No Surprises Act Overview

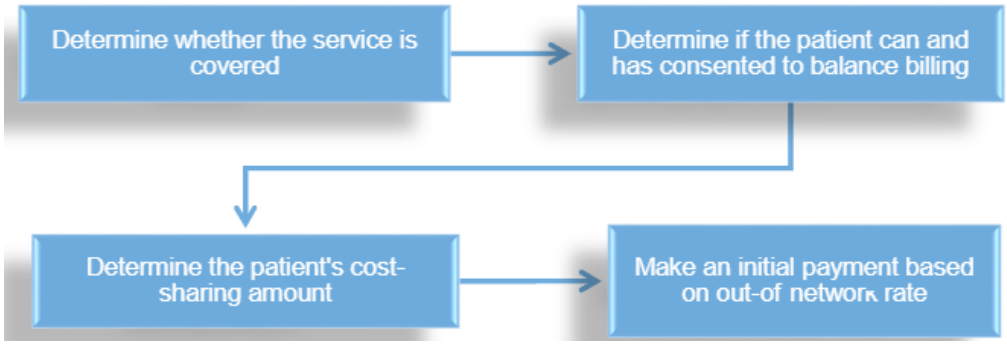
The No Surprises Act protects people covered under group and individual health plans from receiving surprise medical bills when they receive most emergency services, non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers. It also establishes an independent dispute resolution process for payment disputes between plans and providers and provides new dispute resolution opportunities for uninsured and self-pay individuals when they receive a medical bill that is substantially greater than the good faith estimate they get from the provider.

Provides insurance companies and health care providers a fair process to resolve out of network bill without additional cost to patients.

The requirements apply to 3 categories of healthcare:

1. The provision of emergency services by a nonparticipating emergency facility or nonparticipating provider,
2. Non-Emergency services furnished by out-of-network providers in in-network facilities, and
3. Air ambulance service provided by out-of-network providers.

Under the NSA, covered payments consist of two components – Cost sharing from patients and out-of-network provider payments from plans or insurers based upon an out-of-network rate. However, there are several steps involved before payment is made. Below is a chart to show the steps:



Non-participating providers may balance bill patients for non-emergency services provided in a participating facility, but only if specific notice and consent requirements are satisfied. The notice must:

1. State that the providers is a non-participating provider;
2. Include a good faith estimate of the amount that the provider may charge for the services involved; and
3. State clearly that the individual may seek care from an available participating provider, in which case, in-network cost sharing will apply.

No Surprises Act Frequently Asked Questions

Q: What are surprise medical bills?

A: Before the No Surprises Act, if you had health insurance and received care from an out-of-network provider or an out-of-network facility, even unknowingly, your health plan may not have covered the entire out-of-network cost. This could have left you with higher costs than if you got care from an in-network provider or facility. In addition to any out-of-network cost sharing you might have owed, the out-of-network provider or facility could bill you for the difference between the billed charge and the amount your health plan paid, unless banned by state law. This is called "balance billing." An unexpected balance bill from an out-of-network provider is also called a surprise medical bill.

Q: What if I don't have health insurance or choose to pay for care on my own without using my health insurance (also known as "self-paying")?

A: If you don't have insurance or you self-pay for care, in most cases, these new rules make sure you can get a good faith estimate of how much your care will cost before you receive it.

Q: What if I'm charged more than my good faith estimate?

A: For services provided in 2022, you can dispute a medical bill if your final charges are at least $400 higher than your good faith estimate, and you file your dispute claim within 120 days of the date on your bill.

Q: What if I do not have insurance from an employer, a Marketplace, or an individual plan? Do these new protections apply to me?

A: Some health insurance coverage programs already have protections against surprise medical bills. If you have coverage through Medicare, Medicaid, or TRICARE, or receive care through the Indian Health Services or Veterans Health Administration, you don't need to worry because you're already protected against surprise medical bills from providers and facilities that participate in these programs.

Q: What if my state has a surprise billing law?

A: The No Surprises Act supplements state surprise billing laws; it does not supplant them. The No Surprises Act instead creates a "floor" for consumer protections against surprise bills from out-of-network providers and related higher cost-sharing responsibility for patients. So as a general matter, as long as a state's surprise billing law provides at least the same level of consumer protections against surprise bills and higher cost-sharing as does the No Surprises Act and its implementing regulations, the state law generally will apply. For example, if your state operates its own patient-provider dispute resolution process that determines appropriate payment rates for self-pay consumers and Health and Human Services (HHS) has determined that the state's process meets or exceeds the minimum requirements under the federal patient-provider dispute resolution process, then HHS will defer to the state process and would not accept such disputes into the federal process.

As another example, if your state has an All-payer Model Agreement or another state law that determines payment amounts to out-of-network providers and facilities for a service, the All-payer Model Agreement or other state law will generally determine your cost-sharing amount and the out-of-network payment rate.