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Don't Let the 'No Surprises Act' Catch You by Surprise

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As of January 1, 2022, certain provisions of the "Consolidated Appropriations Act," commonly referred to as the "No Surprises Act" (Act), are in effect. The Act amends the Public Health Service Act, Employee Retirement Income Security Act, the Internal Revenue Code, and the law governing the Federal Employees Health Benefits Program.

There are two main components to the Act, commonly referred to as the "balance-billing" provisions and the "good-faith estimate" provisions.

Balance-Billing

When is the Balance-Billing Provision Applicable? This portion of the Act applies when an individual receives emergency care, or non-emergency care from an out-of-network provider at in-network facility.

What is Required? Patients who receive out-of-network emergency services, or services from out-of-network providers at in-network facilities, generally only will have to pay the amount they would have paid if the services were provided by an in-network provider. This is commonly referred to as a "balance-billing" prohibition, as the patient is not required to pay the difference between what is paid by the patient's insurance and the out-of-network rates. There are limited exceptions to the balance-billing prohibition if the patient provides informed consent to receive the out-of-network services. There is no balance-billing allowed for emergency services.

Providers must deliver a notice (before requesting payment from the patient), in plain language, stating:

- The balance-billing restrictions;
- If there are any state balance-billing restrictions that apply; and
- How to contact relevant agencies if the patient believes he or she was billed in violation of the Act.

The provider also must place the notice on its website (in a searchable format) and prominently display it where patient scheduling occurs and other locations where patients may ask questions about their bills or costs of service. The notice must be made available in accessible formats in compliance with nondiscrimination laws as set forth by the Department of Health and Human Services for similar documentation.

What is the "Arbitration Provision"? If the payment that an out-of-network provider receives for services as a result of the balance-billing provision is unsatisfactory to the provider, the provider and insurer may negotiate an agreed payment amount. If the parties cannot agree after negotiating for thirty days, they can submit to an arbitrator who will decide a reasonable payment based on a review of several factors and considerations.

Good-Faith Estimates

When is the Good-Faith Estimate Applicable? Unlike the balance-billing provisions, the good-faith estimate (GFE) component of the Act applies to "health care providers" and "health care facilities," which includes physician in private practice. Providers are required to provide a GFE to patients who: (i)

have no insurance (including patients who have NO coverage for out-of-network provider services and the provider is out-of-network); or (ii) are choosing not to bill their insurance for services that otherwise would be covered.

What is Required? All patients who fit into one of the above categories must be informed orally of the availability of a GFE when the scheduling of an item or service occurs, or when questions about the cost of items or services arise. Additionally, providers must prominently display a notice on their website (in a searchable format), in their office(s), and on-site where scheduling or questions about the cost of items or services occur. The notice must be made available in accessible formats in compliance with nondiscrimination laws as set forth by the Department of Health and Human Services for similar documentation.

What Must be Included in a GFE? The GFE notice must include the following information:

- Name and birthdate of uninsured
- Description of the primary item or service in clear and understandable language (and if applicable, the date the primary item or service is scheduled)
- Itemized list of items and services reasonably expected to be furnished for the primary item or service, and items or services reasonably expected to be furnished in conjunction with the primary item or service for the period of care
- Service codes, diagnosis codes, and expected charges
- Name of providers and facilities and location
- NPI number and Tax-ID number
- List of items and services requiring separate scheduling
- Disclaimers stating that:
    - the GFE only is an estimate and subject to change
    - there may be additional items and services not in the GFE
    - the right to initiate the patient-provider dispute resolution process
    - the GFE is not a contract

When and How Must the GFE be Provided? The GFE must be provided within three (3) business days upon patient request. Information regarding scheduled items and services must be furnished within one (1) business day of scheduling an item or service to be provided within at least three (3) business days; and within three (3) business days of scheduling an item or service to be provided within at least ten (10) business days. The GFE must be provided in a written format (electronically or in paper format). If the patient requests one of these options, then that is how it should be sent. Any electronic transmission must be capable of being printed and saved by the patient on their end. If a patient requests verbal transmission of a GFE, the provider still must provide a written version. The GFE must be saved as part of the patient's medical record. It is important to note that the GFE can be updated whenever new information or pricing becomes available that could impact the estimate provided.

In the future, the Act is expected to require GFE notices to insured patients. Additionally, as of January 1, 2023, CMS will begin enforcement of GFE notices that include information from co-providers. This is a situation where additional provider(s) will provide services related to the primary service.

The attorneys at Roetzel can assist you in determine whether and to what extent the Act applies to your practice and how it is impacted by Illinois' balance-billing law. Please contact one of our firm's healthcare attorneys for more information.

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