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How the No Surprises Act Protects Against Shocking Medical Bills

Navigating through the twists and turns of U.S. healthcare insurance is not easy – but with the enactment of the No Surprises Act, patients have protection from surprise medical bills.

The $1.4 trillion Consolidated Appropriations Act of 2021 was signed into law on Dec. 27, 2020, with a provision entitled the No Surprises Act (NSA) included under title I of the law.

The NSA went into effect on Jan. 1, 2022, giving consumers much-needed billing protection when receiving care from emergency departments, out-of-network providers and in-network facilities, and air ambulance services from out-of-network providers.

The Ins and Outs of Insurance Networks

Imagine having a medical emergency and needing to choose between going to a nearby hospital that is out-of-network, or an in-network hospital that would take precious, life-saving time to get to – all in order to avoid devastating medical bills after.

This was all too common for insured patients before the NSA. Most insurance plans do not cover the entire cost of care received from a facility or provider not in their network – leaving it up to the patient to research where they could go for care without paying those higher costs.

In cases where a patient receives care from an out-of-network provider, the balance would be owed by the patient to the provider directly – the unexpected balance bill is known as a surprise bill.

A Not-So-Nice Surprise

Examples Of Scenarios Resulting in Surprise Bills Include:

- An accident victim is taken to an out-of-network emergency department.
- A patient has surgery at an in-network facility, but the anesthesiologist is out-of-network.
- An in-network provider has lab work done at an out-of-network lab.

No Surprises Act criteria

The NSA provides new rules aimed to protect consumers, restricts excessive out-of-pocket costs, and requires emergency services to continue to be covered without any prior authorization – regardless of whether or not a provider or facility is in-network.

These protections must meet the following criteria:

- Service is covered under private or commercial health plans that began on **Jan. 1, 2022, or after**.
- Services were rendered **on or after Jan. 1, 2022**.

It's important to note that the law does not apply to limited-duration plans, stand-alone plans or Medicare, Medicaid or TRICARE.

Some requirements also apply to providers when caring for uninsured (or self-pay) individuals, like requirements that providers and facilities provide good faith estimates for scheduled care, or upon request.

Continuity of Care

Providers and facilities can change status from being in-network to out-of-network. Before the NSA, it could come as quite a shock for patients when they suddenly receive hefty bills for recent care from what were once in-network services for them.

Consider a cancer patient who needs to be continuously followed by an oncologist. If that doctor becomes an out-of-network provider, the patient is forced to make a distressing decision: stay with the doctor and pay the price or find a new doctor right away.

The NSA protects Continuity of Care by allowing individuals 90 days to find a new, in-network provider to transition to. It also puts the responsibility on the health insurance plans to notify patients when a provider is no longer in-network.

Is your medical bill a violation of the No Surprises Act?

The HHS Office of the Assistant Secretary for Planning and Evaluation released a report that shows nearly one in five patients with private insurance who go to the emergency room, have an elective surgery or give birth in a hospital receive surprise bills. **The average cost ranges from $750 to $2,600 per episode.**

Not a fun surprise.

The No Surprises Act protects consumers from surprise medical bills in the U.S.—but no law is cut and dried.

Surprise medical bill? It could be a violation of the No Surprises Act.

It's never a good feeling to receive a surprise medical bill. Once the shock wears off, it's time to do some research to see if that bill is a mistake or a violation. But how do you know if the bill you've received from a healthcare provider is in violation of the No Surprises Act?

For insured consumers, a bill must meet three criteria to be considered a possible violation of the No Surprises Act:

1. They received a surprise medical bill.
2. The insurance plan year start date is on or after Jan. 1, 2022.
3. The items or services associated with the disputed bill are covered benefits under the health insurance plan.

Uninsured consumers also have three criteria to meet for a bill to be considered a possible violation:

1. The date of service was on or after Jan. 1, 2022.
2. The appointment for the bill being disputed was scheduled by the consumer.
3. The services were provided by either a healthcare facility or healthcare provider.

You have a surprise medical bill – now what do you do?

If a medical bill meets criteria as being a surprise bill, it's time to take action.

Both federal and state governments enforce the No Surprises Act. Some states share the responsibility with the federal government while others do not have the means to take it on themselves.

So where do you go for help? **The Centers for Medicare & Medicaid Services No Surprises Help Desk** answers questions and takes complaints from consumers.

Phone (seven days a week, 8 a.m. to 8 p.m. ET): 800.985.3059

Online Complaint Form

You'll need documentation to accompany your complaint. Some examples include:

- Bill pertaining to the date of service you are disputing
- Explanation of Benefits (EOB) pertaining to the date of service you are disputing
- Copy of your insurance card
- A good faith estimate (if uninsured or self-pay)
- Your health insurance plan year's start date

It's also important to know that the No Surprises Act protects people from the negative side effects of unlawful debt collection and credit reporting. You do not need to be a Medicaid or Medicare customer to ask for help from the CMS Help Desk.

What Providers Need to Know

The No Surprises Act requires healthcare providers to be clear and transparent about their billing practices and what patients should expect to pay for medical treatment.

The new law protects patients from balance billing and other medical bills not expected at the time of treatment. Impacted facilities and individual providers should already have measures in place to be compliant—we'll go over the basics here.

Medical Provider Compliance

Healthcare facilities, providers and health insurance companies must provide an easy and accessible explanation of the No Surprises Act, the federal/state requirements and prohibitions related to balance billing, good faith estimates for the uninsured or self-pay patients, and agency contact information for filing complaints.

This information should appear on the homepage of websites and be visible in physical locations.

The law applies to:

- **Health Care Facilities**
- **Emergency Health Care Facilities, such as:**
  - Hospital emergency departments
  - Independent, freestanding emergency departments
- **Providers, such as:**
  - Physician Assistants
  - Nurse Practitioners
  - Anesthesiologist assistants
  - Certified registered nurse anesthetists
  - Physical and occupational therapists
  - Laboratory service providers
  - Psychologists
  - Air Ambulance Providers

Resources for Consumers

You can find more details and resources regarding the No Surprises Act from the **Centers for Medicare & Medicaid Services** and the **U.S. Department of Health & Human Services**.

- Notices you may get and whether you should sign them.
- Where to go for help (state or federal map).
- How we are protecting people from the side effects of surprise medical bills.
- CMS Online complaint form.

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Tools and Resources for Providers

As surprise medical bills can be overwhelming for patients, the No Surprises Act requirements can be overwhelming for healthcare providers. **The American Medical Association** has an Online Toolkit for providers looking for guidance on operational challenges they need to address.

The toolkit explains rules for emergency care and patients who cannot or do not consent to out-of-network post-stabilization care. It also answers questions about good faith estimates and how quickly they must be provided for self-pay and uninsured patients.

In addition, requirements ensuring patients receive notice and consent to care provided by out-of-network clinicians at in-network facilities are discussed in the toolkit. The Department of Health and Human Services also offers a model notice providers can use to provide patients with disclosures regarding their protections regarding the No Surprises Act.