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Provider Payment for Emergency Services under New Plan Rules

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Section 10101(h) of the Affordable Care Act[1] health reform legislation requires that health plans and insurers provide coverage for all emergency services without regard to whether the provider is in- or out-of-network, without requiring preauthorization, without imposing administrative requirements more burdensome than those applicable to emergency care provided in-network, and without imposing higher cost-sharing burdens on patients.

The Internal Revenue Service and Department of Labor have now published interim final rules (*75 FR 37188*, June 28, 2010) to implement these requirements. Other aspects of these interim final rules were discussed in (link to our Alert Health Care Reform: Interim Final Regulations Released for Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections Client Alert, June 28, 2010). The interim rules are effective for plan years beginning on or after September 23, 2010. These requirements do not apply to grandfathered health plans.

The text of the regulation (26 CFR 54.9815-2719AT(b)) begins by largely tracking the statute. However, explaining that "it would defeat the purpose of the protections in the statute if a plan or issuer paid an unreasonably low amount to a provider," the rules provide a method to determine what plans and insurers must pay for emergency services. The amount must be at least the greatest of: (i) the median "in-network" amount payable by the plan for the service; (ii) an amount calculated in the manner usually used by the plan to pay for the service in question when rendered out of network (e.*g.*, the usual, customary and reasonable rate); and (iii) the amount that would be paid by Medicare. In each case, the amount that the plan must pay to the out-of-network provider is reduced by the in-network amount of co-payments or co-insurance (and not by a possibly higher out-of-network co-pay). The interim final rule provides a number of helpful illustrative examples.

The definitions of “emergency services” and “emergency medical condition” and “stabilize” are as set forth under EMTALA (modified as appropriate to the slightly different context).

Neither the statute nor the regulation prohibits providers from balance billing. The interim final rules recognize that “the statute does not require plans or issuers to cover balance billing amounts, and does not prohibit balance billing.” From the perspective of plans, the statute modifies the risks dramatically in regard to contract termination or non-participation with a hospital that gets a significant amount of emergency room volume. Heretofore, the non-participating provider would charge the plan its standard charge (usually much higher than negotiated plan rates), and the plan would have to pay this amount or challenge the charge. While case law has generally trended toward a required “quantum meruit” (“fair and reasonable”) payment in this context, a number of courts have required plans to pay full charges. Under the new rule, the plans will face a much reduced risk of being required to pay full charges. It has also been established that at least under Federal law, a provider may “balance bill” non-governmental patients. If non-participating providers do “balance bill” patients for the difference between their charges for emergency services and what the plan pays the provider, problems in the triangular relationship between non-participating providers, payers, and enrollees could be exacerbated. However, if non-participating providers do not “balance bill,” some question whether the provider’s “charge” is lowered. Comments on the interim final rules are due by August 27, 2010.

[1] The “Affordable Care Act” means The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA). For more information about the Act, please visit our Health Care Reform Task Force website at http://www.proskauer.com/practices/health-reform-task-force.

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