

# No Surprises Act: Expert insights to help doctors follow the law

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Implementation of the No Surprises Act, intended to protect patients from unexpected out-of-network medical expenses, will take a while. But there are things that doctors must know and do now to comply and be prepared as regulations are developed and put in place.

A recently published AMA toolkit to help prepare doctors for implementation of the No Surprises Act (PDF) contains information that can help ensure that the doctors themselves won't be taken by surprise by elements embedded deep within the regulations.

Experts from Manatt Health recently detailed enforcement challenges and the interaction between state and federal surprise billing regulations in an AMA Advocacy Insights webinar.

Manatt partner Michael Kolber presented during the webinar and outlined four key areas that physicians need to know about and prepare for:

- How is patient cost-sharing and physician payment determined for these out-of-network situations?
- What obligations exist to provide good faith estimates to patients?
- When a patient chooses to be treated by an out-of-network physician at an in-network facility, when can the physician get consent to balance bill for those nonemergency services?
- When can the physician get consent to balance bill for post-stabilization services in connection with an emergency visit to a hospital or a freestanding emergency department?

“Underlying all of these is how do the existing state surprise billing laws interact with the federal law, and who is going to be responsible for enforcing them?” Kolber said. “It gets pretty complicated.”

These concerns are also addressed in a ReachMD podcast, “What to know about the No Surprises Act.”

## Patient cost-sharing, doctor payment

The core issues of the law concern patients receiving emergency care at an out-of-network hospital emergency department or freestanding ED; or patients receiving care from an out-of-network physician or other health professional for an ancillary service such as anesthesiology, pathology or radiology at an in-network facility.

“In either of those two situations, one of the core protections is that the patient can only be required to pay the in-network cost-sharing amount under the patient's health plan,” Kolber said. “In all of these, the context is this is an insured patient that either has employer-sponsored coverage or has individual market commercial coverage.”

The process involves two calculations: Patient cost-sharing, which happens at the front of the process; and physician payment, which is at the back end.

“The patient's obligation should be resolved relatively soon in this process—even if there continues to be a dispute between the provider and the plan about what the out-of-network reimbursement should be,” Kolber said.

He added that, if a disputed payment between a health plan and a physician or other health professional goes to arbitration, it doesn't affect the amount the patient will pay.

“It's just between the plan” and the doctor, Kolber explained. “That's one of the core protections—taking the patient out of that dispute.”

The independent-dispute resolution process created by the regulations differs from what was written in the law, and Kolber noted that this is the subject of some lawsuits—including one jointly filed by the AMA and the American Hospital Association.

Kolber said the courts may issue rulings in the spring, or about the time the first arbitration proceedings begin—which would be 90 days after services were rendered. There is also the likelihood that the decisions would be appealed.

Learn how the Biden administration's surprise billing rule provision jeopardizes patient access to care.

## Good faith estimates for uninsured

“The good faith estimate has been an area of enormous agita” among physicians and others, Kolber said, adding that it only applies to services provided to uninsured or self-pay patients—including those who are covered by commercial insurance but are choosing not to use it.

A template for such estimates is available on the Centers for Medicare & Medicaid Services website.

If the actual charges for the episode of care exceed the good faith estimate by more than \$400, the patient can dispute that bill through a new patient-physician dispute-resolution process. Patients can also choose to be treated by an out-of-network physician at an in-network facility. But to do so, the physician must gain the patient’s formal consent.