The No Surprises Act

New federal law protections under the No Surprises Act began on January 1, 2022.

What Are the New Protections?

- **Protections from surprise bills from out-of-network providers**
- **Notice about surprise billing protections**
- **Good faith estimates for planned treatment**
- **More information on your insurance card**
- **Protections when in-network providers become out-of-network**
- **Other protections**

Surprise Billing Protections

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing" (sometimes called “surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

“Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you receive services at an in-network hospital or ambulatory surgical center, certain providers at the facility may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, and intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out-of-network providers can't balance bill you unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

Maryland-specific balance billing protections:

If you are in a Health Maintenance Organization (HMO) governed by Maryland law, you may not be balance billed for services covered by your plan, including ground ambulance services.

If you are in a PPO or EPO governed by Maryland law, hospital-based or on-call physicians paid directly by your PPO or EPO (assignment of benefits) may not balance bill you for services covered under your plan and can't ask you to waive your balance billing protections.

If you use ground ambulance services operated by a local government provider who accepts an assignment of benefits from a plan governed by Maryland law, the provider may not balance bill you.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

When your health plan says the new protections don't apply, you have appeal rights:

If your health plan denies payment of all or part of your claim because the plan says the item or service isn't covered or that there are limitations on the coverage, or because the plan considers the item or service not medically necessary, experimental or investigational, you can appeal that denial. Under the new law you can ask for an independent external review of whether your health plan's denial complies with the new surprise billing and cost-sharing protections.

For example, if your health plan covers emergency care and you go to the emergency room and your plan denies payment for the services because it doesn't believe the items or care you received were “emergency services," you can dispute this decision using an appeal process to help determine whether your health plan needs to cover the services.

If your health plan uses your out-of-network cost-sharing (copay, coinsurance, or deductible) when you think it should have used your in-network cost-sharing, you can appeal that decision.

If you believe you've been wrongly billed or your health plan has improperly processed your claim, call or email us for more information, or file a complaint here: https://www.marylandattorneygeneral.gov/Pages/CPD/HEAU/compOLBillEquipDispute.aspx

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If you believe your health plan processed your claim incorrectly, you may also contact the Maryland Insurance Administration:

Maryland Insurance Administration
Life and Health Complaints Unit
200 St Paul Place, Suite 2700
Baltimore, Maryland 21202
Phone (410) 468-2000 or toll free 1-(800) 492-6116
Fax: (410)468-2260
Website: http://www.insurance.maryland.gov

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

The rules don't apply to people with coverage through programs like Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE because these programs have other protections against high medical bills.

Notice About Surprise Billing Protections

Providers who provide items or services in a hospital or ambulatory surgical facility and those facilities must disclose to consumers enrolled in a health plan information regarding federal and state balance billing protections and how to report violations. Providers or facilities must post this information prominently at the location of the facility and post it on a public website (if applicable). Providers or facilities must give consumers a notice in-person or through mail, or email, as selected by the consumer, on or before the date the provider or facility requests payment, or if no payment is requested, on or before the date the provider or facility submits a claim to the consumer's health plan.

The federal Department of Health and Human Services developed a model notice for providers and facilities to use and the HEAU and MIA developed the required state-specific language to assist providers and facilities in satisfying the No Surprises Act requirement. The model notice with Maryland-specific language can be found here.

Good Faith Estimates for Planned Treatment

Starting January 1, 2022, the No Surprises Act protects uninsured and other or self-pay patients from many unexpectedly high medical bills.

Good faith estimates for uninsured or self-pay patients

Beginning January 1, 2022, health care providers and facilities must provide a good faith estimate of expected charges to uninsured consumers, or to insured consumers if they don't plan to have their health plan help cover the costs (self-paying individuals).

You are generally considered an uninsured or self-pay individual if you do not have health insurance, or do not plan to use your insurance to pay for a medical item or service. If you are an uninsured or self-pay individual, a provider or facility must give you a “good faith estimate" detailing what you may be charged before you receive the item or service.

The good faith estimate will include:

- A list of items and services that the scheduling provider or facility reasonably expects to provide you for that period of care.
- Beginning in 2023, a list of items and services and their associated costs, that can be reasonably expected to be given to you by another provider or facility involved in your care (a co-provider or co-facility). For example, a doctor probably expects that along with an individual's knee replacement surgery, the patient will also be given anesthesia. Both of these items and services should be included in your good faith estimate, and starting in 2023, the anesthesia items and services will have to be included.
- Applicable diagnosis and service codes.
- Expected charges or costs associated with each item or service.
- A notification that if the billed charges are higher than the good faith estimate, you can ask your provider or facility to update the bill to match the good faith estimate, ask to negotiate the bill, or ask if there is financial assistance available.
- Information on how to dispute your bill if it is at least $400 higher for any provider or facility than the good faith estimate you received from that provider or facility.

When can you expect a good faith estimate?
If you schedule an item or service at least 3 business days before the date you will receive the item or service, you must be given a good faith estimate no later than 1 business day after scheduling. If you schedule the item or service at least 10 business days before the date you will receive it, or request cost information about an item or service, the provider or facility must give you a good faith estimate no later than 3 business days after scheduling or requesting.

Is the good faith estimate a bill?
No. The good faith estimate shows the costs of items and services that your provider or facility expects to charge you for an item or service. The estimate should be based on information known at the time the estimate was created and does not include any unknown or unexpected costs that may arise during the course of treatment. For example, you could be charged more if complications or special circumstances occur.

Can I get an estimate from other providers involved in my care before 2023?
Yes, you can ask any other provider or facility for a good faith estimate and they are required to provide it to you.

What if I am using my insurance?
Consumers with health insurance will be able to get estimates from their health plans in the future, but the No Surprises Act requirement to provide the estimates has been delayed. Maryland law offers some protections now. If you are visiting a hospital in Maryland as an outpatient for an outpatient clinic service, supply, or equipment, under Maryland law, the hospital is required to tell you the hospital's facility fee in advance if known. If not known in advance, the hospital is required to provide you with an estimate/likely range of what the facility fee is expected to be based on typical or average fees for the same or similar appointments. Maryland hospitals are also, upon request, required to provide you with a written estimate of the total charges for nonemergency services, procedures, and supplies that are reasonably expected to be provided for professional services by the hospital. And out-of-network physicians that seek to be paid directly by your health plan

(assignment of benefits) are required to give you a written estimate of the cost of services prior to performing services. You can ask for a pre-treatment estimate from other providers, but those providers generally aren't required to automatically give you an estimate.

If you are billed more than your good-faith estimate

The HEAU can help you by mediating any good faith estimate billing dispute with your provider or facility.

If you are uninsured or self-pay and you get a bill that is at least $400 more than the total expected charges for that provider or facility on the good faith estimate, there is a new federal patient-provider dispute resolution (PPDR) process available to you under the No Surprises Act. Under the PPDR process, you may request a payment review and decision from an independent company certified by the federal Department of Health and Human Services. These companies are referred to as Selected Dispute Resolution (SDR) entities. The SDR entity will decide what amount you must pay if your bill is at least $400 more for any provider or facility than your good faith estimate from that provider or facility.

There are deadlines for using this process. You must file a request for help within 120 calendar days (about 4 months) of the date on your first bill. The HEAU can help you with the process.

There is a $25 fee to use the dispute process. If the SDR entity reviewing your dispute agrees with you, you will have to pay the price on the Good Faith Estimate less the $25 fee. If the SDR entity disagrees with you and agrees with the health care provider or facility, you will have to pay a higher amount as determined by the SDR. The HEAU can help you with negotiating a payment plan if needed.

Dispute resolution process

During the patient-provider dispute resolution process, you can continue to negotiate the bill with your provider. During this process, providers:

- May not move the bill into collections or threaten to do so.
- Must pause collections if the bill is already in collections.
- Can't collect late fees on unpaid amounts.
- Can't threaten to take any retaliatory action against you for initiating the patient-provider dispute resolution process.

Where to get help

If you need help obtaining a good faith estimate, believe you've been wrongly billed, or need more information, call or email us, or file a complaint here: https://www.marylandattorneygeneral.gov/Pages/CPD/HEAU/compOLBillEquipDispute.aspx

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Visit CMS for more detailed information about the good faith estimate and the patient-provider dispute resolution (PPDR) process.

For more information or to start a dispute under the patient-provider dispute resolution (PPDR) process, visit: https://www.cms.gov/nosurprises/consumers/medical-bill-disagreements-if-you-are-uninsured

For more help from the federal Department of Health and Human Services

- Call the No Surprises Help Desk at 1-800-985-3059.
    - Get help in a language other than English through the Help Desk..
    - Get this information in an accessible format, like large print, Braille, or audio, at no cost to you, through the Help Desk.

Health Insurance ID cards

Starting in 2022, new pricing information will be shown on any physical or electronic plan or insurance identification card (ID) cards.

This will include:

- Applicable deductibles
- Applicable out-of-pocket maximum limits
- A telephone number and website for you to get assistance
- Additional information may be provided on a health plan's website that can be accessed through a Quick Response code (commonly referred to as a QR code) on a physical ID card, or through a hyperlink on a digital ID card.

Continuity of Care

For health plan years beginning on or after January 1, 2022, if you are a continuing care patient of an in-network provider or facility and the provider or facility's contract is terminated with your health plan, your health plan will have to notify you and permit you to continue your care with that provider or facility as if they were still in-network with your plan for 90 days, or until you are no longer a continuing care patient, whichever comes first.

Who is a continuing care patient?

An individual who, with respect to a provider or facility:

- Is undergoing a course of treatment for a serious and complex condition from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;
- is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or,

- is or was determined to be terminally ill and is receiving treatment for such illness from such provider or facility.

What is a serious and complex condition?

- In the case of an *acute illness*, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- In the case of a chronic illness or condition, a condition that:
  - is life-threatening, degenerative, potentially disabling, or congenital; and
  - requires specialized medical are over a prolonged period of time.

What can the provider or facility charge the consumer?

The provider or facility can charge you the in-network copayment, coinsurance and deductible amounts for your care.

Are there exceptions to the continuity of care protections?

Yes, if your treating provider or facility's contract with your health plan was terminated because of quality standards or fraud, the protections do not apply.

Other Protections

- Protections from inaccurate provider directories

If you need more information about these protections, call or email us for more information, or file a complaint
here: https://www.marylandattorneygeneral.gov/Pages/CPD/HEAU/compOLBillEquipDispute.aspx

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