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No More Balance Bills for Emergency, Air Ambulance and Other Services

The Consolidated Appropriations Act, 2021 (the CAA) includes a number of benefits-related measures to help Americans in 2021 and beyond. One of the most prominent is the No Surprises Act, which bans most surprise medical bills. Currently, in addition to needing to pay cost-sharing amounts (such as deductibles, coinsurance and copays), patients frequently receive unanticipated "balance bills" after visiting the emergency room or receiving care from an out-of-network provider at a network facility. The No Surprises Act addresses both of these situations, along with charges from out-of-network air ambulances, which can often be up to six figures.

The No Surprises Act's requirements take effect for plan years beginning on or after January 1, 2022. With such a short turn around and with the extent of these changes, plan sponsors will need to carefully coordinate with their service providers, potentially renegotiate agreements and amend their plans in the coming months.

Emergency Services

The No Surprises Act revises the Affordable Care Act's (ACA) patient protections to require that grandfathered and non-grandfathered plans cover emergency services both in- and out-of-network, without prior authorization.

Currently, only non-grandfathered plans are subject to the ACA emergency services rule. As such, this change may require extensive revisions to grandfathered plans' rules and could increase costs for these plans. While the Departments of Labor, Treasury and Health and Human Services have also recently issued guidance that will purportedly provide flexibility to grandfathered plans, the CAA's changes may make it more difficult for grandfathered plans to retain their status if the plan is forced to offset any increased costs due to the No Surprises Act changes with design changes elsewhere.

Expanded Definition of Emergency Services

The No Surprises Act revises the definition of emergency services in two ways—first in relation to the location of emergency services and second as to which services qualify as emergency services.

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Emergency services currently include, in essence, those services necessary to stabilize an individual with an emergency condition, but only when provided in a hospital emergency room. Under the No Surprises Act, emergency services will also include services by an independent freestanding emergency department and services by an out-of-network provider or facility after the patient is stabilized but undergoing outpatient observation or an inpatient or outpatient stay. These post-stabilization services will no longer qualify as "emergency services" once the patient can travel using nonmedical or nonemergency medical transportation and is in a condition to receive notice of, and to consent to, out-of-network treatment.

Calculating Cost-Sharing and Allowable Amounts

In addition to expanded coverage, the No Surprises Act goes beyond the ACA to protect individuals against increased costs from medical emergencies by changing the cost share crediting rules. Not only must health plan cost-sharing requirements for out-of-network emergency services be no greater than for in-network emergency services, but cost-sharing for out-of-network emergency services must now count toward any health plan in-network deductible and out-of-pocket maximum.

The No Surprises Act also creates two separate cost calculations for determining: (a) how a plan must calculate a covered person's cost-sharing amounts for out-of-network emergency services; and (b) how the plan identifies the allowable amount used to determine the plan's payment of its share of benefits. Typically, plans use the same allowable amount for calculating the covered person's share and the plan's share, but the No Surprises Act requires two calculation processes, even if the calculated amounts may ultimately be the same.

Participant Cost-Sharing

The participant cost-sharing amount must be calculated *as if* the total amount that would have been charged were equal to either the amount determined under state law (to the extent not preempted by ERISA), the amount under a state's All-Payer Model Agreement, or if no state law or All-Payer Model Agreement applies, the median of contracted rates (collectively referred to as the "Recognized Amount"). If a plan utilizes a vendor to calculate the allowed amount for covered services, presumably the vendor would also provide this amount.

Then, within 30 days after the provider sends the bill, the plan must make an initial payment or provide a payment denial notice. This 30-day deadline seemingly negates use of the 15-day extension available under the DOL's claims and appeals procedures. With the potential for increased claim amounts being

billed for out-of-network emergency services (or the other new out-of-network charges that must be paid as in-network described below) and the need to calculate the "Out-of-Network Rate" consistent with the rules under the No Surprises Act, plans may run up against the 30-day deadline and still need additional information to fully process a claim. Without the benefit of the 15-day extension, plans may be forced to deny the claim and then chase the additional information to be prepared for the appeal.

Allowable Amount

In total, the plan must pay the “Out-of-Network Rate,” as defined in the No Surprises Act, less the covered person’s cost-sharing responsibility. The Out-of-Network Rate is determined in one of three ways, depending on within which state the service was provided: by state law (to the extent it applies under ERISA), a state’s All-Payer Model Agreement, or in a state with no applicable law or All-Payer Model Agreement, by negotiations or an independent dispute resolution process between the provider or facility and the plan or insurer. Providers and facilities must accept the plan's payment as payment in full and cannot balance bill individuals.

Non-Emergency Services

Similar rules apply when out-of-network providers perform services at network facilities. In general, when a covered person receives non-emergency services from an out-of-network provider at a network facility, the plan will need to calculate the person’s cost-sharing responsibility as if the provider were a part of the network, based on the Recognized Amount. These cost-sharing amounts then must count toward any in-network deductible or out-of-pocket maximum. An exception to these rules generally will apply, however, if the person received notice from the provider of his or her non-network status at least 72 hours in advance and gave written consent to treatment.

As with the rules applicable to emergency services, the plan must pay an initial amount or provide a notice of denial of payment within 30 days after that provider sends the bill. In total, the plan must pay benefits based on the Out-of-Network Rate less the covered person's cost-sharing amount. Providers cannot balance bill individuals, unless the patients received notice of and consented to the potential for a balance bill.

Many plans may already apply in-network cost-sharing to out-of-network pathologists, emergency room physicians, anesthesiologists and radiologists that

perform services at in-network facilities. These plans' payment systems will need to be revised to expand the coverage and the change to the calculation of the covered person's cost-share and the Out-of-Network Rate.

Air Ambulances

Under the No Surprises Act, grandfathered and non-grandfathered plans can charge participants only in-network cost-sharing for out-of-network air ambulance services, provided in-network air ambulance services are covered. Any coinsurance or deductible must be based on the rates that would apply if the air ambulance was in-network. Further, these cost-sharing amounts must count toward the in-network deductible and out-of-pocket maximum, and the plan must apply the in-network deductible, the same as if the cost-sharing payments were for an in-network air ambulance.

It is uncertain what "rate" means in this instance. Perhaps "rate" means the median negotiated rate for the in-network air ambulance, but the CAA is not clear. Additional guidance, and examples in the regulations, will hopefully provide some clarity.

Similar to other emergency services, the plan must send an initial payment or payment denial notice within 30 days after the provider sends the bill. Then, the plan must pay directly to the air ambulance provider the remainder of the Out-of-Network Rate, less the covered person’s cost-sharing payment.

Once these rules take effect, air ambulance services cannot balance bill. An out-of-network air ambulance can only bill a person with air ambulance benefits for their cost-sharing amount, as calculated by the person’s plan.

Air Ambulance Claims Data Reporting

The No Surprises Act also requires plans to submit reports related to air ambulance services to HHS, jointly with the DOL and Treasury Department, by March 31, 2023. A second report will be due by March 30, 2024.

The reports will need to include claims data for air ambulance services, broken down by each of the following factors:

- Whether the services were for an emergency;
- Whether the air ambulance provider was part of a hospital-owned or sponsored program, municipality-sponsored program, hospital independent partnership (hybrid) program, independent program, or tribally operated program in Alaska;

- Whether the transport originated in a rural or urban area;
- The type of aircraft, such as helicopter or airplane;
- Whether the air ambulance provider was in-network; and
- Other information specified by the agencies.

The No Surprises Act imposes many new requirements on group health plans and insurers. This article is part of a series that addresses the changes in the CAA for group health plans. The next alert in this series will focus on the No Surprises Act's rules for out-of-network rate negotiations with respect to the above emergency, nonemergency, and air ambulance services, and the independent dispute resolution process for when negotiations fail. These rules will be key to compliance starting in 2022.