HHS and Other Agencies Issue Interim Final Rule on Surprise Billing

Earlier this month, the U.S. Department of Health and Human Services, Department of Labor, Department of the Treasury, and the Office of Personnel Management issued an interim final rule with a comment period on the issues of patient surprise billing and high patient cost-sharing for health care items and services (the Rule). The Rule implements many requirements of the No Surprises Act, passed by Congress late last year.

Most provisions of the Rule are applicable beginning January 1, 2022, and the Rule impacts group health plans, health insurance issuers, health care providers, health care facilities, and providers of air ambulance services. To be considered, public comments on the Rule must be received by the Centers for Medicare and Medicaid Services (CMS) by 5 p.m. on September 7, 2021.

The Rule's requirements include the following:

Coverage of Emergency Services

If a health plan provides or covers benefits for emergency services, such services must be covered:

- Without prior authorization;
- Even if the provider is an out-of-network provider or emergency facility; and
- Regardless of any other term or condition of the coverage other than the exclusion, coordination of benefits, or a permitted affiliation or waiting period.

Emergency services include certain services in an emergency department of a hospital or an independent freestanding emergency department (this typically includes urgent care centers if they are licensed under state law to provide emergency services), as well as some post-stabilization services.

Cost-Sharing Limitations

Cost-sharing limitations apply with respect to out-of-network emergency services in the emergency departments of hospitals or independent freestanding emergency departments, air ambulance services furnished by out-of-network providers, and certain non-emergency services furnished by out-of-network providers at certain in-network health care facilities, including hospitals (as well as hospital outpatient departments), and ambulatory surgical centers[1]. Individual cost-sharing limitations for these services are as follows:

- The cost-sharing requirement for out-of-network services must not be greater than in-network cost-sharing requirements for the same services (e.g., if the coinsurance rate for emergency services from in-network providers or facilities is 20%, the coinsurance rate for the same emergency services from out-of-network providers or facilities must not be greater than 20%);
- Permitted cost-sharing must count toward any in-network deductibles and out-of-pocket maximums; and
- Provider "balance billing" (i.e., billing patients for any excess of charges over and above what their insurance will reimburse and in excess of permitted cost-sharing) is prohibited.

Calculation of Cost-Sharing Amounts

For emergency services provided by out-of-network emergency facilities and providers, and for certain non-emergency services furnished by out-of-network providers at certain in-network facilities, cost-sharing must be:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act (i.e., an agreement between CMS and a particular state to test and operate systems of all-payer payment reform for medical care provided to state residents);
- If there is no applicable All-Payer Model Agreement, an amount determined under a specified state law (such as a state balance billing law that meets certain criteria); or
- If neither of the above determination methods are available, the lesser of the billed charge or the plan's or issuer's "qualifying payment amount," which is generally the plan's or issuer's median contracted rate for the same or similar item or service provided by a provider in the same or similar specialty in the applicable geographic region (based on January 31, 2019, rates and increased for inflation).

Cost-sharing for air ambulance services by out-of-network providers must be calculated (i) using the lesser of the billed charge or the plan's or issuer's median contracted rate and (ii) the cost-sharing requirement must be the same as if the services were provided by an in-network air ambulance provider.

Calculation of Out-of-Network Rates

Total out-of-network rates, **including cost sharing**, must be:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
- If there is no applicable All-Payer Model Agreement, an amount determined under a specified state law;
- If neither of the above determination methods are available, an amount agreed upon by the plan or issuer and the provider or facility; or
- If none of the foregoing is available, an amount determined by an independent dispute resolution (IDR) entity. Notably, regulations on IDR entities and process have not yet been issued.

However, the Rule includes a requirement that insurance plans or issuers must send an initial payment or notice of denial of payment within 30 calendar days of receipt of a "clean claim" that is within the scope of the Rule. The Rule also addresses complaint filing mechanisms for receipt and handling of complaints alleging violation of requirements by insurance plans or issuers, health care providers and facilities, and providers of air ambulance services.

Notice and Consent Exception to Prohibition on Balance Billing

For certain post-stabilization services or non-emergency services provided by out-of-network providers at in-network facilities, a provider can give notice to an individual of out-of-network care and obtain consent for that care and extra costs — avoiding application of the cost-sharing and balance billing restrictions discussed above. As an example CMS provides, this option could be useful to a patient who desires to see an out-of-network specialist if the specialist will not provide the care without being permitted to bill the individual directly for care (and balance bill).

However, this option is not available for emergency or air ambulance services. Furthermore, this option is also not available for "ancillary" services, including (i) items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology (whether provided by a physician or non-physician); (ii) items and services provided by assistant surgeons, hospitalists, and intensivists; (iii) diagnostic services, including radiology and laboratory services; and (iv) items and services provided by an out-of-network provider if there is no in-network provider who can furnish the item or service at the applicable facility.

Notably, HHS is seeking comment on other ancillary services that should not be eligible for the notice and consent exception, and on which advanced diagnostic laboratory tests should not be considered "ancillary" services. Lastly, the notice and consent exception is not available for items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.

Consumer Notice Requirement

The Rule requires that certain health care providers and facilities (but not air ambulance services) create a one-page notice with information on the following:

- Federal surprise billing requirements and prohibitions that pertain to health care providers and facilities;
- State balance billing limitations and prohibitions, if applicable; and
- How to contact federal or state agencies to report violations of the requirements described in the notice.

Providers and facilities must make the notice publicly available via a sign posted prominently (for providers and facilities with a publicly accessible location), on a public website (for those that have a website), and provide it directly to individuals in person, via postal mail, or e-mail. Providers and facilities must provide the notice no later than the date and time on which the provider or facility requests payment from the individual (which includes requesting copayments).

Although the Rule applies to many common "surprise" billing situations, it does not apply to all services or settings. The Rule does not apply to providers that do not furnish items or services at health care facilities or in connection with visits at health care facilities. Moreover, as the Rule commentary discusses, the applicability of the Rule to specific services depends, to a certain extent, on the scope of coverage that an individual's health insurance provides. The Rule's restrictions will not apply with respect to particular health care services if an individual's health plan does not provide any coverage for such health care services, although it is possible that some state surprise billing laws may still apply. When providers and facilities do not know ahead of time whether particular services are covered services, HHS has indicated that they should avoid billing individuals until they have worked out with the applicable insurance plan whether the services in question are covered.

Our Chambliss team continues to monitor health care developments and the legal impacts of the COVID-19 pandemic. Please contact Cal Marshall or your relationship attorney if you have any questions or need additional information.

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[1] Notably, the issuing agencies are seeking comments on facilities that should be appropriately designated "health care facilities" for purposes of the Rule.