

# What Physicians Need to Know About the No Surprises Act

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A new law enacted in late 2020 to protect consumers from unexpected medical bills took effect on January 1, 2022, and may require immediate action. The federal No Surprises Act is aimed at reducing “surprise bills” to patients in the context of services provided at hospitals and ambulatory surgical centers, and includes requirements for healthcare facilities as well as physicians providing services at such facilities.

Generally, a “surprise bill” is one that the patient receives for services from a provider who the patient was not aware was out-of-network with their insurer. Surprise bills often occur with emergency services or with non-emergency services received from nonparticipating providers at in-network facilities, such as out-of-network anesthesiologists at an in-network hospital.

The Act and its implementing regulations prohibit certain balance billing practices by out-of-network providers and mandate a set of disclosures with respect to health care services provided at hospitals and ambulatory surgical centers. The Act also contains notice requirements for health insurers and establishes an arbitration process for out-of-network services in this context.

For physicians, the key elements of the Act are the limitations on balance billing for emergency services; the notice and consent requirements for balance billing for out-of-network non-emergency services in an in-network facility; and the required good faith cost estimates that must be provided to uninsured or self-pay patients. Physicians should also be familiar with the dispute resolution process which applies to payments for out-of-network claims subject to the Act’s limitations.

Three Interim Final Rules have been published in the Federal Register interpreting and implementing the Act using a process that bypasses the usual advance notice and comment requirements for federal regulations. Accordingly, additional changes may be adopted in the future in response to health industry and consumer advocate comments and other input after the Act takes effect.

### **The Act prohibits:**

- Surprise billing for emergency services. Emergency services, regardless of where they are provided, must be treated on an in-network basis without requirements for prior authorization.

- Out-of-network charges for ancillary care (such as from an anesthesiologist or pathologist) at an in-network facility in all circumstances.
- Out-of-network charges for surgeons and other non-ancillary professional services without advance notice to and consent of the patient.
- Out-of-network cost-sharing for emergency services, and for non-emergency services in this context without the patient’s advance consent. Patient cost-sharing, such as co-insurance or a deductible, cannot be higher than if such services were provided by an in-network provider, and any coinsurance or deductible must be based on in-network provider rates.

### **The Act mandates a plain-language consumer notice regarding:**

- The restrictions on balance billing for such services under the Act.
- Any state law balance billing protections that may apply.

- How to contact relevant state and federal agencies if a patient believes that the provider has violated any of the restrictions.

This notice must be given to the patient no later than the date and time on which the provider requests payment from the individual (including cost-sharing amounts). The notice must also be published on an easily searchable part of the provider's website and prominently displayed on-site at the provider's location where scheduling or questions about the cost of items or services occur. Sample notices are posted at [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises).

## Disclosure and Consent to Out-of-Network Rates

The Act permits certain out-of-network physicians to bill a patient and the patient's insurance plan at the full out-of-network rate for services provided at an in-network facility, but only if the physician provides a separate disclosure to the patient and obtains the patient's written consent at least 72-hours prior to their appointment. Otherwise, balance billing for that service is prohibited.

Such notice and consent requirements are met if the patient is provided written notice and consent 72 hours in advance of appointment, must include a good faith estimate of the costs of the services and a list of in-network providers at the facility and information regarding medical care management, such as prior authorization.

The disclosure and consent exception for out-of-network billing described above does not apply to

emergency medicine, anesthesiology, pathology, radiology, neonatology, diagnostic testing, or services provided by assistant surgeons, hospitalists and intensivists, which cannot be provided at higher out-of-network rates and for which a patient cannot be asked to give consent.

The Secretary of HHS may apply civil monetary penalties of up to \$10,000 for failure to comply. Hardship exemptions or penalty waivers may be available for providers and facilities that did not knowingly violate the Act.

## Good Faith Estimates

The Act requires providers to give a good faith estimate of the expected charges for non-emergency services to any uninsured (or self-pay) patient within certain timeframes following the scheduling of that service.

The estimate must contain certain information as detailed by the Act. These estimates must generally be provided no later than 3 business days after scheduling the service if the appointment was made at least ten days in advance; not later than three business days after the patient requested an estimate, and if the service is scheduled at least three business days before the appointment date (but less than 10 business days), no later than one business day after the date of scheduling. Guidance and templates are posted at [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises). The estimate must contain:

- The patient's name and date of birth;
- A description of the primary item or service being furnished to the

patient (and if applicable, the date the primary item or service is scheduled);

- An itemized list of items or services that are 'reasonably expected' to be furnished;
- Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service;
- The name, National Provider Identifier, and Tax Identification Number (TIN) of each provider or facility represented in the good faith estimate, and the state(s) and office or facility location(s) where the items or services are expected to be furnished.;
- A list of items or services that the provider or convening facility (the provider or facility that handles the scheduling of the service) anticipates will require separate scheduling and that are expected to occur before or following the expected period of care for the primary item or service;
- A disclaimer that there may be additional items or services the convening provider or convening facility recommends as part of the course of care that must be scheduled or requested separately and are not reflected in the good faith estimate;
- A disclaimer that the information provided in the good faith estimate

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is only an estimate and that actual items, services, or charges may differ from the good faith estimate; and

- A disclaimer that informs the patient of their right to initiate a patient-provider dispute resolution process if the actual billed charges substantially exceed the expected charges included in the good faith estimate; and
- A disclaimer that the good faith estimate is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from any of the providers or facilities identified in the good faith estimate.

The Act also requires providers to inform all uninsured (or self-pay) patients of the availability of a good faith estimate of expected charges in connection with scheduling a service or upon request. The notice must be prominently displayed on-site at the provider where scheduling or questions about the cost of items or services occur and published on an easily searchable part of the provider's website.

## Dispute resolution

The Act establishes an arbitration process to determine the amount insurers must pay out-of-network providers in scenarios where the patient did not consent to being balance billed for a scheduled service. If an out-of-network provider is dissatisfied with a health plan's

payment, it can initiate a 30-day negotiation period, after which the parties must submit their final offers to an arbitrator, who must select the most reasonable offer. This process uses "baseball-style" arbitration where the arbitrator may only pick between two proposed alternatives, and may not split the difference.

In making its determination, the arbitrator will consider a number of factors, including, but not limited to, the health plan's historical median in-network rate for similar services in the geographic area and whether the parties have made good faith efforts to reach a network agreement within the last four years.

The American Medical Association (AMA) and the American Hospital Association (AHA), among others, filed suit in December 2021 to challenge a provision in the regulations that may result in underpayments to providers and impaired access to care. Specifically, they assert that the regulations create a presumption in favor of the commercial insurers' median in-network rate during the independent dispute resolution process, which deprives the independent arbitrator of his or her discretion to consider all other factors such as whether a teaching hospital might have higher costs than average, the training and experience of a treating physician, or the complexity of the care that physicians provided. This suit is still pending in the courts.

There is also a process to resolve disputes between certain patients and providers if bills exceed the required good faith estimate by more than \$400.

A third-party arbitrator will review the good faith estimate, final bill, and other information submitted by the provider or facility. This process is available if the patient is uninsured or self-pay; received a good faith estimate from the provider or facility; received a bill within the last 120 calendar days, and the difference between the good faith estimate and the bill is at least \$400.

## Next Steps

Hospital-based physicians, including emergency physicians, radiologists, anesthesiologists and pathologists, will need to ensure that no balance billing occurs for their services after January 1, 2022. Surgeons and other procedure-oriented physicians need to understand the notice and consent requirements when treating a patient in an in-network facility if the physician is not in the patient's insurer's network. All physicians must be ready to provide good faith estimates to patients/prospective patients who are uninsured or plan to self-pay – note that further guidance is anticipated regarding future good faith estimate requirements for patients using insurance. And all physicians whose out-of-network charges are capped under the Act should become familiar with the dispute resolution process to challenge underpayments from insurers.

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