NO SURPRISES ACT:

NEW LAW TARGETS SURPRISE BALANCE BILLING ON NATIONAL LEVEL

In addition to stimulus relief and the 2021 federal budget, the Consolidated Appropriations Act, passed in December of 2020, included the No Surprises Act, which targets the practice of surprise balance billing. Surprise balance billing occurs when a patient receives an unexpected bill from a medical provider. Typically, these bills are connected to emergency or hospital-based services wherein the costs of services or the fact that a provider is out of network was not disclosed in advance. In addition to being totally unexpected, these bills can also be incredibly expensive, leaving patients with a nasty surprise. The No Surprises Act is designed to remove the patient from negotiations between medical providers and insurers; in addition, it also requires that some information about estimated costs be provided to patients in advance of scheduled medical services. The law goes into effect for plan or policy years beginning on or after January 1, 2022.

How does the No Surprises Act change what's currently happening?

Surprise balance billing generally comes about when an insured patient needs to seek emergency care from an out-of-network facility or when they go to an in-network hospital but later find out that their doctor or some other provider they saw during that visit was actually out of network. In these situations, if the insurance company and providers cannot negotiate a price, the patient may be left with a substantial medical bill.

The No Surprises Act includes prohibition of surprise balance billing and sets up an arbitration process for disputes between health insurers or group plans and out-of-network providers. It is set up to coordinate with existing state surprise balance billing laws.

Please note that this law does not apply if a patient opts to receive services from an out-of-network provider; it only applies in situations where a patient did not know or did not have a choice of using an in-network provider.

To what plans does the No Surprises Act apply?

The No Surprises Act applies to individual, small group, and large group fully insured markets and self-insured group plans including grandfathered plans and transitional relief

plans. Coverage offered through an Exchange and for federal employees through the Federal Employees Health Benefits Program is also covered.

Excepted benefits and short-term limited duration insurance are excluded. Excepted benefits include non-health coverage (such as workers compensation, disability, accidental death and dismemberment, and automobile insurance), limited health benefits (such as dental, vision, and long-term care insurance), specific disease or illness coverage (such as cancer policies and hospital indemnity plans), and supplemental health benefits (benefits that are supplemental to other coverage, such as Medicare, Veterans coverage, Tricare, or a group health plan). For reference, here is the link to the legal definition of excepted benefits: https://www.law.cornell.edu/cfr/text/45/148.220.

To what bills does the law apply?

The law applies to medical bills related to the following situation(s):

- Out-of-network emergency covered services at a hospital or free-standing facility.
- Covered items and services provided by an out-of-network medical provider at an in-network facility.
- Out-of-network air ambulance items and services.

Providers are prohibited from balance billing patients for out-of-network emergency services. In addition, out-of-network providers of ancillary services at an in-network facility are also prohibited from balance billing patients. Ancillary services are those for emergency medicine, anesthesiology, pathology, radiology, neonatology, and laboratory and diagnostic services, and where there is not an in-network provider available.

How are emergency services handled?

Under the No Surprises Act, like the Affordable Care Act, emergency services include coverage for items and services for medical screening to stabilize the patient. The No Surprises Act defines emergency services to include additional services provided by an out-of-network provider or facility as part of an out-patient observation or in-patient or out-patient stay with respect to the emergency services visit if the benefits would be otherwise covered.

An out-of-network provider may balance bill the patient for covered services provided after the patient is stabilized if the following conditions are met:

- The provider or facility must determine the individual can travel using nonmedical transportation or nonemergency medical transportation.
- The provider must furnish the notice that the additional items/services are out-of-network, provide the cost and receive an acknowledgement from the patient that they received the notice.
- The individual must be in a condition to acknowledge the notice.

For More Information

For more information or assistance, please contact our Employee Benefits team at **210–640–1789**, toll-free at **1–888–757–2104**, or **EmployeeBenefits@BFGonline.com**.

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