HEALTH LAW ALERT
July 13, 2021

"Part I" of No Surprises Act Rules Published

First Set of Rules Affecting Health Plans under the Consolidated Appropriations Act, 2021

Today, the Departments of Health and Human Services, Labor, and the Treasury (the Agencies) formally[1] published Interim Final Rules adopting standards for some provisions of the "No Surprises Act," which was part of the Consolidated Appropriations Act, 2021 (CAA). Health plans must comply with the Interim Final Rules for plan years beginning on or after January 1, 2022. These Rules address some, but not all, aspects of the No Surprises Act. The Agencies call these "Part I" of the No Surprises Act Rules and explain that they will be "issuing regulations in several phases" to implement the requirements of the No Surprises Act and the Transparency provisions of the CAA.

These Part I Rules address provisions of the No Surprises Act that "provide protections against balance billing and out-of-network cost sharing" for the following "No Surprises Act Services":

- Emergency services;
- Non-emergency services furnished by nonparticipating providers at participating health care facilities; and
- Air ambulance services furnished by nonparticipating providers.

The Rules also implement a provision of the No Surprises Act that requires grandfathered health plans to comply with the "patient protection provisions" of the Affordable Care Act related to a member's choice of health care professional (*i.e.*, primary care provider, pediatrician (for children), and OB-GYN (for women)). These Rules ***do not*** address the CAA's requirements for Advanced Explanations of Benefits, price comparison tools, reporting agent and broker compensation, among other provisions. The Agencies plan to

[1] The Department informally published the Rules and released them to the public when they were published by the Agencies on their respective websites on July 1st.

address some of these matters "[l]ater this year" and others in 2022, subject to a delayed compliance date and good faith compliance in the interim.

These Interim Final Rules are published at 86 *Federal Register* 36872 (July 13, 2021) (click here). Interim Final Rules are published before the public has the opportunity to provide comment on the Rules. This may happen when, as in this case, the normal rulemaking process is "impracticable and contrary to the public interest" because there is insufficient time to obtain public feedback before the effective date of the applicable requirements (as determined by Congress in statute). Comments on the Interim Final Rules may be submitted until 5 p.m. on September 7, 2021.

Click here for Volume I of my compilation of Selected Federal Health Insurance Provisions, which includes the new Part 149 (beginning on page 191). *See* the first line under "Compiled Rules") (or see the "Resources" page at tbixbylaw.com).

Out-of-Network Cost-Sharing and Payment of Out-of-Network Providers

Under the Interim Final Rules, the Department of Health and Human Services establishes a new Part 149 in Title 45 of the Code of Federal Regulations. The new Part 149 is called "Surprise Billing and Transparency Requirements," Subparts B and D of which apply to group health plans and insurers in the group and individual markets (including grandfathered health plans). Subpart E applies to health care providers. (Subpart A contains "general provisions," applicable to all parties subject to the Rules; HHS has not yet published content for Subpart C, which is "Reserved.")

Under the Rules, when a health plan provides out-of-network coverage for the three categories of No Surprises Act Services listed above, the health plan must:

(1) Not impose on the member cost-sharing obligations that are greater than the obligations that would apply if the services were provided in-network;

(2) Count cost-sharing payments toward the member's ***in-network*** deductible and ***in-network*** out-of-pocket maximums (notwithstanding that the services are provided by an out-of-network provider);

(3) Send the out-of-network provider "an initial payment" or notice of denial (as applicable) within 30 days of receipt of "the information necessary to decide a claim for payment"; and

(4) Directly pay the out-of-network provider any balance due (in addition to the initial payment and any member cost sharing) for any covered services within 30 days of making a payment determination.

In each case, arrangements (including timelines and amounts payable) that are established by a State law on balance billing or an "All-Payer Model Agreement" with CMS supersede the provisions set out above.

For purposes of calculating an out-of-network cost sharing amount (*e.g.*, coinsurance or deductible) for the No Surprises Act Services, the health plan must use a "recognized amount," rather than simply applying the amount that the provider actually charges. The "recognized amount" is the lesser of what the provider actually charges and the "qualifying payment amount." The qualifying payment amount is the health plan's median in-network rate (*i.e.*, the middle value, not the average) for the Services provided on January 31, 2019, adjusted for inflation. A health plan will be required to provide a notice to the out-of-network provider concerning the "qualifying payment amount" whenever that amount is used as the "recognized amount" for purposes of calculating out-of-network cost sharing.

The "initial payment" a health plan is required to make "should be an amount that the [health plan] reasonably intends to be payment in full based on the relevant facts and circumstances and as required under the terms of the plan or coverage." The parties may subsequently negotiate an alternative rate or, if negotiations are not successful, initiate an Independent Dispute Resolution (IDR) process, which is to be established by the Agencies in future rulemaking. The difference between the initial amount and the negotiated amount (or the amount determined through the IDR process) would be the "balance due" described in item (4), above.

Prohibition on Balance Billing

Subpart E of the new Part 149 prohibits out-of-network providers from "balance billing" members for No Surprises Act Services. Thus, providers cannot bill members (or otherwise hold them liable for) an amount that exceeds the cost-sharing requirement for the Services, as calculated in the manner described above. An out-of-network provider may only require a member to pay for other services after giving the member appropriate notice and obtaining consent from the member, which must be given "freely, without undue influence, fraud, or duress."

No Surprises Act Notice to Members: EOBs and Website

The No Surprises Act requires health plans to provide notices concerning the prohibition on balance billing under the No Surprises Act and these Rules. The notice must be published on health plans' websites and in any Explanation of Benefits for an item or service that is subject to these Rules. Although these Rules do not address this notice requirement, the Agencies include in the preamble to the Rules a model notice and instructions for using the notice, which will constitute good-faith compliance with the notice requirements until such time as the Agencies publish Rules that are more specific.

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