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Healthcare Alert

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Surprise billing restrictions effective January 2022

By Michele Masucci and Rebecca Simone[1]

The government released an interim final rule restricting surprise billing and balance billing to individuals participating in certain health plans—what does this mean for health care facilities and providers?

What's the Impact?

- The rule applies to individuals receiving health care coverage through employers, government marketplaces, or individual market health insurance providers
- Restrictions and bans for costs of certain services are explained in the rule and go into effect on or after January 1, 2022

The Biden-Harris administration, through the U.S. Departments of Health and Human Services, Labor, and Treasury and the Office of Personnel Management recently issued "Requirements Related to Surprise Billing; Part I," an interim final rule that restricts surprise billing and balance billing to participants, beneficiaries, or enrollees in group health plans or health insurance

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coverage offered by health insurance issuers.[2] The rule will take effect January 1, 2022, for facilities and health care providers. For group health plans and insurance issuers, the rule will take effect for plan years beginning on or after January 1, 2022. For carriers under the Federal Employees Health Benefits (FEHB) Program, the rule will take effect for contract years beginning on or after January 1, 2022.

What is surprise billing and balance billing?

Balance billing occurs, if permitted by state law,[3] when an out-of-network provider bills an individual for the remainder of what the individual's insurance does not pay. Surprise billing occurs when participants, enrollees, or beneficiaries receive an unexpected balance bill. Out-of-network providers and facilities usually charge higher amounts than the contracted rates in-network providers receive from plans and issuers. Balance billing by out-of-network providers leaves individuals with higher out-of-pocket costs than if they had been seen by in-network providers. Balance billing can occur for both emergency and non-emergency care. The rule provides protections to participants, enrollees, and beneficiaries by prohibiting surprise billing under certain circumstances.

Who does the interim final rule apply to?

The rule applies to individuals who receive coverage through employers (including federal, state, or local governments), federal and state marketplaces, or individual market health insurance providers. The rule will restrict surprise billing to individuals who receive emergency services and non-emergency services from out-of-network providers at in-network facilities and air ambulance services from out-of-network providers. Because Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, and TRICARE already prohibit balance billing, this rule does not apply to individuals who receive coverage through those programs.

How does the interim final rule limit surprise billing?

Bans surprise billing for emergency services

Surprise billing for emergency services occurs when participants, enrollees, and beneficiaries unknowingly get emergency care from out-of-network providers. This frequently occurs in emergency situations where individuals are usually taken to the nearest emergency department without regard to the individual's health plan network. Under the rule, emergency services must be treated as in-network services, regardless of where the services are provided, and without any pre-authorization requirements.

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[2] The interim final rule with comments can be found here.

[3] States that have balance-billing restrictions include Arizona, California, Colorado, Delaware, Indiana, Iowa, Maine, Massachusetts, Minnesota, Mississippi, Missouri, New Mexico, North Carolina, Pennsylvania, Rhode Island, Texas, Vermont, and Washington.

Bans excessive out-of-pocket costs by limiting cost-sharing for out-of-network services

Patient cost-sharing, such as co-insurance and deductibles, for out-of-network services are limited to in-network levels and must be based on in-network rates. These cost-sharing limitations apply to out-of-network emergency services, non-emergency services provided by out-of-network providers at certain in-network facilities, and air ambulance services provided by out-of-network providers.

Bans out-of-network costs for ancillary services

Ancillary services, such as anesthesiologist services, provided at in-network facilities must be billed at in-network rates.

Bans other out-of-network charges without advance notice to the patient

In order to permit the provider or facility to bill at an out-of-network rate, providers and facilities must provide participants, enrollees, and beneficiaries with a one-page consumer notice explaining that patient consent is required to receive care on an out-of-network basis. The notice must also outline any applicable state balance-billing restrictions and how the individual can contact appropriate state and federal agencies if the individual believes the provider or facility has violated any of the requirements outlined in the notice.

Our Health Care team will keep you apprised of legislative activity affecting health care facilities and providers. For more information on the content of this alert, please contact your Nixon Peabody attorney or:

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