Isler Dare PC

Employee Benefits Update

August 19, 2021

Interim Final Regulations Issued That Prohibit Surprise Medical Bills

Executive Summary

On July 1, 2021, the Department of Labor, the Department of Treasury, and the Department of Health and Human Services, along with the Office of Personnel Management, jointly issued Interim Final Regulations implementing the first series of regulations under the No Surprises Act, which was part of the Consolidated Appropriations Act, 2021 (please review the January 2021 Isler Dare newsletter here). There are three specific circumstances this new rule addresses:

- Emergency services, when patients are typically rushed to the nearest hospital without regard to whether that hospital is in network;
- Non-emergency services, when patients are at participating hospitals or other facilities but receive care from an out-of-network provider; and
- Air ambulance services furnished by out-of-network providers.

This newsletter will discuss the regulations as they relate to group health plans.

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Interim Final Rule

Surprise billing occurs when people unknowingly get care from providers that are outside of their health plan's network. When a person with group health plan or health insurance coverage gets care from an out-of-network provider, their health plan or issuer usually does not cover the entire out-of-network cost, leaving them with higher costs than if they would have been seen by an in-network provider.

The goal of the No Surprises Act, and of these interim regulations, is to prevent patients from incurring significant financial hardship as a result of obtaining medical care from a provider who is outside of their health plan's network of preferred or participating providers. The regulations apply to health insurance carriers that offer group or individual coverage, which includes: (i) fully insured plans; (ii) self-insured plans; (iii) group health plans subject to ERISA; (iv) grandfathered plans; (v) governmental plans not offered by the federal government; (vi) church plans; and (vii) traditional indemnity plans.

Important Dates

August 14:

- Confirm recordkeeper has provided quarterly statements to participants
- File Form 990 returns for tax-exempt trusts or VEBAs, unless extended to November 15

September 15:

- File Form 8928 to report excise taxes for noncompliance with certain group health plan requirements
- Forms 5500 for calendar-year plans eligible for an automatic extension (without filing a Form 5558)
- Minimum funding deadline for pension plans

September 30:

- Distribute Summary Annual Report for calendar-year plans, if 5500 was filed on July 31

However, the regulations do not apply to people with coverage through programs such as Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE, nor do they apply to health reimbursement arrangements or retiree-only plans.

I. Emergency Services

The regulations provide that plans must cover emergency services without limiting what constitutes an emergency medical condition solely on the basis of diagnosis codes. "Emergency services" is defined to include any pre-stabilization services that are provided after the patient is moved from the emergency department and admitted to the hospital, as well as emergency services provided at an independent freestanding emergency department.

Under the regulations, cost-sharing for out-of-network emergency care can be no greater than the in-network cost-sharing amount. Participant cost-sharing amounts for emergency services furnished by a non-participating emergency facility will be calculated as follows:

- By using the amount determined by an applicable All-Payer Model Agreement; or
- If there is no such applicable All-Payer Model Agreement, by using an amount determined by specified state law; or
- If there is no applicable All-Payer Model Agreement or specified state law, by using the lesser of (1) the amount billed by the provider or facility and (2) the median of the contracted rates of the plan or issuer for the item or service in the geographic region, otherwise referred to as the "qualifying payment amount" or the "QPA".

II. Non-Emergency Services

The regulations prohibit out-of-network charges for ancillary care at an in-network facility in all circumstances, meaning that out-of-network providers will no longer be allowed to bill patients for out-of-network charges without advance notice. However, patients may agree to receive non-emergency care from certain out-of-network providers at participating healthcare facilities and waive the surprise billing protections.

The notice and consent waiver cannot be used for the following ancillary services under any circumstances:

- Emergency medicine
- Anesthesiology
- Pathology
- Radiology
- Neonatology
- Diagnostic Services (including radiology and laboratory services)
- Items and services provided by the following:
    - Assistant surgeons
    - Non-participating providers at a facility where there is no participating provider who can furnish such item or service

Participant cost-sharing amounts for non-emergency services provided by non-participating providers in a participating health care facility will be calculated using the same methodology described above for Emergency Services.

III. Air Ambulance Services

The regulations apply to air ambulance services where the plan or coverage has a network of participating providers and provides or covers any benefits for air ambulance services, even if those air ambulance providers are all out-of-network.

Participant cost-sharing amounts for air ambulance services provided by non-participating providers are based on the lesser of the billed amount and the QPA, and the cost-sharing amount that would apply if such services were provided by a participating provider. The "out-of-network rate" for non-participating providers and facilities is based on the following:

- The amount determined under an applicable All-Payer Model Agreement; or
- If there is no such applicable All-Payer Model Agreement, then the amount determined under specified state law; or
- If there is no applicable All-Payer Model Agreement or specified state law, then an amount to which the plan/issuer and provider/facility have agreed; or
- If none of the above three conditions apply, then an amount determined by an Independent Dispute Resolution (IDR) entity.

New Notice Requirements

The surprise billing regulations require group health plans and health insurance issuers who offer group or individual health insurance coverage to make publicly available, either by posting on a public website or providing to individuals directly, a notice describing plan participant rights and protections against surprise medical bills. Plans can use a model notice published with the regulations (found here), which will be considered to demonstrate good faith compliance with the new disclosure requirements. To facilitate this new disclosure requirement, we recommend that our clients include this new model notice in their Fall open enrollment materials and that they post it on their public website.

In addition to new participant notices, the regulations require an additional notice to an out-of-network provider, with each initial payment or notice of denial, when a plan determines that the QPA cost-sharing amount is the recognized allowed amount under the terms of the plan. This notice must identify the QPA for each item or service, as well as a statement clarifying that the QPA was determined to be in compliance with the methodology described in the regulations; the plan's contact person if the plan wishes to institute a 30-day negotiation period with respect to the plan's total payment; and the deadline to initiate independent dispute resolution if agreement cannot be reached. In addition, upon request, a plan must promptly provide detailed information about the QPA pricing used.

Complaints

The Departments intend to set up a unified complaint system to report violations of the No Surprises Act, and will issue additional guidance on that process. To date, there is no specific deadline under which complaints must be filed, but the Departments will respond to complaints within 60 days of receipt. Such responses will acknowledge receipt of the complaint, notify the complainant of their rights and obligations under the complaint process, and describe next steps. At any time, additional information may be requested in order to process the complaint and make a determination of facts for an investigation. Additional

information requested may not be limited to just the claim itself (*i.e.*, explanations of benefits, processed claims, evidence of coverage, summary plan descriptions, policies, certificates, or contracts of insurance), but also information about the plan or issuer covering the claimant, as well as any information about the provider, facility, or air ambulance service involved.

To discuss the Interim Final Regulations related to Surprise Billing, or any other employee benefits matters, please contact any member of our Employee Benefits and Executive Compensation Group below.

IslerDare PC

Your workplace, our insight

1945 Old Gallows Road
Suite 650
Tysons Corner, VA 22182
(703) 748-2690

1111 East Main Street
Suite 1605
Richmond, VA 23219
(804) 489-5500

Andrea I. O'Brien
aobrien@islerdare.com

Jeanne Floyd
jfloyd@islerdare.com

Vi D. Nguyen
vnguyen@islerdare.com

Ashley Hedge
ahedge@islerdare.com