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New Protections from Unexpected Medical Bills: What You Need to Know about the No Surprises Act

On January 1, 2022, a new law went into effect that helps protect people from unexpected charges for some types of medical care. This law, the No Surprises Act, applies to people with health insurance they get through an employer, through the Marketplace, or that they have purchased themselves, as well as people who are uninsured.[1]

[1] The No Surprises Act does not apply to people who have other types of insurance, such as Medicaid, Medicare, or veterans' benefits – but they have other protections. For Medicaid protections, contact your state Medicaid agency at https://www.medicaid.gov/about-us/beneficiary-resources/index.html#when2contactstate. To find a free legal services program to help with Medicaid issues, contact LawHelp at www.lawhelp.org. For Medicare protections, contact https://www.shiphelp.org/ or https://www.medicare.gov/talk-to-someone. For information for Veterans about dealing with medical debts, see https://www.consumerfinance.gov/about-us/blog/new-va-rule-relieves-financial-distress-for-thousands-of-veterans-with-medical-bills/ and https://www.ecfr.gov/current/title-38/chapter-I/part-17/subject-group-ECFR8aa781583c86421/section-17.1008.

Your rights under the new law

If you have health insurance through your or your spouse's job or a plan that you bought through the Marketplace or from an individual market health insurer, the No Surprises Act gives you new protections against unexpected bills for care that you get out of your health plan's network (out-of-network care).

- **If you have a medical emergency:** You cannot be charged more than your health plan's deductible, copay, or coinsurance (cost-sharing) when you get care in a hospital, a freestanding emergency facility such as an urgent care center that provides emergency services, or if you use an air ambulance. This applies whether or not the emergency services provider is in your insurance plan's network of health care providers.

  This means that if you have an emergency, the above providers cannot charge you extra for using out-of-network services during the emergency. Also, your health plan cannot require you to get prior authorization for emergency care.

- **If you receive non-emergency services from an in-network hospital or ambulatory surgical facility, you can't be billed extra for using certain out-of-network services:** You cannot be charged higher out of network rates for anesthesiology, lab work, pathology, x-rays or radiology, neonatal care. You also cannot be charged more if you receive care from a hospitalist, assistant surgeon, or intensivist (a doctor who treats critically ill patients).

  In most hospitals and surgical facilities, there may be some doctors who are in a health plan's network and others who are out-of-network. For non-emergency care, it is important to find out in advance if the doctors who will treat you accept your insurance.

- **Insurance plans must keep their health care provider directories up-to-date. If the directory says a provider is in your network, you can't be billed out-of-network rates by that provider.** Providers sometimes leave plan networks. When that happens, the provider and health plan are responsible for updating that information. However, your plan or provider may not do so promptly. If you rely on a provider directory that turns out to be incorrect, you can only be charged in-network prices.

  It is also important to know that if you have a serious or complex condition and were already receiving care from a provider who leaves a network, you generally have the right to continue seeing that provider for up to three months and only be charged in-network rates.

- **If you are uninsured or planning to pay the full cost of care out-of pocket, you can get an itemized estimate of the charges up front before you get care.** This is called a "good faith estimate."

  When you ask for that estimate, your provider must give it to you within three business days. Save the estimate. If the actual amount you are charged is higher than the estimate by $400 or more, you can dispute the charges.

How to Dispute a Bill Higher Than the Good Faith Estimate

- You have up to four months (120 days) to start using a billing dispute process through the federal government.
- You can't be charged late fees while you are disputing a bill.
- This process will be handled by an independent entity, meaning that the people handling your dispute won't be connected to your health plan or to your provider.
- The dispute resolution process costs $25.
- The dispute resolution entity will decide if there was a good reason for you to be billed higher than the estimate you got. To determine a reasonable charge for any unforeseen items and services, the dispute resolution entity will consider charges by similar providers in your area.*
- The dispute resolution entity will send you and your provider notice of its decision. The provider can then bill you for the amount the entity determines is reasonable.
- After you get the decision, you can still ask your provider if he or she is willing to accept a lower payment amount and/or whether you are eligible for any financial assistance with your bill.

*"Unforeseen circumstances," such as medical complications that the provider did not know about in advance of the procedure, could cause a higher bill than the estimate.

Consumer Tip

When asking for a good faith estimate, find out if additional providers will be involved in your care. For example, will your doctor be asking a specialist to help who might send you a separate bill? If so, make sure to get estimates from them as well. If the actual amount you are charged for items and services furnished by any one provider is higher than the estimate by $400 or more, you can dispute the charges.

FAQ

Q1: What counts as an emergency?

An emergency is a medical condition with symptoms such as severe pain that give you reason to believe your health is in serious jeopardy, that you may have a serious injury to a body part or an organ, or that you have a mental health or substance use emergency. Emergency services include:

A. Medical screening to figure out if you are having a true emergency.

B. Treatment to stabilize your medical condition so that it will not worsen and become dangerous to you when you leave the hospital or emergency facility.

If you disagree with the hospital or emergency facility about whether you had a medical emergency, you can appeal the decision with your health plan or an outside reviewer.

Q2: What happens after you are treated for the emergency?

After your condition is stabilized, the provider will decide if you need further treatment. If you do, the provider will decide whether it is safe for you to travel to an in-network facility or in-network provider for that treatment.

Consumer tips

- *You can't be required to travel if the distance is unreasonable, or if you would need to use an ambulance or other emergency medical transportation.*
- *You (or your representative) must be able to provide "informed consent." That means your provider has explained to you the relevant medical facts and the risks involved. If you consent, you will be given a form to sign agreeing to the transfer. If you (or your representative) don't believe your medical condition is stable enough for you to be transferred, if you are not mentally able to make an informed decision, or if you don't believe that it is safe for you to go to the in-network facility, don't sign the consent form. If your treating physician agrees that it isn't safe or reasonable for you to travel for further treatment, the facility cannot balance bill you. For further questions or problems, contact the No Surprises Help Desk at 1-800-985-3059.*

Q3: What if the provider who treated you doesn't agree with the amount that your health plan pays for emergency services?

If this happens, the provider and your plan can go through an "independent dispute resolution process" to determine how much the provider must be paid. You do not need to be part of that process – you are protected against charges that are higher than your plan's copays or coinsurance and deductible.

Q4: What if you need *non-emergency* care at an in-network hospital or facility? Can you be billed higher amounts if that care is provided by an out-of-network surgeon or specialist?

Yes, you can be billed more for out-of-network non-emergency care. Even when you go to a hospital or other facility that's in your network, some services or providers may not be in that network. And normally, you would be charged more for that care. But if you have scheduled your care in advance, you can get a good faith estimate of those charges in advance and decide if you still want to see the out-of-network provider. If you do, you will sign a notice and consent form, agreeing to the higher charges. To determine whether or not you should sign a notice and consent form go to the Centers for Medicare & Medicaid Serives webpage at https://www.cms.gov/nosurprises/consumers/notices-you-may-get-whether-you-should-sign-them.

For instance, let's say you want to use a certain specialist even though they are not in your plan's network. If you schedule your appointment or procedure at least 72 hours (three days) in advance, the providers must give you an itemized estimate of your charges. You can then ask your plan if it will pay any of those charges. Then you can decide if you want to go ahead and use the out-of-network provider or look for a different provider who is in your plan's network or who will charge less.

You should *never* be asked to consent to the following types of out-of-network services at an in-network hospital, outpatient department or ambulatory/surgical facility – you cannot be balance billed for these services:

> *Emergency medicine; anesthesiology; pathology; radiology; neonatal items or services provided by physician or non-physicians; services provided by assistant surgeons, hospitalists, and intensivists; or diagnostic services, including radiology and laboratory services.*

Q5: Where can you get more information or get help if you have a problem?

To learn more about your specific rights and the new protections, visit www.CMS.gov/nosurprises/consumers, or call the Help Desk at 1-800-989-3059. TTY users can use the same number.

The No Surprises Help desk should be able to assist you with surprise billing problems and put you in touch with the right agency in your state that is enforcing these new rules for further help. That could be an insurance department, a health department, an attorney general's office, or other department. In some states, there are health consumer assistance programs, health consumer ombudsman programs, or free legal services programs that specialize in health care that can help you for free.

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