No Surprises Act and Navigating The Good Faith Estimate Mandate

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What is the No Surprises Act?

On December 27, 2020, the No Surprises Act ("NSA") was signed into law as part of the Consolidated Appropriations Act COVID-19 relief bill. The NSA establishes new federal protections against surprise medical bills that took effect January 1, 2022. This new federal law includes regulations to promote price transparency and patient financial protections that impact health plans, physicians, facilities, and other licensed health care professionals. Some of these requirements although newly enacted at the federal level, overlap with comprehensive balance billing protections that have existed under Florida law for many years, with the objective of protecting state residents from surprise bills. Recognizing this overlap, the NSA expressly defers to state laws in certain regards, and limits the extent to which the NSA preempts state laws. The result is added complexity in certain cases in determining whether the existing Florida law rule applies, or if the NSA rules apply. As a general rule federal laws preempt state laws when the state law "prevents the application of" the federal rule. This same analysis will apply to determining whether the NSA preempts Florida laws.

The NSA goes further, however, and expressly defers to state law in two key areas for fully insured plans in the individual and group markets: 1) state methods for determining payment, and 2) provider directories. This deference does not apply to self-funded group health plans.

Existing Florida laws already prohibited providers from balance billing commercially insured patients for emergency services. Under laws applicable to PPO, for emergency services provided by out-of-network providers and facilities, the provider or facility is prohibited from charging PPO members for any balance not paid by insurance.[1] The PPO patient's cost sharing amount is limited to the in-network amount. Under laws applicable to HMOs, providers may not collect or attempt to collect payment from a HMO member for any amount that is the responsibility of the HMO.[2] A member's copayment for emergency services is limited to a reasonable copayment[3] not to exceed $100 per claim.[4]

[1] Fla. Stat. § 627.64194(5)
[2] Fla. Stat. § 641.3154
[3] Fla. Stat. § 641.513(4)
[4] Fla. Stat. § 641.31(12)

Similarly, the intended purpose of the NSA is to protect consumers from surprise medical bills by (i) requiring private health plans to cover these out-of-network claims and apply in-network cost sharing; and (ii) prohibiting doctors, hospitals, and other covered providers from billing patients more than in-network cost sharing amount for surprise medical bills. *Note: This article primarily discusses the Good Faith Estimate requirement, and later touches on additional obligations physicians must follow pursuant to the NSA. To learn more about physician responsibilities under the NSA, you can find more information here.*)

What is the Good Faith Estimate Requirement?

Under the NSA, uninsured patients and commercially insured patients who choose not to use their benefits are entitled to a good faith estimate ("GFE") of charges from providers before their scheduled services. The GFE requirement under the NSA aims to give patients and consumers a clear sense of what upcoming health services will cost.

Who must provide a GFE?

Physician responsibilities differ depending on whether they serve as a "convening provider" or a "co-healthcare provider." A convening health care provider (or facility) is one that receives an initial request for a GFE or that is responsible for scheduling the primary service. A convening provider is required to provide a GFE to all uninsured patients and all commercially insured patients, including if the patient is covered by the Federal Employees Health Benefits Program. For the calendar year 2022, the Department of Health and Human Services ("HHS") will not enforce the requirement that the convening provider's or facility's GFE incorporate estimates from the co-providers or co-facilities. This requirement will, however, be enforced in 2023.

The GFE must be provided either in writing or electronically, as requested by the patient. If provided electronically, the GFE must be provided in a manner such that the patient can both save and print it.

When Must a GFE Be Provided?

The short answer: as soon as possible after a service is scheduled or when a patient requests a GFE. The longer answer depends on when the service is to be provided. If the service is scheduled at least three business days before the service, a GFE is to be provided not later than one business day after the date of scheduling. If the service is scheduled at least 10 business days in advance, the GFE is required to be provided within three business days of scheduling. If a patient requests a GFE before the service is scheduled, the GFE is due within three business days. A new GFE must then be provided pursuant to the above schedule once the service is scheduled.

What Must Be Included in a GFE?

HHS has published a template GFE here, however providers and facilities are not required to use that template. The GFE is required to include: the patient's name and date of birth; a description of the primary item or service in "clear and understandable language" and, if applicable, the date of scheduled service; the items or services expected to be provided in conjunction with primary service, grouped by provider or facility, with their diagnosis code, procedure code, and expected charge; the name of and identifying information for each provider or facility; the items or services that require separate scheduling and that will be estimated in a separate GFE; and various required disclaimers that can be found on page 8 of the HHS template linked above.

Enforcement of the GFE and Related Penalties

States will have primary enforcement authority for the No Surprises Act, both of issuers who offer health insurance coverage in the individual or group markets in the state, and for facilities or providers offering services in the state. If the state does not provide adequate enforcement, the Center for Medicare and Medicaid Services (CMS) will take over enforcement. The enforcing authority must provide notice of a violation, including the information that prompted the investigation, and the potential for a civil monetary penalty or imposition of a plan of corrective action. The violator will typically have 14 days to respond, although that period can be shortened to 24 hours or extended to 30 days or more depending on the circumstances.

The No Surprises Act imposes civil monetary penalties of up to $10,000 for each violation. In determining what penalty to impose, CMS may consider a variety of factors, including the degree of culpability, history and frequency of prior violations, the impact on affected individuals, the gravity of the violation, and whether any violations have been corrected. The penalty will be waived if a provider or facility does not knowingly violate, and should not have reasonably known it violated, the act, and reimburses any incorrect payments plus interest. There is also a hardship exemption to the civil monetary penalties.

What Happens if the Medical Bill is Greater than the Estimate?

If an uninsured or self-pay patient receives a bill that exceeds the GFE by more than $400, the patient may be eligible to start a patient-provider dispute resolution process to dispute the charges.

Once the patient initiates the dispute resolution process with HHS, the dispute resolution entity will notify the provider or facility if it determines the dispute is eligible for resolution. Once notified that the dispute resolution process has begun, the provider or facility has 10 business days to provide a copy of the GFE and bill, and any documentation showing that the difference was based on a medically necessary item or service that could not have been reasonably anticipated when the GFE was provided.

While the bill is being disputed, providers and facilities must suspend collections and accrual of late fees on unpaid bills. Providers and facilities may not take or threaten any retributive action for a patient's use of the dispute resolution process. Additionally, the patient and provider may agree to settle at any point prior to the resolution of the dispute.

Additional Requirements Under the NSA

Aside from the GFE, the No Surprises Act enacted a variety of physician requirements that went into effect on January 1, 2022. These requirements of providers, facilities, and provider of air ambulance services generally apply to items and services provided to individuals enrolled in group health plans or group or individual health insurance coverage, and Federal Employees Health Benefit Plans. The Good Faith Estimate requirement discussed above is the only new regulation that also applies to uninsured persons. Finally, these requirements not do apply to beneficiaries or enrollees in federal health care programs such as Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE.

No balance billing for out-of-network emergency services. A physician may not bill enrollees or participants in group health plans or group or individual insurance coverage who received emergency services at a hospital or an independent freestanding emergency department for a payment amount greater than the in-network cost-sharing requirement for such services. More information can be found here.

No balance billing for non-emergency services by nonparticipating providers at certain participating health care facilities. Physicians may not bill enrollees or participants in group health plans or group or individual health insurance coverage who received covered non-emergency services with respect to a visit at a participating health care facility by a nonparticipating provider for a payment amount greater than the in-network cost-sharing requirement for such services, unless notice and consent requirements are met. The codified rules can be found here, including specific requirements as to notice and consent. Similar prohibitions have existed under Florida law pursuant to which out-of-network providers who provide non-emergency services at in-network facilities are prohibited from billing PPO patients for any amount beyond their in-network level of cost sharing for covered services. The out-of-network provider, however is not prohibited from collecting or attempting to collect from the patient an amount due for the provision of non-covered services.

Disclose protections against balance billing. A provider or facility must disclose to any participant, beneficiary, or enrollee in a group health plan or group or individual health insurance coverage to whom the provider or facility furnishes items and services information regarding federal and state (if applicable) balance billing protections and how to report violations. Providers or facilities must post this information prominently at the location of the facility, post it on a public website (if applicable) and provide it to the participant, beneficiary or enrollee in a timeframe and manner outlined in the regulations, which can be found here.

No balance billing for air ambulance services by participating air ambulance providers. Providers of air ambulance services cannot bill or hold liable beneficiaries, enrollees or participants in group health plans or group or individual health insurance coverage who received covered air ambulance services from a nonparticipating air ambulance provider for a payment amount greater than the in-network cost-sharing requirement for such services. You can read the codified rules regarding this new requirement here.

Ensure continuity of care when a provider's network status changes. Under the NSA, a physician that ends a contractual relationship with a plan or issuer and has a continuing care patient must generally accept payment from the plan or issuer for a continuing care patient at the previously agreed to payment amount for up to 90 days after the date on which the patient was notified of the change in the provider's network status. Additionally, the physician must continue to adhere to all policies, procedures, and quality standard imposed by the plan or issuer for such items or services as if the contract were still in place.

Physicians must improve their directories and reimburse enrollees for errors. Any health care provider or health care facility that has or has had a contractual relationship with a plan or issuer to provide items or services under such plan or insurance coverage must submit provider directory information to a plan or issuer. Under the NSA, this must occur at the beginning of the network agreement with a plan or issuer, at the time of termination of a network agreement with a plan or issuer, when there are material changes to the content of the provider directory information of the provider or facility, upon request by the plan or issuer, and at any other time determined appropriate by the provider, facility, or HHS. Additionally, any health care provider or health care facility that has or has had a contractual relationship with a plan or issuer to provide items or services under such plan or insurance coverage must also reimburse enrollees who relied on an incorrect provider directory and paid a provider bill in excess of the in-network cost-sharing amount.

Questions?

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