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ADDITIONAL GUIDANCE ISSUED ON SURPRISE BILLING PROTECTIONS

The Consolidated Appropriations Act of 2021 (CAA) introduced numerous protections against surprise billing for plan participants that impact group health plans, health insurance issuers, and providers. The federal Departments of Health and Human Services, Labor, and Treasury recently released a document discussing frequently asked questions (FAQs) about these surprise billing protections that provides clarity on a number of topics within the regulations. The key points from this guidance are outlined below.

Application to Reference Based Pricing Plans

It has been unclear how the surprise billing rules apply to plans without networks, such as reference-based pricing plans. The new guidance clarifies that:

- The surprise billing rules apply to plans without networks;
- Plans without networks need to protect against balance billing for emergency care and air ambulance services; and
- Plans without networks do not need to comply with the surprise billing rules as they relate to non-emergency out-of-network services provided at in-network facilities.

In other words, participants covered by such plans can still receive balance bills for non-emergency care, but not for emergency care or covered air ambulance services.

In cases where there is no network, the "in-network" rate for this purpose is determined based on the first of the following, as applicable:

- All-Payer Model Agreement
- Specific state law
- The lesser of the billed charge or the qualified payment amount (QPA).

Plans Without Out-of-Network Coverage

The FAQs affirm and clarify that the surprise billing protections apply to closed network plans, such as HMOs and EPOs, if the plan covers these items generally. This is the case even if the plan does not typically provide coverage for out-of-network items or services. As a result, many plans that do not typically offer out-of-network coverage will be required offer such coverage for the items and services subject to the surprise billing protections.

Applicability to Air Ambulance Services

The CAA does not require that plans cover air ambulance services. However, if a plan does cover air ambulance services, then the surprise billing protections apply when service is rendered by an out-of-network air ambulance provider. Of note, if the plan only covers emergency air ambulance services, the CAA's protections would not also extend to non-emergent air ambulance services. When a plan does cover air ambulance services, the surprise balance billing protections apply even when the participant is picked up outside of the United States

Application to Behavioral Health Crisis Facilities

Out-of-network behavioral health facilities that (1) are either part of a hospital's emergency department *or* geographically distinct from a hospital, (2) have a state license designating them as capable of providing emergency care services, and (3) provide behavioral health crisis response services are subject to the CAA's surprise billing protections. This means that plan participants who receive emergency care from these facilities cannot receive surprise bills.

Notice and Disclosure Requirements

The CAA requires group health plans and insurance carriers to notify plan participants about various balance billing protections available to them. These notices should be posted on the plan's website (or the website of a plan vendor pursuant to a written agreement) and included on each explanation of benefits for applicable covered items or services.

Calculating Qualifying Payment Amounts (QPAs)

The FAQs specify that:

- Plans and issuers can calculate separate QPAs for each provider specialty if the plan's/issuer's contracted rates for service codes vary based on provider specialty; and
- Self-funded groups that offer multiple plan options managed by multiple TPAs can calculate their QPAs separately per plan option.

Nuances of the Independent Dispute Resolution Process

Providers must wait until they receive an initial payment or a notice of denial of payment from the plan/insurer to start the Federal independent dispute resolution process. This is true even if the plan or insurer fails to comply with their obligation to send the initial payment or a notice of payment denial within 30 calendar days of receiving the bill from the provider.

The FAQs also note that:

- An initial payment does not need to be the full QPA for an item or service, but it must be an amount that could reasonably be considered full payment;
- Notices of denials of payment must (1) be in writing and (2) explain why the payment is being denied; and
    - Payment denials differ inherently from benefit denials because payment denials may be disputed through the Federal IDR process, whereas benefit denials due to adverse benefit determinations can be disputed through the plan's claims and appeals process.

These FAQs indicate that guidance surrounding the CAA's surprise billing protections may evolve further as parties engage with the Federal IDR process. We will continue to notify you of relevant updates as they become available.

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