Health Care Reform in Indian Country
Self-Governance Communication & Education
Self-Governance Tribes Striving Towards Excellence in Health Care

Tribal Guidance on the No Surprises Act
April 27, 2022

This issue brief from the IHS Tribal Self-Governance Advisory Committee seeks to provide guidance to Tribes and Tribal organizations on those provisions of the No Surprises Act that may be applicable to Tribal providers and facilities.[1]

The No Surprises Act was enacted as part of the Consolidated Appropriations Act of 2021. The Act, which went into effect on January 1, 2022, works to protect consumers from surprise billing, also known as balance billing. On January 1, 2022, interim final rules (referred to as the Surprise Billing Rules) took effect that were issued jointly by the Centers for Medicare & Medicaid Services (CMS), Internal Revenue Service, and the Department of Labor to implement the Act. Future rulemaking will address enforcement of the Surprise Billing Rules, including the imposition of civil and monetary penalties.

The Surprise Billing Rules contain balance billing protections related to emergency services, post-stabilization services, and services received at facilities considered in-network by a person's private insurance. The Surprise Billing Rules also impose requirements for providers and facilities during the treatment of uninsured or "self-pay" individuals. Some states previously enacted restrictions on balance billing, but the No Surprises Act creates new restrictions at the Federal level.[2]

Background

Surprise billing often occurs when a consumer is charged beyond the amount that health insurance has paid for services. An example of this is when an out-of-network facility or provider collects payment from an insurance company and charges the remainder that was unpaid to the patient.

Surprise billing most often occurs in emergency situations, where patients have very little choice as to whether the provider they see or the emergency department they visit is in-network or not. While patients seeking non-emergent care often have the ability to choose their facility and the primary provider who furnishes the services, they may not have a choice regarding other providers who are not the primary care provider. Under the No Surprises Act, balance billing is strictly prohibited for emergency services and for post-stabilization services at emergency facilities.

The No Surprises Act also outlines specific guidelines on how facilities and providers should provide transparency regarding the cost of services for those who are uninsured or "self-pay."[3]

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[1] This brief is for informational purposes only and is not intended as legal advice. For questions on this brief, please contact Cyndi Ferguson, ACA Project Lead at cyndif@senseinc.com

[2] "The No Surprises Act's Prohibitions on Balance Billing." Centers for Medicare and Medicaid Services, 2022, https://www.cms.gov/files/document/a274577-1a-training-1-balancing-billingfinal508.pdf.

[3] "Requirements Related to Surprise Billing; Part I." edited by Internal Revenue Service Personnel Management Office, Employee Benefits Security Administration, Health and Human Services Department, 7/13/2021. https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i#h-.

Applicability to Tribal Providers and Facilities

The No Surprises Act and the Surprise Billing Rules apply to "emergency departments of hospitals and independent freestanding emergency departments, health care providers and facilities, and providers of air ambulance services." There is no exemption for Tribal providers and facilities. As a result, the rules apply to Tribal health care providers. As discussed below, however, some of the requirements do not apply to individuals with federal forms of health care coverage, like IHS, Medicare, Medicaid or VA.

Balance Billing Prohibitions

The Surprise Billing Rules prohibit balance billing for emergency services, and they also prohibit balance billing without informed consent for post-stabilization services at emergency facilities and for non-emergency services provided by nonparticipating providers at a participating facility. Balance billing is when the patient is charged the difference between what the insurance would normally cover for in-network services and the amount insurance pays for out-of-network services.

As a general rule, Tribal health providers do not charge IHS beneficiaries for the services they provide. As a result, they generally accept the reimbursement from any insurance plan their IHS beneficiaries have and do not balance bill those patients for amounts not covered by insurance. However, Title V Self-Governance Tribes have the option to charge IHS beneficiaries for the services they provide. If they elect to do so, the balance billing requirements of the No Surprise Billing rules would apply.

Title I and Title V Tribes may also elect to provide services to non-IHS-beneficiaries, provided that those individuals cover the cost of the care that they receive. If those IHS beneficiaries are enrolled in third-party insurance for which the Tribal provider or facility is out-of-network, then the Surprise Billing Rules would apply to prevent balance billing the individual.

Inquiry and Disclosure Requirements

There are two components of the Surprise Billing Rules with which all providers and facilities must comply: first, when scheduling an individual for an appointment, all providers and facilities must inquire as to whether the individual has health coverage; and, second, all providers and facilities must comply with the disclosure requirements set forth in the Surprise Billing Rules.

All providers and facilities (including Tribal) are required to publicly disclose information about balance billing protections on their website (if they have one), on a sign posted in a prominent location at their facility, and in a one-page handout to individuals. The disclosures must include a statement explaining the requirements of the provider or facility under the No Surprises Act, contact information for the relevant state and federal agencies, and if applicable, any state laws relating to balance billing.

Additionally, all providers must inquire as to whether an individual has health coverage when scheduling an appointment. If the individual is considered uninsured or self-pay under the rules, then certain requirements apply regarding the availability of good faith estimates of the cost of care.

Uninsured and Self-pay Protections

One of the primary objectives of the No Surprises Act is to provide uninsured or self-pay individuals with the ability to receive good faith estimates for non-emergency services so that they can understand the cost of their care and make informed choices when selecting a provider.[4] As discussed above, providers and facilities must inquire as to a person's health coverage when scheduling appointments. For patients who are uninsured or self-pay, the provider must: (1) inform them of the ability to request a good faith estimate; and (2) if requested, provide such estimate in accordance with the requirements and timeframes established in the rules.

The good faith estimate requirements do not apply if an individual is enrolled in a Federal health care program (IHS, Medicare, Medicaid, Veterans Affairs, or TRICARE). As a result, these requirements would not apply to IHS beneficiaries, and they also do not apply to any non-beneficiaries who are enrolled in Medicare, Medicaid or coverage through the VA. They also do not apply if the individual has a private form of insurance and bills that insurance. They only apply where the individual either has no form of coverage (is uninsured) or has private insurance coverage but elects not to use it (self-pay).

Individuals for whom the additional protections apply must be informed about requesting good faith estimates on the provider's website, by an on-site notice where scheduling occurs, and orally at the time of scheduling. If a Tribal health program treats non-IHS-beneficiaries who are not enrolled in another federal health program and who either do not have or do not choose to bill private insurance, then the provider must provide a good faith estimate in accordance with the Surprise Billing Rules.

The following chart provides a summary of the good faith estimate timelines:

<table>
<tr><td colspan="4">When do I need to provide a good faith estimate?[5]</td></tr>
<tr><td rowspan="3">IF….</td><td>It is at least 3 business days before the scheduled date of service…</td><td rowspan="3">THEN you must provide the good faith estimate by…</td><td>No later than 1 business day after date of scheduling</td></tr>
<tr><td>It is at least 10 business days prior to the scheduled date of service…</td><td>No later than 3 business days after date of scheduling</td></tr>
<tr><td>A service is unscheduled but an individual requests a good faith estimate…</td><td>No later than 3 business days</td></tr>
</table>

It is crucial for Tribal providers and facilities to ensure compliance with the requirement to document both the time and date the notice is provided and the time and date that consent is given. These forms must be kept on file for at least 7 years from the date of service.

[4] "No Surprises Act Implementation: What to Expect in 2022." 2021, 2022, https://www.kff.org/health-reform/issue-brief/no-surprises-act-implementation-what-to-expect-in-2022/#:~:text=The%20No%20Surprises%20Act%20(NSA,providers%20they%20did%20not%20choose.

[5] *Requirements Related to Surprise Billing; Part II*, 86 Fed. Reg. 55986-55987, 56135-56136

Next steps for Tribal health programs to comply with the Surprise Billing Rules

All Tribal health programs must implement the following actions:

1. Establish procedures for inquiring as to health coverage when scheduling appointments.
2. Update websites and signage to provide required notices of balance billing protections.

Additional steps that Tribal health programs that bill third-party insurance should take include, but are not limited to:

- Developing a balance billing disclosure one-pager, notice and consent forms, and forms for notifying plans or issuers;
- Updating billing policies and manuals to prevent unauthorized balance billing;
- Updating record retention policies to ensure retention of notice and consent forms; and
- Training providers and staff regarding the new balance billing requirements.

Additional steps to take for Tribal health programs that treat individuals who are not IHS beneficiaries or enrolled in other Federal health programs include, but are not limited to:

- Updating websites to provide information regarding the availability of good faith estimates for uninsured/self-pay individuals;
- Developing forms for notifying uninsured/self-pay individuals on-site about the availability of good faith estimates;
- Establishing procedures for providing good faith estimates within required timelines; and
- Training providers and staff regarding uninsured/self-pay requirements.