

Benefits BULLETIN



The No Surprises Act: Key Provisions for Employers

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On July 1, 2021, the Departments of Labor, Treasury, and Health and Human Services (the Departments) released Part One of the regulations addressing the highly anticipated No Surprises Act (the Act), which was introduced in December 2020 as part of the Consolidated Appropriations Act, 2021 (CAA). These [interim final rules](#) of the Act are just the first in a series of guidance that can be expected this year. However, according to the Departments, the set of regulations for the transparency requirements under the Act might be delayed until 2022.

The Basics

Why Was the No Surprises Act Created? The Act was issued to help protect consumers from unexpected medical bills resulting from a medical service where it was unlikely they had known part of their care team was out-of-network (i.e., not contracted with their health plan).

For example, imagine someone is experiencing symptoms of a heart attack; it is unreasonable to expect them to look up if the closest hospital is in-network. So, they seek care at the nearest emergency room or hospital only to find out later it was out-of-network, and they have to pay more. Unfortunately, sometimes even if the individual did happen to use an in-network emergency room or hospital, the provider performing the service might not be in-network, resulting in the individual receiving a large unexpected bill. In both situations, the individual can't control who is involved in their care, yet they are stuck with the bill that often they can't afford to pay. Situations like these, along with many more, are reasons behind the considerable outcry and demand for regulations by the public.

What is Balance Billing (also known as "Surprise Billing")? Balance billing (as illustrated in the example above) is when an individual receives a medical service and is billed for the balance remaining after the health plan pays the in-network contracted amount

towards an out-of-network provider's total charges for a service. This amount often comes as an unexpected bill to the individual. Surprise!

What Does Interim Final Regulations Mean? The Departments are still accepting comments from the general public, which could result in some changes to the regulations. So, as they stand today, the regulations should be followed as if they are final until (if necessary) amended ones are issued.

Who Must Comply with the Rules? Group health plans (fully insured and self-funded), health insurance carriers (for both group and individual plans), providers, and some facilities must comply with these new regulations. Federal Employees Health Benefits Program (FEHBP) also must comply with *certain provisions* of the Act. Refer to the Office of Personnel Management's (OPM) issued interim final rules for additional information, as they won't be addressed in this Bulletin.

What Types of Services Does it Cover? Services include emergency care, air ambulance services, and non-emergency care, as described in more detail later in this Bulletin.

When Does it Go Into Effect? For group health plans and insurance carriers, the rules go into effect for the plan and policy years beginning on or after January 1, 2022. The HHS-only regulations that apply to health care providers, facilities, and providers of air ambulance services are applicable beginning on January 1, 2022.

What about States that Already Have Similar Laws? It is important to note, some states have already taken action against these balance billing practices by implementing various forms of consumer protection laws over recent years. For a list of these states and their specific regulations, visit The Commonwealth Fund's [website](#).

For fully insured plans, the insurance carriers will need to update the plans they issue to incorporate the new regulations and maintain compliance with both state and federal laws. Self-insured plans are not subject to state insurance laws; however, they must follow federal laws, including these interim final regulations.

Summary of Provisions

The interim final rules, titled "Requirements Related to Surprise Billing; Part 1," places restrictions on group health plans, carriers, and healthcare providers. Among other provisions, the requirements included in this set of guidance focuses on participant cost-sharing, specific notices, and consent obligations. The regulations provide these consumer protections for individuals receiving certain medical services at particular facilities or by particular providers (such as out-of-network providers providing services at an in-network facility).

- **Emergency Care and Air Ambulance Services:** When an individual receives air ambulance services or emergency care at an out-of-network facility or provider, the most the individual can be billed is their health plan's in-network cost-share (i.e., copay, coinsurance, etc.), and these must count towards the in-network deductible and out-of-pocket maximum. In other words, the individual can't be balance-billed for these services. Also, for these services (except for air ambulance), the individual cannot be asked to give up their balance billing and cost-sharing protections.
- **Non-Emergency Services and Certain Ancillary Care:** Certain non-emergency services and ancillary care (including anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services) are also included in the balance billing and in-network cost-share protections.

Imagine an individual is having surgery at an in-network hospital (or ambulatory surgery center). They checked to ensure the hospital and surgeon were in-network, so they thought they would only pay their in-network cost-share. However, the anesthesiologist or assistant surgeon wasn't in-network. Then the individual receives a large unexpected bill for their services. In these cases, the individual is only responsible for their plan's in-network cost-sharing amount and can't be balance billed.

- **Advanced Notice and Written Consent:** The regulations prohibit out-of-network providers, facilities, and air ambulance service providers from balance billing individuals in certain circumstances, but permit these providers and facilities to balance bill individuals if specific notice and consent requirements in the Act are satisfied.

However, providers and facilities may not provide such notice or seek consent from individuals in certain circumstances where surprise bills are likely to occur, such as for ancillary services provided by nonparticipating providers in connection with non-emergency care in a participating facility. In such circumstances, balance billing is prohibited, and the other protections of the Act, such as in-network cost-sharing requirements, continue to apply.

The Act also provides additional protections for individuals when their health plan covers emergency services. The rules require emergency services (in and out-of-network) to be covered: (1) without any prior authorization (approval required beforehand); (2) regardless of whether the provider is an in-network provider or an in-network emergency facility; and

(3) regardless of any other term or condition of the plan or coverage other than the exclusion or coordination of benefits, or a permitted affiliation or waiting period.

Model Notice for Plans and Insurance Companies

The regulations require group health plans and insurance carriers to provide a notice about the requirements under the Act. The notice must be posted on a public website of the plan or issuer and be included in each explanation of benefits for an item or service subject to the Act. [Model notices](#) were issued with the interim final rules to aid plans and carriers with this obligation.

Certain health care providers and facilities are also required to create, post, and distribute notices to individuals. HHS outlines these in the issued regulations.

Penalties

If a provider still sends a balance bill that violates the Act, HHS can impose civil monetary penalties of up to \$10,000 per violation. These penalties can be waived but only if: (1) the provider did not knowingly violate and should not have reasonably known it violated the Act; and (2) the provider withdraws the bill and reimburses the plan or individual plus interest. HHS also intends to undertake additional rulemaking on the Act's related enforcement requirements.

Next Steps for Employers

Employers should:

- Reach out to the plan's insurance carrier or TPA to discuss how they can support the employer with these new obligations.
 - For fully insured plans, generally, the insurance carrier will be required to comply with the rules. However, it would be prudent to discuss this further with the carriers.
 - Self-insured plans should discuss these regulations with their TPA. The employer should ask if there will be an additional fee for assistance, what services they will perform, and what is still the employer's responsibility to complete.
- Consult with their trusted advisors (e.g., benefits attorneys, consultants, CPAs service providers, etc.).
- Update their plan communications (e.g., enrollment kits, new hire packets, etc.)

to include the new notice requirements.

- Post the notice on their public website.
- Review and update (if necessary) the plan SPD.
- Collect the insurance carrier's updated policy, certificate of coverage (also known as the member booklet), and other plan documents which describe the services included in the Act.

As the additional parts of the regulations come out later this year, employers should seek further guidance on how they impact their health plans and what actions they will need to take to comply.

ADDITIONAL RESOURCES

[Interim Final Rule](#)

[Model Notice](#)

[Fact Sheet for Consumers](#)

[Fact Sheet for Group Health Plans
and Health Insurance Issuers](#)

[HHS News Release](#)