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Surprise! Tri-Agencies Meet Deadline with First Set of Surprise Billing Rules, With More to Come

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On July 1, 2021, the Office of Personnel Management, Department of the Treasury, Department of Health and Human Services ("HHS"), and Department of Labor ("DOL") (collectively, the "Departments"), released the interim final rule "Requirements Related to Surprise Billing; Part I" ("the IFR"). The IFR generally applies to group health plans and health insurance issuers with respect to plan (or policy) years beginning on or after January 1, 2022. The rules apply to health care providers and facilities, as well as providers of air ambulance services, beginning on January 1, 2022.

This is the first in a series of rules implementing the Consolidated Appropriations Act of 2021's ("CAA") surprise billing and transparency requirements. Based on statements by the Departments, we expect that they will issue rules on the independent dispute resolution or IDR process, transparency and patient-provider dispute resolution, price comparison tools, and air ambulance reporting. Further, we understand that HHS intends to separately issue rules on broker compensation disclosure for individual and short-term, limited duration coverage, as well as provisions related to HHS enforcement of requirements on issuers, non-federal governmental group health plans, providers, facilities, and providers of air ambulance services.

The Departments also recognize that some rulemaking necessary to fully implement the CAA may not occur on time under the statute. Specifically, the rules required to implement CAA provisions regarding transparency in plan and insurance identification cards, continuity of care, accuracy of provider network directories, prohibition on gag clauses, and pharmacy benefit and drug cost reporting, may not occur before the provisions take effect under the CAA. If that occurs, the Departments stated that plans and issuers are

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expected to implement the requirements using a good faith, reasonable interpretation of the statute once the provisions take effect until the rulemaking is finalized. (Similarly, while not addressed in this IFR, we expect that the DOL will not issue formal rules implementing the CAA's new section 408(b)(2) disclosure requirements for brokers and consultants this year. However, we expect that DOL may require good faith compliance with the statutory provisions.)

The IFR is largely focused on how the surprise billing protections apply to group health plans and health insurance issuers, as well as how the Qualified Payment Amount ("QPA") is calculated. There are some rules related to the initial payment for surprise billing claims from providers and notices of denial, as well as provider-focused rules.[1] The IFR generally hews closely to the CAA's provisions and provides some clarity regarding the calculation of the QPA amount.

1. *Applicability*

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 years (in the individual market, policy years) beginning on or after January 1, 2022" and to Federal Employee Health Benefit ("FEHB") carriers (subject to Office of Personnel Management regulation and contract provisions). Grandfathered health plans are included, as are "grandmothered" (transitional) plans. In addition, the rules are generally applicable to indemnity only plans, though it recognizes certain provisions may not be relevant in that context. The IFR does not apply to health reimbursement arrangements, or other account-based plans, plans exempted from the IFR by statute (e.g., excepted benefits), and retiree-only plans.

2. *Coverage of Emergency Services*

Following the statute, the IFR establishes a number of requirements for any 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.

Also following the statute, if the services are out-of-network,

(i) there can be no additional administrative requirements or limits on coverage (no more restrictive than in-network);
(ii) cost-sharing cannot be greater than in-network;
(iii) Cost-sharing is based on the "recognized amount" (defined by statute and regulation);

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[1] This summary generally does not address the provider provisions of the rule, except when those provisions overlap with plan or issuer requirements.

(iv) with certain exceptions, must make an initial payment (or deny payment) within 30 days of receipt of the bill from a provider and 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 less any initial payment amount;

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

GROOM INSIGHT: Notably, in the preamble to the rule, the Departments explain that denials cannot be based solely on diagnosis code (sometimes referred to as a "True ER" list) and must instead be evaluated under the prudent layperson standard. This condition is also included in the regulatory text. This effectively codifies DOL's enforcement position under the Affordable Care Act's ("ACA's") emergency services rule that the use of a "True ER" list is impermissible as a sole basis to deny claims. In addition, the statute did not include the limitation "(to the extent not inconsistent with benefits for an emergency medical condition)" when allowing a plan or issuer to continue to apply exclusions of benefits, but that limit is also now included in the regulatory text. There is one illustration of this condition in the preamble: "the Departments are aware of some plans and issuers denying claims for emergency services provided to dependent women who are pregnant, based on a general plan exclusion for dependent maternity care." The Departments then explain that

this provision does not permit plans and issuers to exclude benefits for items and services that would otherwise constitute benefits for an emergency medical condition as defined under these interim final rules. This provision does not permit plans and issuers that cover emergency services to deny benefits for a participant, beneficiary, or enrollee with an emergency medical condition that receives emergency services, based on a general plan exclusion that would apply to items and services other than emergency services.

83 Fed. Reg. at 36880. Plans and issuers should be particularly mindful of this interpretation when processing emergency claims. Note that this provision also codifies an enforcement position DOL has taken under the existing ACA emergency services rule. It is unclear how this provision will impact other general plan exclusions.

Post-stabilization services will generally be treated as emergency services unless the following four-part test is satisfied:

first, the attending emergency physician or treating provider must determine by assessing all relevant factors that the participant, beneficiary, or enrollee (hereinafter referred to as "participant") 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 consideration the individual's medical condition;

second, the provider/facility must satisfy notice and consent criteria (note that a model notice was published simultaneously to the IFR);

third, the participant or their authorized representative must be in a condition to provide informed, voluntary consent; and

fourth, the provider/facility must satisfy any additional state law requirements.

GROOM INSIGHT: As required under the statute, this means that the scope of "emergency services" has expanded beyond what many plans and issuers may have traditionally considered emergency services. Properly processing post-stabilization services may be a particular challenge. Under this provision, 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. Additional guidance on this issue from the Departments would be helpful.

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3. *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 (except for ancillary providers, as discussed below), which could permit the provider to bill outstanding balances to the patient in some circumstances.

If a group health plan or health insurance issuer covers items and services (other than emergency services) furnished to a participant by a nonparticipating provider at a participating health care facility, unless the provider has satisfied the notice and consent criteria, the plan or issuer:

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

(ii) 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;

(iii) must make an initial payment within 30 days;

(iv) must pay a total plan or coverage 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, less any initial payment amount; and

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

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.

Notice and consent does not apply to emergency services (pre-stabilization) or air ambulance services. The IFR contains a number of provisions detailing requirements for the notice and consent process including the use of a standard notice document, who may act as an authorized representative, the precise timing of when notice and consent may be obtained, the standards for consent (including that it may be revoked), and the languages in which the notice must be available. The IFR specifies that notice and consent does not apply to emergency services (with some exceptions for post-stabilization services), specific services that are ancillary and services for an unforeseen urgent medical need. The IFR requires that providers retain notice and consent documents for at least seven years.

Providers/facilities must timely notify plans and issuers where the notice and consent criteria have been satisfied, as well as provide a copy of the consent, and requires plans/issuers to assume that notice and consent have not been satisfied where they have not received that notice. Where notice is received, plans and issuers are permitted to rely on the notice, unless they know, or reasonably should know, that the notice and consent were not proper.

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

Definition of a "visit." The regulation 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, and such other items and services as the Secretary may specify, regardless of whether or not the provider furnishing such items or services is at the facility."

GROOM INSIGHT: The preamble reiterates that a "visit" for these purposes is not limited to a single facility. For example, the IFR provides that a visit includes samples being sent to a lab offsite for testing and for telemedicine consultations by specialists. The broad scope of a "visit" along with the requirement to cover "post-stabilization services" as part of emergency services will require close attention by plans and issuers to ensure that claims are processed accurately.

Both the emergency services and nonemergency services by a non-participating provider at a participating facility rules tie their application to defined *facilities*. For emergency services, there are

specific definitions for *emergency department of a hospital*, *independent freestanding emergency department*, and *participating and nonparticipating emergency facilit[ies]*. For the non-participating provider at a participating facility rule, there are definitions for *health care facilities* and *participating health care facilities*.

GROOM INSIGHT: The Departments ask for comment on whether the definition of health care facility should be extended to urgent care centers, including those that are not licensed as facilities under state law.

Recognized amount. Plans and issuers 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.

GROOM INSIGHT: The "initial payment amount"—the amount that the plan or issuer sends to the provider or facility after receiving of the bill—or a denial, must be made within 30 days of receipt of a "clean claim." This means that the plan or issuer must have sufficient information from the provider or facility to decide the claim. This is a helpful provision for plans and issuers as it affords time to send the initial payment amount from the date complete claims records are received.

The rule does not specify an initial payment amount, which is important for plans and issuers. However, the preamble provides that the initial payment should "be an amount that the plan or issuer reasonably intends to be payment in full based on the relevant facts and circumstances and as required under the terms of the plan or coverage." This creates uncertainty for issuers and group health plans and suggests that, in the context of enforcement, the DOL could take action on initial payment amounts that are set very low. The Departments asked for comment on whether a minimum initial payment amount should be set.

Also, the IFR addresses difference between an "adverse benefit determination" ("ABD") and an independent dispute resolution-eligible claim, which hinges on whether the individual can be held responsible by the provider for payment. If yes, this is an adverse benefit determination; if no, the dispute can go to IDR. Specifically, the Departments

note there is a significant distinction between an ABD, which may be disputed through a plan's or issuer's claims and appeals process, and a denial of payment or an initial payment that is less than the billed amount under this interim final rules, which may be disputed through the open negotiation process or through the IDR process. In general, when an adjudication of a claim results in a participant, beneficiary, or enrollee being personally liable for payment to a provider or facility, this determination may be an ABD … Conversely, when: (1) The adjudication of a claim … does not affect the amount the participant, beneficiary or enrollee owes; (2) the dispute only involves payment amounts due from the plan to the provider; and (3) the provider has no recourse against the participant, beneficiary, or enrollee, the decision is not an ABD and the payment dispute may be resolved through the open negotiation or the IDR process."

For emergency services furnished by a nonparticipating emergency facility or provider, and for non-emergency services furnished by nonparticipating providers in a participating health care facility, **cost sharing is generally calculated as if the total amount that would have been charged for the services were equal to the *recognized amount* for such services**.

The **recognized amount** is determined in one of three ways:

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

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

third, if not established by the first two options, it is the lesser of the QPA or the billed amount.[2]

GROOM INSIGHT: Applicable state law ("specified state law" in the rule) is not straightforward. The applicable law must apply to the plan, issuer or coverage; it must apply to the nonparticipating provider or facility; and it must also apply to the items or services involved. All three requirements must be met for the state law to "apply."

Also note that the Departments added the "lesser of" requirement to the last option to determine the recognized amount. The statute did not include a "lesser of"

[2] Note that air ambulance cost-sharing is not based on the recognized amount; instead, it is based on the lesser of QPA or the billed amount. The Departments seek comment on other approaches to air ambulance cost-sharing.

requirement and did not require plans and issuers to calculate cost-sharing based on the amount billed in any instance.

Out-of-Network rate. The IFR defines an out-of-network rate as, generally, the total amount paid by a plan or issuer for items and services subject to these 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 or issuer 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 their deductible. In terms of payment to the provider, the plan or issuer must make a total payment equal to one of the following four amounts, less any cost-sharing from the participant, beneficiary, or enrollee:

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

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

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

fourth, failing any of the three prior options, the amount set by the independent dispute resolution process.

GROOM INSIGHT: The statute provided a special rule for High Deductible Health Plans ("HDHP") with Health Savings Accounts, so that if a plan must pay the provider or facility the difference between the out-of-network rate and the cost-sharing amount, before the individual has satisfied their deductible, the individual is not treated as ineligible to contribute to an HSA and the plan will continue to be treated as an HDHP. Catastrophic plans also generally cannot provide benefits before the annual limit on cost-sharing is reached. The IFR amends the catastrophic plan rules to allow them to make required surprise billing payments before the annual limit is reached.

5. *Qualifying Payment Amount (QPA) Methodology*

A. General Definition and Calculation

The QPA is 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. Parsing the meaning and specifics of this definition requires diving into the definitions of key phrases included in the IFR.

Median contracted rate is calculated by arranging in order from least to greatest the contracted rates of all plans of the plan sponsor (or of the administering entity, if applicable) or all coverage offered by the

issuer 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, and selecting the middle number. Each contract is treated individually, even where they are for the same amount and in event that there are an even number of contracted rates, the median is the average of the middle two rates.

GROOM INSIGHT: The median contract rate must be indexed annually. Helpfully, the Internal Revenue Service ("IRS") will calculate the combined percentage increase for 2019, 2020, and 2021 that should be used and the IRS will calculate the percentage increase annually for years after 2022.

Contracted rate is the total amount (including cost sharing) that a group health plan or health insurance issuer has contractually agreed to pay a participating provider, facility, or provider of air ambulance services for covered items and services, whether directly or indirectly, including through a third-party administrator or pharmacy benefit manager. The rate for a provider group or facility is treated as a single contracted rate if it is universally applicable to that provider or facility. This rate refers only to contracted rates with participating providers or facilities.

GROOM INSIGHT: Note that Non-Fee-for-Service Contractual Arrangements must be included in the QPA calculation (e.g., capitated payments). The IFR specifies that this will be accomplished by use of either an underlying fee schedule, or via calculation of a derived amount (based on internal accounting) if an fee schedule is not available.

If a plan or issuer has contracted rates for emergency services that vary based on the type of facility (e.g., an emergency department of a hospital or an independent freestanding emergency department), the median contracted rate is calculated separately for each such facility type. Other characteristics (for example, being a teaching hospital) are not accounted for.

The Departments also note that contracted rates for a rental network would be considered contracted rates by the plan or issuer for purposes of calculating the QPA, however, a single case agreement would not be considered a contracted rate.

Same or similar item or service means a health care item or service billed under the same service code (CPT, HCPCs, or DRG), or a comparable code under a different procedural code system and includes a

requirement that plans and issuers must calculate separate median contracted rates for CPT code modifiers that distinguish the professional services ("26") component from the technical component ("TC").

Insurance market means individual market (not including short-term, limited duration), small group market, or large group market, irrespective of the state. Medicare Advantage rate, Medicaid Managed Care Organization rates, and excepted benefits rates are not included in a QPA calculation.

GROOM INSIGHT: For self-funded plans, insurance market means all self-insured group health plans *of the plan sponsor*, or at the option of the plan sponsor, all self-insured group health plans *administered by the same entity* (including a third-party administrator ("TPA") contracted by the plan), to the extent otherwise permitted by law, that is responsible for calculating the QPA on behalf of the plan. Plan sponsors that utilize TPAs should consider whether to use a QPA calculated based on its own plans or based on all self-funded plans administered by that TPA.

Same or similar specialty is the practice specialty of a provider, as identified by the plan or issuer consistent with the plan's or issuer's usual business practice. All providers of air ambulance services (including inter-facility transports) are considered to be a single provider specialty.

Geographic region is generally defined as one region for each metropolitan statistical area ("MSA") in a state and one region consisting of all other portions of the state. In cases of insufficient data for an MSA, first, geographic regions will be combined (treating all MSAs as one region), and second, Census division will be utilized. Air ambulances treat the location of pickup as the geographic region and default first to Census divisions.

Special rules apply where pricing is set by reference to another unit of measure (for example, time or miles). There are very detailed rules about anesthesia, as well as a unique QPA calculation for Air Ambulance services that, among other requirements, specifies an indexing calculation for the applicable air mileage rate year over year. The IFR also includes detailed instructions for both determining if sufficient information to calculate the QPA is available (general rule is that you need at least three contracted rates) and performing the QPA calculation where insufficient information is present.

6. *Disclosure Requirements and Model Notice*

The IFR also specifies that certain QPA information that 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

(i) the QPA for each item or service involved;

(ii) a statement certifying that the plan has determined that the QPA applies and was calculated in compliance with the rules;
(iii) a statement providing specifics on the IDR process and its deadlines; and
(iv) 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,

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

Plans and issuers 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.**

7. 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 Public Health Service Act ("PHSA"), Employee Retirement Income Security Act ("ERISA") and the Internal Revenue 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.

Surprise billing complaints. 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 also provides that a complaint will be considered received upon receipt of an oral or written statement sufficient to identify the parties involved and the complained of action or inaction. The IFR also requests further comment on the process and required information for complaints. 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.

8. Sunsetting Provision

The statute amended the ACA's emergency services rule. It also moved the other provisions that had been in the same ACA section (the "Patient Protections" section). The Patient Protections sections of the ACA generally required plans and issuers to allow individuals to choose their own Primary Care Provider ("PCP") (when the plan or issuer requires or permits PCP designation), required plans and

issuers to allow pediatricians to be PCPs (when the plan or issuer requires or permits PCP designation), and prohibits plans and issuers from requiring a referral for female participants to see a health care professional who specializes in obstetrics or gynecology. Those provisions have been moved to new statutory sections, and the parallel regulatory requirements have been moved without material modifications. This allows the Departments to sunset the current emergency services rules; those rules apply through the end of the year.

GROOM INSIGHT: The IFR clarifies that "the requirements regarding patient protections for choice of health care professional under these interim final rules *will newly apply to grandfathered health plans* for plan years beginning on or after January 1, 2022. Until the requirements under section 9822 of the Code, section 722 of ERISA, and section 2799A-7 of the PHS Act and these interim final rules become applicable, non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage must continue to comply with the applicable requirements under section 2719A of the PHSA and its implementing regulations." (emphasis added). Plans and issuers with grandfathered plans should review their benefit designs to ensure compliance.
