HEALTH CARE OVERVIEW

Patient Protections from Surprise Medical Bills

The "No Surprises Act" (NSA) was enacted on Dec. 27, 2020, as part of the Consolidated Appropriations Act, 2021 (CAA), to increase health care transparency and protect consumers from surprise medical bills. Effective for plan years beginning on or after Jan. 1, 2022, the NSA provides federal protections against surprise medical billing by **limiting out-of-network cost sharing and prohibiting "balance billing"** in many of the circumstances in which surprise medical bills arise most frequently.

The NSA's protections for surprise medical billing apply to group health plans and health insurance issuers offering group or individual health insurance coverage. The Departments of Labor, Health and Human Services, and the Treasury (Departments) have issued guidance detailing how health plans and issuers determine provider payment amounts for services subject to the NSA's balance billing protections. If the parties cannot agree on a payment amount, they can use the NSA's federal independent dispute resolution (IDR) process to resolve the dispute.

LINKS AND RESOURCES

- Interim final rules from July 13, 2021, prohibiting balance billing for items and services subject to the NSA's protections
- Interim final rules from Oct. 7, 2021, implementing the federal IDR process
- Final rules from Aug. 26, 2022, addressing certain issues related to the federal IDR process and payment disclosures
- Model notice for surprise medical billing

Covered Services

The NSA's surprise medical billing protections apply to the following services:

- Emergency services received in a hospital's emergency department or an independent freestanding emergency department;
- Nonemergency services provided by an out-of-network provider at an in-network facility; and
- Air ambulance services provided by an out-of-network provider.

Consumer Protections

The NSA provides the following protections for covered services:

- Limits cost sharing for out-of-network services to in-network levels;
- Requires the cost sharing to count toward any in-network deductibles and out-of-pocket maximums; and
- Prohibits balance billing in most situations.

Background

The NSA was enacted to increase health care transparency and protect health care consumers from surprise medical bills in situations where they frequently occur. While the NSA does not protect individuals from every unexpected medical bill, it does provide federal protections against surprise medical billing for most emergency care and some nonemergency care where unexpected bills often arise. It also limits cost sharing to in-network rates under many of the circumstances in which surprise bills arise most frequently.

What Is a Surprise Medical Bill or a "Balance Bill"?

A surprise medical bill is an unexpected "balance bill" from a health care provider that occurs when an individual receives medical services from a provider that, usually unknown to the individual, is out of network. A "balance bill" is a medical bill from the out-of-network provider for the difference between the provider's billed charges and the amount collected from the plan and from the patient in the form of cost sharing (such as a copayment or deductible amount). Surprise medical bills often arise when an individual does not have the opportunity to select an in-network provider, such as in a medical emergency. For nonemergency care, an individual might choose an in-network facility or an in-network provider but not know that a provider involved in their care (for example, an anesthesiologist or radiologist) is an out-of-network provider.

State Laws

Some states have enacted laws to reduce or eliminate balance billing, but these protections do not extend across all states. In addition, states are limited in their ability to address surprise medical bills that involve an out-of-state health care provider. Moreover, state law protections typically apply only to individuals enrolled in health insurance coverage—they do not usually apply to self-funded group health plans due to ERISA's broad preemption clause.

Applicability

The NSA's ban on surprise medical billing broadly applies to group health plans (including fully insured, self-insured and level-funded plans) and health insurance issuers of individual and group coverage. These protections also apply to group health plans that have grandfathered status under the Affordable Care Act (ACA) and transitional plans that are subject to a nonenforcement policy for certain ACA market reforms. The ban on surprise medical billing does not apply to health reimbursement arrangements (HRAs) or other account-based plans, excepted benefits, short-term, limited-duration insurance and retiree-only plans.

Consumer Protections

Effective for plan years beginning on or after Jan. 1, 2022, the NSA creates federal protections against surprise billing and limits out-of-network cost sharing for three categories of medical services.

Types of Medical Services Protected by NSA	
1.	**Emergency services received in an emergency department of a hospital or an independent freestanding emergency department**—"Emergency services" include an appropriate medical screening examination, including ancillary services, to evaluate whether an emergency medical condition exists, and any further medical examination and treatment that may be needed to stabilize the individual (regardless of the department of the hospital in which the further medical examination and treatment is furnished).

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Types of Medical Services Protected by NSA	
2.	**Nonemergency services provided by an out-of-network provider during a visit at an in-network health care facility**—A "health care facility" includes hospitals, hospital outpatient departments, critical access hospitals and ambulatory surgical centers. In addition to items and services furnished by a provider at the facility, a ''visit'' to an in-network health care facility includes the furnishing of equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the provider furnishing these items or services is at the facility.
3.	**Air ambulance services provided by an out-of-network provider of air ambulance services**

With respect to these categories of services, the NSA provides the following consumer protections:

- ✓ Limits cost sharing (such as copayments, coinsurance and deductibles) for out-of-network services to in-network levels;
- ✓ Requires the cost sharing to count toward any in-network deductibles and out-of-pocket maximums; and
- ✓ Prohibits balance billing in most situations.

Balance Billing—Limited Exception

Surprise medical billing (or balance billing) for items and services covered by the NSA's protections is generally not allowed. There is a limited exception for certain post-stabilization services and for certain nonemergency services performed by out-of-network providers at in-network facilities if the provider or facility provides notice to the patient and obtains the patient's consent for the out-of-network care and extra costs. However, this exception does not apply in certain situations when surprise medical bills are likely to happen, like for specified ancillary services connected to nonemergency care, such as anesthesiology or radiology services provided at an in-network facility.

Additional Patient Protections for Emergency Services

The ACA imposed patient protections for emergency care services, effective for plan years beginning on or after Sept. 23, 2010. The NSA reorganized and expanded the ACA's patient protections, effective for plan years beginning on or after Jan. 1, 2022. The NSA applies the patient protections to plans that have grandfathered status, which were exempted from the ACA's original protections. The CAA also expands the definition of "emergency care" to include care received in an independent freestanding emergency department and care received in an emergency department of a hospital.

In addition to the NSA's ban on surprise medical billing, health plans and issuers that provide benefits for emergency services must provide those benefits without requiring prior authorization and without regard to whether the provider or facility is an in-network provider or in-network emergency facility, as applicable. Also, the plan or issuer may not impose administrative requirements or limitations on coverage for out-of-network emergency services that are more restrictive than those applicable to in-network emergency services.

Determining Payment Amounts

Cost-sharing Amounts

A patient's cost sharing for emergency services furnished by out-of-network providers or facilities and for nonemergency services furnished by out-of-network providers with respect to patient visits to certain in-network facilities must be

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calculated as if the total amount charged for the services is equal to the ''**recognized amount**.'' Interim final rules from July 2021 define the "recognized amount" as one of the following amounts:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
- An amount determined by a specified state law if there is no such applicable All-Payer Model Agreement; or
- The lesser of the billed charge or the qualifying payment amount (QPA) if there is no such applicable All-Payer Model Agreement or specified state law.

Cost-sharing amounts for air ambulance services provided by out-of-network providers must be the same as the cost-sharing amounts that would apply if the services were provided by an in-network provider, and these cost-sharing amounts must be calculated using the lesser of the billed charge or the QPA.

In general, the QPA is the median of the contracted rates recognized by the plan or issuer for the same or similar item or service provided by a provider in the same or similar specialty (or facility of the same or similar facility type) and provided in the geographic region in which the item or service is furnished.

Total Amount of Payment

Not later than 30 calendar days after a provider, facility or provider of air ambulance services submits a bill related to items or services subject to the NSA's protections, the plan or issuer must send the provider an initial payment or notice of denial of payment. When the QPA serves as the recognized amount (or as the amount upon which cost sharing is based with respect to air ambulance services), plans and issuers must disclose the QPA and certain information related to the QPA for the item or service involved.

The health plan or issuer must pay the provider or facility the **out-of-network rate**, less any cost sharing paid by the participant. The July 2021 interim final rules define the "out-of-network rate" as one of the following amounts:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
- An amount determined by a specified state law if there is no such applicable All-Payer Model Agreement; or
- An amount agreed upon by the plan or issuer and the provider or facility through negotiations If there is no such applicable All-Payer Model Agreement or specified state law.

When the parties cannot agree on a payment amount, they can use the NSA's IDR process to resolve the dispute.

Ongoing Litigation: Some aspects of the final rules regarding the IDR process and determining payment amounts have been the subject of ongoing litigation between health care providers and the Departments. Overall, health care providers have succeeded in many of their court challenges. It is expected that the Departments will continue to update their rules and guidance to reflect these court rulings.

Notice Requirements

The NSA requires health plans and issuers to provide a notice regarding surprise medical billing protections to participants, beneficiaries and enrollees. In general, plans and issuers must make this notice publicly available, post it on a public

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website of the plan or issuer, and include it on each explanation of benefits (EOB) for an item or service with respect to which the NSA's protections apply.

This notice must include information on:

- The NSA's protections against surprise medical billing;
- Applicable state laws on out-of-network balance billing; and
- Contacting appropriate state and federal agencies if an individual believes the provider or facility has violated the prohibition against balance billing.

The Departments issued a model notice that plans and issuers may use (but are not required to use) to meet these disclosure requirements. The Departments will consider the use of the model notice in accordance with the accompanying instructions to be good faith compliance with the NSA's notice requirements if all other applicable requirements are met.

Compliance FAQs

The Departments' FAQs from Aug. 19, 2022, include the following helpful information regarding the NSA's notice requirement:

- **Health plans without public websites**: A health plan that does not have its own website can satisfy the requirement to post the notice by entering into a written agreement where its issuer or a third-party administrator (TPA) agrees to post the notice on a public website where information is normally made available to plan participants on the plan's behalf. This guidance applies even in instances where the employer has its own public website but the group health plan does not. However, if a plan enters into a written agreement under which an issuer or TPA agrees to post the required information on its public website on behalf of the plan, and the health insurance issuer or TPA fails to do so, the plan violates the NSA's notice requirement. To help avoid this type of situation, employers should monitor their issuer or TPA for compliance with this notice requirement.
- **State balance billing laws:** Plans are only required to include information on applicable state balance billing laws, not all state balance billing laws, in their NSA notice. The Departments do not expect a plan or issuer to provide information on state laws that do not apply to individuals enrolled in the plan or coverage. Note that many state laws regarding balance billing do not apply to individuals who are enrolled in coverage provided by a self-insured group health plan or out-of-state issuer.

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