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BULLETIN 21-24

Date: September 17, 2021

To: Insurers, Nonprofit Health Service Plans, and Health Maintenance Organizations ("Carriers")

Re: Contract Amendment Templates for Compliance with the Consolidated Appropriations Act of 2021

The Maryland Insurance Administration ("MIA") has developed the attached amendment template to assist carriers in drafting amendments to bring their policy forms and contracts into compliance with portions of the Consolidated Appropriations Act of 2021 ("CAA") and interim final regulations issued by the Department of Health and Human Service, under 45 CFR Parts 144, 147, 149, and 156.

This amendment template addresses the issues of:

- coverage of emergency services;
- cost-sharing, payment and balance billing protections for emergency services, certain non-emergency services received in a facility that participates in a carrier's network, and air ambulance services;
- cost-sharing and balance billing protections for services provided based on reliance on incorrect provider network information;
- continuity of care; and
- choice of provider.

The amendment template may be used with individual, small group and large group contracts and certificates. The template is designed to be used for plan years (for individual contracts, policy years) that begin on or after January 1, 2022. The template includes drafting notes to identify terminology and provisions that may vary based on the type of contract to which the amendment will be attached, and based on the language of the specific contract with which the amendment will be used.

A carrier is still required to file the template with the MIA for review and approval prior to use, in accordance with applicable form filing requirements. However, the MIA will expedite the review and approval of filings that substantially conform to the language and format of the

amendment template. Additionally, for amendment template filings, the MIA will not require, as part of the form review process, examination of the previously approved contracts with which the carrier intends to use the amendment.

Finally, carriers are advised that this template was drafted to meet the minimum requirements of Maryland and federal law. If the contract to which a template is attached is more generous to the covered individuals than the template, the template may not be used to reduce the benefits of the contract.

Questions about this Bulletin may be directed to the Life & Health Division of the Maryland Insurance Administration at 410-468-2170.

KATHLEEN A. BIRRANE.
Commissioner

By: signature on original

David Cooney
Associate Commissioner
Life and Health

[COMPANY NAME]

No Surprises Act Amendment

[*Drafting note: References to "enrollee" throughout this amendment template may be replaced with the specific term used in the underlying contract to refer to individuals covered under the contract (e.g., insured, covered person). "We," "our," or "us" may be substituted for company name, as appropriate, throughout this amendment*]

The [group contract or certificate] [individual contract] to which this amendment is attached is amended as described below.

Definitions

The following definitions are being added to the [group contract or certificate] [individual contract] and apply only to the provisions in this amendment:

"Air ambulance service" means 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, for patients.

"Ancillary services" means:

1. items and services furnished by a non-participating provider in a participating facility related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
2. items and services provided by assistant surgeons, hospitalists, and intensivists;
3. diagnostic services, including radiology and laboratory services; and
4. items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

"Authorized representative" means an individual authorized under State law to provide consent on behalf of a patient, provided that the individual is not a provider affiliated with the facility or employee of the facility, unless such provider or employee is a family member of the patient.

"Continuing care patient" means an individual who, with respect to a provider or facility:

1. is undergoing a course of treatment for a serious and complex condition from the provider or facility;
2. is undergoing a course of institutional or inpatient care from the provider or facility;
3. is 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;
4. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
5. is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

"Emergency facility" means an emergency department of a hospital, or an independent freestanding emergency department where emergency services are provided. "Emergency facility" includes a hospital, regardless of the department of the hospital, in which items or services with respect to emergency services are provided by a non-participating provider or non-participating emergency facility: after the individual is stabilized; and as part of outpatient

observation or an inpatient or outpatient stay with respect to the visit in which other emergency services are furnished.

“Emergency medical condition” means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

“Emergency services” means, with respect to an emergency medical condition:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd, or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition;

2. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished); and

3. Except as provided in item 4. below, covered services that are furnished by a nonparticipating provider or nonparticipating emergency facility after the individual is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in item 1. above are furnished.

4. The covered services described in item 3. above are not included as emergency services if all of the following conditions are met:

    a. The attending emergency physician or treating provider determines that the individual is able to travel using nonmedical transportation or nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into account the individual’s medical condition;

    b. The provider or facility furnishing such additional items and services satisfies the notice and consent criteria of 45 C.F.R § 149.420(c) through (g) with respect to such items and services, provided that the written notice additionally satisfies items 4.b.i. and ii. below, as applicable;

i. In the case of a participating emergency facility and a nonparticipating provider, the written notice must also include a list of any participating providers at the facility who are able to furnish such items and services involved and notification that the participant, beneficiary, or enrollee may be referred, at their option, to such a participating provider.

ii. In the case of a nonparticipating emergency facility, the written notice must include the good faith estimated amount that the individual may be charged for items or services furnished by the nonparticipating emergency facility or by nonparticipating providers with respect to the visit at such facility (including any item or service that is reasonably expected to be furnished by the nonparticipating emergency facility or nonparticipating providers in conjunction with such items or services);

c. The individual (or an authorized representative of such individual) is in a condition to receive the information described in item b. above, as determined by the attending emergency physician or treating provider using appropriate medical judgment, and to provide informed consent in accordance with applicable State law; and

d. The covered services are not rendered by [*Drafting note: {Include the following for EPO and PPO plans:* an on-call physician or a hospital based physician who has obtained an assignment of benefits from the enrollee} {*Include the following for HMO plans:* a health care provider who is subject to § 19-710(p) of the Health-General Article};].

"Independent freestanding emergency department" means a health care facility that is geographically separate and distinct and licensed separately from a hospital under applicable State law; and provides any emergency services.

"Non-participating emergency facility" means an emergency facility that has not contracted directly with [*insert company name*] or indirectly, such as through an entity contracting on behalf of [insert company name] to provide health care services to [*insert company name*]'s enrollees.

"Non-participating provider" means a physician or other health care provider that has not contracted directly with [*insert company name*] or an entity contracting on behalf of [insert company name] to provide health care services to [*insert company name*]'s enrollees.

"Other health care provider" means any person who is licensed or certified under applicable State law to provide health care services, and is acting within the scope of practice of that provider's license or certification, but does not include a provider of air ambulance services.

"Out-of-network rate" means, with respect to an item or service furnished by a non-participating provider, non-participating emergency facility, or non-participating provider of air ambulance services:

1. In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies to the plan/carrier, non-participating provider/non-participating emergency facility, and item/service, the amount that the State approves under the All-Payer Model Agreement for the item or service. For certain items or services billed by

Maryland hospitals, this is the amount for the item or service approved by the Health Services Cost Review Commission (HSCRC).

2. If there is no such All-Payer Model Agreement applicable to the item or service, but a specified State law is in effect and applicable, the amount for the item or service determined in accordance with such specified State law. [*Drafting note: Include the following for HMO, EPO, and PPO plans.* Under specified Maryland law, {*For HMO contracts insert the following:*} this is the amount required by §19-710.1 of the Health-General Article. {*For EPO and PPO plans insert the following*:} for an on-call physician or a hospital based physician who has obtained an assignment of benefits from the enrollee, this is the amount required by § 14–205.2 of the Insurance Article.]

3. If there is no such All-Payer Model Agreement or specified State law applicable to the item or service, an amount agreed upon by [*insert Company name*] and the non-participating provider or non-participating emergency facility.

4. If none of the three conditions above apply, an amount determined by a certified independent dispute resolution (IDR) entity under the IDR process described in section 2799A–1(c) or 2799A–2(b) of the federal Public Health Service Act, as applicable.

"Participating emergency facility" means any emergency facility that has contracted directly with [*insert company name]* or an entity contracting on behalf of [*insert company name*] to provide health care services to [*insert company name*]'s enrollees. A single case agreement between an emergency facility and [*insert Company name*] that is used to address unique situations in which an enrollee requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement.

"Participating facility" means a health care facility that has contracted directly with [*insert company name*] or an entity contracting on behalf of [*insert company name*] to provide health care services to *[insert company name*]'s enrollees. A single case agreement between a health care facility and [*insert Company name*] that is used to address unique situations in which an enrollee requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement. Additionally, for purposes of this definition and in the context of non-emergency services, "health care facility" is limited to a hospital (as defined in section 1861(e) of the Social Security Act); a hospital outpatient department; a critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

"Participating provider" means a physician or other health care provider that has contracted directly with [*insert company name*] or an entity contracting on behalf of [*insert company name*] to provide health care services to [*insert company name*]'s enrollees.

"Qualifying payment amount" means the amount calculated using the methodology described in 45 C.F.R. § 149.140(c), which is based on the median contracted rate for all plans offered by the carrier in the same insurance market for the same or similar item or service that is: provided by a provider in the same or similar specialty or facility of the same or similar facility type; and provided in the geographic region in which the item or service is furnished. The median contracted rate is subject to additional adjustments specified in federal regulations.

"Recognized amount" means, with respect to an item or service furnished by a non-participating provider or non-participating emergency facility, an amount that is determined as follows:

1. In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies to the plan/carrier, non-participating provider/non-participating emergency facility, and item/service, the amount that the State approves under the All-Payer Model Agreement for the item or service. For certain items or services billed by Maryland hospitals, this is the amount for the item or service approved by the HSCRC.

2. If there is no such All-Payer Model Agreement applicable to the item or service, in a State that has in effect a specified State law, the amount for the item or service determined in accordance with such specified State law. [*Drafting note: Include the following for HMO, EPO, and PPO plans.* Under specified Maryland law, {*For HMO contracts insert the following*:} this is the amount required by §19-710.1 of the Health-General Article. *{For EPO and PPO plans insert the following*:} for an on-call physician or a hospital based physician who has obtained an assignment of benefits from the enrollee, this is the amount required by § 14–205.2 of the Insurance Article.]

3. If neither an All-Payer Model Agreement or a specified State law apply to the item or service, the lesser of: the amount billed by the non-participating provider or non-participating emergency facility, or the qualifying payment amount.

"Serious or complex condition" means in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

"To stabilize," with respect to an emergency medical condition, means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

"Treating provider" means a physician or other health care provider who has evaluated the individual.

"Visit" means the instance of going to or staying at a health care facility, and, with respect to items and services furnished to an individual at a health care facility, includes, in addition to items and services furnished by a provider at the facility, equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the provider furnishing such items or services is at the facility.

Emergency Services

Any provision of the contract that provides benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department, is amended to provide emergency services:

1. Without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis;

2. Without regard to whether the health care provider furnishing the emergency services is a participating provider or a participating emergency facility, as applicable, with respect to the services;
3. If the emergency services are provided by a non-participating provider or non-participating emergency facility, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers;
4. Without limiting what constitutes an emergency medical condition solely on the basis of diagnosis codes; and
5. Without regard to any other term or condition of the coverage, other than:
    a. applicable cost-sharing; and
    b. for emergency services provided for a condition that is not an emergency medical condition, the exclusion or coordination of benefits.

Cost-Sharing Requirements, Payment and Balance Billing Protections for Emergency Services

1. If any copayment amount, coinsurance percentage, or other cost-sharing requirement described in the contract for emergency services is different for a service received from a participating provider or participating emergency facility than for a service received from a non-participating provider or non-participating emergency facility, the copayment amount, coinsurance percentage, and/or other cost-sharing requirement for emergency services provided by a non-participating provider or non-participating emergency facility is amended to be the same as the copayment amount, coinsurance percentage, and/or other cost-sharing requirement listed in the contract for emergency services provided by a participating provider or participating emergency facility;

2. If the contract has separate in-network and out-of-network deductibles or separate in-network and out-of-network out-of-pocket maximums, the contract is amended to provide that any cost-sharing payments made with respect to emergency services provided by a nonparticipating provider or a nonparticipating emergency facility will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum;

3. The contract is amended to provide that if emergency services are provided by a non-participating provider or nonparticipating emergency facility, any cost-sharing requirement will be calculated based on the recognized amount;

4. If emergency services are provided by a non-participating provider or non-participating emergency facility, [*insert Company name*] will make payment for the covered emergency services directly to the non-participating provider or non-participating emergency facility. The payment amount will be equal to the amount by which the out-of-network rate exceeds the cost-sharing amount for the services; and

5. Any provisions of the contract that describe the enrollee's responsibility for charges for emergency services furnished by non-participating providers or non-participating emergency facilities are amended to provide that the enrollee will not be liable for an amount that exceeds the enrollee's cost-sharing requirement under this amendment.

Cost-sharing Requirements, Payment and Balance Billing Protections for Non-Emergency Services Performed by Non-participating Providers at Participating

Facilities, including Ancillary Services and Services for Unforeseen Urgent Medical Needs

The contract is amended to cover items and services furnished by a nonparticipating provider with respect to a covered visit at a participating facility in the following manner, except when the non-participating provider has satisfied the notice and consent criteria of 45 C.F.R. § 149.420 (c) through (i):

1. The copayment amount, coinsurance percentage, and/or other cost-sharing requirement for such items and services furnished by a nonparticipating provider with respect to a visit in a participating facility is the same as the copayment amount, coinsurance percentage, and/or other cost-sharing requirement listed in the contract for the items and services when provided by a participating provider;

2. Any cost-sharing requirement for the items and services will be calculated based on the recognized amount;

3. Any cost-sharing payments made with respect to the items and services will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum;

4. [*insert Company name*] will make payment for the items and services directly to the nonparticipating provider. The payment amount will be equal to the amount by which the out-of-network rate exceeds the cost-sharing amount for the items and services; and

5. Any provisions of the contract that describe the enrollee's responsibility for charges for such items or services that exceed [*insert Company name*]'s payment are amended to provide that the enrollee will not be liable for an amount that exceeds the enrollee's cost-sharing requirement under this amendment.

Provisions 1 – 5 above are not applicable when the non-participating provider has satisfied the notice and consent criteria of 45 C.F.R. § 149.420 (c) through (i), including providing notice to the enrollee of the estimated charges for the items and services and that the provider is a non-participating provider, and obtaining consent from the enrollee to be treated and balance billed by the non-participating provider. The notice and consent criteria of 45 C.F.R. § 149.420 (c) through (i) do not apply to non-participating providers with respect to:

1. [*Drafting note: {Include the following for EPO and PPO plans:* covered services rendered by an on-call physician or a hospital based physician who has obtained an assignment of benefits from the enrollee} {*Include the following for HMO plans:* covered services rendered by a health care provider for which payment is required under § 19-710.1 of the Health-General Article};]

2. ancillary services; and

3. items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the nonparticipating provider satisfied the notice and consent criteria;

and such items and services furnished by non-participating providers will always be subject to the above five provisions.

Cost-sharing Requirements, Payment and Balance Billing Protections for Non-participating Providers of Air Ambulance Services

Any provision of the contract that provides benefits with respect to air ambulance services is amended to provide the following when services are received from a non-participating provider of air ambulance services:

1. The copayment amount, coinsurance percentage, and/or other cost-sharing requirement for the air ambulance service is the same as the copayment amount, coinsurance percentage, and/or other cost-sharing requirement listed in the contract for air ambulance services when provided by a participating provider of ambulance services;

2. Any cost-sharing requirement will be calculated based on the lesser of the qualifying payment amount or the billed amount for the services;

3. Any cost-sharing payments made with respect to the air ambulance service will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum;

4. [*insert Company name*] will make payment for the air ambulance services directly to the non-participating provider of ambulance services. The payment amount will be equal to the amount by which the out-of-network rate exceeds the cost-sharing amount for air ambulance services; and

5. Any provisions of the contract that describe the enrollee's responsibility for charges for covered air ambulance services furnished by non-participating providers are amended to provide that the enrollee will not be liable for an amount that exceeds the enrollee's cost-sharing requirement under this amendment.

Cost-sharing and Balance Billing Protections for Services Provided Based on Reliance on Incorrect Provider Network Information [*Drafting Note: include this provision for plans that include a provider network*]

If an enrollee is furnished, by a nonparticipating provider, an item or service that would otherwise be covered if provided by a participating provider, and the enrollee relied on a database, provider directory, or information regarding the provider's network status provided by [*insert Company* name] through a telephone call or electronic, web-based, or Internet-based means which incorrectly indicated that the provider was a participating provider for the furnishing of such item or service, then the following apply:

1. The copayment amount, coinsurance percentage, and/or other cost-sharing requirement for such item or service furnished by a nonparticipating provider is the same as the copayment amount, coinsurance percentage, and/or other cost-sharing requirement listed in the contract for the item or service when provided by a participating provider; and

2. Any cost-sharing payments made with respect to the item or service will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum.

3. The enrollee will not be liable for an amount that exceeds the cost-sharing that would have applied to the enrollee if the provider was a participating provider.

Continuity of Care [*Drafting Note: include this provision for plans that include a provider network]*

A continuing care patient receiving care from a participating provider may elect to continue to receive transitional care from such provider if the provider's participating provider contract is terminated or non-renewed for reasons other than for failure to meet applicable quality standards or for fraud[.][*Drafting note: include for group contacts:* ; or if the group contract terminates resulting in a loss of benefits with respect to such provider or facility.] [*insert Company name*] will notify each enrollee who is a continuing care patient at the time of termination or non-renewal on a timely basis of such termination and the enrollee's right to elect transitional care.

When elected, benefits will be provided under the same terms and conditions as would have applied with respect to items and services that would have been covered had termination not occurred, with respect to the course of treatment provided by such provider or facility relating to the enrollee's status as a continuing care patient. Benefits will be provided during the period beginning on the date [*insert Company name*] notifies the continuing care patient of the termination and ending on the earlier of: (i) 90 days after the date of such notice; or (ii) the date on which such enrollee is no longer a continuing care patient with respect to such provider or facility.

The enrollee will not be liable for an amount that exceeds the cost-sharing that would have applied to the enrollee had the termination not occurred.

Choice of Provider [*Drafting note: include this provision for grandfathered plans only, however, do not include this provision if the contract does <u>not require</u> the selection of a primary care provider by an individual*]

Any provision of the contract that indicates that an individual is required to designate or provide for the designation of a primary care provider is amended to permit the individual to select any participating primary care provider who is available to accept the individual.

Any provision of the contract that indicates that a primary care provider is required to be designated for a child, is amended to permit the designation of any participating physician (allopathic or osteopathic) who specializes in pediatrics (including pediatric subspecialties) as the child's primary care provider, if the provider is available to accept the child.

Any provision of the contract that requires a woman to receive a referral or authorization from the primary care provider before receiving obstetrical or gynecological care from a participating provider who specializes in obstetrics or gynecological care is deleted. The contract is also amended to provide that the obstetrical and gynecological care received from a participating provider who specializes in obstetrics or gynecological care without the referral or authorization from the primary care provider includes the ordering of related obstetrical and gynecological items and services that are covered under the contract.

This amendment rider takes effect [*insert effective date of amendment rider*] and terminates when the contract terminates.

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Signature of Officer