Brown & Brown

EMPLOYEE BENEFITS

Fundamentals of the No Surprises Act

December 2020

On December 27, 2020, President Trump signed Congress' $900 billion COVID-19 relief package. As expected, the final bill includes the language of the "No Surprises Act," a long-anticipated, largely bipartisan bill that provides patient protections against surprise medical bills from out-of-network providers. This act will have significant impact on the health care industry, including group health plans offered by our customers. Included below is a summary of the major provisions of the landmark legislation.

Health Plan Surprise Medical Billing Requirements

- Participants and beneficiaries cannot be required to pay anything other than the in-network cost-sharing amounts for:
  - Out-of-network emergency care,
  - Out-of-network air ambulance services,
  - Certain ancillary services provided by out-of-network providers at in-network facilities, and
  - Out-of-network care provided at in-network facilities when the patient has not provided informed consent.
- Any cost-sharing payments by participants and beneficiaries for out-of-network emergency services and air ambulance services must be counted towards any in-network deductible or out-of-pocket maximums.
- Participants will not be involved in billing disputes between health care providers and insurers.

Determining Out-of-Network Rates Paid by Health Plans

- Establishes an independent dispute resolution (IDR) process when providers and insurers are unable to settle out-of-network claims within a 30-day negotiation period.

Health Care Providers Surprise Medical Billing Requirements

- Participants and beneficiaries may not be billed by out-of-network facilities and providers for amounts exceeding the in-network cost-sharing amount for certain emergency care and ancillary services.
- Unless the patient is given notice of the providers network status within 72 hours prior to receiving out-of-network care, and the patient consents to that care, the out-of-network provider is prohibited from balance billing the patient. When an appointment is made within 72 hours of care, the patient must receive a notice of the network status on the day the appointment is made and provide consent to receive out-of-network care.

Health Plan Transparency

- Group and individual health plans must include the amount of in-network and out-of-network deductibles and out-of-pocket maximum limitations on insurance identification cards issued to enrollees.

Other Consumer Protections

- Health plans are required to provide patients with an Advance Explanation of Benefits that describes the provider's network status, the estimated amount the plan is responsible for paying, an estimate of any cost-sharing for which the participant is responsible for and an estimate of the amount the participant has incurred towards meeting any out-of-pocket limits.
- Health plans must offer a price comparison guidance tool for consumers that allows an individual enrolled under the plan to compare the amount of cost-sharing the individual would be responsible for paying if they receive a specific service by the provider.
- Health plans are required to develop up-to-date directories of their in-network providers available to patients. These directories may be displayed online and must be distributed within one business day of an inquiry by a patient.

How Brown & Brown Can Help

Connect with your Brown & Brown service team to learn more about how we can help find solutions to fit your unique needs.

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