NO SURPRISES ACT

On December 27, 2020, President Trump signed into law the No Surprises Act, which changes health insurance benefits in a couple of important ways.

For plan years beginning January 1, 2022, the No Surprises Act restricts so-called "surprise billing" for out-of-network emergency care and requires health plans to provide transitional "continuity of care" to certain members when a doctor or facility stops being a member of the plan's network.

Surprise Billing

What is a surprise medical bill?

When a person with a group health plan or health insurance coverage gets care from an out-of-network provider, their health plan or issuer usually does not cover the entire out-of-network cost, leaving them with higher costs than if they had been seen by an in-network provider. In many cases, the out-of-network provider can bill the person for the difference between the billed charge and the amount paid by their plan or insurance, unless prohibited by state law. This is known as "balance billing." An unexpected balance bill is called a surprise bill.

This rule protects patients from surprise bills under certain circumstances.

How does this rule help?

If your health plan provides or covers any benefits for emergency services, this rule requires emergency services to be covered:

- Without any prior authorization (meaning you do not need to get approval beforehand).
- Regardless of whether a provider or facility is in-network.

This rule also limits cost sharing for out-of-network services to in-network levels, requires cost sharing (deductibles, co-insurance and copayments) for these services to count toward any in-network deductibles and out-of-pocket maximums, and prohibits balance billing by doctors and medical facilities under certain circumstances. The protections in this rule apply to most emergency services, air ambulance services from out-of-network providers, and non-emergency care from out-of-network providers at certain in-network facilities, including in-network hospitals and ambulatory surgical centers.

Additionally, this rule requires certain health care providers and facilities to furnish patients with a one-page notice on:

- The requirements and prohibitions applicable to the provider or facility regarding balance billing.
- Any applicable state balance billing prohibitions or limitations.
- How to contact appropriate state and federal agencies if the patient believes the provider or facility has violated the requirements described in the notice.

This information must be publicly available from the provider or facility, too.

Continuity of Care

For plan years beginning on or after January 1, 2022, a group health plan must provide transitional care for up to 90 days for a member that is a "continuing care patient" with respect to an in-network health care provider or facility when certain events occur.

Specifically, these continuity of care requirements apply when any of the following occurs:

- The contractual relationship between the plan and provider or facility is terminated;
- Benefits provided under the plan with respect to the provider or facility are terminated because of a change in the terms of participation of the provider or facility; or
- A contract between the plan and its health insurer is terminated, resulting in a loss of benefits with respect to the provider or facility.

An individual covered under a group health plan is considered a continuing care patient of a particular provider or facility if the individual is:

- Undergoing a course of treatment for a serious and complex condition,
- Undergoing a course of institutional or inpatient care,
- Scheduled to undergo nonelective surgery (including postoperative care),
- Pregnant and undergoing a course of treatment for the pregnancy; or
- Terminally ill and receiving treatment for that illness.

If these continuity of care conditions are satisfied, the group health plan will—

- Timely notify continuing care patients of terminations affecting their provider or facility and their right to elect continued transitional care from that provider or facility;
- Provide each patient an opportunity to notify the plan of the need for transitional care; and
- Permit the patient to elect to continue to have plan benefits provided under the same terms and conditions as would have applied, and for the items and services that would have been covered, for an additional 90 days.

If you have any questions regarding these changes, please contact your plan administrator at ____.