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No Surprises Act Regulations – Insurer Requirements

Health Care Law Brief Blog on **July 14, 2021**

This post provides an update to our previous publication summarizing the federal No Surprises Act and is part two of two in a series on new interim regulations implementing certain requirements of the No Surprises Act.

In part one of this series, we discussed the recently issued interim final rule implementing the No Surprises Act and the protections afforded to patients in connection with emergency services furnished by out-of-network (OON) facilities and providers or in connection with non-emergency services performed by OON providers at certain in-network facilities.

Here, in part two of the series, we address the interim final rule's plan coverage requirements, the methodology a health plan offering group or individual health insurance coverage must use to determine a patient's cost-sharing responsibility, and communications between insurers and providers detailing payment amounts.

Plan Coverage Requirements

Under the interim final rule, health plans offering coverage for emergency services must do so without requiring prior authorization and without regard to whether the services are provided at an OON facility or by an OON provider.

The interim final rule also limits cost-sharing for OON emergency services and certain non-emergency services furnished by OON providers at certain in-network facilities to no higher than in-network levels, requires such cost-sharing to count toward any in-network deductibles and out-of-pocket maximums, and prohibits balance billing.[1]

Specifically, the consumer cost-sharing amount must be calculated based on all-payer models (if applicable), state law requirements, or if the former do not apply, the lesser amount of either the billed charge or the qualifying payment amount.

Qualifying Payment Amount

The interim final rule defines the Qualifying Payment Amount (QPA), which serves as the basis for any patient financial responsibility, for services furnished in 2022 as the median of the contracted rates recognized by a plan on January 31, 2019, for the same or similar item or service that is provided by a provider in the same or similar specialty and provided in a geographic region in which the item or service is furnished, increased for inflation. The median contracted rate is determined with respect to all group or individual health insurance coverage offered by the health plan that is offered in the same insurance market.

If the plan lacks sufficient information (defined as at least three contracted rates in the insurance market) to calculate the median contracted rate for an item or service, or in the case of a newly covered item or service, the health plan must calculate the QPA by first identifying the rate that is equal to the median of the in-network allowed amounts for the same or similar item or service provided in the geographic region in the year immediately preceding the year in which the item or service is furnished, through use of any eligible third-party database, and then increasing that rate by the percentage increase in the CPI-U over such preceding year.

It is noteworthy that while the QPA serves as the basis for any patient responsibility in OON contexts, it does not determine the OON payment amount to the OON provider.

Initial Payment Amount

To prevent billing disputes between providers and insurers, the interim final rule requires plans to make an initial OON payment (or send a notice denying payment) within 30 calendar days after a clean claim is submitted for emergency services or non-emergency services performed by nonparticipating providers at participating facilities. The initial payment should reflect the amount that the plan intends to be payment in full; it is not intended to be a first installment. While the interim final rule did not provide guidance on the dollar amount of the initial payment, the agencies requested comments on whether and how the rate should be set in the future, and noted that some states already set standards for minimum initial payment amounts, which should be followed.

OON Payment Rates

Under the interim final rule, the OON payment rate is (i) any State law or All-Payer Model Agreement mandated rate, (ii) the amount agreed by the parties or (iii) the rate determined through an independent dispute resolution (IDR) process contained in the statute (i.e., 30 day negotiation period, if no agreement is reached, followed within 4 days by a demand for IDR, which is “baseball” arbitration, with the arbitrator choosing one of the parties’ proposals based on the QPA and other factors such as acuity of illness, academic/teaching status, market share, and efforts to enter into managed care agreements; the IDR process cannot consider “usual and customary” rates or public payer rates in determining the OON payment amount). Note, however, that the regulators are committed to providing further regulatory guidance on the IDR process.

More to Come

The interim final rule is set to take effect on January 1, 2022. The No Surprises Act also implements price transparency initiatives and as noted above, an IDR process, which OON providers may utilize if they disagree with a payment made by a health plan for services subject to the surprise billing protections described above. Regulations on such are forthcoming, and we will be sure to provide updates in a timely manner.

[1] Remember, however, that in general, under the No Surprises Act and the interim final rule, the protections that limit cost-sharing and prohibit balance billing do not apply to certain non-emergency services performed by OON providers at participating health care facilities, if the provider or facility provides notice to the enrollee, and obtains the individual’s consent to waive the balance billing protections. However, providers and facilities may not provide such notice or seek consent from individuals in certain circumstances where surprise bills are likely to occur, such as for ancillary services provided by OON providers in connection with non-emergency care in a participating facility. In such circumstances, balance billing is prohibited, and the other protections of the No Surprises Act, such as in-network cost-sharing requirements, continue to apply.

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