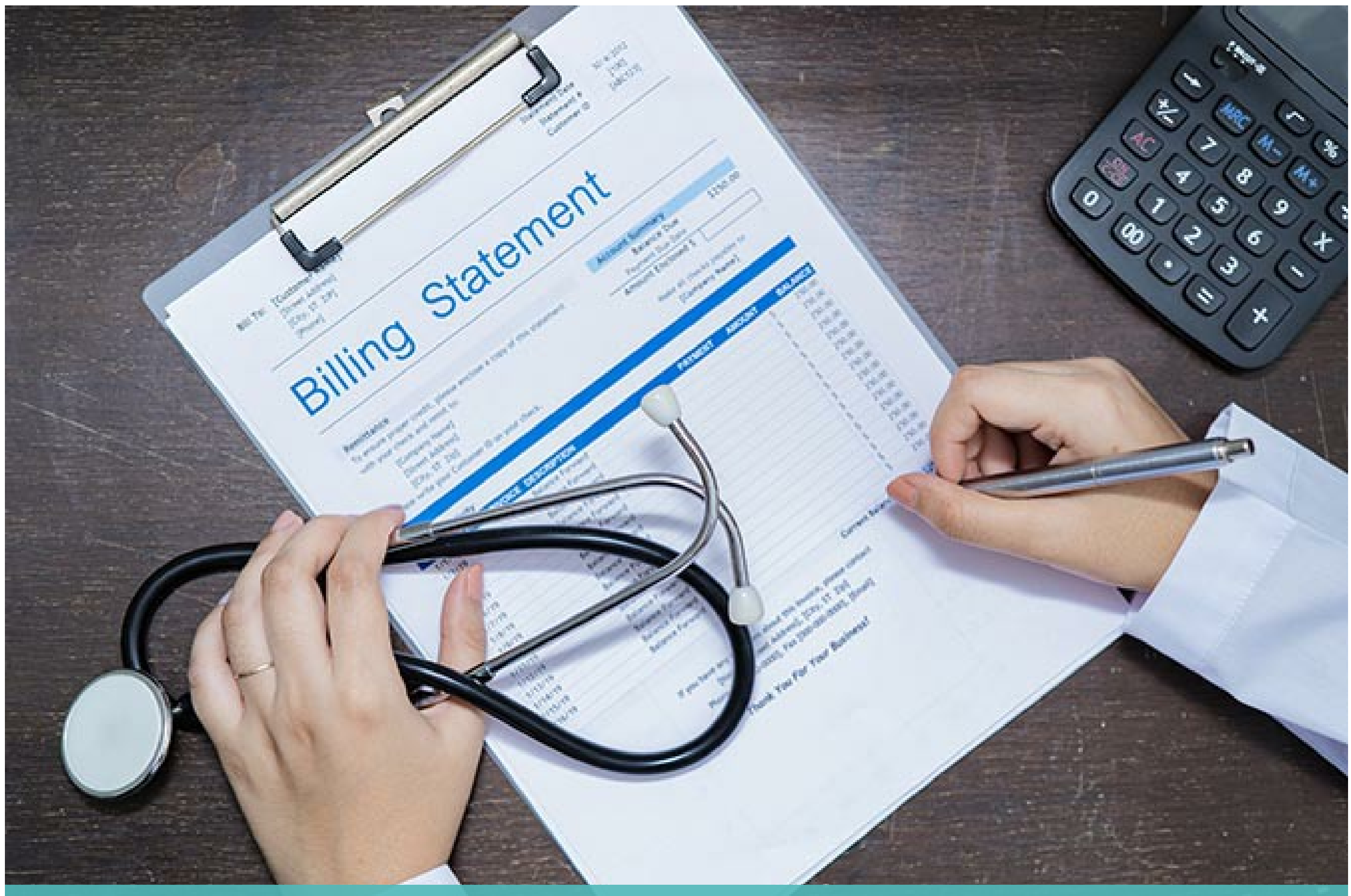
Surprise billing regulations: Action steps for healthcare providers



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Updated on July 13, 2021, to reflect the Federal Register publication date.

On July 1, four federal agencies[1] issued an interim final rule with comment period (the IFC), which will implement various provisions of the No Surprises Act relating to unexpected medical costs for out-of-network medical services. The IFC was published in the Federal Register on July 13, 2021. This article addresses implications and action steps for healthcare providers.

No Surprises Act

The No Surprises Act was enacted in December 2020 on a bipartisan basis to protect patients from surprise medical bills for non-emergency services furnished by out-of-network providers at in-network healthcare facilities, emergency services, and out-of-network air ambulance services. The Act also sets the framework for procedures to determine payment amounts by the patient and health plan or insurer for out-of-network services, and will require disclosures by nonparticipating providers and their healthcare facilities.

The No Surprises Act will apply to plan and policy years that begin on or after January 1, 2022. Healthcare providers and facilities will be required to comply with the Act starting January 1, 2022.

Providers and Facilities Subject to Balance Billing Restrictions

- Healthcare facilities: hospitals, hospital outpatient departments, critical access hospitals and ambulatory surgical centers

- Independent freestanding emergency departments
- Providers of air ambulance services
- Nonparticipating providers: physicians and other healthcare providers who do not have a direct or indirect contractual relationship with the health plan or insurance carrier with respect to the items or services, and furnish services with respect to a visit at a participating healthcare facility or who provide emergency services at a hospital or independent freestanding emergency department.

IFC Regulations

The IFC sets forth regulations addressing issues including the following:

- Health plan and insurer obligations to cover emergency and related post-stabilization services, as well as items and services furnished by nonparticipating providers with respect to a visit[2] at a participating healthcare facility.
- Patient protections from balance billing[3] and from cost sharing obligations (e.g., copayments, coinsurance and deductibles) that exceed the in-network cost sharing amounts unless notice and patient consent requirements are satisfied.
- Standards for providing notice and obtaining patient consent to allow balance billing, along with categories of ancillary services for which balance billing will not be allowed even with consent.
- Healthcare provider and facility public and individual disclosure requirements.
- Determination of the payment amount (the “out-of-network rate”) that nonparticipating providers will be entitled to receive for their out-of-network services and related timing requirements.
- Processes for the filing of complaints of No Surprises Act violations.

Implications and Action Plans for Healthcare Providers

Although the No Surprises Act does not take effect until 2022, healthcare providers who furnish services at healthcare facilities and bill on an out-of-network basis should start preparing to navigate these changes as well as related state law restrictions. Important action steps include:

1. Analyze the likely impact of the No Surprises Act on the provider’s business model and professional practice, and plan for appropriate adjustments to relationships as well as participation and negotiation strategies.
2. With an eye on compliance, implement policies and procedures to determine when the No Surprises Act is implicated, satisfy disclosure requirements, submit appropriate billing and related information to third party payors, determine appropriate cost sharing amounts, avoid billing the patient for more than the permitted amount, and identify and promptly refund any overpayments.
3. Develop strategies, policies and procedures to identify whether out-of-network rates will be determined under state law or under the No Surprises Act, determine when and how to challenge payment amounts and file for independent dispute resolution (IDR) of out-of-network rates, and manage the tight timeframes for contesting and negotiating payment amounts and for the IDR process.
    - Keep in mind that the initial payment amount could become the de facto out-of-network rate if the provider fails to request negotiation on a timely basis, or if the parties fail to agree upon the payment amount and neither party invokes the IDR process. The IFC and the No Surprises Act do not establish any minimum amount for the initial payment, although the IFC expresses the expectation

   that the initial payment should be reasonably intended as payment in full based on the relevant facts and the terms of the plan or coverage. The IFC asks for comment on whether a minimum payment amount should be required and, if so, the payment rate or methodology
4. Prepare to provide disclosures that will be required commencing January 1, 2022 for all healthcare providers who furnish items or services at healthcare facilities or in connection with visits at healthcare facilities. The IFC invites healthcare providers and facilities to use model disclosures provided by the agencies in order to satisfy disclosure obligations. In order to lighten overlapping administrative burdens and potential confusion, providers can enter into written agreements with their healthcare facilities so that the facilities can furnish the required disclosures to patients and on signage.
5. Determine whether their services are eligible for balance billing under the notice and patient consent provisions and, if so, the feasibility and desirability of obtaining consent. Keep in mind that a broad range of items and services that fall within the following categories will not be eligible for the consent exception and therefore will not be subject to balance billing:
   - Emergency medicine, anesthesia, pathology, radiology or neonatology
   - Assistant surgeon, hospitalist and intensivist items and services
   - Diagnostic services, including radiology and laboratory services
   - Items or services provided by a nonparticipating provider if there are no participating providers who can furnish the item or services at the facility
   - Items or services that result from unforeseen, urgent medical needs that arise when the item or service is furnished.
6. If a provider intends to balance bill with patient consent, the provider should implement policies and procedures to ensure that the items or services are eligible for the patient consent exception and that No Surprises Act requirements are satisfied, including notice, patient consent, timely notification to the plan or issuer, and retention of the written notice and consent for at least 7 years.
7. If interested in commenting on the IFC, please do so during the comment period that runs through 5 p.m. EDT on September 7, 2021.
8. Watch for upcoming regulations implementing more provisions of the No Surprises No Surprises Act, including the following:
   - Establishment of the independent dispute resolution (IDR) process to determine out-of-network rates when the provider and payor are unable to agree and the rates are not determined under state law or a state all-payer model agreement
   - Patient protections through transparency and a provider-patient dispute resolution process
   - Price comparison tools
   - Enforcement

For more information on these regulations, the No Surprises Act or related matters, please contact the attorney below.

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[1] The Department of Health and Human Services, the Department of Labor, and the Department of the Treasury (referred to in the IFC as the “Departments”), and the Office of Personnel Management.

[2] The IFC defines “visit” to include equipment and devices, as well as telemedicine, imaging, laboratory and preoperative and postoperative services, whether or not provided at the facility. The IFC solicits comments regarding other items and services that would be appropriate to include within the scope of a “visit.”

[3] “Balance billing” involves out-of-network providers billing patients for the amount by which the provider’s billed charges exceed the amounts collected by the provider from the third party payor (e.g, the health plan or insurer) and from patient copayments, coinsurances and deductibles.

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