Providers, Payers, and What's Ahead with the "No Surprises Act"

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Intended to address the persistent problem of balance billing patients for the costs of services of facilities and providers who are not in their health plan network—often with no prior notice—the "No Surprises Act" was signed into law in December 2020 as part of the Consolidated Appropriations Act, 2021.

The No Surprises Act's requirements become effective on January 1, 2022. With proposed regulations yet to be released, there could be a few surprises yet for healthcare providers. Below is an overview of the situation the new law seeks to address, the anticipated ramifications of the No Surprises Act (the Act) in practice, and issues to consider as the regulations are developed.

Overview

A "surprise" bill is an unexpected bill that a patient receives after he or she has obtained services from an out-of-network provider at an in-network facility. For example, a patient might have surgery at a hospital that participates in his or her health plan's network while the anesthesiologist and pathologist who provide services as part of the surgery do not. In this situation, patients are often surprised to learn that all of the services are not in-network, and they are stunned to discover that they are expected to pay the difference between the providers' fees and their health plan's out-of-network rates.

Surprise billing also creates problems for payers and providers. Payers are often required to spend additional time helping unhappy employees or enrollees understand why the services they received were not covered under their health plans. For providers, the disparities in payment rates may lead to uncollected fees and patient dissatisfaction. In response, multiple states have passed legislation aimed at addressing this practice. The Act is the first comprehensive effort at the federal level, and it affects health plans, hospitals, physicians, and air ambulance transportation companies.

The Act requires federal agencies including the Department of Health and Human Services and the Department of Labor to publish regulations and further requires some of these regulations to be published by July 1, 2021. Although the full scope of the regulatory scheme will not be known until final regulations are published, the Act itself makes it clear that healthcare providers, insurers, and self-insured health plan sponsors should be ready to address budgetary, operational, and administrative changes in the near future.

These changes include the following significant provisions.

Out-of-Network Services and Patient Financial Responsibility

- When a patient receives out-of-network emergency services, the hospital or physician providing emergency services may not hold the patient liable for copayments, coinsurance, and deductible amounts that exceed in-network rates.
- Emergency services must be provided without requiring prior authorization or any other term or condition of coverage and regardless of whether the provider is part of the patient's health plan network.
- Health plans must count any cost-sharing payments for emergency services toward in-network deductibles or out-of-pocket maximums.
- For non-emergency services, providers cannot impose cost-sharing requirements that would exceed the requirements applicable to in-network services, unless certain notice and consent rules are met.

Provider Reimbursement Rates

- Reimbursement rates will be set by applicable state law or, if no such law exists, a calculation that is based on the median contracted rate among other payers for the same service and in the same market.
- An "independent dispute resolution" mechanism will be established to arbitrate claims between providers and payers that cannot be resolved by the parties themselves. Using "baseball-style" arbitration, the dispute resolution entity must accept one of the parties' proposals without modification or "splitting" the difference.

Other Patient Protections

- To facilitate patient understanding about pricing, health plans must provide "price comparison guidance" to their members by phone or online.
- Health plans must provide updated directories that include, among other things, network status of healthcare providers.
- The rules and scope of information in "explanation of benefits" documents will be expanded.
- Patients will enjoy a transition period of 90 days to facilitate continuity of care if a provider terminates network participation during a particular course of care.
- Transparency rules will require providers to inquire about a patient's health plan coverage at the time of scheduling and provide patients with a good faith estimate of anticipated charges. These transparency rules will be in addition to the Hospital Price Transparency final rule that became effective at the beginning of this year.

Key Board Takeaways

- The No Surprises Act takes effect on January 1, 2022, and proposed regulations implementing some of the Act's requirements are expected on July 1, 2021.
- Healthcare providers, insurers, and self-insured health plan sponsors will need to quickly address the budgetary, operational, and administrative changes due to the Act.
- Hospitals or physicians providing emergency services may not hold a patient liable for copayments, coinsurance, and deductible amounts that exceed in-network rates.
- For non-emergency services, unless certain notice and consent rules are met, providers cannot impose cost-sharing requirements that would exceed those applicable to in-network services.
- It remains to be seen how the Act will affect the overall nature of network agreements and who will bear responsibility for the costly administrative burdens that will be needed to ensure compliance with the Act.

The end of surprise billing is certain to be a blessing for patients, but for providers, insurers, and employers, it could result in significant compliance hassles. Boards need to watch this law develop because the implementing regulations are yet to be proposed.

Unanswered Questions

Because the Act is a broad change to the laws applicable to an entire industry, it is not clear how its requirements will work in practice, and many issues remain to be clarified. Among them are issues such as:

- How will the Act affect the nature of network agreements overall? Will it compress prices such that the benefits of network agreements are significantly diminished or entirely meaningless?
- Who will shoulder the array of administrative burdens and costs that are necessary to ensure compliance with the Act?
- How will patient consents for waivers work in practice? Patients are already required to sign countless forms to receive medical treatment. Will there be protections to ensure that patients understand what they are signing when they sign forms related to out-of-network billing?
- How will the Act be applied in states where there are existing and complementary surprise billing laws?
- The Act provides that it does not supersede state law, except to the extent a particular state law prevents it from applying. It is not clear, however, how this will apply in practice.
- How, if at all, will Congress address surprise bills from out-of-network ground ambulance providers? Such providers are frequently a source of surprise bills, but the Act only addresses air ambulance providers (although it does establish an advisory committee to study ground ambulance bills).
- The Act attempts to remove patients from the process of resolving conflicts between health plans and providers regarding payment rates. Will it be effective in doing so, or will further legislative updates be necessary?

A more detailed discussion of the Act's requirements for health plans, providers, and air ambulance providers and the Act's dispute resolution procedure can be found at http://communications.wallerlaw.com/surprise-billing-white-paper.

The Board's Role

Regardless of how the regulations implement the Act, hospital and health system boards can take action now to be prepared for the new rules. First and foremost, providers should examine their existing experiences with balance billing. Doing so will provide important information about the context of the issue and how operational changes are going to affect business. Second, boards should consider how they will communicate with their constituents about the changes, which may include being prepared to answer to past practices, particularly those that may appear aggressive when compared to the new regime. Third, boards should consider whether the changes to the law should result in adjustments to negotiating strategies for network agreements going forward.

The board should be certain that the hospital's billing department is aware that the hospital will not be able to bill patients with health insurance for more than the in-network rate for emergency services. If a third-party service provider handles billing for the hospital, the contract(s) with that entity should be reviewed and, if necessary, amended. The contracts likely include a requirement that all billing be done in accordance with applicable law, but something more specific could prove helpful. At a minimum, review the contract's indemnity language to see if the hospital will be protected in the event the third-party service provider makes a mistake after the Act is effective. While third-party billing companies should be aware of the No Surprises Act, it could be helpful to confirm that they are aware of the Act and are taking appropriate steps to comply with it.

Because the dispute resolution process for payments will likely be expensive and time-consuming, the board should get a sense (or ensure that management has a sense) of the reimbursement rates that it will be willing to accept from insurers and what rates it will want to negotiate further. It might also be helpful to start discussing rates with common payers in the hospital's area. Subject to state law, the Act allows parties to agree on reimbursement, so the hospital may be able to avoid some difficult situations if it already has an idea of what a payer is willing to pay under the Act. Of course, to the extent that the hospital reaches a formal agreement about rates with a payer, the hospital may effectively be in-network with that payer, which means that the hospital may not have to worry about the surprise billing portions of the Act with respect to that payer.

Additionally, the board should review the consent process the hospital uses for non-emergency services. The board should ask management to ensure that the people responsible for obtaining patient consent are ready to obtain consent for out-of-network patients to be treated by a non-participating facility (i.e., the hospital). It is too soon to start working on the language of a consent form for this process, but once the Act's final regulations are published, the consent process will require close attention.

When the proposed rules that will implement the Act are published there will be a comment period. We recommend that boards review the regulations and utilize the comment process to make known any concerns or questions. It will be critical for board members to take the time to understand the rules and influence their development.

Conclusion

The Act is an attempt to address issues related to surprise billing, but the government must provide more guidance to enable affected parties to comply with the Act's requirements by January 1, 2022. For their part, providers, insurers, health plan sponsors, and others should continue to monitor activities related to the regulations and rollout of the Act. Among other things, interested parties will have an opportunity to submit comments to the proposed regulations following the publication of the Notice of Proposed Rule Making.

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