Know Your Benefits

What You Need to Know About the Biden-Harris Administration's Actions to Prevent Surprise Billing

On July 1, 2021, the Biden-Harris Administration, through the U.S. Departments of Health and Human Services (HHS), Labor, and the Treasury, as well as the Office of Personnel Management, issued "Requirements Related to Surprise Billing; Part I," an interim final rule with comment period that will restrict surprise billing for patients in job-based and individual health plans and who get emergency care, non-emergency care from out-of-network providers at in-network facilities, and air ambulance services from out-of-network providers.

This first rule implements several important requirements for group health plans, group and individual health insurance issuers, carriers under the Federal Employees Health Benefits (FEHB) Program, health care providers and facilities, and providers of air ambulance services.

What is a surprise medical bill?

When a person with a group health plan or health insurance coverage gets care from an out-of-network provider, their health plan or issuer usually does not cover the entire out-of-network cost, leaving them with higher costs than if they had been seen by an in-network provider. In many cases, the out-of-network provider can bill the person for the difference between the billed charge and the amount paid by their plan or insurance, unless prohibited by state law. This is known as "balance billing." An unexpected balance bill is called a surprise bill.

This rule protects patients from surprise bills under certain circumstances.

Who will benefit from this rule?

These surprise billing protections apply to you if you get your coverage through your employer (including a federal, state or local government) or through the federal Marketplaces, state-based Marketplaces or directly through an individual market health insurance issuer.

The rule does not apply to people with coverage through programs such as Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care or TRICARE. These programs already prohibit balance billing.

Who is affected by surprise bills?

Surprise medical bills and balance bills affect many Americans, particularly when people with health insurance unknowingly get medical care from a provider or facility outside their health plan's network. This can be very common in emergency situations, where people usually go (or are taken) to the nearest emergency department without considering their health plan's network.

An in-network hospital still might have out-of-network providers, and patients in emergency situations may have little or no choice when it comes to who provides their care.

For non-emergency care, an individual might choose an in-network facility or an in-network provider but not know that a provider involved in their care (for example, an anesthesiologist or radiologist) is an out-of-network provider.

Know Your Benefits

How does this rule help?

If your health plan provides or covers any benefits for emergency services, this rule requires emergency services to be covered:

- Without any prior authorization (meaning you do not need to get approval beforehand)
- Regardless of whether a provider or facility is in-network

This rule also protects people from excessive out-of-pocket costs by limiting cost sharing for out-of-network services to in-network levels, requiring cost sharing for these services to count toward any in-network deductibles and out-of-pocket maximums, and prohibiting balance billing under certain circumstances. Cost sharing is what you pay out of your own pocket when you have insurance, such as deductibles, coinsurance and copayments when you get medical care.

The protections in this rule apply to most emergency services, air ambulance services from out-of-network providers and non-emergency care from out-of-network providers at certain in-network facilities, including in-network hospitals and ambulatory surgical centers.

Additionally, this rule requires certain health care providers and facilities to furnish patients with a one-page notice on:

- The requirements and prohibitions applicable to the provider or facility regarding balance billing
- Any applicable state balance billing prohibitions or limitations
- How to contact appropriate state and federal agencies if the patient believes the provider or facility has violated the requirements described in the notice

This information must be publicly available from the provider or facility, too.

When does the rule take effect?

Consumer protections in the rule will take effect beginning on Jan. 1, 2022.

The regulations are generally applicable to group health plans and health insurance issuers for plan years beginning on or after Jan. 1, 2022, and to FEHB program carriers for contract years beginning on or after Jan. 1, 2022. They are applicable to providers and facilities beginning on Jan. 1, 2022.

Source: U.S. Centers for Medicare & Medicaid Services