A July Surprise From the Department of Treasury, HHS and DOL!

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On July 1, 2021, the Office of Personnel Management, Departments of the Treasury, Health and Human Services ("HHS"), and Labor ("DOL") (the "Departments") released the an interim final rule ("IFR"), which is the first of a series of rules implementing the Consolidated Appropriations Act of 2021's ("CAA") surprise billing and transparency requirements.

The provisions of the IFR generally apply to group health plans and health insurance issuers offering group or individual health insurance coverage with respect to plan (or policy) years beginning on or after January 1, 2022. The rules apply to both grandfathered and "grandmothered" (transitional) plans. In addition, the rules are generally applicable to indemnity-only plans, though the IFR recognizes that certain provisions may not be relevant in that context. Importantly, the rules do not apply to account-based plans, such as health reimbursement arrangements and flexible spending arrangements, plans exempted by statute (e.g., excepted benefits), and retiree-only plans.

1. Coverage of Emergency Services

The IFR establishes a number of requirements for group health plans or health insurance issuers that cover emergency services in any capacity:

- Emergency services coverage must be without regard to any other term or condition of the coverage, other than the exclusion or coordination of benefits (to the extent not inconsistent with benefits for an emergency medical condition), an affiliation or waiting period, or applicable cost sharing.
- Coverage must not require prior authorization, even if out-of-network.
- Coverage must be provided without regard to whether the provider or facility is a participating provider.
- If the services are out-of-network:
    - there can be no additional administrative requirements or limits on coverage than in-network;
    - cost-sharing cannot be greater than in-network;
    - cost-sharing is based on the "recognized amount";
    - with certain exceptions, the plan/policy must make an initial payment (or deny payment) within 30 days of receipt of the bill from a provider

- the plan/policy generally must pay a total payment directly to the provider that is equal to the amount by which the out-of-network rate for the services exceeds the cost-sharing amount for the services; and

- the plan/policy must count cost-sharing toward in-network deductibles and out-of-pocket maximums.

Post-stabilization services will generally be treated as emergency services unless a specific four-part test is satisfied. This means that the scope of "emergency services" has expanded beyond what many plans and issuers may have traditionally considered emergency services. For example, where a patient is admitted on an in-patient basis through an emergency room, it appears the entire episode of care may be treated as an emergency services benefit unless there is consent by the patient.

2. Coverage of Nonemergency Services Provided by Nonparticipating Provider at Participating Facility

The treatment of services in this category generally track the treatment under the emergency services rule, unless the provider satisfies notice and consent requirements, which could permit the provider to bill outstanding balances to the patient in some circumstances.

If the plan/policy covers items and services (other than emergency services) furnished to a participant by a nonparticipating provider at a participating health care facility, the plan/policy:

- must not impose cost-sharing greater than would apply if services had been provided by a participating provider;

- must calculate the cost-sharing requirements as if the total amount that would have been charged for the items and services by such participating provider were equal to the recognized amount for the items and services;

- must make an initial payment within 30 days;

- must generally pay a total payment directly to the nonparticipating provider that is equal to the amount by which the out-of-network rate for the items and services involved exceeds the cost-sharing amount for the items and services; and

- must count cost-sharing toward in-network deductibles and out-of-pocket maximums.

However, the protection from balance billing does not apply when a provider provides notice and receives consent from the participant. Notice and consent can only be sought for certain non-emergency services or certain post-stabilization services. A nonparticipating provider or nonparticipating emergency facility may obtain notice and consent from the individual in order to balance bill for post-stabilization services only in the case where a participant has received emergency services and that individual's condition has stabilized, and then only if the four conditions noted above are met.

3. Definitions and Provisions That Apply to Both Emergency Services and Nonemergency Services by Nonparticipating Providers in Participating Facilities

- *Definition of a "visit"* – the IFR largely follows the statutory definition of "visit" to include, in addition to items and services furnished by a provider at the facility, equipment and devices, telemedicine services, imaging services, laboratory services, preoperative and postoperative services, even if performed off-site.

- *Recognized amount* – plans/policies must base the cost-sharing paid by a participant for items and services subject to the balance billing rules on the recognized amount, which is an amount that is separate and distinct from the amount that the plan or issuer pays the provider. The recognized amount is determined in one of three ways:

    - the amount determined by an applicable All-Payer Model Agreement (under section 1115A of the Social Security Act) (e.g., Maryland);

    - if no All-Payer Model Agreement, it is set by applicable State law;

    - if not established by the first two options, it is the lesser of the qualified payment amount (generally, the median of the contracted rates recognized by the plan or issuer on January 31, 2019 for the same or similar item or service in the same insurance market that is provided by a provider in the same or similar specialty and provided in a geographic region in which the item or service is furnished, increased for inflation) or the billed amount.

- *Out-of-Network rate* – the IFR defines an out-of-network rate generally to mean the total amount paid by a plan/policy for items and services subject to the above provisions, without including cost-sharing paid by participant. Where the out-of-network rate exceeds the amount upon which cost-sharing is based, a plan/policy must pay the provider or facility the difference between the out-of-network rate and the cost-sharing amount, even in cases where an individual has not satisfied his/her deductible (see below regarding how this impacts HSA eligibility). The plan/policy must make a total payment equal to one of the following four amounts, less any cost-sharing from the participant:

    - the All-Payer Model amount (see above);

    - if not the first, an amount specified by state law;

    - if not the first or second options, an amount agreed to by the parties; and

    - if not any of the above, the amount set by the independent dispute resolution process.

The statute and IFR provide a special rule for HSA-compatible high deductible health plans ("HDHP"), so that the plan's payment pre-deductible does not render an individual ineligible to contribute to an HSA, and the plan will continue to be treated as an HSA-compatible HDHP.

4. Disclosure Requirements and Model Notice

The IFR also specifies that certain qualified payment amount ("QPA") information must be disclosed to providers. When the QPA is the recognized amount for a claim to a nonparticipating provider, emergency facility, or provider of air ambulance services, the plan or issuer must provide to the provider or facility:

- the QPA for each item or service involved;
- a statement certifying that the plan has determined that the QPA applies and was calculated in compliance with the rules;
- a statement providing specifics on the IDR process and its deadlines; and
- contact information for the appropriate office or person to contact to negotiate.

Upon request by the provider or facility, the plan or issuer must also provide:

- information about whether fee schedules were used where contracted rates were not set on a fee-for-service basis;
- in the case of a new service code, identify any related service codes used; and
- in the case that an eligible database was used, information to identify the database.

Plans/policies are also required to provide certain disclosures to participants about the surprise billing protections. The Departments issued model disclosure notices that providers and facilities and group health plans and issuers may, but are not required to, use. The Departments may engage in more detailed rulemaking in the future. Until those rules are issued, plans and issuers should "exercise good-faith compliance" with this disclosure provision.

5. Enforcement

The statute does not have specific enforcement mechanisms or penalties that apply to group health plans or health insurance issuers, although HHS received additional enforcement and penalty authority over providers and facilities. However, because the statute amends the PHSA, ERISA, and the Code, those statutory enforcement mechanisms apply. The IFR states that the Departments will generally achieve the CAA-required oversight through existing processes, though HHS intends to amend its enforcement regulations through future notice and comment rulemaking.

The IFR temporarily extends the complaint process included in the CAA to all of the consumer protection and balance billing requirements in the IFR (as opposed to just the QPA) and requests comments on whether the complaint process should remain extended beyond the QPA in that manner. The IFR further establishes an HHS-only complaints process for health care providers, facilities and providers of air ambulance services that is similar to the process that the Departments are establishing for plans and issuers.