POWERS

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ATTORNEYS AT LAW

MEMORANDUM

To: **Powers Clients and Friends**

From: **Peter Thomas, Hannah Comeau, and Joe Nahra**

Date: **August 2, 2021**

Re: **Interim Final Rule Banning Surprise Billing**

The Department of Health and Human Services (HHS), together with the Departments of Labor, Treasury, and Office of Personnel Management (OPM) (collectively "the Departments"), issued an interim final rule ("IFR" or "rule") on July 1, 2021. The rule implements legislative provisions from the Consolidated Appropriations Act of 2021 which bans so-called "surprise billing" for patients that unknowingly receive out-of-network health care items or services. The rule text can be found here. A consumer-focused fact sheet on the rule can be found here and a more detailed fact sheet from HHS can be found here.

The rule is the result of a years-long debate in Congress over how to protect patients from surprise medical bills and has been the subject of intense advocacy from payer and provider representatives as to the specifics of the reimbursement process for impacted services. This first rule is part I of an anticipated three-part rulemaking from the Administration this year. The second part, which will establish an audit process for plan issuers, is expected by October 1, 2021, and the third is required by legislation no later than December 27, 2021. It will address the specifics of the Independent Dispute Resolution ("IDR") process that will be used to determine payments between insurers and providers on services that would have received a surprise bill prior to the enactment of the No Surprises Act ("Act") (Title I of Division BB of the Consolidated Appropriations Act, 2021).

The rule's provisions take effect on January 1, 2022. Comments on the rule are due September 7, 2021 and can be submitted electronically at this link or by visiting www.regulations.gov and searching CMS-9909-IFC.

I. Overview of Interim Final Rule

Purpose of the Rule

The purposes of this rule include providing protections against "balance billing" (when it is likely to result in a surprise bill); establishing a methodology for defining and implementing Qualifying Payment Amounts ("QPAs"); and setting limitations on out-of-network consumer cost-sharing with respect to emergency services, non-emergency services furnished by nonparticipating providers at certain participating health care facilities, and air ambulance services furnished by nonparticipating providers of air ambulance services. It seeks to balance these goals with making out-of-network specialist services reasonably available to those who

knowingly seek it out, even when the specialist insists on balance billing. For instance, in the provision of rehabilitation services, an IRF physiatrist brought in by an acute care hospital to consult on a particular patient will likely be impacted by this rule if that physiatrist is not a member of the patient's health plan network.

What the Rule Does

The IFR bans surprise billing, and therefore most balance billing practices, at the federal level. Surprise billing occurs when enrollees[1] receive bills for higher amounts than anticipated after unknowingly receiving care from out-of-network providers or facilities. This can occur in both the emergency and non-emergency context. Often, insurance providers or "payors" do not cover the full cost of out-of-network services. In these situations, individuals are sometimes billed for the difference between the amount charged by the out-of-network provider and the amount their insurance covers. This practice is known as "balance billing" and most often results in a "surprise bill" for the patient. Balance billing is currently illegal in some, but not all, states.[2]

For the purposes of this IFR, the method of balance billing does not necessarily result in a surprise bill. The rule will continue to allow the balance billing methodology under appropriate conditions with proper notice and consent requirements. The rule's key aim is to prohibit *surprise* billing.

The rule sets forth methods (including alternative methods if needed) for defining, calculating, and implementing Qualifying Payment Amounts ("QPAs"). Payors will calculate QPAs for individual items or services using median contracted rates. These rates are then indexed using the *consumer price index for all urban consumers* ("CPI-U") to determine the specific percentage increase for each subsequent year. The median contracted rate is set according to the same or a similar service or item, facility type, and provider specialty in the same geographic region.

The rule also sets forth disclosure requirements and establishes a complaints process regarding violations of the protections against balance billing and out-of-network cost sharing under the Act. Details on the complaints process may be accessed here.

Application of the Rule

The protections against surprise billing and high consumer cost-sharing apply to emergency services, non-emergency services furnished by out-of-network (or "nonparticipating") providers at certain in-network (or "participating") health care facilities, and air ambulance services that nonparticipating providers of air ambulance services deliver. They apply to group health plans, health insurance issuers offering group or individual health insurance coverage, and carriers in

[1] We use the terms "enrollees," "consumers," and "individuals" interchangeably throughout this memorandum.
[2] States with comprehensive balance billing protections include Washington, Oregon, California, Colorado, New Mexico, Texas, Illinois, Michigan, Ohio, Georgia, Virginia, Maryland, New Jersey, New York, Connecticut, New Hampshire, and Maine. Other states have partial balance billing protection, including Nevada, Arizona, Nebraska, Minnesota, Iowa, Missouri, Mississippi, Indiana, North Carolina, West Virginia, Delaware, Pennsylvania, Rhode Island, Massachusetts, and Vermont.

the Federal Employees Health Benefits (FEHB) Program. This rule does not apply to individuals with coverage through programs such as Medicare, Medicaid, the Indian Health Service, Veterans Affairs Health Care, or TRICARE. These federal programs already prohibit balance billing, and therefore surprise billing, within the scope of this rule. In addition, the rule is not meant to supersede applicable state law.

II. The Balance Billing Method

To protect against surprise billing, the IFR makes balance billing illegal at the federal level, subject to certain exceptions. It completely bans balance billing for emergency care, as defined below. It also bans balance billing for non-emergency care at in-network facilities where the patient was not given prior notice that some care they would receive was out-of-network before the provider rendered services.

The balance billing method continues to be permitted in two circumstances. The first is the rare circumstance that the IFR does not apply. This occurs when the *non-emergency* services provided to an individual occur at facilities that are not included within the IFR's definition of "health care facility."[3] The second is when an individual may appropriately waive the item or service through notice and consent, and proper notice and consent is, in fact, given (discussed in section IV of this memorandum). Even under such circumstances, state law continues to apply. This rule does not make balance billing legal in states that have prohibited the practice.

III. Emergency Services

If a plan provides or covers any benefits for emergency services as defined in the IFR, this rule requires the plan to cover those emergency services:

- Independent of prior authorization;
- Regardless of whether the provider is an in-network provider or emergency facility; and
- Regardless of any other term or condition of the coverage or plan other than the exclusion or coordination of benefits, or a permitted affiliation or waiting period.

Emergency services include evaluation, treatment, and stabilization services. The rule also considers post-stabilization services to be emergency services unless certain conditions are met. The IFR discusses these conditions, in detail, here. The Act's definition of emergency is broad and includes emergency services provided at an emergency department of a hospital *or* an independent freestanding emergency department. The Act defines an independent freestanding emergency department as "a health care facility . . . that provides emergency services, and is

[3] "The No Surprises Act defines a health care facility as each of the following with respect to non-emergency services: (1) a hospital (as defined in 1861(e) of the Social Security Act); (2) a hospital outpatient department; (3) a critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); (4) an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act; or (5) any other facility, specified by the Departments, that provides items or services for which coverage is provided under the plan or coverage, respectively."

geographically separate and distinct from a hospital, and separately licensed as such by a state."[4] The facility need not be licensed under the specific title of "independent freestanding emergency department."

IV. Out-of-Network Providers at Non-Emergency Facilities and Out-of-Network Emergency Facilities in the Non-Emergency Context

Waiver of Balance Billing Protections

The IFR permits 1) out-of-network, non-emergency providers rendering care at in-network facilities and 2) out-of-network emergency facilities (when providing non-emergency care) to balance bill individuals ***if*** the providers and facilities properly satisfy the rule's notice and consent requirements. Subject to certain conditions, an authorized representative may receive notice and provide consent on behalf of the patient.

Notice and consent requirements. The individual must receive a written notice that includes sufficiently detailed information for them to "knowingly accept" any balance billing or out-of-pocket charges. The notice pertains to care that an out-of-network provider renders at the in-network facility and care that the individual *elects* to receive at an out-of-network emergency facility. Nonparticipating providers (including in-network facilities on behalf of nonparticipating providers) and facilities must use HHS's standard notice and consent document, accessible for download here, and tailor it to include individual-specific information.

The written notice must include information such as:

- Disclosure that the provider or facility is out-of-network with the individual's health plan;
- A good faith estimated amount that the provider or facility may charge the enrollee;
- Language that the estimated amount does not constitute a contract with respect to those estimated charges;
- A list of any participating providers at the emergency facility who can deliver the items and services involved *and* that the enrollee may be referred, at their option, to that provider; and
- Information about whether the facility will require prior authorization or other care management limitations in advance of receiving the items or services.

Access the specific notice content requirements here.

The nonparticipating provider, the participating health care facility on behalf of the nonparticipating provider, or nonparticipating emergency facility must obtain consent from the enrollee to be treated and balance billed under circumstances where the individual elects to receive such items or services. The individual must sign the consent form, provided in the standard notice and consent document. Find the specific consent requirements here.

[4] Definition of independent freestanding emergency department.

Providers or facilities must give the notice and consent documents directly to the patient. This may occur electronically or on paper as the individual chooses and is feasible. The rule discusses time parameters regarding notice and consent here. Providers and facilities must provide the notice and consent documents unattached to, or incorporated into, any other document. The facility or provider must provide the individual with a copy of the notice and signed consent. They may provide the copy in person, through mail, or through email.

No possibility of waiver for out-of-network providers providing specified ancillary services connected to non-emergency care.

Under certain circumstances, individuals may not waive the protections of this rule through notice and consent. This includes situations where surprise bills are most likely to happen. These include:

- Items and ancillary services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
- Items and services that assistant surgeons, hospitalists, and intensivists provide;
- Diagnostic services, including radiology and laboratory services; and
- Items and services that a nonparticipating provider provides, only if there is no participating provider who can furnish such item or service at such facility.

The Act authorizes HHS to specify a list of advanced diagnostic laboratory tests that would not be considered ancillary services and, thereby, still be subject to notice and consent waivers. HHS now seeks comments on which tests it should include on this list.

V. Payment Rates: Consumer Cost Sharing Amounts and QPAs

Cost-Sharing

The IFR provides three methods for determining appropriate cost-sharing amounts for emergency services provided at out-of-network emergency facilities; emergency services provided by out-of-network providers; and certain non-emergency services provided by out-of-network providers at in-network facilities. These cost sharing amounts do not apply to items or services appropriately waived through proper notice and consent.

Cost-sharing amounts must not be higher than in-network levels. Plans must calculate cost-sharing amounts according to these guidelines:

- An amount that an applicable All-Payer Model Agreement under Section 1115A of the Social Security Act determines.
- If no applicable All-Payer Model Agreement exists, an amount that a specified state law determines.
- If neither of the above apply, the lesser amount of either the billed charge or the qualifying payment amount ("QPA").

Qualifying Payment Amounts

The rule specifies that insurers will calculate QPAs for items and services using median contracted rates. The median contracted rate is set according to the prices for a same or similar service or item, facility type, and provider specialty, in the same geographic region. Beginning in 2022, insurers will first determine the median contracted rate as of January 31, 2019. They will then index that rate using the CPI-U to determine the specific percentage increase for each year after 2019.[5] The Internal Revenue Service (IRS) will publish the combined percentage increase from 2019, 2020, and 2021 to ensure uniformity.

The rule sets forth alternative methodologies for calculating the median contracted rate when payors have insufficient information. The rule indicates that: "a plan or issuer is considered to have sufficient information to calculate the median of contracted rates if the plan or issuer has at least three contracted rates on January 31, 2019, to calculate the median of the contracted rates in accordance with the methodology in these interim final rules."[6] More information is available here. The rule also discusses QPA calculations under non-fee-for-service contractual arrangements here. Discussion of the calculation methodology for QPAs begin here, with more specific calculations beginning here.

Total Out-of-Network Rates

The total amount to be paid to the facility or provider, including the cost-sharing amount, constitutes the total out-of-network rate. The total out-of-network rate is the 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 that is specified in state law is used. If there is no applicable All-Payer Model Agreement or specified state law, the payment rate is an amount upon which the plan or issuer and the provider or facility agree. If none of these three conditions apply, an amount that an IDR entity determines is used (via a process to be determined in forthcoming regulations).

VI. Disclosure Notice to Consumers

The rule requires providers and facilities (including emergency facilities) to make publicly available, post on a public website, and provide a one-page notice to individuals regarding:

- This rule's applicable requirements for patient protections against surprise billing;
- Any applicable state balance billing limitations or prohibitions; and
- Information for contacting the appropriate state and federal agencies if any individual believes that the provider or facility has violated the requirements that the notice describes.

[5] "The combined percentage increase for any year will be calculated as CPI-U present year/CPI-U prior year." Pg. 263.
[6] Definition of sufficient information.

Plans and issuers must also make the above information publicly available. Health care providers subject to this notice requirement need only provide the required disclosure to individuals to whom they render items or services and only if the items or services are provided at, or in connection with, a visit at a health care facility. This notice requirement does not apply to air ambulance service providers.

These disclosure requirements are subject to future guidance and rulemaking. The Departments have issued a model disclosure accessible here, though the rule does not mandate its use. Further discussion of these disclosure requirements is available here.

Conclusion

HHS seeks comments on all areas of this IFR. The rule text can be found here. Comments are due on September 7, 2021 and can be submitted electronically at this link: Regulations.gov or by visiting www.regulations.gov and searching CMS-9909-IFC. Please let us know if Powers can be of any assistance in drafting or submitting comments on the interim final rule.