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First Rules Addressing Surprise Medical Billing Released

To implement provisions of the No Surprises Act included in the Consolidated Appropriations Act, 2021 (CAA), enacted in December 2020, the government on July 1, 2021, released an interim final rule entitled "Requirements Related to Surprise Billing, Part I" that contains the first set of regulations. These rules are intended to protect patients from excessive out of pocket costs resulting from surprise billing and balance billing. Surprise billing occurs when a patient unknowingly receives care from providers who are not included in the patient's health plan (i.e., "out of network"). This can happen in both emergency and non-emergency situations, often in cases in which the care is provided at an "in-network" facility. Balance billing occurs when a provider bills the patient for any charges not covered by the patient's health plan. Balance billing is already prohibited for Medicare and Medicaid beneficiaries, but these new rules would extend similar protections to patients covered by other payers.

The surprise billing protections extend to a scope of services including:

- Emergency services, whether provided in the emergency department (ED) of a hospital or at a freestanding ED;
- Post-stabilization services, which include services provided after a patient has been stabilized but in connection with the visit in which the emergency services are furnished, unless and until notice and consent provisions to waive the protections have been satisfied;
- Non-emergency services performed by "out of network" providers at participating healthcare facilities; and
- Air ambulance services.

Services subject to the provisions of the interim final rule include telemedicine, imaging, lab, and pre- and post-operative services, regardless of whether the provider furnishing the services is at the facility or another location (e.g., an off-site lab or remote telemedicine service).

For purposes of these rules, emergency services include:

- Medical screening exam, including ancillary services routinely available to the ED to evaluate whether an emergency medical condition exists; and
- Further medical exam and treatment as necessary to stabilize the patient, regardless of the hospital department in which such services are provided.

While the rules explicitly apply to both hospitals and independent freestanding EDs, applicability for urgent care centers depends on state licensing requirements. If urgent care centers are allowed under state licensure laws to provide emergency services, then such centers would be considered independent freestanding EDs for the purpose of the interim final rule.

Post-stabilization services are considered emergency services until all of the following conditions are met:

- The attending emergency physician or treating provider deems that the patient 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 patient's medical condition." In making this determination, the provider must also consider the patient's social and economic circumstances that may create additional barriers to obtaining post-stabilization services without a disruption in care.

- The provider or facility provides appropriate notice and obtains consent to waive surprise billing protections.
- The patient (or authorized representative) is in a condition to receive the information in the notice and provide informed consent, considering the medical condition, state of mind, and emotional state, and provides consent voluntarily (without undue influence, fraud, or duress).
- The provider or facility satisfies any additional requirements under state law, as applicable.

Generally, nonemergency services provided by nonparticipating providers at a participating facility (hospital, hospital outpatient department, critical access hospital, or ambulatory surgery center) are subject to the surprise billing protections unless the notice and consent requirements have been satisfied.

The surprise billing rules provide protection to patients both by limiting the amount they may be charged for covered services as well as requiring that the amounts paid by the patient for such services apply towards any in-network deductible or out-of-pocket maximums that apply to their healthcare coverage plan, just as they would if the payments were made for services provided by an in-network provider or facility. Currently, payments to out of network providers are often not applied towards these thresholds.

The interim final rule details the methodology that must be utilized to calculate the "cost-sharing" amount, or the portion that the patient is obligated to pay. Additionally, a methodology is prescribed to determine the "out of network rate" to be paid by the payer to the provider or facility for covered services (less any cost sharing from the participant).

A key factor in determining the cost-sharing amount is the Qualifying Payment Amount (QPA), which is calculated as the median of contracted rates recognized by the payer as of January 31, 2019, for the same (or similar) item or services provided by a provider in the same (or similar) specialty in the applicable geographic region, adjusted for inflation. For the purpose of this calculation, the amount negotiated under each contract is treated as a single data point, regardless of the number of claims paid at that rate. The rules require that separate rates be calculated for each service code and modifier combination, to the extent that modifiers (such as indicators that the service was performed by a certain type of provider or was reflective of only the professional services or technical component of the service) impact the contracted payment rate. If the payer has different contracted rates that vary based on the type of facility where the services are provided (e.g., a hospital ED or an independent freestanding ED), the median contracted rate should be calculated separately for each facility type.

The interim final rule does not include regulations addressing the independent dispute resolution (IDR) process that comes into play with regard to determination of the "out of network rate" to be paid by the payer to the provider or facility for covered services. However, the rule states that "later this year, the Departments intend to issue regulations regarding the federal IDS process…"

The interim final rule is effective 60 days after it is published in the federal register (during which period it is open for public comment), but generally is effective on January 1, 2022, for providers and for insurance plans that begin on or after January 1, 2022.

Additional Resources:

- HHS News Release: ***HHS Announces rule to Protect Consumers from Surprise Medical Bills***
- HHS Fact Sheets:
  - What You Need to Know about the Biden-Harris Administration's Actions to Prevent Surprise Billing
  - Requirements Related to Surprise Billing; Part I Interim Final Rule with Comment Period