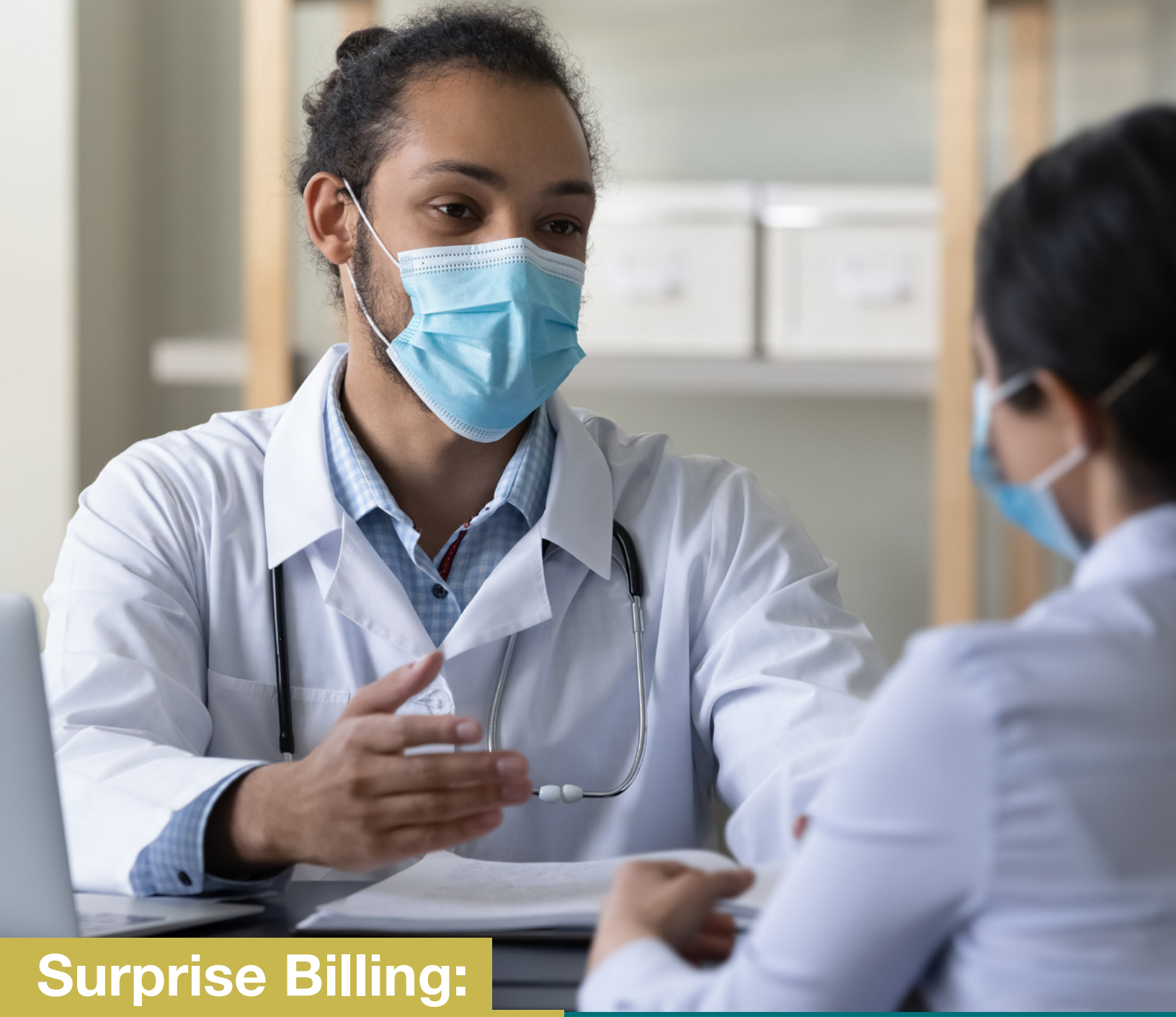

Surprise Billing: An Overview of the Federal No Surprises Act

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Introduction

In December 2020, Congress passed the No Surprises Act (NSA), which was part of the Consolidated Appropriations Act of 2021. The provisions in the NSA were intended to protect patients from unexpected medical bills incurred as a result of potentially confusing in-network/out-of-network relationships between physicians, healthcare facilities, and insurance plans. Specifically, the NSA was enacted to prevent patients from receiving "surprise bills" for services received from physicians or other healthcare professionals who are not part of the patient's insurance plan provider network. Many of the provisions of the NSA became effective Jan. 1, 2022.

The NSA is a federal law, and protects most patients with private health insurance. It applies to patients who are insured through employer-sponsored group health plans (those generally regulated by ERISA are exempt from state-level insurance regulations) and individual plans purchased through the health insurance exchanges or on the individual market. The Act does not apply to Medicare and Medicaid, which already have protections against surprise billing.

What Physicians Need to Do Now

DON'T bill insured patients if you provide care as an out-of-network physician at an in-network healthcare facility, and do not collect cost-sharing amounts from the patient that are more than the in-network amount. *Physicians must have prior written consent from the patient to receive out-of-network services and be balance billed in order to collect additional payments directly from patients.*

DO provide information to patients about their rights under the No Surprises Act. Healthcare facilities and physicians who may provide out-of-network care at healthcare facilities must make readily available in clear notice an outline of patient protections against surprise billing. The information must be posted publicly and provided to patients as appropriate.

DO confirm at the time a service is scheduled whether the patient will be using insurance or plans to self-pay. If the patient indicates self-pay, you will need to provide a Good Faith Estimate for the services.

What Is a Surprise Bill?

The concept of surprise billing is different from balance billing, and different from billing a patient who knowingly seeks care from a physician or healthcare professional who does not participate in the patient's health plan network. Surprise bills happen when a patient receives care at a hospital or other facility that is in their insurance network, and subsequently receives a bill from an out-of-network physician or clinician who provided services during the patient's visit to the facility.

Patients generally understand that they can maximize the benefits of their health insurance coverage by seeking care from physicians and facilities that are in their health plan network. Surprise bills happen for reasons outside the patient's control. Once patients present at an in-network healthcare facility, they often have no way of knowing exactly who might be involved in their care, and it is not always possible for patients to receive care only from physicians who participate in their insurance network.

In-Network or Out-of-Network

An "in-network" physician, health professional or healthcare facility has contracted with a health insurance plan to provide services to plan enrollees at a certain reimbursement rate. A combination of patient cost-sharing (as determined by the terms of coverage) and reimbursement from the health insurer are accepted as final payment by the healthcare provider. There are no such contracts between health insurers and out-of-network healthcare professionals, and while plan enrollees may have partial coverage for out-of-network services, the reimbursement paid by the insurer may not reflect the charges.

In some cases, such as a patient specifically choosing or consenting to receive out-of-network services, the patient expects to be responsible for any difference between the insurance reimbursement amount and the charged amount. In other cases, however, if a patient has tried to select in-network care, and through no fault of their own receives services from out-of-network physicians, any bill beyond the expected co-pay or cost-sharing amount is a "surprise," and could cause significant stress and financial hardship for the patient.

No Surprises Act

Surprise bills create tension between patients, healthcare professionals, facilities and insurance companies about how services should be reimbursed and by whom. The intent of the federal No Surprises Act is to take patients out of the equation, since they have no way of knowing that they would receive care from healthcare professionals who are out-of-network at an in-network facility.

The No Surprises Act **protects patients who have health insurance by preventing health insurers and healthcare professionals from charging patients more for unexpected out-of-network services when patients choose care at an in-network facility.** This applies to emergency services that are provided out-of-network (including air ambulance services), as well as non-emergency services provided by out-of-network health professionals at an in-network hospital or ambulatory service center. Unless a patient has specifically consented to receive care from an out-of-network professional and agreed to be balanced billed, **patients may not be balance billed, and are only responsible for cost sharing amounts they would incur if the services had been provided in-network**.

The provisions in the law were developed with stakeholder input, including from physicians, hospitals, patient groups and the insurance industry, and the language that passed is the product of extensive negotiations between and among these stakeholders. From the beginning, however, there was widespread agreement among all parties that patients should not be financially responsible for reimbursement disputes between health insurers and healthcare professionals.

How Do Out-of-Network Physicians Get Paid?

Once a patient's cost-sharing obligations are met, if out-of-network physicians and insurance companies cannot agree on a reimbursement amount, the No Surprises Act outlines an independent dispute resolution (IDR) process that out-of-network healthcare professionals and insurers must follow to reach an agreeable rate. The provisions of the law were carefully negotiated to minimize the advantage either party might have in negotiating an equitable settlement. However, the regulatory guidance issued by the Administration on Oct. 7, 2021, seriously misinterpret the intent of the law, and, if implemented, would significantly favor rates set by insurance companies. Several state and national medical societies have joined with the American Medical Association (AMA) in expressing strong objection to the rules and have joined an amicus brief supporting the lawsuit initiated by the AMA and the American Hospital Association to halt implementation of the rules.

To further minimize the risk of patients receiving unexpected medical bills, the law also provides for increased transparency regarding network status and the protections available to patients against surprise bills. The Centers for Medicare and Medicaid Services (CMS) has developed model disclosure language that can be used to alert

patients of the protections under the NSA. *Note that individual physicians are only required to provide disclosure language if they treat patients at a facility (i.e., hospital or ambulatory surgical center) or in conjunction with a visit to a facility. Physicians do not need to provide a separate disclosure if one is already provided by the facility. Disclosure statements about the NSA are not required for services unrelated to a facility visit*.

Another Way To Prevent Surprises – Good Faith Estimates

The NSA also protects patients by requiring a "good faith estimate" (GFE) for scheduled medical services. Although the law requires that all patients be provided with a GFE, this requirement is being phased in, so, as of Jan. 1, 2022, only **uninsured patients, or those who choose to "self pay" must receive a written GFE.** This requirement applies to services provided in conjunction with a healthcare facility ***as well as*** office-based services. That means **all physicians, regardless of their specialty or practice setting, are expected to provide a GFE to patients who schedule services in advance and indicate they will not be using insurance**.

Although the GFE is understood to be an estimate, patients may dispute final charges if they exceed the amount of the GFE by $400 or more. Additional information about GFEs, including a standard form that may be used, is available in documents provided by CMS.

Who gets a GFE and what should be included

Beginning Jan. 1, 2022, practices and facilities should ask patients at the time of scheduling a service or procedure if they have health insurance coverage, and whether they plan to submit a claim to a third-party insurer. If the patient indicates that they will be paying out-of-pocket for the service, and the service is scheduled at least three days in advance, the patient must be offered a good faith estimate of charges for the planned service. The information must include expected charges for the primary item or service, as well as any other items or services that would reasonably be expected.

As noted GFEs will ultimately need to be provided for all patients, and estimates that involve services provided by multiple healthcare professionals (for example, a surgery rather than an office visit) will need to be incorporated into a single GFE. In this case, the entity "convening" the service (e.g., the hospital) will be responsible for assembling the estimates for the total cost of care, by gathering individual cost estimates from individual healthcare professionals. The process of providing GFEs that involve multiple healthcare professionals has not been defined at this point, so physicians are only responsible for preparing GFEs for their own portion of services rendered.

Some States Already Address Surprise Billing

A small portion of health insurance plans are regulated directly at the state level. These are generally plans purchased by individuals in the individual health insurance market, or through a healthcare marketplace established by the Affordable Care Act. Several states already have laws and regulations to help protect patients against surprise medical bills. To the extent that state laws already apply to policies issued in a particular state, the NSA does not supersede current state law, but is intended to work in a complementary fashion to ensure broad protections under all insurance plans. The provisions of the NSA apply to plans (notably employer-sponsored health insurance plans) and in situations in which state law did not already apply.

States that have surprise billing laws on the books have unique implementation challenges that will need to be addressed directly by regulators at the state level. As noted, most employer-sponsored health plans are not subject to state-level regulation, so the overlap between state and federal insurance regulations is relatively small. However, it is important that you confirm whether there are any laws in your state that address surprise billing or any of the provisions raised in the NSA, and work with your state medical society or regulatory agency to understand how the state and federal laws work together.

Final Thoughts

Even though the new rules are in place and certain parts of the NSA took effect January 1, implementation details of are still being negotiated, including the interaction between the state and federal law. However, physicians should keep in mind the three operational changes that they should be incorporating now:

1. Do not balance bill patients for out-of-network charges if you provided care to that patient at a facility that was in their insurance network.

2. If you do not contract with a facility where you provide care, clearly and publicly disclose to patients their rights under the federal No Surprises Act.

3. Establish a process for providing good faith estimates to any patient scheduling a healthcare service in advance if that patient does not have health insurance or does not plan to submit a claim to an insurer.

For Additional Information

The provisions in the No Surprises Act are complex, and implementation rules and regulations continue to evolve. This Issue Brief provides a high-level overview of the new law, but practices may want to familiarize themselves with more information to better understand their obligations.

The Centers for Medicare and Medicaid Services and the American Medical Association have comprehensive resources that provide more detailed information about the law, regulations and how physicians should be responding to the new law.

Contact us by email with questions.

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