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Interim Final Rule on the No Surprises Act

On July 1st, 2021, the federal government released an interim final rule with a 60-day period for comments regarding the requirements related to surprise billing. This rule comes as the newest development of the No Surprises Act which instates protections against excessive cost to consumers and minimizes surprise billing overall. The final rule, entitled "Requirements Related to Surprise Billing, Part 1," acts as the initial point of implementation for the new rules created to stymie surprise billing in accordance with the goals of legislators, both nationally and at the state level. It is expected that this nationwide implementation of surprise billing rules will yield greater consistency and effectiveness across states.

APS has written a number of white papers in the past on surprise billing, both at the state and federal levels. Broadly speaking, the rules attempt to minimize surprise billing by requiring providers to give patients good-faith estimates up-front, enhance transparency by identifying out-of-network (OON) services, and giving patients as much information as possible to make informed decisions about who provides services and how much it will cost. The laws also identify various strategies for providers and insurers to resolve disputes without involving the patient if possible. That said, the variability from state to state in how this sort of legislation addresses the surprise billing concern yields a myriad of occasionally confusing consumer protections, compounded by the fact that states are limited in their ability to handle surprise billing issues that involve out-of-state providers. All of this has encouraged legislators to take action on the national level, which will hopefully yield a more consistent, predictable, and effective standard that meets the needs of all stakeholders involved.

The interim final rule with comment (IFC) focuses on protecting individuals from surprise bills resulting from emergency services, air ambulance services from OON providers, and non-emergency services from OON providers at in-network facilities. If a patient's insurance plan covers any benefits for emergency services, the IFC requires the services to be covered:

- Without prior authorization
- Regardless of if a provider is an in-network provider or an in-network facility
- Regardless of terms or conditions of the plan (except for the exclusion or coordination of benefits, or a permitted affiliation or waiting period)

The IFC also bans balance billing, limits cost sharing for OON services to in-network levels, and requires cost sharing to count toward in-network deductibles and out-of-pocket maximums. Generally, the OON rates are determined using an applicable All-Payer Model Agreement or an independent dispute resolution (IDR) entity. The departments in charge of the IFC plan to release the regulations regarding IDR entities and their process relatively soon.

The regulations described above generally apply to group health plans and health insurance issuers beginning on or after January 1st, 2022. Written comments from those who wish to weigh in on these new regulations must be received by 5pm, 60 days after display in the Federal Register to be considered.

APS will continue to monitor the progress of this legislation and publish more white papers on specific elements as necessary. We encourage you to stay informed and to reach out to your Practice Manager with any specific questions as to how this may affect your business.

Information provided by APS Medical Billing, July 2021