Biden Administration Announces New Rule to Shield Consumers from Surprise Medical Bills

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Patients will soon get protection from unexpected medical bills for care received in emergencies and other certain situations. New federal rules implementing the No Surprises Act (enacted at the end of 2020 and hereafter referred to as the "Act") will require health care providers and health insurers to take measures to reduce or eliminate most of the "surprise billing" that occurs in health care today.

These Interim Final Rules, entitled "Requirements Related to Surprise Billing Act; Part I" ("the Rules"), were promulgated by the Departments of Health and Human Services, Labor, and Treasury in conjunction with the Office of Personnel Management on July 13, 2021. The Rules are now open for comment and will take effect January 1, 2022.

What is surprise billing and balance billing?

Surprise billing, as defined in the Act, occurs when patients are charged out-of-network fees for care they either anticipated would be in-network or for care for which there is no reasonable in-network alternative. Surprise billing often occurs when a patient receives medical care from a hospital-based health care provider who is physically located in an in-network hospital, yet that provider does not participate in the network of the patient's health insurer.

While surprise billing often occurs in emergency situations, non-emergency medicine can result in receipt of a surprise out-of-network bill as well — e.g., patients who receive planned treatments or services at facilities that contract with out-of-network third-party providers. Further, out-of-network cost-sharing and payments for surprise bills typically do not count towards deductibles or maximum out-of-pocket spending.

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Relatedly, balance billing is the practice by which out-of-network providers charge patients the difference between the total billed charges and the amount collected from the patient's insurance issuer. Surprise medical bills and balance billing can be financially catastrophic for families and individuals. Confusion about the cost and content of medical bills is widespread, especially in at-risk populations.

The Rules seek to establish protection for consumers against these unexpected medical bills.

Who is impacted by changes in the Rules?

- Group health plans
- Health insurance issuers offering group or individual health insurance coverage
- Emergency departments of hospitals
- Freestanding emergency departments
- Health care providers and facilities
- Providers of air ambulance services
- Health benefits plans offered by carriers under Federal Employee Health Benefits Act (certain provisions)

What do the Rules change for health care providers?

Under the Rules, the Affordable Care Act's requirements for coverage of emergency services are extended to grandfathered plans. Beginning in 2022, the Rules eliminate restrictive coverage practices for grandfathered plans, including, for example, denying emergency services based on general plan exclusions such as an exclusion for dependent maternity care.

Additionally, the Act expands patient protection related to emergency services. The Rules prohibit out-of-network providers, health care facilities, and providers of air ambulance services from balance billing patients, beneficiaries, and enrollees in most situations. For situations where balance billing is permitted, the Rules mandate that consent and notice obligations are satisfied.

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Moreover, the Rules provide a calculation formula for determining a patient's cost-sharing responsibilities. Cost-sharing amounts for out-of-network emergency services or out-of-network providers providing care within in-network facilities should be calculated based on one of the following:

- An amount determined by an applicable All-Payer Model Agreement ("APMA") under Section 1115A of the Social Security Act;
- If there is no such applicable APMA, an amount determined by a specified state law; or
- If neither of the above, the lesser of the billed charge or the plan's or insurance issuer's qualified payment amount (usually, a plan/insurance issuer's median contracted rate).

These limits on cost-sharing and balance billing generally do not apply to certain post-stabilization services or to certain non-emergency services (out-of-network provider at an in-network facility) if notice and consent requirements have been fulfilled. The Rules do apply to emergency services including services classified as such under the Emergency Medical Treatment & Labor Act, as well as pre-stabilization services provided after the patient is moved out of the emergency department and admitted into a hospital, and services provided at an independent freestanding emergency department.

How can health insurance issuers and providers prepare for the changes to come with the Rules?

- Stay aware of the new complaints process established by the Rules for issues related to the new balance billing process.
- Prepare a one-page disclosure statement to be given to patients and posted on the provider's website regarding requirements and prohibited actions under this Act, state balance billing requirements, and how to contact state/federal agencies if the provider/ facility has violated these requirements. (A model disclosure notice, which, if used, guarantees compliance with the Rules' disclosure

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requirements, is available here for use through the Department of Labor.)

- Work with internal teams such as billing, compliance, and internal audit to ensure compliance with both notice and billing requirements and to review the calculation of out-of-network rates.
- Inform health care providers of their role in disclosing information to patients.
- Determine which services are eligible for balance billing with sufficient notice and which services will not be eligible for this type of billing.
- If providers plan to continue balance billing using the consent exception, implement procedures for informing patients and documenting consent to be billed in this fashion.

What can we expect to see in parts 2-4?

- Later this year, the agencies promulgating the Rules intend to issue regulations regarding the federal independent dispute resolution process (sections 103 and 105 of Division BB), patient protections through transparency and the patient-provider dispute resolution process (section 112), and price comparison tools (section 114).
- Changes are expected to come with regard to reporting mechanisms for air ambulance services providers.
- Increased disclosure requirements for health insurance issuers regarding direct information to agents and brokers are also forthcoming.
- Further guidance from HHS is also anticipated regarding its enforcement of requirements on insurance issuers, non-federal governmental group health plans, providers, facilities, and air ambulance service providers.

For any questions on this article or for more information about surprise billing regulations, please contact Cami Trachtman (at ctrachtman@fbtlaw.com or 317.237.3806) or any attorney with Frost Brown Todd's Health Care Innovation Team.

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Note: Catherine Buck co-authored this article. Catherine is a summer associate in Frost Brown Todd's Cincinnati office and will be a third-year law student at Notre Dame Law School this fall. She is not a licensed attorney.

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