From:	DMHC Licensing eFiling
Subject:	APL 22-011 - No Surprises Act (NSA) Guidance
Date:	Monday March 21, 2022 4:57 PM
Attachments:	APL 22-011 – No Surprises Act (NSA) Guidance (3.21.22).pdf

Dear Health Plan Representative,

Please find attached All Plan Letter (APL) 22-011 – No Surprises Act (NSA) Guidance. This APL address selected provisions of the NSA.

Thank you.

Gavin Newsom, Governor
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ALL PLAN LETTER

DATE: March 21, 2022

TO: All Full-Service Commercial Health Care Service Plans[1]

FROM: Sarah Ream
Chief Counsel, DMHC

SUBJECT: APL 22-011 – No Surprises Act (NSA) Guidance

In 2020, Congress passed the Consolidated Appropriations Act of 2021. Among other provisions, this omnibus appropriations bill contained the No Surprises Act (NSA). Effective for plan years beginning on or after January 1, 2022, the NSA prohibits surprise balance billing, as specified, and establishes other consumer protections. To date, the federal government has issued four rulemaking packages, issued guidance, and established a dedicated web page, No Surprises to implement the NSA.

This All-Plan Letter (APL) addresses selected provisions of the NSA. The DMHC may issue further guidance regarding the NSA and the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act or the Act).[2]

I. Applicable Law

The NSA prohibits health care service plans, as well as providers and facilities, from surprise balance billing consumers in specified nonemergency, emergency, and air ambulance circumstances. The NSA limits enrollee cost sharing and sets parameters for disputes between plans and providers regarding reimbursement amounts. However, the NSA also recognizes some states have established their own laws to address balance billing, enrollee cost-sharing and provider reimbursement. These “specified” state laws control over the NSA if they meet certain requirements. This APL provides guidance on which California laws are specified state laws.

Under the NSA, a “specified state law” sets enrollee cost-sharing and determines provider reimbursement. Federal law states, in part:

[1] This APL does not apply to Medicare Advantage, Medi-Cal managed care, or specialized health plan products.
[2] Health and Safety Code section 1340 et seq.

> Specified State law means a State law that provides for a method for determining the total amount payable under a group health plan or group or individual health insurance coverage offered by a health insurance issuer to the extent such State law applies for an item or service furnished by a nonparticipating provider or nonparticipating emergency facility. …[3]

For plans licensed by the DMHC, if a "specified state law" does *not* control, the NSA governs with respect to enrollee cost-sharing, provider reimbursement, and the dispute resolution process between plans and non-contracted providers/facilities. This APL provides an overview of the applicability of California and federal law pertaining to enrollee cost-sharing, provider reimbursement, and dispute resolution in three scenarios: (1) when non-emergency services are provided by a noncontracted provider at an in-network facility; (2) emergency services provided by an out-of-network provider; (3) air ambulance services provided by a non-contracted provider.

II. Non-emergency, noncontracted services at an in-network facility by a noncontracted provider

California anti-balance billing laws enacted by AB 72[4] are specified state laws, as described in this APL, within the meaning of the NSA for out-of-network, non-emergency services provided at an in-network facility by a provider who does not have a contract with the enrollee's plan. Because AB 72 satisfies the criteria to be a "specified state law" under the NSA, when enrollees receive non-emergency care from a non-contracted provider at an in-network facility in circumstances controlled by AB 72, AB 72 shall continue to apply notwithstanding the NSA with regard to enrollee cost-sharing, provider reimbursement, and dispute resolution for those claims.[5]

AB 72 prohibits plans and noncontracting providers from collecting from an enrollee more than the in-network cost-sharing amount for covered services rendered to the enrollee at a contracted facility at which, or as a result of which, the enrollee receives services provided by a noncontracting individual health professional, as specified.[6] AB 72 provides that the enrollee's health plan must reimburse the out-of-network providers the greater of the average contracted rate (ACR), or 125 percent of the Medicare reimbursement rate, whichever is greater, and that the enrollee shall not owe the non-contracting provider more than the in-network cost sharing amount.[7]

In addition, AB 72 defines in-network facilities more broadly than does the NSA. The NSA applies to hospitals and ambulatory surgery centers. AB 72 includes not only hospitals and ambulatory surgery centers but also laboratories, radiology or imaging

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[3] 45 C.F.R. section 149.30.
[4] AB 72 (Stats. 2016, Ch. 492), Health and Safety Code sections 1371.30, 1371.31, and 1371.9, and their attendant regulations.
[5] The DMHC plans to issue future guidance regarding consent to be balance billed.
[6] Health and Safety Code section 1371.9(a)(1) and (2).
[7] Health and Safety Code sections 1371.31, 1371.9.

centers, and other outpatient settings defined in Health and Safety Code section 1248.1, subdivisions (a), (d), (e), (g) and (h).

If the health plan and provider disagree about the appropriate reimbursement for circumstances controlled by AB 72, they must utilize the Independent Dispute Resolution Process (IDRP) established by the DMHC.[8]

III. Out-of-network emergency services

California case law and the Knox-Keene Act prohibit plans and providers from balance billing enrollees for out-of-network emergency services, including post-stabilization care consistent with Health and Safety Code section 1371.4.[9] The DMHC confirmed with the federal Centers for Medicare and Medicaid Services (CMS) that these laws are "specified state law" within the meaning of the NSA. Therefore, for out-of-network emergency services, DMHC-licensed health plans must continue to comply with California law regarding enrollee cost-sharing, provider reimbursement, and the resolution of disputes between plans and providers/facilities for out-of-network emergency services.

IV. Out-of-network services provided by air ambulance providers

Under the NSA, a plan that provides or covers any benefits for air ambulance services must impose the same cost-sharing requirements that would apply if the services were provided by a participating air ambulance provider when such services are delivered by an out-of-network air ambulance provider. [10] Cost-sharing must be calculated as if the total amount that would have been charged by a participating provider were the lesser of the Qualifying Payment Amount (QPA) or the billed amount.[11]

The Knox-Keene Act similarly prohibits balance billing for out-of-network air ambulance services, limiting an enrollee's financial liability to the "in-network cost-sharing amount."[12] However, the federal Airline Deregulation Act preempts state laws regulating the "rates, routes and services of any air carrier," including air ambulance providers. Consequently, California does not have a specified state law for the purposes of determining reimbursement rates or creating an IDRP for air ambulance services and the NSA provisions and federal rules apply.

Plans must follow the NSA and its implementing regulations when calculating reimbursement amounts for noncontracted air ambulance providers. In those instances, for enrollee cost-sharing amounts that vary based on the amount the plan paid the provider (e.g., coinsurance), the enrollee's cost sharing must be calculated based on the *lesser* of the reimbursement amount dictated by the NSA or the amount the provider

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[8] Health and Safety Code section 1371.30.
[9] *Prospect v. Northridge*, 45 Cal. 4th 497 (2009); *see also* 28 CCR §§ 1300.71(s)(4) and 1300.71.39.
[10] 45 CFR § 149.130(a) and (b)(1).)
[11] 45 CFR § 149.130(b)(3).)
[12] AB 561 (Stats. 2019, Ch. 537), Health & Safety Code. § 1371.55.

billed. If the enrollee's cost-sharing for in-network services is a fixed copayment, then the enrollee is obligated to pay no more than the in-network copayment amount.

If you have questions or concerns regarding this APL, please contact your health plan's assigned reviewer in the DMHC's Office of Plan Licensing.