Key Responsibilities for Group Health Plans and Health Insurance Issuers Under the No Surprises Act

The No Surprises Act is a federal law that created new requirements for group health plans and group and individual health insurance issuers to follow, to prevent surprise billing in certain situations. Surprise billing (a type of balance billing) occurs when an out-of-network provider or facility unexpectedly bills a consumer for the remaining balance that is not covered by their health plan. Copayments, coinsurance, and deductibles owed by a consumer are generally not considered to be part of a surprise bill. However, surprise billing may include charges for cost sharing that exceed a consumer's in-network cost sharing requirements.

The No Surprises Act requirements described below generally apply for individuals in group health plans, group and individual health insurance coverage, and the Federal Employees Health Benefits Program. This fact sheet can help consumers understand their rights and protections under the law. See No Surprises Act Overview of Key Consumer Protections for more detailed information.

Health plans and health insurance issuers subject to the No Surprises Act must:

1 Cover most emergency services as though the services were in-network.

If the health plan or issuer covers benefits with regard to services in an **emergency department of a hospital** or emergency services in an **independent freestanding emergency department**, it must cover emergency services:

- Without requiring prior authorization,
- Regardless of whether the emergency provider or facility is in-network with the plan, and
- Without imposing any administrative requirement or limitation on out-of-network coverage that is more restrictive than those that apply in-network.

See Surprise Bills for Emergency Services in the No Surprises Act Overview of Key Consumer Protections.

This document is intended to provide clarity to the public about requirements related to surprise billing. It does not have the force and effect of law.

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Health plans and health insurance issuers subject to the No Surprises Act must: (cont'd)

2 Ensure that consumer cost-sharing requirements are not greater than the requirements that would apply for in-network services.

Health plans and issuers must calculate cost sharing to ensure that enrollees are only liable for cost sharing under requirements that are no higher than in-network requirements when they receive the following types of care:

- Most out-of-network emergency services, including certain post-stabilization emergency services;
- Certain non-emergency services furnished by out-of-network providers with respect to a visit at an in-network hospital, hospital outpatient department, critical access hospital, or ambulatory surgical center; and
- Air ambulance services by out-of-network air ambulance providers.

In addition, in these circumstances, health plans and issuers must apply any cost-sharing payments paid by the enrollee towards any in-network deductible and in-network out-of-pocket maximums.

Note: The No Surprises Act surprise billing protections do not apply if the items or services provided would not have been covered by the person's health plan or insurance, even if they had been provided in-network.

See Calculating Cost Sharing Under the No Surprises Act in the No Surprises Act Overview of Key Consumer Protections.

3 Use the prudent layperson standard to process claims for emergency services.

Health plans and issuers must use a prudent layperson standard to analyze whether a consumer experienced an emergency when seeking care in a hospital emergency department or independent freestanding emergency department.

- If there is a question as to whether an emergency existed, plans and issuers must review all relevant documentation and apply the prudent layperson standard based on presenting symptoms, and not solely on final diagnosis codes.
- The prudent layperson analysis must be done before an initial denial of an emergency services claim (as opposed to waiting for an appeal).

When processing claims, plans and issuers must also ensure that they do not restrict the coverage of emergency services:

- By imposing a time limit between the onset of symptoms and the presentation of the consumer at the emergency department, or
- Because the patient did not experience a sudden onset of the condition.

4 Cover emergency services that may otherwise be subject to a general plan exclusion.

If a plan or issuer covers emergency care, it may not deny emergency care claims based on a plan exclusion that applies to non-emergency care. For example, if a covered dependent (including a dependent woman or child) receives care for a pregnancy-related emergency medical condition, the plan may not deny the claim based on a dependent maternity care exclusion.

Health plans and health insurance issuers subject to the No Surprises Act must: (cont'd)

5 Expand the scope of external appeals review practices to comply with No Surprises Act provisions.

When complying with an external review request, a health plan or issuer must, as part of the full and fair review of the adverse benefit determination, provide information to the independent review organization to demonstrate its compliance with No Surprises Act provisions, including:

- Patient cost sharing and surprise billing protections for emergency services;
- Patient cost sharing and surprise billing protections related to non-emergency care provided by out-of-network providers with respect to a visit at certain types of in-network health care facilities;
- Whether patients are in a condition to receive notice and provide informed consent to waive No Surprises Act protections; and
- Whether a claim for care received is coded correctly, accurately reflects the treatments received, and is a claim eligible for external review because adjudication of the claim involves medical judgment.

6 Ensure the accuracy of provider directories.

Health plans and issuers must:

- Establish processes to keep their provider directories current.
- Put provider directories or databases on a public website, with the name, address, specialty, telephone number, and digital contact information of each in-network provider or facility.
- Develop a process for responding, within one business day, to questions about the network status of a provider or a facility.
- Apply in-network cost sharing when an individual was provided inaccurate information about provider network status by the database, provider directory, or response protocol.

See Improving the Accuracy of Provider Directory Information in the No Surprises Act Overview of Key Consumer Protections.

7 Include certain information on insurance cards.

Health insurance ID cards (physical or electronic) must show:

- Any deductibles that may apply.
- Any out-of-pocket maximum limitations that may apply.
- A telephone number and website address to contact for more information.

See Transparency on Health Insurance Cards in the No Surprises Act Overview of Key Consumer Protections.

8 Provide continuing benefit coverage in certain situations.

In certain situations, health plans and issuers must continue to cover an enrollee's ongoing care for a limited period of time as if the care were provided in-network, even if the provider's in-network contract expired or was not renewed.

See Continuity of Care Protections in the No Surprises Act Overview of Key Consumer Protections.