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HHS Issues Interim Final Rule for the No Surprises Act

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On July 1, U.S. Departments of Health and Human Services (HHS), Labor, and Treasury, as well as the Office of Personnel Management, issued an interim final rule implementing the No Surprises Act (Act) and requesting stakeholder comments on several issues.[1] The No Surprises Act, a bipartisan bill passed as part of a massive funding package in the final days of 2020, seeks to protect patients against surprise billing and balance billing at the federal level.[2] The Act "provides federal protections against surprise billing and limits out-of-network cost sharing under many of the circumstances in which surprise bills arise most frequently."[3] We previously issued a client alert summarizing the Act.

Specifically, the interim final rule issued earlier this month will restrict "excessive out of pocket costs to consumers from surprise billing and balance billing" and out-of-network charges for several types of services.[4] The interim final rule applies to health benefits plans beginning on January 1, 2022.

Surprise billing occurs when patients unknowingly receive emergency or nonemergency care from providers outside of their health plan's network.[5] Patients typically bear the burden to pay the additional costs for out-of-network emergency and nonemergency services in these situations unless otherwise protected by state law.[6] Providers often seek payment through balance billing charging a patient the remaining balance of what their insurance does not cover.[7] Medicare and Medicaid already prohibit balance billing. The new federal rule will extend similar protections to patients insured through employer-sponsored and other commercial health plans.[8]

The interim final rule, which is the first in a series of regulations implementing the No Surprises Act, mandates the following:[9]

- Emergency services, regardless of where they are provided, must be covered on an in-network basis, including the calculation of copayments, coinsurance, and deductibles, without requirements for prior authorization.

- Out-of-network balance billing and/or increased patient financial responsibility (*e.g.*, higher copayment) for ancillary care (such as care rendered by an anesthesiologist or assistant surgeon) at an in-network facility will be prohibited in all circumstances; and

- Health care providers 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 a higher out-of-network rate (*e.g.*, one-page disclosure notice provided in person or through mail or email).[10]

Notably, however, neither the Act nor these interim final rules protect patients from every high or unexpected medical bill.[11] For example, the rule does not apply if the health care services are not a covered benefit in the patient's health plan.[12] Moreover, "balance billing continues to be permitted, unless prohibited by state law or contract, in circumstances where these interim final rules do not apply, such as for non-emergency items or services provided at facilities that are not included within the definition of health care facility in these interim final rules."[13] A "facility not included within the definition" is a facility geographically separate and distinct from a hospital and not licensed by a state to provide emergency services (*e.g.,* an urgent care facility not permitted by state licensure to provide emergency services).[14]

The interim final rule also mandates that out-of-network rates for providers, inclusive of any cost sharing, will be determined by (in order of priority):[15]

- An amount determined by an applicable All-Payer Model Agreement — "an agreement between the Centers for Medicare & Medicaid Services (CMS) and a state to test and operate systems of all-payer payment reform for the medical care of residents of the state, under the authority granted under section 1115A of the Social Security Act"[16]; or

- An amount determined by an applicable state law.

And if neither apply (in order of priority):[17]

- An amount agreed upon by the payer and provider; or

- An amount determined by a binding third-party arbiter.[18]

The agencies are inviting comments for 60 days following publication in the *Federal Register*.[19] Some specific topics on which the agencies have requested comment include:

- Additional or alternative policies to help remove barriers for notice and consent information for individuals with limited English proficiency or disabilities;

- Guidelines needed to determine when an individual is in a condition to receive the written notice and provide consent;

- Other facilities considered appropriate to designate as health care facilities and identifying the types of facilities where surprise bills frequently arise;

- Whether urgent care centers or retail clinics should be designated as health care facilities and data on how frequently surprise bills arise in the context of urgent care centers.

[1] *See* https://medcitynews.com/2021/07/federal-agencies-issue-rule-enforcing-surprise-billing-ban/.

[2] *See* https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf.

[3] *See* https://www.cms.gov/files/document/cms-9909-ifc-surprise-billing-disclaimer-50.pdf.

[4] *See* https://www.cms.gov/newsroom/press-releases/hhs-announces-rule-protect-consumers-surprise-medical-bills.

[5] *See* https://www.cms.gov/newsroom/press-releases/hhs-announces-rule-protect-consumers-surprise-medical-bills.

[6] See https://www.jdsupra.com/legalnews/the-no-surprises-act-congress-takes-aim-3016690/.

[7] *See* https://www.cms.gov/newsroom/press-releases/hhs-announces-rule-protect-consumers-surprise-medical-bills.

[8] *See* https://www.cms.gov/newsroom/press-releases/hhs-announces-rule-protect-consumers-surprise-medical-bills.

[9] *See* https://www.cms.gov/newsroom/press-releases/hhs-announces-rule-protect-consumers-surprise-medical-bills.

[10] HHS developed a model notice that health care providers and facilities may adopt, but are not required to use. In an effort to ensure clear and understandable language for the required information, HHS is seeking comment on the content of the required disclosures. HHS seeks further comment on the disclosure methods, including whether additional methods of providing information should be required or permitted. *See* https://www.cms.gov/files/document/cms-9909-ifc-surprise-billing-disclaimer-50.pdf.

[11] *See* https://www.cms.gov/files/document/cms-9909-ifc-surprise-billing-disclaimer-50.pdf.

[12] *See* https://www.cms.gov/files/document/cms-9909-ifc-surprise-billing-disclaimer-50.pdf.

[13] *See* https://www.cms.gov/files/document/cms-9909-ifc-surprise-billing-disclaimer-50.pdf.

[14] The Act broadens the definition of emergency services to include services provided at an “independent freestanding emergency department.” An independent freestanding emergency department includes any health care facility geographically separate and distinct from a hospital, and is licensed by a state to provide emergency services, even if not licensed under the term “independent freestanding emergency department.”

[15] *See* https://www.cms.gov/files/document/cms-9909-ifc-surprise-billing-disclaimer-50.pdf.

[16] *See* https://www.cms.gov/files/document/cms-9909-ifc-surprise-billing-disclaimer-50.pdf.

[17] *See* https://medcitynews.com/2021/07/federal-agencies-issue-rule-enforcing-surprise-billing-ban/.

[18] The interim final rules do not yet include guidelines for the arbitration process. Further information will be released soon, according to a fact sheet released by the Centers for Medicare & Medicaid Services. *See* https://www.cms.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-i-interim-final-rule-comment-period.

[19] *See* https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i

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