FAQ

New Protections Against Surprise Medical Bills

Starting in 2022, there is a new law, the No Surprises Act, that protects people from "surprise medical bills." These protections apply to anyone enrolled in a private health insurance plan, including employer plans or a plan purchased on or off the marketplace. Surprise medical bills are common, especially in emergency care and non-emergency hospitalization, and can create serious hardship and even bankruptcy for families. Even though surprise bills are now banned in many circumstances, enrollees should monitor their medical bills because they might need to take action to protect their rights.

Also, some states have protections that are stronger than the No Surprises Act. State departments of insurance often provide additional information on their websites about implementing the No Surprises Act and interactions with existing state laws.

Note: Most of the law's protections only apply to people with private insurance, including marketplace health insurance plans, and not to people who are uninsured or enrolled in Medicaid, CHIP, or Medicare (which have their own protections against surprise medical bills).

1 What is a surprise medical bill?

Generally, before getting health care services, people enrolled in private insurance are responsible for checking their plan's network to ensure that the medical provider they've selected is in-network. This means that, in most situations, people who get medical services from an out-of-network provider are responsible for paying the out-of-network medical bills they receive. The majority of plans pay less for out-of-network care than they would pay for in-network care, and some don't cover out-of-network bills at all, leaving the enrollee responsible for paying most or all of the out-of-network bill.

There are some situations where a person doesn't get to choose their medical provider and ends up receiving out-of-network care. This can happen in medical emergencies when people are taken to the closest ER, but it can also happen when people select an in-network hospital for scheduled care but receive care from an out-of-network doctor they did not get to pick (such as the anesthesiologist). These scenarios are common; a hospital can be in-network while some doctors who provide care there are out-of-network. An out-of-network medical bill a person receives after getting care from an out-of-network provider they didn't get to choose is known as a surprise medical bill.

People are often "surprised" by other types of medical bills that they didn't expect or can't afford to pay, like high deductibles or care from an out-of-network provider they chose themselves. The No Surprises Act doesn't protect people in those situations.

2

What types of medical bills are now banned?

The new law protects insured people in two major ways:

- For emergency care: An insured person can get care at any emergency department, even if the care is out of network. The out-of-network emergency facility, and the doctors and other providers who treat the patient, cannot bill the patient for more than in-network cost-sharing amounts (i.e., deductible, copay, coinsurance). The plan also must apply only in-network cost-sharing.
- For non-emergency care: If the insured person goes to an in-network facility, they cannot be billed for more than the in-network cost-sharing amount for their services, even if they receive care from an out-of-network provider.

Note: While out-of-network air ambulance services are covered by the No Surprises Act, out-of-network ground ambulance services are not and can still lead to high bills.

Here are two examples to show how this works:

- An insured person is brought to the emergency room after a car accident and needs an MRI. The radiologist that performs the MRI is out-of-network. Prior to 2022, the radiologist could bill the patient directly, which means the patient would have to contact their insurance company to request a reimbursement. Typically, the insurance company would reimburse an amount it considered reasonable, but it would not provide reimbursement for the radiologist's full bill, so the patient would pay the difference. This kind of surprise medical bill is now banned. Now, the patient can only be billed in-network cost-sharing for emergency services, even if care was provided by out-of-network providers. This applies to care at any emergency department.
- An insured person goes to an in-network hospital for a scheduled knee surgery by an in-network surgeon. An assistant surgeon who is out-of-network is brought into the procedure. Prior to the new law, the assistant surgeon could have billed the patient for their full rate, and the patient would have had to submit the out-of-network claim to her insurance to collect whatever reimbursement, if any, that she could. Now, the patient's plan cannot deny coverage for this surprise bill simply because it is out of network; instead, the service must be covered with in-network cost sharing. And the out-of-network assistant surgeon is prohibited from billing the patient for more than the in-network cost sharing amount. For non-emergency care, this protection only applies when the patient is at an in-network facility.

Key Terms

In-network providers: Facilities and doctors who contract to accept a payment rate with your insurer. In-network care generally costs less than care that is out-of-network. You might still have to meet a deductible before your insurance pays the bill, or you might owe a copayment or coinsurance, depending on the type of service and your health plan.

Out-of-network providers: Providers who do not contract with your insurer and instead charge you separately for their services. Unlike in-network providers, out-of-network providers set their own charges. Your health plan might cover some of the cost but often covers none of the cost of out-of-network services.

Surprise medical bill: An out-of-network medical bill a person receives from an out-of-network provider for emergency services, or for non-emergency care while at an in-network facility.

3

What out-of-network providers and services must follow the new law?

Any health care provider at any emergency department or at the insured person's in-network facility must follow the new law. A "provider" is defined broadly to include doctors, radiologists, therapists, and others. Services like imaging and lab work, preoperative and postoperative services, telemedicine, and equipment and devices are also covered. "Facilities" are hospitals, hospital outpatient departments, and ambulatory surgery centers. They don't include other settings, such as urgent care.

4

How should billing work under the No Surprises Act?

Before an out-of-network provider sends a bill for emergency care or for care provided at an in-network facility, they are required to first check with the patient's insurance company to find out the amount of in-network cost-sharing (i.e., deductible, copay, coinsurance) that applies. Providers can only bill the patient for that in-network cost-sharing amount.

Once the insurance company tells the provider the in-network cost-sharing amount, it must also provide the patient with an Explanation of Benefits (EOB) showing that the out-of-network provider is following the No Surprises Act rules and charging only the in-network cost-sharing. The insurance company must count the cost-sharing the insured person pays toward the person's annual in-network deductible and out-of-pocket maximum.

5

Are all high medical bills considered surprise bills?

Cost-sharing charges can vary widely across insurance plans, which means that a person could still receive *very high* medical bills due to their plan's standard in-network cost-sharing charges being high. These kinds of bills are not considered surprise medical bills.

6

What should people do if they think they received a surprise medical bill?

The first step is to check with the insurance company to see if the provider made a mistake. The out-of-network provider shouldn't bill for more than the in-network cost-sharing amount for the service(s) indicated on the EOB. If there is no EOB it might mean that the provider didn't contact the insurance company as required.

The second step is to contact the out-of-network provider and ask them to correct the bill. Providers can face fines up to $10,000 per violation for not following the new rules.

If the provider refuses to resolve the issue by correcting the bill, then it might be necessary to file a complaint by calling the **No Surprises Help Desk at 1-800-985-3059**. The No Surprises Help Desk is also available for people who have questions or want more information about the new rules. Complaints can also be filed online at www.cms.gov/nosurprises.

A mistake made by a person's insurance company could also result in a surprise medical bill. If that happens, the person should call their insurance company, explain the situation, and ask them to treat the claim as a surprise medical bill. If the insurance company doesn't correct the issue, the next step is to file an appeal with the insurance company. If this is unsuccessful, the next step is to request an external appeal.

Note: Every EOB is required to include instructions for how to file an appeal.

In most states, there is a Consumer Assistance Program (CAP) that can help people file appeals and resolve billing and coverage problems, including surprise medical bills. Contact information for state CAPs can be found here.

7 **What out-of-network providers and services are not covered by the new law?**

It's still important for people to understand what facilities and providers are in-network or out-of-network under their health plan. Services that are scheduled in advance directly with an out-of-network provider are not covered under the new law, and the provider can charge patients the full cost for services.

For example, an out-of-network provider can charge their full costs if the patient:

- ✖ Schedules surgery at an out-of-network hospital
- ✖ Gets primary care from a doctor who is out-of-network
- ✖ Has a non-emergency office visit with an out-of-network provider
- ✖ Uses ground ambulance services
- ✖ Has a service that is not covered under the plan, such as elective cosmetic surgery

8 **How will people find out about these new protections?**

Providers and facilities will post a one-page notice on their website and in their facility and give this notice to every patient who gets a service covered by the new law. Insurers will also provide this notice with the enrollee's EOB.

9 **What if a person is asked to waive their protections?**

In some cases, a person might be asked to waive their protections, but signing this kind of waiver is never required. People should only agree to waive their legal protections if they're sure they want care from a specific out-of-network provider and are willing to pay the full cost. The waiver must be presented in advance for the person to sign, but for same-day procedures, they could be given the waiver as little as 3 hours before the scheduled service.

Waivers are not permitted in many circumstances, including for emergency services. For non-emergency care at in-network hospitals, certain providers can ask for waivers (like surgeons), but others are never allowed to ask people to waive their surprise bill protections. People cannot be asked to waive protections by: anesthesiologists, pathologists, radiologists, neonatologists, intensivists, hospitalists, or assistant surgeons. In addition, no out-of-network provider at an in-network facility can ask people to waive their surprise bill protections when there is no in-network provider in that facility who can provide the care.

10 **What protections exist for people who are uninsured?**

Most of the No Surprises Act's protections don't apply to people who are uninsured. However, one new protection gives people who are uninsured the right to request an estimate of the cost of care. For 2022, this estimate is just for care by the provider the person contacts. After 2022, the provider will be required to include other possible charges, like lab work and radiology, in one estimate. If the actual cost of care from any single provider is more than $400 higher than the estimate, the person can file a dispute here. State Consumer Assistance Programs can also help people navigate this process.

See the Beyond the Basics Plan Design webinar for more information about how health plans work.

Fact sheets and instructions on how to file disputes are available at www.cms.gov/nosurprises.