CAPLAW enews brief

New Rules Under the No Surprises Act Take Effect in January

December 2021

Starting January 1, 2022, interim final regulations issued under the No Surprises Act and aimed at protecting individuals from large unexpected medical bills will go into effect. The new rules were issued earlier this year by the U.S. Departments of the Treasury, Labor, and Health and Human Services, along with the federal Office of Personnel Management, and will affect health plans, health insurers, and health care providers under certain circumstances and situations.

While these new rules primarily affect health care providers, plans, and, insurers, CAAs, as group health plan sponsors, should be aware of the impact the new rules will have on the types and costs of coverage offered under their health plans. Most CAAs will have to rely on their insurers and other outside administrators to take the necessary operational measures to allow them to comply with the new rules. CAAs that sponsor self-funded plans should discuss the new rules with their Third Party Administrators (TPAs) that handle claims, processing, and reporting, to ensure their plan documents and descriptions are updated accordingly. Under the new rules, plan fiduciaries have an ongoing obligation to monitor their TPAs' compliance with these new protections.

Generally, the new rules are meant to protect individuals enrolled in group health plans from large unexpected medical bills from providers that do not participate in the health plan's or insurer's network (often referred to as "out-of-network providers"). The rules apply to the following situations:

1. When an out-of-network provider renders **emergency care** in any facility;
2. When an out of-network provider renders **non-emergency care** at an in-network facility; or
3. When air ambulance services are rendered by an out-of-network provider.

For purposes of these rules, "emergency services" are, generally, those required under the Emergency Medical Treatment and Labor Act (EMTALA) to evaluate and stabilize a medical condition of sufficient severity such that a prudent layperson would consider immediate medical attention necessary.

The new rules will not apply to account-based plans (such as health reimbursement accounts), plans offering only excepted benefits (benefits that are not included in traditional health insurance plans), short-term limited duration insurance arrangements that provide coverage to policy holders for a fixed, brief period of time (usually less than a year, but sometimes up to three years), and retiree-only plans.

Below is a summary of some of the key provisions in the new rules:

1. **Cost-sharing requirements.** The rule introduces new cost-sharing requirements and establishes a process for determining what amount the group health plan or insurer will pay. Under the new rules, in each of the situations when it applies, the cost-sharing requirements for the provision of out-of-network care must be identical to the requirements set by the plan for in-network care. Cost-sharing amounts paid in these situations must count toward satisfying in-network deductibles and out-of-pocket maximums for in-network services.

2. **Co-existence with state surprise billing laws.** The new rules intend to accommodate state laws that address surprise billing, as opposed to preempting them. For example, self-funded plans may opt for state law to apply (despite ERISA ordinarily preempting state law in those circumstances). Plans intending to follow state law will need to include a statement about the application of state law in materials that describe coverage for services rendered by out-of-network providers.

3. **Health plan/insurer notification requirements.** The new rules generally require health plans and insurers to notify a provider about how a claim for out-of-network services will be treated under the new rules. In addition, health plans and insurers are required to provide clear information about the new requirements and prohibitions through postings on applicable websites and through the inclusion of information in applicable explanation of benefits forms (EOBs).

4. **Enforcement.** In addition to compliance audits, a coordinated complaint process will be established to allow individuals to report violations. Civil monetary penalties may be imposed for a failure to comply with the new rules.

For more detailed information about the new rules, please refer to this article from Ballard Spahr LLP on the new rules under the No Surprises Act.

This publication is part of the Community Services Block Grant (CSBG) Legal Training and Technical Assistance (T/TA) Center. It was created by Community Action Program Legal Services, Inc. (CAPLAW) in the performance of the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Community Services Cooperative Agreement – Award Number 90ET0482-02. Any opinion, findings, conclusions, or recommendations expressed in this material are those of the author(s) and do not necessarily reflect the views of HHS and ACF. The contents of this publication are intended to convey general information only and do not constitute legal advice. Any communication through this publication or through CAPLAW's website does not constitute or create an attorney-client relationship. If you need legal advice, please contact CAPLAW or another attorney directly.