Key Responsibilities for Health Care Providers and Facilities Under the No Surprises Act

The No Surprises Act is a federal law that created new requirements for health care providers and facilities (including providers of air ambulance services) 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 for providers and facilities are described below. See the No Surprises Act Overview of Key Consumer Protections for more detailed information. This fact sheet can also help consumers understand their rights and protections under the law.

Health care providers and facilities, including providers of air ambulance services, must do the following:

For consumers who are insured, generally including individuals covered under group health plans, group and individual health insurance coverage, and the Federal Employees Health Benefits Program:[1]

✓ **Limit the amount they bill consumers for out-of-network care in certain situations.**

Providers and facilities may not balance bill for:

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

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. However, in instances where

[1] The provisions of the No Surprises Act that are applicable to group or individual health insurance coverage generally apply to grandfathered health plans.

surprise billing is prohibited, cost sharing for covered patients is generally limited to in-network requirements.

See *Surprise Billing Protections: In Depth*.

Out-of-network providers and facilities must bill at in-network cost-sharing levels when:

- The consumer qualifies as a continuing care patient and receives out-of-network care because the provider's network status changes mid-treatment; or
- The consumer receives out-of-network care due to inaccurate provider directory information.

  See *Continuity of Care Protections* and *Improving the Accuracy of Provider Directory Information*.

✓ **Follow the notice and consent guidelines in order for a consent to be valid.**

The No Surprises Act allows some out-of-network providers and facilities to seek written consent from individuals to voluntarily waive their surprise billing protections. However, consenting to waive federal surprise billing protections is only allowed **in very limited situations**. In addition, consent forms must be provided within specified timeframes and presented separately from other documents. The provider or facility must use the standard notice and consent form issued by the federal government or their state.

See *When the Notice and Consent Exception Applies and When It Doesn't: Guidelines for Use*

✓ **Take steps to promote transparency.**

Providers and facilities must:

- Publicly disclose patient protections against surprise billing.

  See *Sample Notice of Surprise Billing Protections* for more information.

- Maintain business processes to submit provider directory information to health plans and issuers to support accurate, up-to-date provider directories.

  See *Improving the Accuracy of Provider Directory Information*

For consumers who do not have health coverage or do not intend to use their insurance (also known as "self-pay" individuals):[2]

✓ **Tell consumers about their right to receive a good faith estimate.**

Providers and facilities must:

- Tell uninsured (or self-pay) individuals that they can have a good faith estimate of expected charges if they schedule an item or service three or more business

[2] The requirements related to good faith estimates also apply for consumers with coverage only through a health care sharing ministry, short-term, limited duration insurance, a farm bureau plan, or self-funded student health coverage.

days in advance, ask for an estimate, or ask about the costs of items or services under consideration.

Information about the availability of good faith estimates must be:

- Written in a way that consumers can understand;
- Displayed in a way that is easy to see (and easily searchable from a public search engine) on the provider's or facility's website, in the office, and on-site where scheduling or questions about the cost of items or services occur;
- Provided orally when a consumer schedules an item or service or asks about the cost of items or services; and
- Made available in accessible formats, and in the language(s) spoken by individual(s) considering or scheduling items or services with the provider or facility.

See *Guidance on Good Faith Estimates and the Patient-Provider Dispute Resolution (PPDR) Process for Providers and Facilities as Established in Surprise Billing, Part II; Interim Final Rule with Comment Period*

✓ **Provide a good faith estimate.**

Providers and facilities must:

- Provide a good faith estimate of expected charges to uninsured (or self-pay) consumers who request a good faith estimate or who schedule an item or service, if done three or more business days in advance.
- Consider any discussions with an uninsured (or self-pay) consumer about potential costs for an item or service as a request for a good faith estimate.

  The good faith estimate must be provided in written form either on paper or electronically, according to the individual's requested method of delivery.

  See *Decision Tree: Requirements for Good Faith Estimates for Uninsured (or Self-Pay) Individuals*.
  See *Content Requirements for a Good Faith Estimate*

- Participate in the Patient-Provider Dispute Resolution (PPDR) process when a consumer elects to use this process, to resolve charges for item(s) or service(s) that are at least $400 more than the amount listed by a provider on the good faith estimate given to the consumer.

  See *Decision Tree: Patient-Provider Dispute Resolution Process*.
  See *What is Considered "Health Insurance"? Determining when Uninsured (or Self-Pay) Good Faith Estimate Rules Apply*

✓ **Refrain from moving certain bills into collections.**

When a consumer elects to use the PPDR process, providers and facilities cannot:

- Move a bill into collections, or threaten to do so, while the PPDR process is pending.
- Charge late fees on unpaid bill amounts, until after the PPDR process has concluded.

See *Decision Tree: Patient-Provider Dispute Resolution Process*