Issue Brief

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"Surprise Billing" Rule Pending

The U.S. Department of Health and Human Services, the U.S. Department of Labor, and the U.S. Department of the Treasury (collectively, the Departments) are issuing an interim final rule with largely parallel provisions that apply to group health plans and health insurance issuers offering group or individual health insurance coverage. HHS also is issuing within this rulemaking additional interim final rules that apply to emergency departments of hospitals and independent freestanding EDs, health care providers and facilities, and providers of air ambulance services related to the protections against surprise billing.

The document has been submitted to the ***Office of the Federal Register*** for publication but has not yet been placed on public display or published in the ***Federal Register***. The rule would be effective 60-days after being placed on display at the ***Federal Register***. However, the regulations generally are applicable for plan years (in the individual market, policy years) beginning on or after Jan. 1, 2022. A 60-day comment period is provided.

The rule does not apply to people with coverage through programs such as Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care or TRICARE. These programs already prohibit balance billing.

A copy of the 370-page rule is available at: https://public-inspection.federalregister.gov/2021-14379.pdf

A surprise medical bill is an unexpected bill from a health care provider or facility that occurs when a covered person receives medical services from a provider or facility that, usually unknown to the participant, beneficiary or enrollee, is a nonparticipating provider or facility with respect to the individual's coverage. Surprise billing occurs both for emergency and nonemergency care. In an emergency, a person usually goes (or is taken by emergency transport) to a nearby ED. Even if they go to a participating hospital or facility for emergency care, they may receive care from nonparticipating providers working at that facility.

COMMENT

This rule is deep in actual regulatory revisions. More than 150 pages of this 370-page document reflect regulatory changes. The economic impact and paperwork burden analysis extends nearly 90 pages.

No table of contents is provided adding considerable burden to the reader.

Consolidated Appropriations Act, 2021

On Dec. 27, 2020, the ***Consolidated Appropriations Act***, 2021, which included the No Surprises Act, was signed into law. The No Surprises Act provides federal protections against surprise billing and limits out-of-network cost sharing under

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many of the circumstances in which surprise bills arise most frequently.

Overview of the Interim Final Rules – Departments of HHS, Labor and the Treasury

Preventing Surprise Medical Bills
The rule prohibits nonparticipating providers, facilities and providers of air ambulance services from billing or holding liable individuals for an amount that exceeds in-network cost sharing determined in accordance with the balance billing provisions in circumstances where the balance billing provisions apply. This includes: (1) when emergency services are provided by a nonparticipating provider or nonparticipating emergency facility, (2) when nonemergency services are provided by a nonparticipating provider at a participating health care facility, and (3) when air ambulance services are furnished by a nonparticipating provider of air ambulance services.

Emergency Services
If a group health plan, or a health insurance issuer offering group or individual health insurance coverage provides or covers any benefits with respect to services in an ED of a hospital or with respect to emergency services in an independent freestanding ED, the plan or issuer must cover emergency services as defined in these interim final rules, and such coverage must be provided in accordance with these interim final rules.

A plan or issuer providing coverage of emergency services must do so without the individual or the health care provider having to obtain prior authorization (including when the emergency services are provided out-of-network) and without regard to whether the health care provider furnishing the emergency services is a participating provider or a participating emergency facility with respect to the services.

Post-Stabilization Services
These interim final rules provide that post-stabilization services are emergency services unless all of the following conditions are met.

- First, the attending emergency physician or treating provider must determine that the participant, beneficiary or enrollee 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 individual's medical condition.
- Second, the provider or facility furnishing post-stabilization services must satisfy the notice and consent criteria of section 2799B-2(d) of the PHS Act.
- Third, the individual (or the individual's authorized representative) must be in a condition to receive the information in the notice described in section 2799B-2 of the PHS Act.
- Fourth, the provider or facility must satisfy any additional requirements or prohibitions, as may be imposed under applicable state law.

Nonemergency Services Performed by Nonparticipating Providers at Participating Health Care Facilities
If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers benefits with respect to items and services (other than emergency services to which section 9816(a) of the Code, section 716(a) of ERISA, or section 2799A-1(a) of the PHS Act applies), the plan or issuer must cover such items and services furnished to a participant, beneficiary or enrollee of the plan or coverage by a nonparticipating provider with respect to a visit at a participating health care facility in accordance with these interim final rules, including

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the requirements regarding cost sharing, payment amounts and processes for resolving billing disputes described elsewhere in this preamble.

Health Care Facilities
A health care facility described in the statute is each of the following, in the context of nonemergency 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), or (4) an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

Items and Services Within the Scope of a Visit
In addition to items and services furnished by a provider at the facility, a "visit" to a participating health care facility includes the furnishing of equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the provider furnishing such items or services is at the facility.

Air Ambulance Services
These interim final rules apply these provisions where a plan or coverage generally has a network of participating providers and provides or covers any benefits for air ambulance services, even if the plan or coverage does not have in its network any providers of air ambulance services.

Determination of the Cost-Sharing Amount and Payment Amount to Providers and Facilities

If a plan or issuer provides or covers any benefits with respect to services in an ED of a hospital or with respect to emergency services in an independent freestanding ED, the cost-sharing requirement for such services performed by a nonparticipating provider or nonparticipating emergency facility must not be greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility.

Cost-Sharing Amount
Consumer cost-sharing amounts for emergency services provided by out-of-network emergency facilities and out-of-network providers, and certain non-emergency services furnished by out-of-network providers at certain in-network facilities, must be calculated based on one of the following amounts.

1. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
2. If there is no applicable All-Payer Model Agreement, an amount determined by a specified state law; or
3. If there is no applicable All-Payer Model Agreement or specified state law, the lesser of the amount billed by the provider or facility or the qualifying payment amount, which under these interim final rules generally is the median of the contracted rates of the plan or issuer for the item or service in the geographic region.

Out-of-Network Rate
In addition to establishing requirements related to cost sharing, the No Surprises Act and these interim final rules also establish requirements related to the total amount paid by a plan or issuer for items and services subject to these provisions, referred to as the out-of-network rate.

All-Payer Model Agreements
In instances where an All-Payer Model Agreement is applicable, the recognized amount (the amount upon which cost sharing is based with respect to items and services furnished by nonparticipating emergency facilities, and nonparticipating providers of nonemergency items and services in participating facilities) and the out-of-network rate are determined using the amount that the state approves under the All-Payer Model Agreement for such items or services.

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These interim final rules defer to the state to determine the circumstances under which, and how, it will approve an amount for an item or service under a payment system established by an All-Payer Model Agreement.

Median Contracted Rate

In general, the median contracted rate for an item or service is calculated by arranging in order from least to greatest the contracted rates of all plans of the plan sponsor (or of the administering entity, if applicable) or all coverage offered by the issuer in the same insurance market for the same or similar item or service that is provided by a provider in the same or similar specialty or facility of the same or similar facility type and provided in the geographic region in which the item or service is furnished, and selecting the middle number.

Same or Similar Item or Service

The term "same or similar item or service" means a health care item or service billed under the same service code, or a comparable code under a different procedural code system. Service code means the code that describes an item or service, including a Current Procedural Terminology, Healthcare Common Procedure Coding System or Diagnosis-Related Group code.

Indexing

The No Surprises Act provides that, in instances when the median contracted rate is determined as of Jan. 31, 2019, the qualifying payment amount for items and services furnished during 2022 is calculated by increasing the median contracted rate by the percentage increase in the consumer price index for all urban consumers (U.S. city average) (CPI-U) over 2019, the percentage increase over 2020 and the percentage increase over 2021.

Surprise Billing Complaints Regarding Group Health Plans and Health Insurance Issuers

The No Surprises Act also adds section 2799B-4(b)(3) of the PHS Act, which directs HHS to establish a process to receive consumer complaints regarding violations by health care providers, facilities and providers of air ambulance services regarding balance billing requirements under sections 2799B-1, 2799B-2, 2799B-3 and 2799B-5 of the PHS Act and to respond to such complaints within 60 days. As such, HHS is issuing HHS-only interim final rules to establish a process by which HHS will receive complaints regarding violations of these requirements by health care providers, facilities and providers of air ambulance services.

Applicability

These interim final rules generally apply to group health plans and health insurance issuers offering group or individual health insurance coverage with respect to plan years (in the individual market, policy years) beginning on or after Jan. 1, 2022. The term "group health plan" includes both insured and self-insured group health plans.

These interim final rules apply to grandfathered health plans.

These interim final rules do not apply to health reimbursement arrangements, or other account-based plans, that make reimbursements subject to a maximum fixed dollar amount for a period, as the benefit design of such plans makes concepts related to surprise billing and choice of health care professionals inapplicable. These interim final rules do not apply to retiree-only plans.

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These interim final rules generally are applicable to traditional indemnity plans, meaning plans that do not have networks of providers or facilities.

Overview of Interim Final Rules – Department of Health and Human Services

The No Surprises Act adds new sections to PHS Act, which protect participants, beneficiaries and enrollees in group health plans and group and individual health insurance coverage from balance bills by prohibiting nonparticipating providers, facilities and providers of air ambulance services from billing or holding liable individuals for an amount that exceeds in-network cost sharing determined in accordance with the balance billing provisions in circumstances where the balance billing provisions apply. This includes: (1) when emergency services are provided by a nonparticipating provider or nonparticipating emergency facility, (2) when nonemergency services are provided by a nonparticipating provider at a participating health care facility, and (3) when air ambulance services are furnished by a nonparticipating provider of air ambulance services.

Notice and Consent Exception to Prohibition on Balance Billing

The protections that limit cost sharing and prohibit balance billing do not apply to certain nonemergency services or to certain post-stabilization services provided in the context of emergency care, if the nonparticipating provider or nonparticipating emergency facility furnishing those items or services provides the participant, beneficiary or enrollee, with notice, the individual acknowledges receipt of the information in the notice, and the individual consents to waive the balance billing protections with respect to the nonparticipating emergency facility or nonparticipating providers named in the notice.

The notice must state that the health care provider furnishing the items or services is a participant, beneficiary or enrollee, with notice, the individual acknowledges receipt of the information in the notice, and the individual consents to waive the balance billing protections with respect to the nonparticipating emergency facility or nonparticipating providers named in the notice.

Nonparticipating providers who are providing this notice are required to provide a good faith estimate for only the items or services that they would be furnishing and are not required to provide a good faith estimate for items or services furnished by other providers at the facility.

Providers and facilities must use the standard consent document specified by HHS in guidance, and the consent document must be provided in accordance with such guidance.

These interim final rules require the provider or facility to notify the plan or issuer so that the plan or issuer is aware when the balance billing and in-network cost sharing protections apply and can process the claim appropriately.

Economic Impact and Paperwork Burden

The Departments are unable to quantify all benefits, costs and transfers of these interim final rules but have sought, where possible, to describe the nonquantified impacts. The effects are reflected in table below. Note, the law appears costly.

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Accounting Statement

Benefits:

Nonquantified:

- Elimination of surprise medical bills for individuals from out-of-network medical care and air ambulance services.
- Reduction in financial anxiety, including anxiety associated with medical debt, for individuals with health coverage, due to a reduction in surprise bills.
- Increased access to care for individuals with health coverage that may have otherwise forgone or neglected needed treatment due to high out-of-pocket expenses, and better health outcomes as a result. Potential improved health outcomes for individuals with grandfathered health coverage due to the ability to choose their own primary care physicians, the ability to choose a pediatrician as the primary care physician for children, and the ability to receive obstetrical and gynecological care without a referral.

Costs:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized ($/year)	$ 2,252.23 million	2021	7%	2021 – 2025
	$ 2,177.12 million	2021	3%	2021 – 2025

Quantitative:

- Costs to issuers and third-party administrators to comply with the requirements related to the recognized amount and QPA, estimated to be one-time costs of approximately $4,958 million to make the necessary information technology system changes in 2021, and ongoing operational costs of $2,047 million in 2022 and $724 million annually from 2023 onwards.
- Costs to issuers and TPAs to revise standard operating procedures and provide training to staff, estimated to be one-time costs of approximately $12.1 million in 2021.
- Costs to health care facilities and emergency facilities to revise standard operating procedures and provide training to staff, estimated to be one-time costs of $117.2 million in 2021.
- Costs to providers of air ambulance services to revise standard operating procedures and provide training to staff, estimated to be one-time costs of $517,086 in 2021.
- Costs to issuers and TPAs to share information related to QPA, estimated to be approximately $55.4 million annually starting in 2022.
- Costs to self-insured plans opting in to state law to include disclosure in plan documents, estimated to be one-time costs of approximately $50,708 in 2022.
- Costs to grandfathered health plans to provide the notice of right to designate a primary care provider, estimated to be $4.5 million in 2022.
- Costs to nonparticipating providers and nonparticipating emergency facilities to comply with requirements related to notice and consent, recordkeeping, and notice to plans and issuers, estimated to be one-time costs of approximately $22.6 million in 2021 and ongoing costs of $117.2 million annually starting in 2022.
- Costs to individuals to read and understand the notice from nonparticipating providers and nonparticipating emergency facilities, estimated to be approximately $99.1 million annually starting in 2022.
- Costs to health care providers and facilities to provide disclosures on patient protections against balance billing, estimated to be one-time costs of approximately $6.8 million in 2021 and $2.5 million annually starting in 2022.
- Costs to states to develop state-specific language for patient disclosures to be provided by health care providers and facilities, estimated to be one-time costs of approximately $10,732 in 2021.
- Costs to health care facilities to enter into agreements for the facilities to provide the disclosure on patient protection on behalf of the providers, estimated to be one-time costs of approximately $6.4 million in 2021.
- Costs to plans and issuers to provide disclosure on patient protections to participants, beneficiaries and enrollees, estimated to be approximately $699,245 in 2021 and approximately $23.4 million annually starting in 2022.
- Costs to individuals and providers to submit complaints related to surprise bills, estimated to be approximately $97,452 annually starting in 2022.
- Costs to the federal government to build a system to receive complaints and expand existing systems, estimated to be one-time costs of approximately $19 million in 2021; and ongoing costs to process complaints, estimated to be approximately $1.6 million in 2021, $9.9 million in 2022, $10.1 million in 2023, and $10.3 million in 2024 and subsequent years.

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Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

Transfers:
Nonquantified: Increase in health care expenditures if health care utilization increases.
Nonquantified: • Transfer from plans and issuers to participants, beneficiaries and enrollees because plans and issuers now will pay additional amounts for some services provided by nonparticipating providers and facilities, and participants, beneficiaries and enrollees will experience a reduction in out-of-pocket expenditures. • Potential transfer from providers, including air ambulance providers, and facilities to the participant, beneficiary or enrollee if the out-of-network rate collected is lower than what would have been collected had the provider or facility balance billed the participant, beneficiary or enrollee. More detailed analysis forthcoming in future rulemaking: • Potential reduction in negotiated rates for certain health care services and air ambulance services, leading to reductions in cost sharing for individuals with health coverage. • Potential change in premiums depending on the impact on provider payments. • Potential transfer from individuals to the federal government in the form of reduced premium tax credits if premiums decrease as a result of these interim final rules. • Potential transfer from the federal government to individuals in the form of increased premium tax credits if premiums increase as a result of these interim final rules.

FINAL THOUGHTS

The fact that three departments and the Office of Personnel Management have coauthored this rule is apparent. The material is quite redundant. Without a complete table of contents, finding specific items is difficult to say the least.

More than 50 times, "the Departments" are seeking comments on various provisions. As a result, it is very difficult to understand the rule being issued as an interim final document. It should be rewritten and made more concise.

Preventing surprise billing sounds simple, but apparently is not.

The accounting statement above suggests that adoption will be quite costly.

Finally, it's time for HHS to revamp its rule writing. For a governmental agency that seeks to streamline the Medicare program, it fails terribly at reducing burdens for those reading and complying new rules. We need a complete table of contents with major and minor heads, paragraphs that sum explanations for each section, and a reduction in the amount of prior history. And, more hyperlinks to other materials and documents.