Administration Issues Initial Rule Limiting 'Surprise' Medical Bills

Interim final rule is first in a series of expected regulations on out-of-network billing

By Stephen Miller, CEBS
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Long-sought curbs on unscheduled "surprise" out-of-network health care charges became law at the end of last year (www.shrm.org/resourcesandtools/hr-topics/benefits/pages/relief-from-surprise-medical-billing-becomes-law.aspx) with the Continuing Appropriations Act, 2021 (CAA), which included a revised version of the bipartisan No Surprises Act.

On July 13, the U.S. departments of Health and Human Services (HHS), Labor, and Treasury, along with the Office of Personnel Management, published in the *Federal Register* an interim final rule, Requirements Related to Surprise Billing; Part I (https://www.federalregister.gov/documents/2021/07/13/2021-14382/requirements-related-to-surprise-billing-part-i), as the first in a series of regulations to implement the CAA's provisions on surprise billing, the agencies said.

The agencies also released, as a downloadable file, a model notice (https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/consolidated-appropriations-act/surprise-billing-model-notice.docx) about the new protections to post online, with instructions for group health plans and health insurance issuers.

The rule takes effect for health care providers and facilities on Jan. 1, 2022. For group health plans and health insurance issuers, the provisions will take effect for plan years beginning on or after Jan. 1, 2022.

"Plan sponsors have a lot to do to prepare for these new rules, including updating their plan documents" such as summary plan descriptions and claims and appeals procedures, advised Amy Gordon and Susan Nash, partners in the Chicago office of law firm Winston & Strawn. "Plan sponsors will also be required to work with their TPAs [third-party administrators] and insurers to ensure that they are taking steps to comply with the new rules."

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Unexpected Bills

Costly surprise billing results when patients receive unplanned care at an out-of-network emergency room or for certain ancillary services, such as when, without the patient's knowledge, an out-of-network anesthesiologist assists in a surgery performed by an in-network surgeon at an in-network hospital. These charges are paid as out-of-pocket expenses by plan enrollees, and in part by employers that sponsor self-funded health plans or by insurance carriers when a plan is fully insured.

Last year, researchers at the nonprofit Kaiser Family Foundation reported 1 in 5 insured adults had received a surprise medical bill in the past two years (https://jamanetwork.com/journals/jama/fullarticle/2760721), and two-thirds of adults were worried about being able to afford unexpected medical bills.

The CAA protects patients from most surprise bills, including from costly air ambulance providers, but does not apply to ground ambulances.

Similarly, it prohibits out-of-network providers from balance billing—when doctors or hospitals charge patients the remainder of what their insurance does not pay—unless health care providers give patients 72 hours' notice before treatment of their network status and an estimate of the charges.

The law allows for an independent dispute resolution process to address surprise medical billing, with self-insured employers, not the contracted insurance carriers that operate as TPAs, responsible for settling claims disputes.

[Related SHRM article: Relief from Surprise Medical Billing Becomes Law (www.shrm.org/resourcesandtools/hr-topics/benefits/pages/relief-from-surprise-medical-billing-becomes-law.aspx)]

Banned Billing

"The rule requires plans to treat certain [unanticipated] services from out-of-network providers and facilities as in-network (https://www.bradley.com/insights/publications/2021/07/no-more-surprises-new-rule-on-surprise-medical-bills) in applying cost-sharing, such as deductibles and co-insurance," with "the same out-of-pockets costs for such services regardless of whether the facility or provider has a contract with the plan," wrote B. David Joffe and Caleb L. Barron, attorneys with law firm Bradley in Nashville."

Among its provisions, the interim rule:

- **Bans surprise billing for emergency services.** Emergency services, regardless of where they are provided, must be treated on an in-network basis without requirements for prior authorization.
- **Bans high out-of-network cost-sharing for emergency and non-emergency services.** Patient cost-sharing, such as co-insurance or a deductible, cannot be higher than if such services were provided by an in-network doctor, and any co-insurance or deductible must be based on in-network provider rates.
- **Bans out-of-network charges for ancillary care** (like an anesthesiologist or assistant surgeon) at an in-network facility in all circumstances.
- **Bans other out-of-network charges without advance notice.** Health care providers and facilities must provide patients with a plain-language consumer notice explaining that patient consent is required to receive care on an out-of-network basis before that provider can bill at the higher out-of-network rate.

Surprise medical bills "have been a scourge on our nation's health care system for a long time, with the problem reaching crisis levels over the last decade as health care costs have exploded," said Ilyse Schuman, senior vice president of health policy at the American Benefits Council, a Washington D.C.-based employee benefits public policy organization. "The surprise billing ban ... and these rules initiating its implementation constitute a critical step toward a more rational health care payment system."

The American Hospital Association, however, said it was concerned that "some aspects of the rule could create a financial windfall for insurers (https://www.aha.org/special-bulletin/2021-07-02-agencies-issue-part-one-regulations-banning-surprise-medical-bills) while financially destabilizing providers" such as hospitals, "without any guarantee that the savings are passed on to consumers."

State-Level Protections

About one-third of states already have their own comprehensive balance-billing protections (https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections), according to The Commonwealth Fund, a private foundation that promotes access to affordable health care.

"When state and federal regulations conflict, the stricter set of regulations will take precedence (https://www.hfma.org/topics/revenue-cycle/article/a-closer-look-at-the-new-surprise-billing-regulations--the-impac.html)," noted the Healthcare Financial Management Association (HFMA), a professional organization for hospital finance executives. "For example, some states may prohibit balance billing regardless of whether patient consent is obtained as described in the new federal rule," HFMA pointed out.

Areas for Further Regulation

Forthcoming federal regulations are expected to address issues such as the law's provision for independent arbitration and dispute resolution between insurers and health care providers that otherwise cannot settle their claims, and how plans must disclose—on a public website and in explanations of benefits—the requirements and prohibitions against surprise billing.

Comments Requested

Federal agencies are accepting comments on the interim rule through Sept. 13, 2021. Written comments may be submitted electronically at https://www.regulations.gov (https://www.regulations.gov/).

The agencies asked interested parties to comment, in particular, on the types of facilities in which surprise bills frequently arise, and on whether the regulations should designate urgent care centers and retail clinics as health care facilities.

Under the interim rule, for instance, emergency services provided at urgent care centers that are licensed by states as independent, freestanding emergency departments would be subject to cost-sharing and balance-billing protections. However, "in cases where non-emergency services are furnished at participating urgent care centers by [non-network] providers," those receiving such services would not be protected against surprise billing under the interim rule, the agencies said.

HHS also could expand the definition of ancillary services subject to surprise billing restrictions based on feedback it receives during the comment period. "In particular, HHS is interested in comments on whether there are other ancillary services for which individuals are likely to have little control over the particular provider who furnishes items or services," the rule states.

Action Steps for Employers

Employers should consider the following actions (https://www.hubinternational.com/products/employee-benefits/compliance-bulletins/2021/07/surprise-billing-rules/), advised the compliance team at benefits broker HUB International:

- Confirm with their insurance carrier or TPA that they are on track to comply with these rules by Jan. 1, 2022.
- Update any plan communications to include the required notice.
- Update any plan communications that describe how payment for emergency or other services are calculated to reflect these new rules (or review communications that the carriers or TPAs provide).
- For self-funded plan sponsors, expect TPAs to issue new contract amendments to potentially cover these rules, and consider engaging legal counsel to review those amendments.