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The No Surprises Act: Practical implications for health and mental health professionals

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What You Need to Know

- the No Surprises Act is designed to protect patients from receiving surprise medical bills, particularly out-of-care network costs.
- One of the key provisions of the new law is that a good faith estimate must be given regarding the expected charges for services and items offered to uninsured and self-pay clients.

- The Act dictates that the arbiter chooses the offer closest to the median in network rate, unless there is additional information that shows that the in-network rate is inappropriate.

As its name implies, the No Surprises Act, effective January 1, 2022, is designed to protect patients from receiving surprise medical bills, particularly out-of-care network costs. While aiming for transparency, the new law will necessitate health and mental health professionals to adjust their claims processing, notice procedures, and administration processes. According to a recent *National Law Review* article, "[B]ills are often a surprise because the patient either was not able to choose whether to use an in-network or out-of-network facility or provider, or was not aware that the provider was out-of-network until after the services were rendered." Emergency services must be provided, whether in- or out-of- network, unless there are established exclusions or coordination of benefits.

Good Faith Estimate

One of the key provisions of the new law is that a good faith estimate must be given regarding the expected charges for services and items offered to uninsured and self-pay clients. The Department of Health and Human Services (DHHS) defines "good faith estimate" as "a notification of expected charges for a scheduled or requested item or service, including items or services that are reasonably expected to be provided in conjunction with such scheduled or requested item or service" (45 CFR § 149.610(a)(2)(vi). These good faith estimates are considered to be a part of the client's record and providers "must provide a copy of any previously issued good faith estimate furnished

within the last 6 years to an uninsured (or self-pay) individual upon the request of the uninsured (or self-pay) individual (45 C.F.R. §149.610(f)(1))."

Right to Dispute

Pursuant to Section 2799B-7 of the Public Health Service Act and its implementing regulations, DHHS must establish a patient-provider dispute resolution process. The purpose of the Selected Dispute Resolution (SDR) process is to resolve payment disputes between individuals who:

1. Are not enrolled in a group health plan, or group or individual health insurance coverage, or
2. Are presenting through a federal health care program, or a Federal Employees Health Benefits (FEHB) program health benefits plan (uninsured individuals), or
3. Do not intend to file a claim with their group health plan, health insurance coverage, or FEHB health benefits plan (self-pay individuals), and health care provider, facility, or provider of air ambulance services by determining the amount such individual must pay to their health care provider, facility, or provider of air ambulance services.

Practical *I*mplications

Based on the No Surprises Act, providers should:

1. Provide a one-page explanation of what the No Surprises Act means for the patient, particularly as to the patient's right to dispute charges.
2. Help patients understand that patients have the right to contest balance billing for out-of-network providers.
3. Obtain written waiver of the patient's rights under the Act:

If a provider seeks to have a patient waive the No Surprises Act's protections, the provider has to give the patient a detailed written

consent form at least 72 hours prior to a scheduled appointment, or 3 hours before a same-day appointment. More details about the required consent are forthcoming, but the existing regulations require that the consent form be provided to the patient separate from other forms, and indicate: (1) whether pre-authorization is required; (2) what in-network providers are available; and (3) the good-faith cost estimate for the total bills for the proposed out-of-network care.

Importantly, patients should not be asked to waive their right to balance billing if faced with the need for emergency services or if faced with the need for collateral but non-emergency services, including anesthesia or radiology. What if the patient is not cognitive, or so sick they cannot focus on reading? If the patient refuses to consent to services (and the estimated costs of those services), a provider might decline to offer services. One of the purposes of the Act is to try to avoid having an out of network provider engage in "balance billing." Exactly what is balance billing? Balance billing occurs when a provider bills the patient for the differential between "the provider's fees and the portion of those fees that insurance pays. Balance billing is not allowed for people insured by Medicare and Medicaid, but until the No Surprises Act, nothing prohibited it in private insurance." Providers must provide patients with notice of which services were the subject of the No Surprises Act rules, provided that the consumer may still need to figure out how to contest bills, and to hold their provider and insurance company accountable. If an initial appeal is unsuccessful, then there is a procedure for an appeal through a third party. Information on the third-party process may be obtained by contacting the No Surprises Help Desk at 800-985-3059.

Median Rate vs. Arbitration Process

The provider must submit a bill to the health insurance plan pursuant to the patient's status. The insurer must respond to the provider with their in-network cost sharing within 30 days, based on their network average (median) network reimbursement rate. Should the parties disagree as to a fair rate for the services rendered, that will trigger a federal arbitration process.

The No Surprises Act dictates that the arbiter chooses the offer closest to the median in network rate, unless there is additional information that shows that the in-network rate is inappropriate. Many provider groups — including the American Hospital Association and American Medical Association — are engaged in litigation with the government, contending in part that the "median in-network rate goes against Congress' intent in passing the law by disregarding other factors that should be considered."

Will the No Surprises Act survive judicial scrutiny? That remains to be seen. In the interim, hospitals, insurance companies, mental health providers, and patients must scurry to be compliant.

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