Departments Issue Final Regulations and Additional FAQs Regarding the No Surprises Act

September 2022

On August 26, 2022, the Departments of Labor, Health and Human Services, and the Treasury (the Departments) published final regulations under the No Surprises Act (NSA) passed by Congress in late 2020. In addition, on August 19, 2022, the Departments issued guidance on the NSA in Frequently Asked Questions (FAQs) Part 55. These FAQs address a number of questions regarding the application and implementation of the NSA.

This Aon bulletin addresses the following:

- Background;
- Final Regulations Under the NSA;
- FAQ Guidance Under the NSA; and
- Employer Actions.

Background

Congress passed the NSA in 2020 as part of the Consolidated Appropriations Act, 2021. The NSA requires health plans and providers to comply with certain provisions when a plan participant receives emergency services from an out-of-network facility or receives non-emergency services from out-of-network providers in an in-network facility. The NSA also requires air ambulance services provided by out-of-network air ambulance providers to comply with certain requirements. In general, the NSA limits cost-sharing for plan participants, prohibits balance billing of plan participants by providers of services covered by the NSA, and sets out a process for resolving disputes between plans and providers regarding payment for these services.

The Departments released interim final regulations in July 2021 and October 2021. Lawsuits were filed in response to some of the provisions in the interim final regulations. These August 2022 final regulations incorporate provisions in response to comments received from stakeholders on the interim final regulations as well as in response to the litigation. The FAQ guidance addresses additional implementation issues that have arisen since the NSA went into effect.

Final Regulations Under the NSA

The Departments note that these final regulations are meant to be narrow in scope and are intended to address only certain issues. Additional regulations will be issued at a later time on the rest of the provisions included in the July 2021 and October 2021 interim final regulations. Accordingly, these August 2022 final regulations set out the following.

Disclosures for "Downcoded" Claims

These final regulations require plans to make certain disclosures to providers (including facilities and providers of air ambulance services) about the qualifying payment amount (QPA) when a plan "downcodes" a claim billed by a provider for services that fall under the NSA and when the QPA applies. For self-insured plans, the QPA (i.e., the median contracted rate) generally will be the most common amount on which participant cost-sharing is based and will be an important factor in a payment dispute process between the plan and the provider. "Downcoding" refers to a plan's alternation, addition, or modification of a service code billed by a provider if the change is associated with a lower QPA than what was initially billed by the provider. If a QPA is based on a downcoded service code, then the plan has to provide specific information regarding the downcoded service code to the provider. This requirement is effective with respect to items or services furnished on or after October 25, 2022, for plan years beginning on or after January 1, 2022.

Requirements for IDR Entities

Under the NSA, disputes between plans and providers that cannot otherwise be resolved may be determined by an Independent Dispute Resolution (IDR) entity. In response to recent litigation, these final regulations set out how an IDR entity should consider the QPA and additional information when determining the amount that the plan must pay the provider for a service subject to the IDR process. The October 2021 interim final rules had required IDR entities to select the offer closest to the QPA unless the IDR entity determined that information submitted by a party clearly demonstrated that the QPA was materially different from the appropriate out-of-network rate, thereby creating a rebuttable presumption in favor of the QPA. In light of a district court decision vacating this requirement under the interim final regulations, these final regulations require IDR entities to consider the QPA as well as additional information submitted by the parties. The final regulations provide various examples to illustrate these requirements.

Additionally, the final regulations require the certified IDR entity to provide a written statement of the IDR entity's decision and the reasoning for a particular determination of the out-of-network rate the plan must pay the provider. Specifically, the IDR entity must explain its determination in a written decision provided to the parties and the Departments in a form and manner specified by the Departments in separate guidance. The rationale for the decision must be included in the written decision, including what information the IDR entity used to demonstrate that the amount selected best represents the value of the item or service. The requirements regarding payment determination standards and written decisions and reporting by IDR entities are applicable with respect to items or services provided on or after October 25, 2022, for plan years beginning on or after January 1, 2022.

FAQ Guidance Under the NSA

The Departments also issued FAQs on August 19, 2022, providing additional guidance on the application of the NSA for plans.

- For emergency services and air ambulance services, the balance billing provisions apply even when a plan does not have a network of providers, since the balance billing requirements related to

emergency services and air ambulance requirements do not depend on whether the plan has a network of providers.

- For non-emergency services provided by out-of-network providers at an in-network facility, the balance billing provisions are not triggered if the plan does not have a network of participating providers. Generally, an in-network facility is one that has a direct or indirect contractual relationship with the plan. If the plan does not have a network of providers, the balance billing provisions for non-emergency services are not triggered and do not apply.

- If a plan does not have a network of providers, participant cost-sharing for emergency services furnished by a nonparticipating provider or facility and for non-emergency services furnished by an out-of-network provider in an in-network facility, should be calculated based on the "recognized amount" set out in the NSA (i.e., the amount determined by the All-Payer Model Agreement, specified state law, or lesser of billed charge or QPA, as applicable). If the QPA is the appropriate amount and a plan does not have enough information to calculate the median contracted rate (because, for example, the plan does not have a network of participating providers) then the plan must calculate the QPA using "an eligible database" as set out in the regulations.

- For group health plans that do not have a network of providers and the QPA applies, then the out-of-network rate paid by the plan is the amount the out-of-network provider, emergency facility, or provider of air ambulance services and the plan agree upon or the amount determined by the IDR entity. This may result in a plan with reference-based pricing and no network of providers paying a total payment that is different from the plan's reference-based pricing amount for items or services subject to the NSA.

- For plans that do not have a network of providers (including those that utilize reference-based pricing), those plans must apply the maximum out-of-pocket (MOOP) requirements under the Affordable Care Act as provided for in prior guidance (i.e., Department FAQs Part XXI). These FAQs clarify that plans may not limit or exclude out-of-pocket spending from counting towards the MOOP for providers that do not accept the reference-based price with respect to post-stabilization services that are included in the definition of "emergency services" in the NSA.

- The NSA provisions regarding emergency services, non-emergency services furnished by an out-of-network provider in an in-network facility, and air ambulance services apply with respect to a group health plan that generally does not provide out-of-network coverage as long as those services are otherwise covered under the plan.

- If a group health plan covers air ambulance services only for emergencies, the NSA does not require the plan to cover non-emergent air ambulance services provided by an out-of-network provider of air ambulance services.

- The NSA applies with respect to air ambulance services furnished by an out-of-network provider of air ambulance services even if the point of pick-up is in a jurisdiction outside of the U.S. For the geographic region used to determine the QPA when the point of pick-up is outside the U.S., plans are expected to use a reasonable method to determine which geographic region under the July 2021 interim final regulations.

- The guidance clarifies that the NSA provisions apply to emergency services furnished with respect to a behavioral health crisis facility. This is true regardless of whether the license issued to the facility uses the term "hospital emergency department" or an "independent freestanding emergency department" and regardless of whether the license issued to the facility uses the term "emergency services" to describe the services the facility is licensed to provide.

- Group health plans that do not have their own website may satisfy the disclosure requirements under the NSA with respect to posting the required information on a public website of the plan if the plan's service provider posts the required information on its public website on behalf of the group health plan. However, the group health plan must enter into a written agreement under which the plan's third-party administrator (TPA) or carrier posts the information on its public website in accordance with the requirements set out in the guidance. This guidance applies in instances where the plan sponsor (e.g., the employer) maintains a public website but the group health plan sponsored by the employer does not. However, if the plan enters into an agreement under which its TPA or carrier agrees to post the required information but does not, the plan violates the required disclosure requirements.

- Group health plans are not required to provide information on state laws that do not apply to particular participants or dependents. The Departments note that many of these state law requirements do not apply with respect to participants enrolled in self-insured plans.

- Group health plans are required to calculate the median contracted rate separately for each provider specialty if the plan's contracted rates vary based on provider specialty. In the case of a group health plan that offers multiple benefit package options administered by multiple TPAs, each TPA is allowed to calculate a median contracted rate separately for those options administered by that particular TPA. Each TPA can then determine the QPA specific to the item or service under that particular TPA's benefit package option.

- Group health plans must send an initial payment or notice of denial of payment to an out-of-network provider, facility, or air ambulance provider for items or services subject to the NSA no later than 30 calendar days after the plan receives a "clean claim." The Departments encourage providers who are concerned about a plan's delay in this timing to submit a complaint to the No Surprises Help Desk or submit a complaint to the Centers for Medicare & Medicaid Services (CMS).

- Providers of services covered under the NSA may not initiate an open negotiation with the plan prior to receiving an initial payment or notice of denial of payment. Again, providers may contact the No Surprises Help Desk or submit a complaint to CMS.

- The term "notice of denial of payment" does not include a notice of benefit denial due to an "adverse benefit determination" where a plan participant is liable for payment to the provider or facility. Those disputes are determined through the plan's claims and appeals process. Instead, a "notice of denial of payment" is generally a dispute between the plan and the provider, does not affect the amount the participant owes, and the payment dispute can be resolved through the open negotiation and the federal IDR process, if necessary, as set out in the NSA.

- Plans must include certain, specific information to providers regarding the QPA when the QPA is the recognized amount. This information must be provided with the initial payment amount or notice of denial of payment to providers. A general statement by the plan that the claim was processed according to applicable law and directing the provider to a website for more information is not an adequate substitute for this required disclosure. If the plan fails to disclose the required information when making the initial payment or sending notice of denial of payment, the provider can initiate an open negotiation process and then proceed to the IDR process.
- Any portal established by a plan for providers to submit information necessary to initiate the open negotiation period must accept the standard open negotiation form developed by the Departments.

Employer Actions

The NSA provisions apply to group health plans and health insurance issuers offering group or individual coverage. For fully insured group health plans, plans should confirm that that their fully insured carriers are complying with the requirements under the NSA. Self-insured group health plans should work with their TPAs or other service providers to ensure that their TPAs or service providers are complying with all of the NSA provisions on their behalf. Self-insured plans should also review any contractual arrangements with their TPAs and service providers, as well understand any additional fees. Further, group health plans that intend to have their TPAs or service providers post the required disclosures on their behalf should enter into a written agreement with those TPAs or service providers and monitor compliance.

Resources

The final regulations are available here.

A Fact Sheet is available here.

The FAQs Part 55 are available here.

The No Surprises Act website is available here.

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