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Surprise, Surprise, Surprise: What's the Deal with Surprise Billing Regulations?

By Mary Paterni, Associate Attorney
Horty, Springer & Mattern, P.C

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Background

On July 13, 2021, the Departments of Health and Human Services, Labor, and Treasury published an Interim Final Rule implementing certain provisions of the No Surprises Act, which was enacted as part of the Consolidated Provisions Act of 2021.

Effective January 1, 2022, the Interim Final Rule:

- affords patients protection against balance billing and cost sharing for certain out-of-network services;
- prohibits out-of-network providers and health care facilities from balance billing patients under specific circumstances absent notice and consent;
- requires providers to disclose federal and state patient protections against balance billing; and
- describes complaint and dispute resolution processes for patients, payers and providers to address potential violations.

Balance Billing

Balance billing, which may comes as a surprise to the patient, often occurs when a patient with health insurance coverage receiving medical services from a physician or other provider who does not participate in the patient's health plan. In most cases, the patient's insurance does not cover all or even some of the charges of the out-of-network services. Thus, the patient is left with a higher cost-sharing amount for the services rendered by the out-of-network as well as a balance bill from the provider.

These surprise bills can occur in emergency and non-emergency care situations when the patient is unable to choose their provider. For instance, a patient may receive a bill for emergency services received from an out-of-network provider when the hospital providing the service is in network. Sometimes, patients are balanced billed for ancillary services, such as radiology, anesthesiology, or pathology from out-of-network providers.

In an effort to restrict this practice, the Interim Final Rule prohibits surprise medical bills for emergency services, non-emergency services furnished by out-of-network providers at in-network facilities, and air ambulance services furnished by out-of-network providers.

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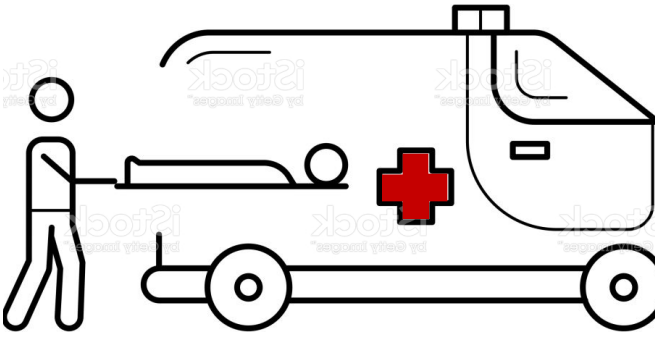
> MARY PATERNI, ASSOCIATE ATTORNEY - HORTY, SPRINGER & MATTERN, P.C



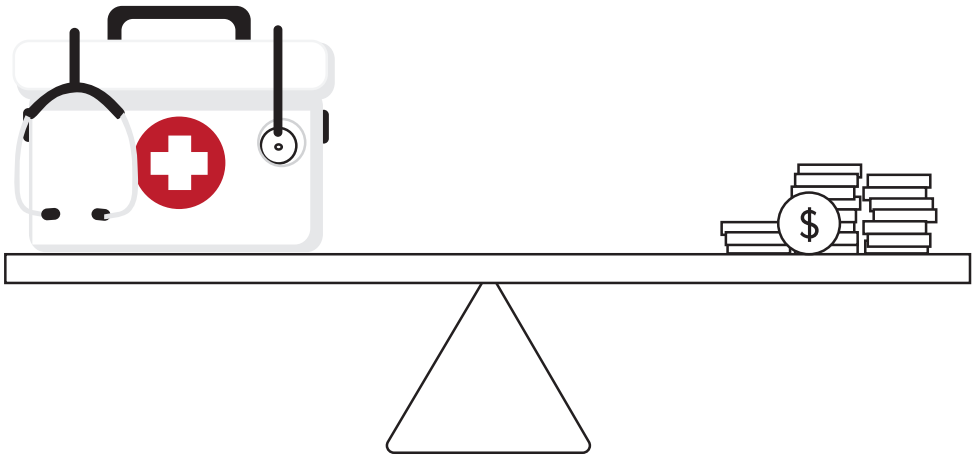
Non-emergency Services

Among other restrictions, the Interim Final Rule prohibits out-of-network providers from balance billing patients for non-emergency services if those services were furnished in an in-network facility. In this case, the patient's cost-sharing responsibility for out-of-network services would be equal to what their responsibility would have been had they received those services in-network. What's more, this cost sharing must count towards in-network deductibles and out-of-pocket maximums. Anything left over, however, must not be billed to the patient.

These billing rules provide an exception to these protections for certain post-stabilization and non-emergency services furnished by out-of-network provides. Specifically, the prohibitions outlined in the Interim Final Rule will not apply if the patient waives these protections by consenting to receiving services from an non-participating provider and by agreeing to pay the out-of-network cost sharing, as well as any subsequent balance billing amounts.

For this exception to apply, the patient must be provided adequate notice, as outlined in the rules. This notice must be tailored to the patient's circumstances. For instance, the notice must include, among other requirements, (1) notice that the patient's provider does not participate in-network, (2) a good faith estimate of the out-of-network charges the patient may be billed; and (3) a list of other participating providers at the facility where the patient will receive services. In most cases, this notice must also be made at least 72 hours in advance of services rendered. When services are provided in a hospital, it is the hospital's responsibility to see that the notice is provided.

It's important to note, however, that this notice and consent exception does not apply to the provision of emergency or ancillary (either emergency or non-emergency) services.



Impact

Although these rules do not take effect until January 1, 2022, it is imperative that hospitals prepare now. Significantly, hospitals should begin to their hospital-based provider contracts in anticipation of these rules taking effect. If such hospital-based provider contracts are silent on how providers bill patients, the hospital should consider building conditional language into the contract that requires the provider to contract with every health plan that the hospital contracts with. In light of the new prohibition on balance billing, hospitals should also consider including language in their hospital-based provider contracts that expressly prohibit out-of-network providers from balance billing patients for services rendered at the in-network facility.

LegalSifter
1918 Smallman Street
Pittsburgh, PA 15222
724.221.7438

legalsifter.com