No Surprises Act Limits Out-of-Network Charges

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As part of the COVID-19 relief legislation passed at the end of 2020, Congress adopted the "No Surprises Act" which prohibits out-of-network providers from balance billing patients for charges above the rates paid by their health plan if the provider is providing emergency services or is providing non-emergency services at an in-network facility.

Exception - Written Notice

An exception applies if the out-of-network provider provides the patient with at least 72 hours advance written notice of the estimated cost and obtains the patient's written consent. The notice must be accompanied by a list of in-network providers available to perform the service at the facility. Out-of-network providers who fail to obtain the patient's written consent are prohibited from charging the patient any more than the in-network cost-sharing for the services. If the patient consents to receive the care from the out-of-network provider, the provider may balance bill the patient.

Disallowed Balance Billing Scenarios

Providers are not allowed to request the patient's consent to balance bill in three common scenarios:

1. The provider provides an ancillary service typically not selected by the patient, such as radiology, anesthesia, or hospitalist services.
2. There are no in-network providers available to provide the service at the facility.
3. The service is urgent or arises from unforeseen circumstances.

In these situations, the out-of-network provider may only bill the patient for in-network cost-sharing. The act also requires health plans to cover these services at in-network rates without prior authorization and apply in-network cost-sharing.

Advanced Estimate Required

Another important provision requires out-of-network providers to provide a patient's health plan (or the patient if he/she is uninsured) with a good faith estimate of all billing and service codes for all items and services expected to be provided. The advanced estimate must be provided prior to obtaining the patient's consent for the treatment. The act also requires health plans to provide beneficiaries with an Advanced Explanation of Benefits (AEOB) upon receipt of the out-of-network provider's estimate.

Timeline

The act's provisions are applicable on January 1, 2022 (with health plans and insurance policies required to comply

on the first day of the plan year on or after January 1, 2022). Regulations implementing the act are to be released by July 1, 2021.

Next Steps for Iowa Providers

We expect many of our clients will be impacted by the new requirements, particularly with regard to specialty services provided in rural hospitals or ancillary services provided by independent physician groups who may not always participate with the same payors as their facility partners. We recommend physicians, hospitals, and other facilities, such as ASCs, begin reviewing their payor relationships to determine when physician services will be out-of-network at an in-network facility. After identifying these situations, the parties should explore whether:

1. The patient consent process is allowed and if so, whether it is feasible considering the timing of such notices and the potential likelihood of patient consent.
2. The out-of-network physician group is agreeable to negotiating an in-network agreement with the impacted payors.
3. Any contracts between the physicians and facility can or should be revised to address the new law.

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