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The Consolidated Appropriations Act may reduce surprise medical bills for most

You do everything right — you get prior authorization from your primary care physician to go to an in-network provider, like an imaging center, because you've squashed some disks in your spine and you need an MRI. Three months later you get a bill for an astronomical amount from the imaging center physician who read your MRI, because, although the imaging center is in your network, the physician isn't.

This is called balance billing (as in you're being charged the balance between what your network paid the out-of-network provider and the provider's fee). Under the Affordable Care Act balance billing was perfectly legal.

Under the Consolidated Appropriations Act, it mostly isn't. The IRS, the Department of Labor, the Office of Personnel Management, and the Department of Health and Human Services have published interim final regulations limiting the circumstances under which group health plans can balance bill employees who go out-of-network.

These regulations haven't yet been published in the Federal Register, but they are anticipated to become effective with plan years beginning Jan. 1, 2022. Self-insured group plans must be updated to include these provisions. If you're fully insured, make sure your insurer makes the appropriate updates.

Here are highlights.

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Bye-bye balance billing

The regulations generally prohibit balance billing by protecting employees from surprise medical bills for emergency services, air ambulance services provided by out-of-network providers, and non-emergency services provided by out-of-network providers at in-network facilities, including hospitals and ambulatory surgical centers. Conspicuously, ground ambulance services aren't covered.

Emergency services

The regulations define emergency services as including certain services in a hospital's emergency room or an independent, free-standing ER, as well as post-stabilization services. If a plan covers benefits for emergency services, these services are required to be covered:

- Without prior authorization.
- Regardless of whether the provider is an in-network provider or an in-network emergency facility.
- Regardless of any other term or condition of the plan, other than the exclusion or coordination of benefits or a permitted waiting period.

Cost-sharing for out-of-network emergency services is limited to no more than in-network charges. Cost-sharing must count toward employees' in-network deductibles and out-of-pocket maximums.

With a few exceptions, the regulations further prohibit employees from being balance billed for emergency services provided at an out-of-network facility.

Nonemergency services

For non-emergency services, they define a participating health care facility as a facility having a direct or indirect contractual relationship with a group health plan or health insurance issuer offering group insurance. Covered facilities include:

- Hospitals.
- Hospital outpatient departments.
- Critical-access hospitals.
- Ambulatory surgical centers.

The same rules apply to non-emergency services. If a group plan covers services in-network, it must cover the items and services provided by an out-of-network physician or facility. Out-of-network providers cannot balance bill for the following ancillary nonemergency items and services:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or nonphysician practitioner.
- Items and services provided by assistant surgeons, hospitals, and internists.
- Items and services related to diagnostic services, including radiology and laboratory services.
- Items and services provided by a nonparticipating provider, if there is no participating provider who can furnish the items or services.

Notice and consent

Quite appropriately, notice and consent requirements don't apply to emergency services.

For non-emergency services, out-of-network providers can continue to balance bill if they provide written notice to employees 72 hours prior to their appointments and receive their consent to balance bill. If providing three days' notice isn't practicable, notice can be provided on the day of the appointment. This notice requirement is

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met if:

- The notice states the health care provider is an out-of-network provider
- The notice includes a good-faith estimate of the out-of-network provider's fee
- The notice states that advance prior authorization or other care management limitations may be required
- The notice clearly states that employees' consent to receive out-of-network items or services is optional and that they may instead seek in-network care.

Employees' consent must acknowledge they have received notice, they are aware they will be balance billed and their payments won't be counted toward their deductibles.

The DOL will provide model notices.

Group plans have their own notice requirements under which they'll be required to provide employees with notices. The DOL has provided a model notice for this purpose.

Prior authorization

Most group plans require employees to choose an in-network primary care physician. The regulations maintain this requirement, but specify that employees must be allowed to choose any primary care physician willing to take them. Prior authorization from an in-network primary care physician to see a specialist isn't required, but is required for out-of-network specialists.

Plans requiring employees to designate primary care physicians must provide notice and sample can be found on pages 305 and 306 of the regulations.

Care to comment?

You can submit comments on these regulations through the end of August. To submit comments electronically, be sure to include the file code CMS-9909-IFC in the search window and then click on comment.

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