Federal Requirements Related to Surprise Billing

July 2021

Background

The No Surprises Act was included as part of the Omnibus Spending package that was signed into law by President Trump on December 27, 2020. There were several provisions contained in the law that address greater transparency around what is called balance billing or surprise billing. Former Senator Lamar Alexander (R-TN) drove much of this work, though it enjoyed bipartisan support from several lawmakers in both chambers of Congress. The sentiment behind these provisions is that no longer can Americans afford unanticipated or surprise bills after they have sought or received both elective and emergency healthcare.

First Wave of Rules

An interim final rule – being referred to as Part 1 as more rules are expected this fall – was published by the U.S. Department of Health & Human Services (HHS) in conjunction with the Departments of Labor (DOL), Department of Treasury (DOT), and the Office of Personnel Management (OPM) to operationalize mandates in the No Surprises Act. As these are interim final rules, providers should begin preparing for compliance even though some policies could change.

The Part 1 rule restricts surprise medical bills for emergency services, air ambulance services provided by out-of-network providers, and non-emergency services provided by out-of-network providers at in-network facilities in certain circumstances. It additionally requires emergency services to be covered without any prior authorization, regardless of whether the provider is an in-network provider an in-network emergency facility and regardless of any other term or condition of the plan or coverage other than the exclusion or coordination of benefits, or a permitted affiliation or waiting period if the patient’s plan or coverage provides or covers any benefits for emergency services.

Future rules are expected to cover issues related to patient protections through transparency and the patient-provider dispute resolution process mandated by law, as well as, price comparison tools. There are also rules for payers but these may not be published until after the new year.

NOTE: The rule advises that since the law contains additional provisions that must be met but for which rules have not yet been published, that stakeholders required to comply should work off of their best faith interpretation of the law. For a list of additional provisions that will be required please see this document’s appendix.

Emergency Care

Requires group health plans or health insurance issuers offering group or individual health insurance coverage to cover emergency care without the need for prior authorization even if the

provider is not a participating provider or facility. Cost-sharing cannot be any greater than would apply if services were delivered by a participating provider / facility. The law requires a rule be published no later than by July 1st to operationalize these policies.

Out of Pocket Costs

The rule limits cost sharing for out-of-network services to in-network levels, requiring cost sharing for these services to count toward any in-network deductibles and out-of-pocket maximums, and prohibiting balance or surprise billing under certain circumstances.

The rule applies to most emergency services, air ambulance services from out-of-network providers, and non-emergency care from out-of-network providers at certain in-network facilities, including in-network hospitals and ambulatory surgical centers.

One Page Notice and Consent

Pursuant to the law HHS will require providers and facilities (including an emergency department of a hospital or independent freestanding emergency department) to post on their website a one-page notice concerning the patient protections against balance or surprise billing. This information must be supplied, according to the rule, "without having to establish a user account, password, or other credentials, accept any terms or conditions, and without having to submit any personal identifying information such as a name or email address."

The one-page notice also must be prominently displayed within the walls of the organization and patients must be given the one-page notice through mail or email depending on the patient's preference. The one-pager may be double-sided and must be no smaller than 12-point font. The notice must be given no later than the date the claim of service is submitted. Notice may be given with the HIPAA Notice of Privacy Practices, however, the notice must be a stand-alone document.

The notice and consent document be made available in any of the 15 most common languages in the geographic region in which the applicable facility is located.

Notice must be given at least 72 hours prior to delivery of care. For care scheduled less than 72 hours before the service, notice must be given at least three hours in advance of care.

The notice must provide information about whether prior authorization may be required in advance of receiving care. The notice must clearly state that the individual is not required to consent to receive care from a nonparticipating provider or nonparticipating emergency facility. Instead, patients may seek care from an available list of participating provider(s) and the list of these must be included. And, the notice must include the good faith estimated amount that such nonparticipating provider or nonparticipating emergency facility may charge.

The consent document must be signed (including by electronic signature) by the patient or patient's authorized representative. A copy of the signed document must be given to the patient / their representative.

The law requires that providers use a standard notice format. HHS will make this available in the future.

Finally, the notice and consent exception does not apply to items or services furnished as a result of unforeseen, urgent medical care that arises.

Effective Date

Compliance for three pieces of the Part 1 rule is January 1, 2022.

Exceptions

Prohibitions around balance billing do not apply to certain non-urgent care and certain post-stabilization services that occur following emergency care if non-participating providers give patients the opportunity to waive balance or surprise billing protections and the patient consents to do so (exception does not apply to emergency care). However, cost-sharing and balance or surprise billing protections still apply to the delivery of care if consent is not obtained.

Civil Monetary Penalties

Failure to comply with these policies could result in civil monetary penalties. Penalties will be waived if a provider does not knowingly violate the policies and withdraws the bill that was a violation. HHS will issue policies on enforcement in future rulemaking.

Determination of Cost-Sharing Amount

Where a payer covers services the cost-sharing requirements cannot be greater than the in-network rate if such services were provided by a participating provider unless the provider has satisfied certain notice and consent.

Cost sharing rates are determined as if the total amount would be charged for the services by a participating provider were equal to the recognized amount. The recognized amount is: 1) the amount determined by an applicable all-payer model agreement; 2) if there is no all-payer model agreement then an amount determined by state law; or 3) if there are neither of these then it is determined by the lesser of the amount billed by the provider or facility or the qualifying payment amount (QPA), which generally is the median of the contracted rates of the plan or issuer for the item or service in the geographic region.

Links

- HHS interim final rule
- HHS press release
- HHS fact sheet
- Additional HHS fact sheet

Appendix

Additional Provisions Contained in Forthcoming Rules

The No Surprises Act also contains the following provisions for which rules are still forthcoming.

Sec. 103.	Determination of out-of-network rates to be paid by health plans; **Independent dispute resolution (IDR) process.**	Expected later this year
Sec. 105	Ending surprise air ambulance bills.	Expected later this year
Sec. 106	Reporting requirements regarding air ambulance services	Expected later this year
Sec. 112.	Patient protections through transparency and patient-provider dispute resolution.	Expected later this year
Sec. 113	Ensuring continuity of care	After Jan. 1, 2022
Sec. 114.	Maintenance of price comparison tool	Expected later this year
Sec. 116	Protecting patients and improving the accuracy of provider directory information	After Jan. 1, 2022
Sec. 201	Increasing transparency by removing gag clauses on price and quality information.	After Jan. 1, 2022
Sec. 204	Reporting on pharmacy benefits and drug costs.	After Jan. 1, 2022