The No Surprises Act: What You Need to Know Now

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Surprise medical bills are a major concern for patients. Visits to the emergency room, and services provided by physicians who are not in the patient's insurance network, have caused patients to incur thousands, and sometimes hundreds of thousands of dollars in medical debt. The No Surprises Act, approved in late 2020 as part of the Consolidated Appropriations Act, is intended to protect patients against surprise medical bills when they receive emergency care or scheduled treatment from doctors and hospitals that are not in their insurance networks. Under the No Surprises Act, consumers are responsible only for their in-network cost-sharing.

Unfortunately, the law is extremely burdensome for providers. Many providers don't understand the depth of their responsibility in complying with the law. The following summary is intended to shed some light on the steps providers must take to comply with the new regulations.

SUMMARY

The No Surprises Act went into effect January 1, 2022 and is designed to protect patients against certain provider balance billing and facilitate a better understanding of the cost of medical services. The regulation has two major components:

Regulations protecting patients from surprise medical bills

- Protects patients who are enrollees in group health plans and group and individual health insurance coverage and receive emergency services, non-emergency services from out-of-network (OON) providers at in-network facilities, and air ambulance services
- Prohibits providers and facilities from directly billing individuals for the difference between the amount they charge and the amount that the individual's plan or coverage will pay plus the individual's cost-sharing amounts (i.e., balance billing)
- With the exception of ancillary providers, certain OON providers at in-network facilities may be eligible to provide notice and receive consent (aka **Notice and Consent**) from the patient to balance bill for their services
- Providers must provide proper public disclosure of patient balance billing protections in their offices and on their website (see Disclosures in Resources)
- These requirements do not apply to beneficiaries or enrollees in federal programs such as Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE

Federal patient transparency protections

- Intended to provide patients with a better understanding of the cost of care, provider networks, and health plan cost sharing amounts
- **ALL** providers must provide self-pay patients (uninsured patients and patients who have insurance but request not to have a claim filed with their insurance) a **Good Faith Estimate (GFE)** upon scheduling care or on request
- Creates a patient-provider dispute resolution process for uninsured (or self-pay) individuals to contest charges that are "substantially in excess" of the good faith estimate
- Limits billed amounts in situations where a provider's network status changes mid-treatment or individuals act on inaccurate provider directory information

KEY COMPONENTS OF THE LAW

Notice and Consent. Except in emergency situations, non-ancillary out-of-network providers may balance bill patients only when notice and consent timing and disclosure requirements are met. The standard notice and consent documents must be given before the service is rendered and be physically separate from and not attached to or incorporated into any other documents. CMS has provided **Standard Notice and Consent Document** for use by providers, which must include a "Good Faith Estimate" (GFE) of each item or service. If a patient schedules an appointment at least 72 hours prior to the date of service, the Notice and Consent documents must be presented at least 72 hours prior to the date the services will be provided. If the appointment is scheduled less than 72 hours prior to the date of service, the documents must be provided on the day of the appointment. In this situation, the documents must be provided no later than 3 hours prior to the relevant services being delivered.

Independent Dispute Resolution (IDR). OON providers and health plans are left to determine the amounts due to the provider for OON services based on the "qualifying payment amount." The qualifying payment amount, or "QPA," is the health plan or issuer's median contracted rate recognized by the plan on January 31, 2019, for the same or similar item or service in the same geographic region, adjusted for inflation. To facilitate this process, Congress established an IDR which may be initiated if a payment arrangement cannot be agreed upon.

Good Faith Estimate (GFE). The GFE is intended to provide transparency regarding the cost of services to enable patients to compare prices across providers. The estimate should reflect the cash price for services and the total cost of expected care furnished by the provider during a "period of care" (defined as the day or multiple days in which the primary service is performed including other additional services that will likely be furnished in conjunction with the primary item or service.) The GFE must also include an itemized list and description of expected services, diagnosis codes, services codes and associated anticipated charges. If the patient service is scheduled more than 10 days in advance, the provider must provide the GFE within 3 business days. If the item or service is scheduled at least 3 business days in advance, the GFE must be provided within 1 business day. If the billed amount is ultimately at least $400 above the GFE, the patient is eligible to start the patient-provider dispute resolution process. Refer to the resource section for links outlining the dispute process.

State Laws: Prior to the No Surprises Act, many states had enacted laws related to the practice of balance billing. It is important to understand whether your state has more protective laws than the No Surprises Act.

Need Assistance? For more information, see the government's resource page at the following link: https://www.cms.gov/nosurprises/policies-and-resources/provider-requirements-and-resources. With so many nuances involved with this issue, consider consulting with your attorney about the No Surprises Act. SVMIC also has experts to assist with your questions. Contact us at ContactSVMIC@svmic.com or 800.342.2239.

RESOURCES

Requirements Related to Surprise Billing: Qualifying Payment Amount, Standard Notice and Consent, Disclosure on Patient Protections Against Balance Billing, and State Law Opt-in: https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780

Independent Dispute Resolution: https://www.cms.gov/nosurprises/help-resolve-payment-disputes/payment-disputes-between-providers-and-health-plans

Good Faith Estimate: https://www.cms.gov/files/document/good-faith-estimate-example.pdf

Patient Provider Disputes: https://www.cms.gov/nosurprises/consumers/medical-bill-disagreements-if-you-are-uninsured; https://www.cms.gov/nosurprises/providers-payment-resolution-with-patients

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