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Federal Surprise Billing Protections: What Employers Need to Know

Federal Agencies Issue Interim Final Rules for Surprise Billing

The Consolidated Appropriations Act, 2021 (CAA) became law on December 27, 2020 and contained several provisions affecting employee health and benefit plans including the No Surprises Act (the "Act").

The Act includes a variety of requirements, including the obligation to provide transparency and price comparison tools, as discussed in our previous Alert. The largest portion of the Act addresses surprise billing protections that apply to group health plans as of the first plan year beginning on or after January 1, 2022. The Act intends these protections to:

- Limit the ability of out-of-network (OON) providers to balance bill plan participants; and
- Create a dispute resolution system between plans and providers (as well as patients and providers).

The U.S. Departments of Labor, Health and Human Services, and Treasury (collectively, the "Agencies") have jurisdiction over enforcement of the Act and the responsibility to issue regulatory guidance. To date, the Agencies have published three sets of regulations relating to surprise billing:

1. The Agencies published interim final rules[1] in July and October, with Part 1 focusing on balance billing protections and Part 2 containing a detailed explanation of the federal independent dispute resolution (Federal IDR) process that plans may use for provider payment disputes.
2. The Agencies also issued proposed regulations in September regarding air ambulance claim reporting requirements.
3. In addition to the release of these rules, the Agencies issued a set of FAQs indicating additional regulatory guidance on the remaining provisions of the law would not likely not appear prior to the applicable effective dates.

The interim final rules label several provisions as "temporary," and the Agencies requested comments on a number of open issues. We expect additional surprise billing guidance, although we do not expect any before January 1, 2022.

Together, this guidance totals over 1,000 pages outlining the surprise billing protections that apply to plans, issuers, providers and facilities for certain qualifying items and services provided to both insured and uninsured individuals. This alert does not attempt to cover all of these requirements, but instead summarizes those most directly affecting group health plans and requiring action by employer plan sponsors and their carriers/third-party administrators (TPAs) in administering qualifying claims.

[1] An interim final rule is a final rule the Agencies acknowledge may be subject to change based upon feedback from interested stakeholders. Changes can – and do – occur either before or after the rule goes into effect, although the changes are usually not drastic.

Surprise Billing Protections

The Act attempts to take the sting out of unexpected medical costs, particularly in emergencies or other situations in which the patient does not have a choice of provider, by limiting OON providers' ability to balance bill for certain qualifying items or services under the following three categories of care:

1. emergency services;
2. non-emergency services obtained at an in-network health care facility;[2] and
3. air ambulance services.

The Act's Surprise Billing Protections apply to both self-insured and fully insured group health coverage (even when grandfathered under the Affordable Care Act (ACA)). State laws that provide for greater balance billing protection law may apply instead of the Act.[3]

Emergency Services

For non-grandfathered health plans, the ACA contains some patient protections for emergency services obtained from OON providers, but the ACA does not prevent providers from balance billing patients for any amounts a plan does not pay. The ACA's limited protections include restricting a plan's ability to impose higher cost-sharing amounts for OON providers, prohibiting preauthorization for OON emergency care, and requiring reasonable payment for OON emergency services based upon a number of factors. The Act duplicates those protections, expands them to grandfathered plans, and prevents balance billing by providers for emergency care.

The regulations clarify the standard for determining whether a service is "emergency care" covered by the Act. In short, plans must take into account whether a prudent layperson with an average knowledge of health and medicine would reasonably consider the situation to require immediate medical care in order to prevent serious harm to the health of the individual (or unborn child, in the case of a pregnant woman).

Emergency care may also include services provided after the patient moves out of an emergency department and additional post-stabilization services. Emergency care obviously includes care received in the emergency department of a hospital, but it can also include emergency care from other types of facilities. The agencies provided some examples of obvious emergency care facilities and requested feedback on other settings that should or should not qualify (e.g. urgent care center). Plans must make emergency care determinations on a case-by-case basis before an initial claims denial and cannot rely on diagnostic billing codes used by providers to classify treatment as emergency care after the fact.

To the extent a plan covers emergency services, those services must be covered without regard to any other term or condition of coverage other than the exclusion or coordination of benefits (as long as it is not inconsistent with benefits for an emergency medical condition). Basically, even if a plan has a general exclusion for a particular service, if the plan covers emergency services, the excluded service must be covered if provided as treatment for a covered individual's emergency medical condition.

Non-Emergency Services Obtained in Network Facilities

The surprise billing protections also apply to OON provider services that do not qualify as emergency care when received from an in-network facility, but there is a loophole. The OON provider may request the patient voluntarily

[2] For purposes of non-emergency services, a health care facility includes a hospital, hospital outpatient department, critical access hospital and ambulatory surgery center. The definition does not currently include urgent care centers.

[3] State balance billing protections do not apply to self-insured ERISA coverage.

waive the Act's protections and may be able to condition treatment on that waiver.[4] In order for the waiver to be binding, the provider must generally give a notice to the patient at least 72 hours in advance of the service.[5] The notice must expressly state that the patient is not obligated to receive services from the OON provider and can seek care from an in-network provider. The notice must also include a good-faith estimate of the amount the OON provider expects to charge the patient for the items or services. HHS and the DOL will develop a consent form that providers must use. Waivers cannot apply to the following:

- Emergency services (including emergency transport);
- Ancillary services (e.g. anesthesia, pathology, radiology) and assistants;
- Unforeseen, urgent medical needs (e.g. a complication during a procedure that requires the aid of an OON provider); and
- Services for which there is no in-network provider who can furnish the service at that facility.

Air Ambulance Services

If a group health plan covers air ambulance services, some additional rules apply when a participant receives services from an OON air ambulance provider.[6] Cost sharing for OON air ambulance services must be the same as for in-network, must be based on the lesser of the "qualifying payment amount" (see discussion below) or actual billed amount, and the cost-sharing amounts should apply to the plan's in-network deductible and out-of-pocket maximum accumulators.

The Agencies issued additional proposed regulations, mentioned earlier, requiring group health plans and insurance carriers to report air ambulance claims data for the 2022 and 2023 calendar years, which are due within 90 days of the end of the applicable calendar year.[7] Reports should include all data for claims paid during the calendar year regardless of the date the services were incurred.

Data reported must include a laundry list of specifics for each claim, including:

- Plan identification information,
- Date of service,
- Billing National Provider Identifier (NPI) information,
- Billing (CPT or HCPCS) codes,
- Transport information, including,
    - Whether the services were provided on an emergency basis;
    - The affiliation of the provider (hospital, municipality, independent, etc.);

[4] HHS is seeking comments to address the circumstances in which a provider can refuse to treat an individual absent consent to balance billing to ensure that providers do not pressure patients to waive protections.

[5] If an appointment is scheduled within 72 hours prior to the date services are to be furnished, the notice should be provided on the date the appointment is made and no later than 3 hours prior to furnishing services.

[6] All covered air ambulance services will be subject to the Act, even when a participant chooses an air ambulance provider on an elective basis in a non-emergency setting (although this should be rare).

[7] The report for 2022 data will be due March 31, 2023 with the report for 2023 due by March 30, 2024 (since 2024 is a leap year). Third party administrators will need to assist plan sponsors for self-insured group health plans.

  - The origin of transport (rural or urban area); and
  - The type of aircraft used for the transport (fixed-wing or rotary-wing air ambulance),
- Whether the provider of the air ambulance service has a contract with the plan or issuer to provide air ambulance services,
- Claim adjudication information (whether claim was paid, denied, appealed, denied and appeal outcome), and
- Claim payment information (submitted charges, amounts paid and cost-sharing amounts).

The regulations include a similar reporting requirement for air ambulance providers.

Exclusions from Surprise Billing Protections

The Act's protections against balance billing do not apply to all claims that fit within the three categories of care. In addition to appropriately waived claims, the protections do not apply to:

- Services received before coverage is effective and/or while the participant is in a waiting period;
- Services that are not covered by the plan; or
- Non-emergency services performed in an emergency setting after the patient is stable, can consent to transport, and can safely use non-emergency transport.

Excluded Plans: Plans that consist solely of excepted benefits (e.g., most health FSAs and limited dental/vision plans), health reimbursement accounts (HRAs), and retiree-only plans are not subject to the Act's surprise billing protections.

The New Process between the Plan and OON Provider for Qualifying Claims

Unless a participant has waived their surprise billing protections, there is a new process plans and OON providers must use to adjudicate covered claims and determine both the plan's and participant's payment obligations. The process between the provider and group health plan involves the following six steps.

1. The OON provider performs the qualifying services/provides the qualifying item and bills the plan.
2. The plan determines the applicable "recognized amount" for the qualifying item or service. This "recognized amount" is the amount used by plans and issuers to determine a participant's cost-sharing responsibility for a particular qualifying item or service. This amount is completely separate from the actual amount billed by the provider. It serves as the OON rate for the qualifying item or service, and the plan calculates the participant's cost-sharing obligation as if the total amount charged for services was equal to the "recognized amount" for those items or services.

   The "recognized amount" is determined under one of three methods, applied in the following order (i.e., if "a" does not apply, move to "b"):

   a) the amount specified by a state All-Payer Model Agreement (if any);[8]

[8] An All-Payer Model Agreement is an advanced alternative payment model agreement between a state and the Centers for Medicare and Medicaid Services that permits the state to establish rates for all services provided by a particular provider or facility regardless of payer. Currently, only Maryland and Vermont hold such agreements.

b) applicable state law governing the plan, issuer, provider, item or service involved (if any); or

c) the lesser of the billed charge or the qualifying payment amount (QPA).

More often than not, the recognized amount will be determined based upon the QPA.

3. The plan must then respond to the claim within 30 days of receiving a "clean claim." This time is measured from the date the plan receives complete records from the provider to properly decide the claim. The plan will either:

   a) deny the claim;

   b) send the provider or facility an initial payment amount that the plan believes to cover the full payment amount based on their understanding of the service/item provided and plan terms; or

   c) pay the provider the plan's portion of the billed amount.

4. If the plan pays less than the amount billed, the provider can initiate an "Open Negotiation Period" during which time the provider and plan try to resolve the dispute between themselves and agree upon an OON rate for the claim. The provider has 30 business days from the receipt of the initial payment or denial to dispute and begin negotiations with the plan. The initiating party must send an "Open Negotiation Notice" to begin the process. The Agencies provided a model notice for use by the parties. The Open Negotiation Period lasts 30 business days, and the parties must exhaust it before the dispute can move to the Federal IDR process.

5. If the parties cannot agree on the recognized amount, either party may request binding arbitration under the Federal IDR process run by the Agencies to determine the amount owed by the plan for the qualifying items or services.

6. Once the recognized amount is settled, the provider bills the covered participant for the fixed cost-sharing amount of the recognized amount for the qualifying item or service, and the plan credits the participant for these amounts paid toward annual limits.

Qualifying Payment Amount (QPA)

As mentioned earlier, comparing the provider's billed charge to the QPA is one of the three ways to determine the final recognized amount for participant cost sharing purposes, and it will likely be the method used most often. The QPA is integral to the claims process, but it is probably unfamiliar to many.

At a high-level, the QPA is equal to

- The median of the in-network contracted rate,
- For the same or similar service within the same medical specialty, and
- Within the applicable geographic area, as of January 31, 2019.

The QPA will also compare these amounts within the same insurance market (individual, small or large group market). The median contract rate must be indexed annually and will be adjusted for inflation after January 31, 2019. Each fully insured plan will look to the contracted rates for its particular carrier network, while self-insured plans will base the QPA on the contracted rate for all plans administered by the same third party administrator (TPA). This means the carrier or TPA will determine the QPA for group health plans.

Depending on the particular item or service and the geographic area where the participant incurs the claim, there may be insufficient information to calculate the QPA. In these instances, an alternative method is available to calculate the QPA for that particular claim.[9]

Independent Dispute Resolution (IDR) Process

Part 2 of the Interim Final Rules (IFRs) outlines a complex process to resolve disputes between plans and providers if there is an initial disagreement over the OON rate for a qualifying item or service. During this process, a certified IDR entity (an impartial third party claims review organization) reviews the information submitted by the parties and reaches a final and binding determination regarding the recognized amount for the claim.

The Agencies administer this process, known as the "Federal IDR process." It applies to grandfathered and non-grandfathered group health plans beginning on or after January 1, 2022, whether maintained by private, federal or non-federal governmental employers.

Note: The Federal IDR process does not apply to claims for qualifying items or services if the OON rate is determined through applicable state law. Additionally, if a state IDR process meets or exceeds the protections provided under the Federal IDR process and meets certain conditions, the plan can go through the state IDR process instead.

There are three separate Federal IDR processes detailed in the IFC for: 1) non-air ambulance claims; 2) air ambulance claims; and 3) disputes between providers and self-pay individuals. The Agencies administer each process through a newly established electronic Federal IDR portal to submit offers, requests, payments, and other required information.

For the most part, the air ambulance and non-air ambulance IDR processes are very similar, with minor differences in the information the IDR entity must consider, how it makes final determinations, and its reporting obligations in connection with an air ambulance claim. The IDR process for self-pay individuals only applies to those who are uninsured, or who are insured but do not use their health insurance to pay for a claim. Since the Federal IDR process for non-air ambulance services will apply to group health plans for the majority of claims, we will limit our discussion below to this process.

Federal IDR Process for Non-Air Ambulance

If the plan and provider/facility cannot reach an agreement on the recognized amount during the Open Negotiation Period, one of the parties may initiate the Federal IDR process once the Open Negotiation Period lapses. The IDR entity will report certain information about the IDR process for each of the claims reviewed. Although carriers and TPAs will generally be responsible for administering this process and complying with the various deadlines on behalf of group health plans, it is helpful to understand how this works at a birds-eye view. At a high-level, the process looks something like this:

1. **IDR Initiation and Required Notice:** Within 4 business days following the end of the Open Negotiation Period, either party may initiate the Federal IDR process by sending the Notice of IDR Initiation to the other party and to the Agencies through the Federal IDR portal. The date the Agencies and other party receive the Notice of IDR Initiation is the initiation date for the IDR process.

2. **Selection of Certified IDR Entity by Parties or Agencies:** The parties have 3 business days following the initiation date to select an IDR entity to make a recognized amount determination. The party initiating the IDR process gets to choose the IDR entity, and the other party may agree or object. The parties must

[9] This alternative method involves combining multiple regions and treating them as one geographic region to get sufficient data, or using Census divisions.

submit their selection through the Federal IDR portal by the 4th business day from the initiation date using the Agencies' model Notice of IDR Entity Selection. If the parties do not select an IDR entity by the deadline, the Agencies will randomly select an IDR entity to make a determination and will notify the parties of their selection by the 6th business day following the initiation date.

3. **IDR Entity Review for Conflicts of Interest:** The IDR entity must review claims information to determine if there is any conflict of interest. In order to remain on the case, the IDR entity must attest that it satisfies the conflict of interest safeguards under the IFRs and provide an attestation to the Agencies through the Federal IDR portal within 3 business days after being selected.

4. **IDR Entity Determines Whether IDR Process Applies:** The IDR entity will review the initial information submitted to determine whether the dispute involves a qualifying item or service subject to the Federal IDR process. It will provide written confirmation that the claim can proceed within 3 business days.

5. **Submission of Offers:** Each party must submit an offer for payment to the IDR entity within 10 business days after selecting the IDR entity. The parties will express the offer as both a dollar amount and as a percentage of QPA, along with other information related to the offer. The parties will submit this offer through the Federal IDR portal using the model Notice of Offer provided by the Agencies.

   Note: The parties can continue separate negotiations outside the IDR process as long as they resolve the dispute before the IDR entity makes its payment determination and provides written notification of that determination to them. If the parties agree to an OON rate or "recognized amount" and resolve the dispute prior to the IDR entity's payment determination, they must send a Notice of Agreement to the Agencies and the IDR entity through the Federal IDR portal within 3 days of entering the agreement.

6. **Selection of Offer by IDR Entity and Written Decision:** After the parties submit all relevant information, the IDR entity will examine certain data points to determine which offer is the most reasonable amount for the qualifying item or service. The IDR entity will generally select the offer closest to the QPA unless there is credible information provided by either party demonstrating the QPA is materially different from the appropriate OON rate for the qualifying item or service. There are different considerations and data points to take into account for air ambulance and non-air ambulance claims, but the process is the same for both types of claims. The IDR entity must provide its written decision of payment determination, along with the rationale for their decision, to the parties and the Agencies through the Federal IR portal within 30 business days after IDR entity selection.

7. **Payment upon Determination:** Within 30 calendar days after the IDR entity's payment determination, the plan must pay any amounts still due for the qualifying item or service. The prevailing party will pay for the entire cost of the IDR entity fee, while both parties will pay the administrative fee due to the Agencies for participating in the IDR process.

8. **Cooling-Off Period:** If the parties enter into another dispute involving a different claim similar to one that already finished the Federal IDR process, the parties must wait at least 90 calendar days from the date of the initial payment determination to initiate the Federal IDR process for the new claim. This is what the Agencies call the "cooling-off" or "suspension" period to minimize unnecessary utilization of the IDR process and associated costs, and hope that will ultimately result in the parties resolving the dispute on their own.

Billing the Participant for Qualifying Services and Items

Health care providers should not bill covered participants for any qualifying items or services subject to the Act until the final recognized amount has been determined, whether this is through separate negotiation and resolution or the Federal IDR process. Regardless of the amount the plan ultimately pays, the OON provider cannot balance bill the covered participant any amount over the applicable fixed cost-sharing amounts under the plan using the final recognized amount.

When setting the cost-sharing requirement for covered participants using the final recognized amount as the billed amount, plans must treat OON qualifying items and services as in-network claims. Any out-of-pocket expenses incurred by a covered participant toward cost sharing for a qualifying item or service must also count toward that individual's in-network deductible and out-of-pocket maximum (OOPM) limit. This rule applies to participants in a qualified high deductible health plan (QHDHP), without affecting the qualified status of the HDHP or the ability of participants to contribute to an HSA.

Example: Brendan is a participant in his employer's HDHP. He has a non-emergency medical procedure performed at an in-network hospital prior to incurring any other medical expenses during the HDHP plan year. The attending anesthesiologist is OON. The anesthesiologist initially charges the plan $3,000, but the final recognized amount for the service is $2,000.

Since Brendan has not paid any expenses toward his in-network $1,400 deductible, he is responsible for paying the first $1,400 of the $2,000 recognized amount. The remaining $600 is subject to the plan's cost sharing for the covered service as an in-network claim. Assuming the plan pays 80% for the service by an in-network anesthesiologist, Brandon would owe another $120 ($600 × 20%). The $1,520 also counts toward his in-network OOPM limit.

Notice Requirements

There are two separate notice requirements applicable to group health plans[10] and insurance carriers under the Act, which apply to plan years beginning on or after January 1, 2022. The compliance obligations belong to the plan sponsor (usually the employer), but employers should heavily rely on insurance carriers and/or TPAs to comply with those requirements, particularly since they will have such a big role to play in the plan's compliance with the surprise billing protections under the Act.

Plan Notice to Participants

The first notice obligation requires plans to provide a notice to participants describing the surprise billing protections under the Act. For plan years beginning on or after January 1, 2022, plans must post a notice describing the surprise billing protections on a publicly available site. Plans should post this notice by the first day of the plan year beginning in 2022. This disclosure must also appear in explanations of benefits (EOBs) involving OON claims.

A model notice is available from the DOL.[11] Plans are not required to use this notice, but the plan's disclosure should be based on the model to ensure all disclosure requirements are met. We strongly encourages employers to use the surprise billing notice provided by the plan's insurance carrier/TPA, if available. The disclosure must include information about any applicable state law surprise billing protections, [12] and insurance carriers/TPAs are in a better position to address this content.

For self-insured plans, guidance indicates the employer should host the notice on its own website. Although the regulations and model notice use the term "public website," we believe a plan should be able to satisfy this

[10] In most instances, this will only apply to medical/Rx plans.

[11] CMS recently issued a memorandum to group health plans, insurers, and health care providers regarding agency contact information that must be included in certain notices and disclosures relating to the No Surprises Act. Although the DOL has not updated this Model Notice to date, plans should add this contact information to the required participant disclosure. The contact information is as follows: Website: https://www.cms.gov/nosurprises/consumers; Phone number for information and complaints: 1-800-985-3059 (will not be operational until 1/1/2022)

[12] These may apply to fully insured plans or self-insured, non-ERISA plans.

requirement by posting the notice on its intranet that is available to employees and plan participants.[13] If the employer does not have an intranet site or other public site for its employees and participants, it could contract with the TPA to host this notice on the internet portal the TPA makes available to plan participants. TPAs will also need to address this required information in EOBs on behalf of the plan.

For fully insured plans, either the employer or insurance carrier can satisfy the notice obligation on behalf of the plan. If the employer posts benefits notices on its intranet, we recommend posting a copy of the notice there, even if the insurance carrier also does so on their website. Insurance carriers will need to address this required information in EOBs on behalf of the plan.

Plan Notice to OON Providers

The second notice obligation involves the disclosure of certain QPA information to providers. A plan must send its determination of the recognized amount (including a calculation of the QPA) on a line-item basis when it sends the initial payment or denial to an OON provider for billed amounts relating to claims for qualifying items or services. The notice must also include information surrounding the IDR process and the provider's right to dispute and negotiate the amount within 30 days of receipt, as well as contact information for the individual to contact to negotiate the claim. The plan must provide additional information upon request by the provider, including any fee schedules used, service codes used, or database information used to come to the recognized amount.

Although the obligation to meet this notice requirement belongs to the plan sponsor (i.e., the employer), insurance carriers/TPAs should meet this disclosure obligation as a part of their claims administration procedures. This will be automatic for fully insured plans, but self-insured plans should contract with the TPA to meet this disclosure requirement on its behalf with indemnification provisions to protect the plan in the event of disclosure failures.

Although the Agencies have not yet provided a model notice or additional guidance addressing how to comply, they have directed plans to exercise "good faith compliance" with this provision until additional rules or guidance appear.

Other No Surprises Act Protections

Continuity of Care

For plan years beginning on or after January 1, 2022, the Act also protects certain patients who are undergoing care received from an in-network health provider or in an in-network facility when there is a change to that network participation status in the middle of treatment.

If plan benefits would terminate for a healthcare provider/facility during a period of continuation care[14] due to:

- A contractual change between the plan and provider/facility;
- A change in provider network participation terms; or
- A contract between the plan and a health insurance issuer; then

[13] The DOL has declined to officially comment on whether an intranet posting would be sufficient.

[14] The continuity of care rules apply to patients who are undergoing a course of treatment for a serious and complex condition from the provider or facility; undergoing a course of institutional or inpatient care from the provider or facility; scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery; pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or determined to be terminally ill and receiving treatment for such illness from such provider or facility.

The plan must notify the individual and provide continuing benefits under the same terms and conditions for up to 90 days.

Prohibitions on Gag Clauses

As of December 27, 2020, the Act prohibits plans and issuers from entering into agreements with providers, TPAs, or other organizations offering provider networks that would restrict the plan or issuer from directly or indirectly:

- Sharing provider-specific cost or quality information to interested parties including referring providers, plan sponsors, plan participants or individuals eligible to become participants;
- Electronically accessing de-identified claims and encounter data for each individual covered under the plan; and
- Sharing such information, consistent with applicable privacy regulations.

Plans and insurance carriers must also submit an annual attestation of compliance to the Agencies.

No regulations are expected to be issued for the gag clause prohibition itself, although the Agencies indicated they intend to issue implementation guidance to explain how plans and issuers should submit their compliance attestations, which will be due beginning in 2022.

Provider Directory Requirements

The Act requires plans and insurance issuers to furnish updated and accurate information about provider network participation status accessible by covered individuals via telephone or a website. If a covered individual receives inaccurate information about a provider's status and subsequently receives an item or service from an OON provider/facility based on information that the provider was in-network, the plan will need to treat the claim as coming from an in-network provider for purposes of cost-sharing requirements (including application to in-network deductible and out-of-pocket maximums). That requirement will go into effect for plan years beginning on or after January 1, 2022.

Expanded Patient Protections Applicable to Grandfathered Plans

Under the ACA, group health plans that maintained grandfathered status since March 23, 2010 were exempt from certain provisions of that law. The Act's surprise billing protections and OON emergency service coverage provisions do specifically apply to grandfathered plans.

In addition, grandfathered group health plans are now subject to the patient protections requirements for choice of health care provider,[15] and the corresponding notice of choice of primary health care provider, which did not previously apply. Specifically, plans requiring or providing for designation of a primary provider must allow each participant, beneficiary, or enrollee to designate any available participating primary care provider or a pediatrician as the primary provider for a child. The plan must also allow women to access obstetrical or gynecological care without preauthorization or referrals. The plan is required to provide notice of those rights in the Summary Plan Description (or other similar description of plan benefits).

Grandfathered group health plans must also now follow external review procedures for claims for qualifying items or services that are subject to the surprise billing protections. Grandfathered plans were previously exempt from any external review requirements.

[15] PHSA Section 2799A-7, as amended by the No Surprises Act

Enforcement

The DOL and IRS have primary enforcement authority over private sector employer-provided group health plans for the surprise billing protections of the Act. HHS will have enforcement authority over federal and non-federal government group health plans, as well as providers and facilities to ensure compliance with these rules. There are no specific penalties in the regulations for compliance failures, however since the Act amends existing ERISA and PHSA sections, those penalties and excise taxes will apply.

The surprise billing regulations establish a complaints process enabling group health plans, issuers, providers/facilities and consumers to submit complaints to the Agencies about violations of the surprise billing protections. There is no deadline to submit complaints, and the Agencies must respond to complaints either orally or in writing within certain timeframes. A complaint to one agency may result in referrals to other state or federal agencies and may result in investigatory and enforcement action.

Client Impact

The surprise billing regulations will significantly change the claims and appeals process for qualified items or services covered by a group health plan. Balance billing protections should lead to an increase in the cost of OON claims paid by plans, although it should also lead to a decrease in OON provider litigation against plans and associated litigation costs.

In most instances, the insurance carriers/TPAs will bear the administration burden (and contractual liability for the delegation of compliance obligations) for employer-provided group health plans, although we expect they will pass the costs through to employers in the form of additional fees.

This does not mean the employers are free and clear of compliance responsibilities. The regulations will require a number of plans to amend their claims and appeals procedures, certain group health plans will require additional plan design changes, and employers will need to address certain disclosure obligations. Additionally OON lifetime or annual limits for particular services, whether they are related to air ambulance or non-air ambulance related services, may not be feasible to the extent that items or services provided under the particular classification are covered by the surprise billing protections of the Act, and coinsurance rates and deductibles may apply differently.

Although there has been a lawsuit filed challenging part of the Act's IDR process, the law as a whole is currently still set to go into effect for plan years beginning on or after January 1, 2022. We recommend proceeding with compliance efforts while litigation is pending. We are already starting to see insurance carriers and TPAs sending communications to employers about options available to assist the group health plan with compliance with these rules. As employers prepare for their 2022 plan years (renewals), we recommend discussing these new requirements and coordinating efforts to ensure appropriate processes and procedures are in place to comply by the start of the 2022 plan year.

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