KILPATRICK TOWNSEND

July 16, 2021

Surprise! Biden Administration Releases Surprise Billing Guidance

by Peter Daines , Mark L. Stember

The Departments of Health and Human Services, Treasury, and Labor jointly released a package of guidance relating to the surprise billing reforms included in the Consolidated Appropriations Act, 2021 ("CAA"). The guidance package includes an interim final rule with a request for comments, a model notice (for group health plans and insurers), two fact sheets (one for consumers, the other for health plans and insurers), and a press release.

Background

In addition to including a fourth round of major coronavirus relief funding and general governmental funding for 2021, the CAA included dozens of pages of substantive reforms designed to remedy the much-discussed issue of surprise medical billing along with a number of other healthcare reforms. Many new CAA requirements apply directly to employer-sponsored group health plans. The new interim final rule begins the process of implementing these requirements prospectively with respect to plan years beginning on or after January 1, 2022.

Emergency Services, Air Ambulance Services, and Service Provided by Out-of-Network Providers at In-Network Facilities

In general, if a group health plan covers *any* benefits for emergency services, the plan must cover the services: (1) without requiring prior authorization, (2) without regard to whether the provider or facility is in-network, (3) without regard to any other plan terms or conditions other than benefit exclusion or coordination provisions and permitted affiliation or waiting period provisions, and (4) with cost-sharing subject to terms and conditions no worse than those that apply to in-network claims. Similar rules apply to air ambulance services and services provided by out-of-network providers at in-network facilities. The definition of emergency services follows the prudent layperson standard.

Cost-Sharing Amount

For most ERISA self-insured group health plans, the cost-sharing amount is generally computed as the lesser of the amount billed or the "qualifying payment amount" (or "QPA"). The QPA is generally the plan's or insurer's median in-network rate for 2019 as subsequently adjusted for inflation. Cost-sharing for air ambulance services generally must be computed in the same manner as if they were provided in-network, using the lesser of the billed charge or the QPA. The interim final regulation includes detailed instructions for computation of QPA and requests further comment on this topic.

Balance Billing

Health providers and facilities providing covered services are generally forbidden from sending balance bills to participants. However, in limited circumstances (for non-emergency, non-ancillary services provided by out-of-network providers at in-network settings and post-emergency once a patient has been stabilized), participants can expressly consent to receiving out-of-network care subject to balance billing after receiving a special disclosure.

It is important to note that the exception allowing for balance billing upon notice and consent does not apply in situations where surprise bills are likely to happen, including, for specified ancillary services connected to non-emergency care, such as anesthesiology or radiology services provided at an in-network healthcare facility.

Notices from Plan or Insurer to Participants

Group health plans or insurers must post a new notice publicly and include it in all explanations of benefits to which the surprise billing protections apply. The notice will describe the prohibition on surprise billing and provide information regarding who may be contacted if a violation is suspected. The agencies have published a model notice (linked above) that may be used for this purpose. It is unclear whether the posting requirement can be satisfied by inclusion in the Summary Plan Description.

Effective Date, Comments, and Further Guidance

The interim final rule is generally applicable for group health plan years beginning on or after January 1, 2022. Provisions not directly applicable to group health plans are generally effective for contract years beginning on or after January 1, 2022, or to services performed on or after January 1, 2022. The agencies request comments on

the interim final rule to be submitted no later than September 7, 2021.

This regulation is the first in a series to be issued under the CAA's surprise billing rules. The CAA requires that regulations be issued according to the following schedule:

- July 1, 2021: Regulations fleshing out the QPA definition and setting out specific notice and consent rules. (The current interim final rule addresses these topics.)
- October 1, 2021: Regulations establishing a QPA audit process.
- December 27, 2021: Regulations establishing an IDR process.

In addition, the departments have indicated that they intend to issue guidance in 2021 regarding the provider transparency and patient-provider dispute process, a price comparison tool, and reporting of air ambulance services by plans and issuers. In 2022, the departments are expected to issue guidance on a number of additional CAA healthcare reforms including provisions relating to ID cards, continuity of care, provider directories, a new prohibition on gag clauses, and prescription drug cost reporting. Until guidance is final and effective, plans and issuers are expected to implement the requirements using a good faith, reasonable interpretation of the statute.