of-network providers, notice requirements, and a federal complaint process. The IFR also includes separate regulations issued by the Department of Health and Human Services that are applicable to healthcare providers. This Technical Bulletin focuses on key elements in the IFR that relate to employer-sponsored health plans and health insurers.

Applicability

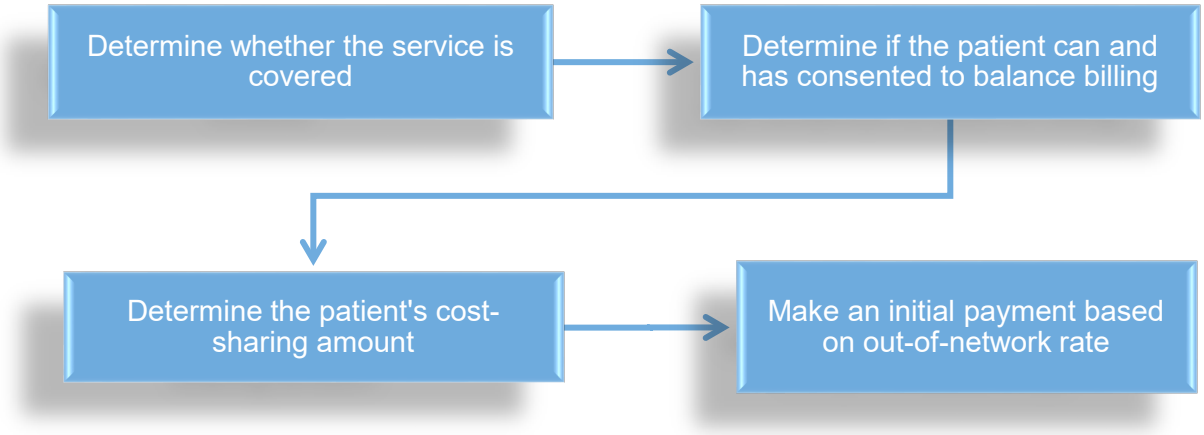
The surprise billing protections added by the NSA apply to individual and group health insurance contracts and self-insured group health plans, including grandfathered health plans. Plans provided by private employers, non-federal governmental employers, and churches are subject to the new rules. The rules do not apply to plans that provide only excepted benefits, retiree-only plans, account-based plans (such as Health Reimbursement Arrangements), or short-term, limited-duration insurance.

The requirements generally apply to three categories of healthcare: (1) the provision of emergency services by a *Nonparticipating emergency facility* or *Nonparticipating provider* ; (2) non-emergency services furnished by out-of-network providers in in-network facilities, and (3) *Air ambulance service* provided by out-of-network providers. In this context, "participating" refers to whether a provider or a *Health care facility* is a part of a network of providers and facilities (i.e., "in-network") who have agreed by contract to accept specific negotiated fees for items and services. "Nonparticipating" refers to providers or facilities who do not have contractually agreed upon rates with a particular plan or insurer and thus are "out-of-network" with regard to that plan or insurer.

The new rules apply to plan (and policy) years that begin on or after January 1, 2022.

Payment

Under the NSA, covered payments consist of two components – *Cost sharing* from patients and out-of-network provider payments from plans or insurers based upon an *Out-of-network rate*. However, there are several steps involved before payment is made. Below, we provide an overview of those steps.



STEP ONE: DETERMINE IF THE ITEM OR SERVICE IS SUBJECT TO THE NSA RULES.

As noted above, the NSA protections only apply in three situations: (1) when emergency services are provided in a nonparticipating facility or by a nonparticipating provider; (2) when non-emergency services are furnished by out-of-network providers in in-network facilities, and (3) when *air ambulance services* are provided by out-of-network providers. To understand whether the rules apply, it is thus important to understand if a particular item or service falls within one of those three categories.

Emergency Services

First, it is important to understand what emergency services are. *Emergency services* include "(1) an appropriate medical screening examination that is within the capability of the *Emergency department of a hospital* or of an independent freestanding emergency department . . . to evaluate whether an emergency medical condition exists; and (2) such further medical examination and treatment as may be required to stabilize the individual . . ." Note that both freestanding and hospital-related emergency departments are included and that efforts to stabilize an individual are covered. An independent freestanding emergency department is a health care facility that provides emergency services, is geographically separate and distinct from a hospital, and is separately licensed by a state. (Depending upon state law, urgent care centers may fall under the definition of *Independent freestanding emergency department* . This means that an urgent care center may be covered, so it will be important to verify inclusion or exclusion under state law.) Notably, pre-stabilization services provided after an individual is moved out of an emergency department and has received services in another area of the facility, or is admitted to a hospital, are also included.

Critical to understanding what emergency services include is understanding what constitutes an "emergency medical condition." Under the guidance, an *emergency medical condition* means a "medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of care to result in . . . (1) placing the health of the individual . . . in serious jeopardy, (2)

serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ." The definition is intended to include mental health conditions and substance use disorders.

Importantly, emergency services also include any additional items or services covered by a plan and furnished by a nonparticipating emergency facility after a patient is stabilized (i.e., post-stabilization) and that are part of outpatient observation, an inpatient stay, or an outpatient stay unless certain conditions are met. The conditions are four-pronged:

1. The attending emergency physician or treating provider must determine that the patient is able to travel using nonmedical transportation or nonemergency transportation to an available participating (i.e., in-network) provider or facility located within a reasonable travel distance (with consideration for the patient's medical condition);
2. The provider or facility must satisfy specific notice and consent requirements;
3. The individual (or the individual's authorized representative) must be in a condition to receive the information in the required notice and to provide informed consent under applicable state law; and
4. The provider or facility must satisfy any additional requirements or prohibitions required under applicable state law.

The Departments may impose additional requirements upon further rulemaking, but until that time, providers and facilities may rely upon the above requirements.

Non-Emergency Services Provided by Nonparticipating Providers in In-Network Facilities

The NSA protections also apply to non-emergency services provided by nonparticipating providers in in-network facilities unless specific notice and consent requirements are met. When determining whether a non-emergency service falls within the NSA's protections, it is thus important to determine whether the facility and/or provider has a contractual relationship directly or indirectly with a group health plan or health insurer addressing the relevant item or service. It is also important to determine whether the facility is a "health care facility" as defined by the NSA. For purposes of the NSA, a health care facility in the context of nonemergency services is: (1) a hospital; (2) a hospital outpatient department; (3) a critical access hospital; or (4) an ambulatory surgical center.

The Departments have asked for comments regarding whether urgent care centers and retail clinics should be included in the definition of health care facilities; however, under the guidance, those facilities do not meet the definition of health care facilities for purposes of non-emergency services.

Notably, the items and services included in this context are fairly broad and encompass the furnishing of equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services (regardless of whether the provider furnishing such items or services is at the facility). For example, if a sample is collected during an individual's hospital visit and that sample is sent to an off-site laboratory, the laboratory services would be included as part of the individual's hospital visit and thus would be subject to the NSA's protections. As with post-stabilization emergency services, balance billing and cost-sharing requirements may be waived if specified notice and consent requirements are met.

Air Ambulance Services

The final category of covered items and services is air ambulance services provided by nonparticipating providers. *Air ambulance services* include medical transport by either a rotary-wing air ambulance or a fixed-wing air ambulance.

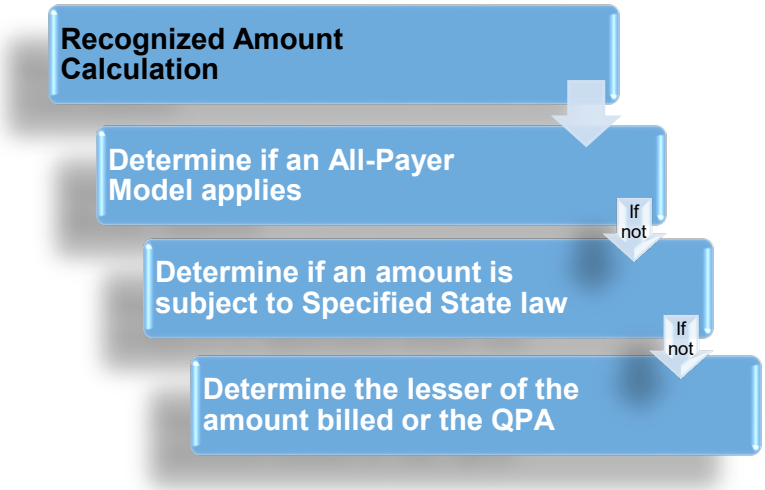
Many plans do not have networks of participating air ambulance providers. Nonetheless, the NSA protections apply to those plans even if they do not have any air ambulance providers in their networks.

STEP TWO: DETERMINE IF THE PATIENT CAN AND HAS CONSENTED TO BALANCE BILLING.

Although the NSA covers specific services and items, balance billing is permitted for these services and items if required notice and consent requirements are met. Those services and items are: (1) post-stabilization items or services that are part of outpatient observation, an inpatient stay, or an outpatient stay; and (2) non-emergency services provided by out-of-network providers in in-network facilities. To be able to balance bill for these items and services, the provider or facility must meet the notice and consent requirements described on page 8.

STEP THREE: DETERMINE THE PATIENT'S COST-SHARING AMOUNT.

Assuming that a patient has not consented or cannot consent to balance billing, the next step is to determine the patient's cost-sharing amount. As a general principle, a patient's cost-sharing for any items or services within the three categories of covered items or services is the same as it would be for in-network levels. Thus, for example, if a plan imposes a 20 percent coinsurance rate for emergency services from *participating providers*, it may not impose a coinsurance rate in excess of 20 percent for emergency services for a nonparticipating emergency provider.



Patient cost-sharing for emergency services provided by a nonparticipating emergency facility or for non-emergency services provided by nonparticipating providers in participating health care facilities is to be calculated based on a "recognized amount." A *recognized amount* is: (1) an amount under a *State All-Payer Model Agreement* [1] (established by the Centers for Medicare and Medicaid), if applicable; (2) an amount stipulated by *Specified State law* , if applicable; or (3) the lesser of the amount billed or the *Qualifying Payment Amount* (QPA).The QPA is generally the median of the contracted (i.e., network) rates of the group health plan or insurer

[1] For example, Maryland has an All-Payer Agreement in effect that applies to hospital services provided within Maryland, but not to physician services provided in hospitals.

for the item or service in the geographical region in which the item or service is provided. A self-insured group health plan may determine the QPA using median contracted rates under all of its own plans, or if the plan uses a third party administrator (TPA) to pay claims, it may choose to use the TPA's median contracted rates.

Cost-sharing amounts with respect to *air ambulance services* are calculated slightly differently than cost-sharing for emergency services in nonparticipating facilities or for nonparticipating providers in participating health care facilities. However, for air ambulance services, cost-sharing must be based upon the same requirements as would be applied to participating providers, and any coinsurance or deductible must be based on the rates that would apply to participating providers. Any coinsurance or deductible is to be calculated using the lesser of the applicable QPA or the billed amount.

The QPA is the median of the contracted rates recognized by the plan or insurer for a given item or service on January 31, 2019 for the *Same or similar item or service* provided by a provider or facility in the same or similar specialty and within the same geographic region, as adjusted for inflation. The median contracted rate is determined with respect to all of a plan sponsor's group health plans (or the TPA's, if a self-insured plan has elected to use the TPA's contracted rates) or all group or individual coverage offered by the health insurance issuer in the same market.

To determine the median contracted rate, the plan or insurer will arrange its contracted rates for an item or service in order from least to greatest and then select the middle number. If there are an even number of rates, then the average of the middle two is to be used. For example, assume that the applicable contracted rates for an item are $475, $490, and $510. The middle number is $490, so the median contracted rate is $490. If there were four rates – $475, $490, $510, and $515 – the middle two numbers ($490 and $510) would be averaged with a resulting median contracted rate of $500.

If there is insufficient data to calculate a median contracted rate, a plan or insurer may use an alternate methodology. In order for data to be sufficient, the plan or insurer must have had at least three contracted rates for the item or service as of January 31, 2019. If it does not, then the data is considered to be insufficient. For such items and services, the plan or insurer may use what is called an "eligible database." The guidance provides standards to recognize eligible databases that plans may rely upon.

Items or services added after January 31, 2019 also fall under special rules. Under those special rules, plans or insurers must use median contracted rates based upon the first year with sufficient information.

Regardless of the methodology, the rates will be increased by the percentage increase in the consumer price index for all urban consumers (CPI-U) over 2019. So, for example, the contracted rate for an item or service provided in 2023 is the 2022 QPA multiplied by the CPI-U 2022/CPI-U 2021. The IRS will provide the factors to be used for indexing in future guidance.

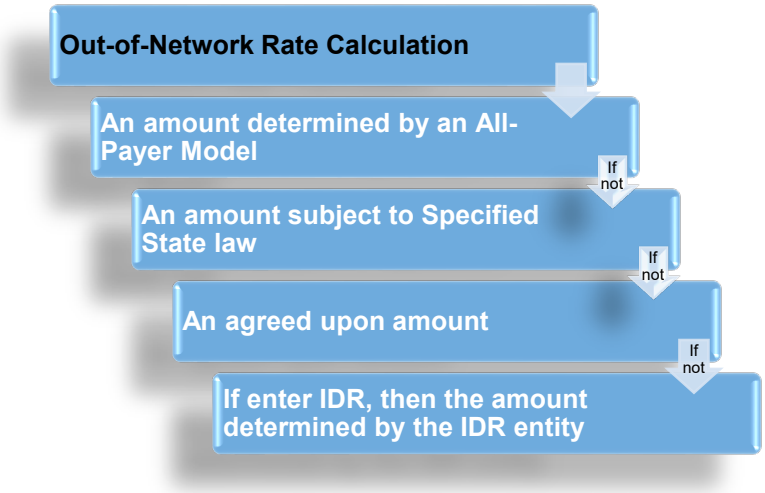
Patient cost-sharing is to be based on the methods noted above even if the amount ultimately paid to the provider (for example through negotiations or the Independent Dispute Resolution (IDR) process) is higher. The plan (or insurer) will be required to pay the difference between the final payment amount owed to the provider and the patient's cost-sharing amount. In addition, patient cost-sharing amounts, such as deductibles, coinsurance, and copayments, must treated as in-network cost-sharing.

A special note about High Deductible Health Plans (HDHPs) intended to be HSA-compatible: Because the individual's cost-sharing amount will be calculated using the Recognized Amount, there may be situations where the plan is required to make a payment before the individual has satisfied the deductible under an HDHP. This could occur in situations where the plan is required to make a payment based on the out-of-network amount (e.g., an amount determined by the IDR process) while the individual's cost-sharing amount is calculated using a lower Recognized Amount. In some cases, the plan will be required to make a payment to the provider before the individual has satisfied the minimum statutory deductible under an HDHP. The regulations include an example where an individual is enrolled in an HDHP with a $1,500 deductible and the plan calculates a recognized amount of $1,000. The individual pays $1,000, which is created toward the deductible under the HDHP. Later, the out-of-network amount is determined to be $1,500 and the plan is required to pay $500 ($1,500 out-of-network amount minus $1,000 cost-sharing) even though the individual has not satisfied the HDHP deductible. Based on the NSA requirements, the plan (not the individual) is required to make the $500 payment. Although this would normally cause an HDHP to lose its qualified status, the NSA provides that a plan will not lose HDHP status when it makes a payment as required by the NSA.

STEP FOUR: MAKE INITIAL PAYMENT BASED ON OUT-OF-NETWORK RATE.

A plan or health insurer is required to make an "initial payment," based on the QPA, to an out-of-network provider within 30 days after the plan or insurer receives the provider's bill as long as the bill has sufficient information for the plan/insurer to decide the claim amount. The "initial payment" is the amount the plan/insurer intends to be payment in full, even if the final amount (e.g., the payment made following negotiations or an IDR determination) differs.

The total payment for items and services subject to the NSA's surprise billing provisions is equal to the sum of a patient's *cost sharing* and the "*Out-of-network rate* " required to be paid by a plan or insurer. The out-of-network rate is based upon one of the following: (1) an amount determined by an applicable *State All-Payer Model Agreement* under section 1115A of the Social Security Act; (2) if there is no such applicable all-payer model agreement, an amount determined by a *Specified State law* ; (3) in the absence of an applicable All-Payer Model Agreement or Specified State law, if the plan or issuer and the provider or facility have agreed on a payment amount, the agreed on amount; or (4) if none of those three conditions apply, and the parties enter into the IDR process and do not agree on a payment amount before the date when the IDR entity makes a determination of the amount, the amount determined by the IDR entity.



The provider may choose to negotiate the payment amount and if no agreement is reached within the 30-calendar-day negotiation period, the provider will have four days to initiate the IDR process.

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Notice and Information Sharing Requirements

The guidance includes requirements for notices to participants, plans, patients, and providers along with specific information that must be shared among group health plans, health insurers, and healthcare providers.

PLAN TO PARTICIPANT NOTICE

Plans are required to post a notice to participants that includes general information on surprise billing and the NSA protections. The notice must include definitions of terms such as balance billing, nonparticipating providers, surprise billing, and emergency services. It must also briefly summarize the balance billing protections provided by the NSA and include information about federal and/or state websites where the individual can obtain additional information or file a complaint. The guidance includes a model notice. Although plans are not required to use the model notice, the Departments will consider use of the model notice in accordance with the accompanying instructions to constitute good faith compliance.

Group health plans or their insurers (if applicable) are required to post the notice on their websites and to include appropriate language in Explanations of Benefits (EOBs) if NSA balance billing protections apply. These disclosure requirements are applicable for plan years beginning on or after January 1, 2022. Thus, a plan sponsor (or a plan's TPA) with a calendar year plan year should post the notice on a publicly available website by January 1, 2022.

PROVIDER TO PATIENT NOTICE TO OBTAIN CONSENT TO BALANCE BILL

Providers are subject to a number of notice and consent requirements when they treat patients. This Technical Bulletin only covers the requirements concerning the general contents and timing of the notice to obtain consent to balance bill that must be provided to patients in order for the provider to balance bill. Providers will be responsible for such notices, but employers should be aware of the notice process.

Notice and Consent when emergency services are provided in a nonparticipating facility or by a nonparticipating provider

As a general rule, providers and facilities cannot obtain consent to balance bill a patient when emergency services are provided in a *Nonparticipating emergency facility* or by a *Nonparticipating provider* An exception, applies, however, for post-stabilization services (even though post-stabilization services are generally treated as emergency services to which the NSA protections apply) if certain conditions are satisfied and the patient consents. As a reminder, post-stabilization care services means covered services, related to an emergency medical condition that are provided after a patient is stabilized where the services are provided in order to maintain or resolve the patient's condition. First, the treating provider or attending emergency physician must determine that the patient is able to travel using non-medical transportation to an available participating provider or facility. Second, the individual (or the individual's authorized representative) must be in a condition to provide informed consent. Third, the provider or facility must satisfy any applicable state law requirements. Fourth, the provider or facility must satisfy the NSA notice and consent requirements.

If post-stabilization services are provided by a nonparticipating provider at a *participating emergency facility*, this notice must include a list of any participating providers at the participating emergency facility who are able to furnish the items or services involved. The notice must also inform the patient that the patient may be referred to a participating provider.

A nonparticipating provider or nonparticipating facility will always be subject to the NSA prohibitions with respect to items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the nonparticipating provider or nonparticipating emergency facility satisfies the notice and consent criteria.

Notice and Consent when non-emergency services are provided in a participating facility

Non-participating providers may balance bill patients for non-emergency services provided in a participating facility, but only if specific notice and consent requirements are satisfied. The notice must:

- State that the provider is a non-participating provider;
- Include a good faith estimate of the amount that the provider may charge for the services involved; and
- State clearly that the individual may seek care from an available participating provider, in which case, in-network cost-sharing will apply.

When the notice must be provided depends on when the individual schedules an appointment as outlined in the chart below.

Appointment Scheduled	Notice Timing
At least 72 hours before the appointment.	No later than 72 hours before the date of the appointment.
Within 72 hours of the date of the appointment.	On the date the appointment is scheduled.
The date that services are to be provided.	At least 3 hours before services are provided.

The notice and consent requirements cannot be used to seek a waiver with respect to the following services: (1) *Ancillary services* , or (2) items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the nonparticipating provider satisfied the notice and consent criteria outlined above.

PROVIDER TO PLAN INFORMATION SHARING

In order to determine a claim payment correctly, plans and insurers will need to know if any applicable provider notice and consent criteria have been satisfied. To accomplish this, providers and facilities must

notify the plan when transmitting a bill for services or items for which the notice and consent requirements have been met. The notice may be provided either on the bill or in a separate document sent with the bill.

In general, a provider must notify a plan as to whether balance billing and in-network *cost-sharing* protections apply and must give the plan or insurer a copy of any signed notice and consent documents. The regulations also state that the provider must timely notify the plan or insurer that the service was furnished during a visit to an in-network facility. If the care includes post-stabilization services, the provider must let the plan know if the notice and consent requirement was satisfied for each service provided.

However, if the provider bills the patient or participant directly (i.e., the healthcare provider does not submit a bill to the plan), then the provider may satisfy this requirement by including the notification with the bill.

If a provider or facility fails to notify the plan or insurer that the notice and consent requirements have been satisfied, the plan and insurer must assume that the individual has not waived the NSA protections. Under these circumstances, the plan and insurer must calculate cost-sharing and make payment using the NSA rules.

PLAN TO PROVIDER INFORMATION SHARING

The regulations require that plans and insurers make certain disclosures with each initial payment or *notice of denial of payment*, and that plans and insurers provide additional information upon request of the provider or facility. This information must be provided, either on paper or electronically, to a nonparticipating provider, emergency facility, or provider of *air ambulance services*, as applicable, when the QPA serves as the recognized amount. Items that must be provided with an initial payment or a denial are:

1. The QPA for each item or service,
2. Certification that the QPA applies for the purpose of the Recognized Amount (cost-sharing amount for air ambulance),
3. Certification that the QPA was determined using the required methodology,
4. A statement that the provider may initiate a 30-day open negotiation period for determining the amount of the total payment,
5. The name of the person or office to contact if the provider wishes to negotiate, and
6. A statement that the provider may initiate the IDR process within four days after the end of the 30-day period if no agreement has been reached.

The 30-day open negotiation period begins when the group health plan or health insurer has received sufficient information to calculate the correct payment amount (i.e., a clean claim).

Additional information that must be provided in a timely manner upon the provider's request is:

1. Information about whether the QPA included contract rates that were not set on a fee-for-service basis,

2. If a related service code was used to determine the QPA for a new service code, a plan or insurer must provide information to identify which related service code was used. Similarly, if an eligible database was used to determine the QPA, a plan or insurer must provide information to identify which database was used to determine the QPA, and
3. A statement that the contract rates include risk-sharing, bonus, penalty, or other incentive-based payments or adjustments that were excluded from the calculation of the QPA.

The Departments seek comments on these particular requirements, so there may be additional requirements when new guidance is issued.

Complaint Process

A complaint is defined as a written or oral communication that indicates there has been a potential violation by a group health plan, health insurer, healthcare provider, healthcare facility, or provider of *air ambulance services*. A complaint is considered filed when the Departments have enough information to identify the parties involved and the action or inaction that is the subject of the complaint. There is no specific time frame for filing a complaint (regulators had considered a 90- or 180-day time frame, but chose not to include a time limit).

The regulations outline the complaint requirements, but provide limited detail on the process. The Departments state that they intend to provide a single system to intake all complaints because individuals filing complaints may not know which Department will be responsible for responding to the complaint. In general, once the Departments receive a complaint they will, within 60 business days, respond by acknowledging receipt of the complaint, notify the complainant of their rights and obligations under the complaint process, and describe the next steps of the complaint resolution process. The Departments may also request additional information needed to process the complaint. Examples of documents that may be requested include an Explanation of Benefits, information about the provider, information about the plan or insurer, information needed to determine if the service was emergency or non-emergency, a summary plan description, and/or an insurance contract. Information may be requested from the complainant, the plan, the insurer, and/or the healthcare provider. The next step in the process may include referring the complainant to a state or federal regulatory authority with enforcement jurisdiction. The Departments will make reasonable efforts to notify the complainant of the outcome of any investigation or enforcement action taken.

In the Preamble, the Departments note that the time frames for deciding post-service claims and appeals under ERISA for private plans and the Public Health Service Act (PHSA) for non-grandfathered medical plans may not always align with the timeframes under the NSA for sending an initial payment or *Notice of denial of payment* . However, they make a distinction between an adverse benefits determination, which is subject to the ERISA or the PHSA time frames, and a situation where there is an initial payment that is less than the billed amount (or a denial of payment), which may be resolved through the negotiation process or IDR. If the adjudication of a claim results in a participant being personally liable for payment, then the ERISA or PHSA process would apply. If the result is a decision that does not affect the amount that the participant owes, the dispute only involves amounts payable by the plan to the provider, and the provider

has no recourse against the participant, then voluntary negotiation and the IDR process will be used for resolution.

The IDR process will be used to determine the amount that the plan is required to pay to the healthcare provider and the healthcare provider is required to accept if the amount is not determined by a *State All Payer Model Agreement*, a *Specified State law*, or the voluntary negotiation process. If a plan and provider cannot agree within a 30-day open negotiation period then either may initiate the IDR process by filing a request with the Departments and notifying the other party. The parties will jointly select an IDR entity and each party will submit a proposed payment amount to an IDR entity. The IDR entity will make the final determination. More detailed information on the IDR process and IDR entities will be provided in future guidance.

State Surprise Billing Laws

A number of states already have some type of surprise billing laws in effect, which, in some cases, include a process for determining the total amount payable under a group medical plan or medical insurance. In general, those state laws govern insured plans and self-insured medical plans that are not subject to ERISA (e.g., nonfederal governmental and non-electing church plans). A few of those states, such as Washington and New Jersey, permit private employers sponsoring ERISA plans to opt in to the state's surprise billing requirements. If a self-insured ERISA plan is permitted and has chosen to opt into a state's surprise billing system, the plan may calculate the required payment amount by complying with that state's surprise billing law. A group health plan that opts in to a state system must do so for all items and services to which the state law applies. In addition, the plan must prominently display in its plan materials a statement that the plan has opted in to the state law, identify the state, and include a general description of the items and services provided by nonparticipating providers that are covered by the relevant state law.

For insured plans required to follow those state surprise billing laws and for group medical plans that have opted in to the state requirements, the state law will be used to determine the Recognized Amount and out-of-network rate only if the law applies to all of the following: (1) the plan or coverage involved, (2) the nonparticipating provider or nonparticipating emergency facility involved, and (3) the item or service involved. Otherwise, the NSA requirements will be used to calculate the Recognized Amount and out-of-network rate. Federal law generally preempts state laws that govern rates charged by "air carriers." As a result, billing associated with air ambulance providers that are "air carriers" (most are) will be determined using the NSA rules rather than a state's method of calculating payment amounts.

Although the general outline of how the state and NSA rules work seems straightforward, application may not always be simple. The regulations include four examples demonstrating how a Specified State law may (or may not) apply.

> **Example #1** – A nonparticipating healthcare provider provides covered services in a *participating health care facility*. Both are located in State A, which has a "surprise billing" law that applies and determines the total amount payable and the cost-sharing amount. In this example, the state law would determine the recognized amount and the out-of-network rate.

Example #2 – The same facts as Example #1 except that the healthcare provider and facility are located in State B. State A's law does not apply because the provider is located in State B. In this case, the lesser of the billed amount of the QPA would be used to determine the Recognized Amount (for the initial payment). The amount determined by negotiation or through the IDR process would determine the out-of-network rate (for the total payment).

Example#3 – An individual receives emergency and post-stabilization services in a hospital in State A. State A has a law that prohibits balance billing for emergency services and provides a method to determine cost-sharing and total payment amounts. However, State A's law does not include post-stabilization in emergency services. In this example, State A's law would apply to determine the cost-sharing and out-of-network rate for emergency services. But it would not apply to post-stabilization services, and the payment for those services would be calculated using the NSA method.

Example #4 – An individual receives non-emergency services from a nonparticipating provider in a participating facility in State A. State A has a surprise billing law that provides a method of determining the cost-sharing and total payment amounts. The law applies to health insurers and healthcare providers in State A. Self-insured plans not subject to the law are permitted to opt in. A self-insured plan that has opted in would use State A's law to determine the Recognized Amount and out-of-network rate.

The Departments state that to the extent state laws do not prevent the application of a federal requirement on balance billing, such laws are consistent with the statutory framework of the NSA and would not be pre-empted.

What's Coming Next?

The Departments have requested comments on various aspects of their guidance in the preamble. Clarification or additional guidance may result once comments have been received and reviewed. In addition, the Departments state that they intend to issue additional guidance implementing provisions of the CAA and NSA including:

- The federal IDR process,
- Patient protections through transparency and the patient-provider dispute process, and
- Price comparisons tools.

The Departments indicate that they intend to issue guidance in these areas later this year. The spring 2021 regulatory agenda for the Departments indicates that a "Part 2" surprise billing regulation has an expected release date of August 2021. Hopefully, the IDR regulations will be included in that guidance. Guidance establishing a QPA audit process may be issued around October 2021.

The Departments also indicate that at least some guidance will be provided in the following areas, but that it may not be released until after January 1, 2022:

- Insurance/plan identification cards,
- Continuity of care requirements,
- Accuracy of provider network directories,
- Pharmacy benefit and drug cost reporting, and
- Prohibition on gag clauses.

Until guidance is issued, plans and insurers are expected to implement the requirements using a good faith, reasonable interpretation of the statute.

Given the rapidly approaching compliance date, employers will want to begin discussing next steps with their insurers and TPAs. Employers will want to know what steps insurers/TPAs will be taking over the next few months in order to be prepared to comply as required. Some questions employers may want to ask include:

- How will they identify claims subject to the new rules?
- When do they expect to be in a position to calculate the QPA, recognized amount, and out-of-network rate?
- Will they be modifying language to be used in EOBs and communications with participants and providers?
- What information do they anticipate posting on their website? When?
- Are or will they soon be making modifications to the claims system to accommodate the additional calculations that may be needed?
- How will they coordinate federal NSA rules with state rules in states that have a “surprise billing” law?

Gallagher will continue to monitor regulatory developments and provide updates and new guidance and/or clarification of existing guidance becomes available.

The intent of this analysis is to provide general information regarding the provisions of current federal laws and regulation. It does not necessarily fully address all your organization’s specific issues. It should not be construed as, nor is it intended to provide, legal advice. Your organization’s general counsel or an attorney who specializes in this practice area should address questions regarding specific issues.

Appendix

Definitions

Air ambulance service means medical transport by a rotary or fixed wing air ambulance.

Ancillary services mean (i) items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner; (ii) items and services provided by assistant surgeons, hospitalists, and intensivists; (iii) diagnostic services, including radiology and laboratory services; and (iv) items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

Cost sharing means the amount a participant, beneficiary, or enrollee is responsible for paying for a covered item or service under the terms of the group health plan or health insurance contract.

Emergency department of a hospital includes a hospital outpatient department that provides emergency services.

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or health of an unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any body organ or part. The definition includes mental health conditions and substance use disorders.

Emergency services means an appropriate medical screening exam including ancillary services used to evaluate whether an emergency medical condition exists and further examination and treatment that may be required to stabilize the individual.

Health care facility, in the context of non-emergency services, is each of the following:

(1) A hospital,

(2) A hospital outpatient department,

(3) A critical access hospital,

(4) An ambulatory surgical center.

Independent freestanding emergency department means a health care facility that is geographically separate and distinct and licensed separately from a hospital under applicable State law, and provides any emergency services. An urgent care center that is permitted under state law to provide emergency services would be included in this definition.

Nonparticipating emergency facility means a hospital when providing emergency services, an emergency department of a hospital, or an independent freestanding emergency department that does not have a contractual relationship directly or indirectly with a group health plan or health insurer.

Nonparticipating provider means any physician or other health care provider who does not have a contractual relationship directly or indirectly with a group health plan or health insurer.

Notice of denial of payment means, a written notice from the plan that payment will not be made for a specified item or service and which includes the reason for denial. It does not include a denial due to an adverse benefit determination (An adverse benefit determination is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, for example as the result of application of a deductible.)

Out-of-network rate means the amount determined by a Specified State law or the amount applicable under a State All-Payer Model Agreement, if applicable. Otherwise it is the amount agreed to by the provider and the plan or insurer, or the amount determined under the IDR process.

Participating emergency facility means any emergency department of a hospital, an independent freestanding emergency department, or a hospital when providing emergency services that has a contractual relationship directly or indirectly with a group health plan or health insurer.

Participating health care facility means any health care facility described in this section that has a contractual relationship directly or indirectly with a group health plan or health insurer. .

Participating provider means any physician or other health care provider who has a contractual relationship directly or indirectly with a group health plan or health insurer.

Qualifying payment amount is the lesser of the billed amount or the median of the plan's or insurer's contract rate for the service as of January 31, 2019 (indexed).

Recognized amount means: (1) an amount under an applicable All-Payer Model Agreement (with CMS), (2) an amount determined under a Specified State law, or (3) the lesser of the amount billed by the provider or facility or the qualified payment amount.

Same or similar item or service means a health care item or service billed under the same service code or a comparable code under a different procedural code system. Procedural code systems include Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), or Diagnosis-Related Group (DRG).

Specified State law means a State law that provides for a method for determining the total amount payable under a group health plan or group or individual health insurance coverage.

State All-Payer Model Agreement means an agreement under section 1115A of the Social Security Act between a State and CMS that applies with respect to the plan or insurer, the nonparticipating provider or nonparticipating emergency, and the item or service provided.