



## Perspective

### The No Surprises Act and Informed Financial Consent

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**A**t the close of 2020, the U.S. Congress passed the No Surprises Act to end the pernicious practice of so-called surprise billing for out-of-network care.<sup>1</sup> But the country's recent

experience with balance-billing prohibitions for Covid-19 testing and treatment offers an ominous warning. The Coronavirus Aid, Relief, and Economic Security (CARES) Act barred providers from collecting copayments and pursuing balance bills for coronavirus testing and treatment in exchange for receiving bailout funds. Reports have documented a nationwide persistence of surprise bills for Covid-related care, however.<sup>2</sup> The continued existence of ostensibly illegal bills has been attributed to multiple causes — including omitted Covid-19 diagnoses, upcoding, human error, billing-related confusion, simple noncompliance with federal rules, and various loopholes<sup>2</sup> — but the lesson is clear: in the health care sector, making certain practices

illegal isn't enough to prevent them from occurring.

The No Surprises Act offers a pathway to addressing this problem. It does so not just by imposing prohibitions but also by enacting affirmative obligations. To avoid a protracted arbitration process, the No Surprises Act requires out-of-network providers to obtain explicit, informed consent from each patient regarding the patient's financial obligation stemming from a planned episode of care.<sup>1</sup> This requirement could not only help stop surprise billing, it could also promote dignity and autonomy for patients.

The No Surprises Act addresses many of the billing behaviors that have attracted widespread outrage in the United States. It prohibits out-of-network providers

from charging patients amounts that exceed the patient's in-network rates for emergency medical care, air-ambulance services, and nonemergency and ancillary services delivered by out-of-network providers at in-network facilities.<sup>1</sup> Such billing practices have traditionally imposed catastrophic prices on vulnerable patients without their knowledge or ability to contest the fees. Instead of allowing providers to recoup from patients the amounts detailed in their chargemasters — which far exceed negotiated commercial rates and are unilaterally set by providers — the Act requires providers and insurers to submit to arbitration, while holding the patient financially harmless.

The No Surprises Act also stipulates important protections for patients seeking nonemergency care from out-of-network providers. In these situations, out-of-network providers may charge a patient more than the amount of their copayments for in-network

care only if they notify the patient of “the good faith estimated amount that [the] provider... may charge” at least 72 hours before care is provided and receive the patient’s written consent. In essence, this provision requires of medical care the commonsense practice that is expected of transactions in the rest of the economy: quote prices in advance and proceed only after customers agree.

Many observers rightfully fear that providers will ignore or evade the No Surprises Act’s dictates, just as some have ignored rules concerning billing for Covid-19 testing and treatment. Poor compliance with new hospital price-transparency rules is another bad omen.<sup>3</sup> Moreover, patients are routinely harassed by medical bill collectors even when they have been erroneously billed. The Act’s affirmative obligations might therefore be especially important. By requiring providers to obtain patients’ consent before charging prices that are above market average, the Act might bring new transparency to medical billing. If this practice becomes widespread, the law’s expectations for out-of-network providers might be extended to in-network care.

There is much at stake. Before the term “surprise billing” was coined, we expressed alarm regarding the proliferation of exorbitant bills being sent to unsuspecting patients.<sup>4</sup> Our concern was not just related to the exploitative use of the chargemaster and its contribution to escalating health care prices.<sup>5</sup> Rather, we were alarmed that the medical profession, for which informed consent is an ethical cornerstone, was so resistant to obtaining patients’ consent to the prices they would be charged. We wrote that “establishing informed financial

consent as an essential element of medical practice would both fulfill the profession’s ethical commitment to patient autonomy and provide a much-needed market-based counterforce to price escalation.”<sup>4</sup>

Surprise billing has become only more pervasive over the past decade, and Congress deserves credit for prohibiting these abusive tactics. But Congress has not just protected patients when they lack capacity and knowledge, it has also created a right for patients to obtain information when they do have the capacity to choose their source of care. The No Surprises Act — albeit covering only limited circumstances — offers a meaningful nudge toward genuine informed financial consent.

Disclosing prices to patients in advance and obtaining informed financial consent might seem like a sea change for U.S. providers, but it’s common practice for self-pay services such as direct primary care, elective plastic surgery, and laser-assisted in situ keratomileusis (LASIK) eye surgery. It’s also a regular feature in other countries that, like the United States, rely at least in part on private insurance to finance health care. In Germany, Australia, and Singapore, for example, medical providers routinely offer detailed financial information and counseling to patients before they receive care. Providers in these countries still manage to keep their administrative costs below those in the United States; in fact, fully informing patients about the cost of care might reduce subsequent administrative complexity and avert expensive arbitration disputes under the No Surprises Act. Making treatment-specific price

disclosures to patients may also stimulate price competition, which is lacking in many U.S. health care markets. Moreover, such disclosures could meaningfully advance patient autonomy and personal agency, thereby instilling broader confidence in the health care sector.

There is still much work to be done. The secretary of health and human services recently issued additional guidance on the consent requirements of the No Surprises Act, but these rules might not be sufficiently rigorous to hold providers accountable for offering detailed and accurate good-faith estimates. We anticipate that there will be challenges when a provider’s estimate is incorrect because of administrative errors (for instance, mispricing their own services or misquoting costs for ancillary providers such as anesthesiologists or radiologists) and for cases in which good-faith estimates fail to account for clinical complications that occur during care delivery. We think the next round of rules should be unforgiving of errors in the former cases and careful in the latter cases. In all circumstances, the priority should be to prevent loopholes that could allow providers to maintain the current billing paradigm.

In particular, the secretary could define circumstances in which a patient is authorized to challenge a provider’s bill and ensure that patients can easily dispute any bill that exceeds a good-faith estimate. Giving patients the prerogative to withhold payment should induce providers to satisfy the Act’s procedural requirements, and the final rules should be written to empower patients to resist in circumstances in which they previously were

steamrolled. The secretary could also expand the conditions under which providers must present patients with good-faith price estimates. We believe there's an important opportunity to put informed financial consent at the center of these new rules.

The persistence of surprise bills in the Covid-19 era, despite Congress's express prohibition of many such bills, is cause for alarm. Surprise-billing practices victimize people who are often already marginalized, undermine trust in the health care system, cause personal bankruptcies, and exacerbate mental and physical illnesses. The No Surprises Act will ideally bring about real progress in ending these practices.

The Act also has the potential to do more than stop bad behav-

ior; it could prompt constructive change. If the law is implemented effectively and forcefully in circumstances in which patients have the capacity and opportunity to provide meaningful consent — to both the care they receive and the prices they pay — it could bring long-needed price transparency to the health care sector and promote long-denied patient autonomy.

Disclosure forms provided by the authors are available at [NEJM.org](https://www.nejm.org).

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