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GENERAL NOTICE TO GROUP HEALTH PLANS (GHPs)

How does the federal No Surprises Act apply to Nebraska's Out-of-Network Emergency Medical Care Act (LB997)?

No Surprises Act

The Interim Final Rule related to the No Surprises Act was released by the federal government in July 2021. The act protects consumers from getting surprise bills from out-of-network providers or facilities for medical care received from out-of-network providers or facilities in emergency situations (to include emergency and related post-stabilization services), nonemergency services provided by a nonparticipating provider in a participating facility and air ambulance services. This federal mandate applies to all individual policies, fully insured group health plans and both ERISA and non-ERISA self-funded groups, where the state law does not apply.

In this rulemaking, the Department of Health and Human Services (HHS), the Department of Labor (DOL), and the Department of the Treasury (collectively, the Departments) are issuing interim final rules with largely parallel provisions that apply to group health plans and health insurance issuers offering group or individual health insurance coverage.

Nebraska's Out-of-Network Emergency Medical Care Act

Legislative Bill 997 (LB997), also known as Nebraska's Out-of-Network Emergency Medical Care Act, passed in 2020. This act keeps consumers from getting surprise bills from out-of-network providers or facilities for emergency medical services. Facilities are defined as a general acute hospital, satellite emergency department or ambulatory surgical center licensed pursuant to the Health Care Facility Licensure Act. Effective Jan. 1, 2021, providers in Nebraska may not balance bill patients for medical care received from out-of-network providers or facilities in emergency situations. This state mandate applies to all fully insured plans and non-ERISA groups.

Both the No Surprises Act and LB997 will apply depending on the plan type, situation, providers and treatment being sought.

What this means for you:

As an **ERISA GHP,** in October 2020, you were given the choice to opt out of the LB997 provision, effective Jan. 1, 2021, for coverage of emergency services provided by an out-of-network provider at an in-network level. However, whether or not you opted out of the provision, you will now be required to adhere to the No Surprises Act for emergency services effective for your plan year beginning on and after Jan. 1, 2022. In addition to covering out-of-network emergency services at an in-network level per state law, the No Surprises Act extends the in-network level of coverage to post-stabilization services related to emergency services, non-emergency services from nonparticipating providers at participating facilities and air ambulance services from nonparticipating providers of air ambulance services.

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As a **non-ERISA GHP**, you will continue to be subject to LB997 for coverage of emergency services; however, in addition to covering these out-of-network emergency services at an in-network level of benefits, the No Surprises Act extends this in-network level of benefits to post-stabilization services related to emergency services, non-emergency services from nonparticipating providers at participating facilities and air ambulance services from nonparticipating providers of air ambulance services.

Air Ambulance Services
The Interim Final Rule related to the No Surprises Act also protects individuals from surprise medical bills for air ambulance services furnished by nonparticipating providers and non-emergency services furnished by nonparticipating providers at participating facilities in certain circumstances.

Section 105 of the No Surprises Act added section 9817 of the Code, section 717 of ERISA, and section 2799A-2 of the Public Health Service (PHS) Act to address surprise air ambulance bills. According to the act, these provisions apply to consumers who receive services from a nonparticipating provider of air ambulance services, meaning medical transport by a rotary-wing air ambulance, as defined in 42 CFR 414.605, or fixed-wing air ambulance, as defined in 42 CFR 414.605. The Interim Final Rule applies these provisions where a plan or coverage generally has a network of participating providers and provides or covers any benefits for air ambulance services, even if the plan or coverage does not have in its network any providers of air ambulance services. With respect to air ambulance services furnished by nonparticipating providers (including inter-facility transports), plans and issuers must comply with the requirements regarding cost sharing, payment amounts and processes for resolving billing disputes described elsewhere in the act**, if such services would be covered if provided by a participating provider** with respect to such plan or coverage.

What this means for you:
For all GHPs, upon plan years beginning and after Jan. 1, 2022, you must cover emergency and non-emergency air ambulance services for out-of-network providers at the in-network level of benefits if you cover these services for in-network providers. If an air ambulance service would not be covered for an in-network provider, then it need not be covered for an out-of-network provider.