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BLOG

Agencies Begin Providing Rules for No Surprises Act Implementation

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On July 1, 2021, the Departments of Labor, Treasury, and Health and Human Services (the Departments) released part one of what will be a series of regulations implementing the surprise medical billing provisions of the Consolidated Appropriations Act, 2021 (the No Surprises Act or the Act). As its name suggests, the No Surprises Act establishes a robust statutory framework to protect participants against surprise medical bills from out-of-network providers and facilities providing emergency medical treatment or, unbeknownst to the participant, out-of-network providers providing certain ancillary services at in-network facilities. For more detailed information on the No Surprises Act, please see our initial client alert available here.

The interim final rule (IFR) primarily focuses on refining the participant cost-sharing rules and certain notice and consent requirements set forth under the Act. Central to the Act is the requirement that participants who receive out-of-network care protected by the Act are only required to pay the same level of cost-sharing they would have paid if the provider had been in-network. Cost-sharing for these out-of-network services must also be counted towards a participant's in-network deductible and annual out-of-pocket maximum. Notably, out-of-network services provided at physicians' offices, urgent care centers, or retail clinics are not covered by the Act, but the Departments have requested comments on the Act's applicability to urgent care centers.

Under the Act, cost-sharing for out-of-network services is required to be based on the "recognized amount" as determined under specified state law for the items and services, plan coverage, and applicable year. For most self-funded plans and in states with no relevant surprise-billing law, cost-sharing is based on the lesser of the provider's billed charges or the "qualifying payment amount" (the QPA). The QPA is the median contracted rate of the plan or issuer for the item or service in a geographic region as of January 31, 2019, indexed in later years for cost of living. The IFR defines the various elements factoring into the QPA including, among other things, details on calculating the contracted rate in various insurance contexts and clarification on the geographic region and specialty under consideration.

Providers are permitted to balance-bill participants for certain out-of-network services only with prior notice and informed consent, and never in the case of emergency services. In addition, plans and insurers are required to apply a prudent layperson's standard, based on the patient's symptoms, to determine whether a visit to a hospital or free-standing emergency facility qualifies as an emergency protected by the Act, and cannot base such assessment on type of service or diagnosis-related group (DRG) code. Accordingly, the IFR details the circumstances under

which a participant can consent to waive the Act's safeguards. The IFR also sets forth procedures under which providers are to notify plans and issuers when patient consent has been obtained, while soliciting public comments on the particular methodology. In addition, the IFR discusses the Act's requirement that plans and issuers notify participants of their rights under the Act and a newly established federal consumer-complaint procedure.

The IFR requires the plan or issuer to share information about the QPA with the out-of-network provider and allows the provider to initiate a 30-day open negotiation period if the provider is not satisfied with the QPA rate. If negotiations do not result in an agreed-upon amount, the provider may initiate an independent dispute resolution process to determine the applicable out-of-network rate. The IFR sets forth specific timeframes for sending an initial payment or notice of denial of payments to out-of-network providers and notes the distinctions between the payment-dispute process and the rules applicable to benefit claims and appeals determinations under ERISA. The IFR clarifies that when an out-of-network claim dispute does not affect the amount the participant owes and involves only the payment amount due from the plan to the provider (with no ability to balance-bill or seek additional payment from the participant under the Act), the Act's independent dispute resolution process, rather than the ERISA claims procedures, would apply.

Winston Takeaway: This highly technical initial guidance is helpful for plan sponsors preparing for the Act's 2022 effective date. Further guidance is anticipated, later this year and next, implementing the Act's other central components, including an independent dispute-resolution mechanism for negotiating disputed bills from out-of-network providers, and other consumer protections including maintaining up-to-date provider directories and listing cost-sharing requirements on participant ID cards. Plan sponsors should reach out to their third-party administrators and insurers to ensure compliance with the latest requirements under the IFR and update plan documents, summary plan descriptions, communication materials, and group health plan administrative services agreements accordingly.

Please contact a member of the Winston & Strawn Employee Benefits and Executive Compensation or Health and Life Sciences Industry teams for further information.

3 Min Read

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