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NO SURPRISES ACT BRINGS NEW COMPLIANCE REQUIREMENTS FOR HEALTH CARE FACILITIES JAN. 1

Effective Jan. 1, 2022, the No Surprises Act (the Act) expressly prohibits out-of-network health care providers (including facilities, physicians and non-physician practitioners) from balance billing patients for covered emergency services or certain covered non-emergency services provided at in-network facilities, unless certain conditions are met. In other words, as of Jan. 1, 2022, "surprise" medical bills, or bills insured patients receive for out-of-network care, either in emergency settings or from out-of-network providers at in-network facilities, are no longer permitted, without certain additional requirements being imposed.

The new rule applies to most private health plans offered by employers, whether self-insured (ERISA plans) or fully insured, as well as to individual policies purchased through the Affordable Care Act exchanges. Notably, Medicare and Medicaid already have longstanding prohibitions against billing patients for the balance of the charges. As such, the new rule harmonizes private insurance with Medicare and Medicaid prohibitions on balance billing for out-of-network services.

CERTAIN CARVE-OUTS WITH NOTICE AND CONSENT

An out-of-network provider may still balance bill a patient for certain items or services if the provider satisfies the Act's notice and consent process, which effectively serves as a patient waiver to the Act's requirements. Notably, however, the notice and consent carve-out may not be used for certain services, including emergency services, certain ancillary services, and items or services that are delivered as a result of an unforeseen urgent medical need that arises during an ancillary procedure for which notice and consent was received.

NOTICE AND CONSENT PROCESS REQUIREMENTS

In situations where the notice and consent are permitted, they must be received in writing, within 72 hours of the item or service being delivered or, if the item or service is scheduled within less than that timeframe, at the time the

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appointment is scheduled. The notice can be the patient's preference between paper, email or other electronic form, and must at least contain the following information:

- notification that the provider is out-of-network;
- a good faith estimate of the charges to be incurred;
- a list of in-network providers at the facility, if any, to which the patient can be referred and for which the patient will not be billed;
- any prior authorization or other care management requirements; and
- a clear statement that consent for the out-of-network services is optional and the patient can instead opt for an in-network provider, which will result in no additional costs to be borne by the patient.

Notably, the notice and consent waiver option cannot be used for the following services:

- items and services related to emergency medicine;
- anesthesiology;
- pathology;
- radiology;
- neonatology; and
- certain diagnostic laboratory services.

Importantly, too, **even when otherwise permissible, an out-of-network provider cannot use the notice and consent process if there is no in-network provider available to furnish the item or service at that facility**. This reinforces the agencies' commitment to ensuring maximized patient choice that is omnipresent throughout the Act.

IMMEDIATE ACTION ITEMS

Health care facilities and providers should immediately take the following steps to ensure timely compliance on Jan. 1:

1. **Prepare and post a one-page Public Disclosure.** The Act requires health care facilities and providers to provide a one-page disclosure providing, in plain language, a summary of the Act and its requirements to patients whose health plans are subject to the Act's requirements. The regulations currently require that the disclosure give patients a clear and understandable statement of the requirements and prohibitions of the Act. The disclosure must be posted, on a public portion of a provider or facility's website, and must be made available and provided to applicable patients prior to the patient's receipt of a bill.
2. **Eliminate the practice of out-of-network balance billing to any patient**

whose health insurance plan is subject to the Act. Under the requirements of the Act, facilities and providers must determine which patients are in-network versus out-of-network, and negotiate any payment amounts for out-of-network care with that patient's health plan, rather than billing the patient directly and shifting the burden onto the patient to negotiate with the plan.

3. **If applicable, obtain the necessary written waiver of the Act's protections.** Under the Act, a provider must give the patient a detailed written consent form at least 72 hours prior to a scheduled appointment, or three hours before a same-day appointment. For now, under the existing regulations, the consent form must be provided to the patient separate from other forms, and must 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. The third requirement – the good-faith cost estimate – will not be immediately enforced, and instead will be the subject of future rulemaking.

Armstrong Teasdale's team of experienced health care attorneys will continue to monitor the forthcoming regulatory developments surrounding these issues. Please contact your regular AT attorney or one of the authors listed below for additional information.