New Laws and Regulations on Surprise Billing Practices

In recent years, balance billing from medical providers has attracted the attention of legislatures at both the state and federal level. On Jan. 1, 2021, Virginia's balance billing law took effect that barred out-of-network providers from billing patients for emergency services, and barred balance billing for some prescheduled, nonemergency services at hospitals or other health care facilities that were in the patient's network.

The No Surprises Act (NSA) takes effect Jan. 1, 2022 and seeks to address the same issues that the Virginia law addressed but at the federal level. Broadly speaking, this Act will force providers to treat out-of-network services as if they were in-network when determining reimbursement, except for ground ambulance transportation, which is not addressed in the law. The law also orders federal agencies to conduct rulemaking to set expectations and give further guidance to affected parties.

In July 2021, various federal agencies worked in tandem to issue an interim final rule (IFR) to expand on key portions of the Act. Although this rule is considered "interim," it is expected to be implemented as written. Federal agencies will likely issue additional regulations to build on this guidance.

Taken as a whole, below are some key points about how the NSA and the IFR may impact doctors, hospitals and insurance providers.

Waiver of Surprise Billing

When it comes to surprise bills for nonemergency services, the NSA still allows for a patient to knowingly elect to receive care from out-of-network providers in certain circumstances, waiving the patient's NSA shield from being balance billed. Because the patient would be opting into such service, it would no longer be deemed "surprise" billing for these services.

Beyond the need for the service to be a nonemergency, there are three further requirements before patients can opt into such out-of-network agreements: (1) there are in-network providers in the facility; (2) the care is not for unforeseen, urgent medical needs such as poststabilization services; and (3) the provider is not furnishing ancillary services. The third restriction is particularly of note, as these types of providers—who are often the cause of balance billing—typically cannot easily obtain patient consent to be balance billed.

The Department of Health and Human Services (HHS) requires that hospitals use standardized waiver forms that must also be personalized for each individual patient. HHS has provided a model form that facilities must tailor to include patient-specific information, including an itemized cost estimate of charges, whether prior authorization needs to be satisfied, and information about the facility or provider. In-network facilities may provide the forms on behalf of out-of-network providers, and multiple providers can join on a single notice, if there is sufficient information on the form regarding each provider.

If a patient qualifies under the above requirements and still wants to waive NSA protection, HHS has additional procedural requirements for obtaining the patient's consent. First, the form must be given to the patient or a representative separate

from any other form, and, once signed, the facility must provide the patient with a copy of the signed form. The forms also must refer to each out-of-service provider involved. Further, the consent must be given at least 72 hours in advance of a scheduled appointment. If the patient schedules within 72 hours of the appointment, the consent must be signed at least three hours in advance of the appointment.

A patient is not required to sign on to waivers. NSA protections persist if the patient refuses to give consent or revokes consent. If the patient refuses to sign the waiver or later revokes consent, the facility cannot charge for a cancelled appointment. The NSA does not require the facility to treat a patient that refuses consent for an out-of-network provider.

The NSA leaves room for state laws to place further restraints on consent forms. Some states may ban the practice altogether; other states may implement additional requirements, such as requiring facilities to provide the waivers further in advance.

Cost-sharing Restrictions

The NSA limits cost sharing. Out-of-network bills cannot be greater than the fee of in-network service. The IFR provides further guidance, stating that the bill must be determined either by state-set charges, or the lesser of the facility's qualifying payment amount or the provider's billed charge.

Provider-Insurer Communication

The NSA and IFR also mandate timely communication between providers and insurers. Within 30 days of submitting a claim, insurers must submit their initial payments to providers. If a patient waives NSA protections, the provider must supply the insurer with a copy of the waiver. With regards to the qualifying payment amount, providers must disclose an itemized breakdown of costs, provide a statement certifying that the amount was calculated in compliance with relevant regulations, and state that there is a 30-day window for negotiating the total payment.

Emergency Care Coverage

One important focus of the IFR is emergency care coverage for items that hospitals later code as nonurgent. For example, insurers under the interim rule cannot deny coverage given as emergency care based solely on diagnostic codes, nor can they deny coverage based on the time between the onset of symptoms and when the patient sought care.

Dispute Resolution Process

Where there is a dispute about how much the health plan must pay for out-of-network providers who cared for the health plan's insured, the NSA also provides a framework for payment disputes to be resolved. Insurers and providers will first attempt to resolve any disputes on their own through negotiations, but, if that fails, the NSA mandates the parties enter arbitration. Patients are relieved of responsibility for surprise bills under the NSA and do not play a role in the dispute resolution process.

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