No More Surprises

A Consumers' Guide to New Patient Protections

On January 1, 2022, Americans will receive new protections against balance bills, also known as surprise bills. Balance bills occur when a provider bills a patient for the remainder—or balance—between his bill and your insurer's out-of-network rate. You cannot receive these bills from an in-network provider. An estimated 1 out of every 5 emergency bills result in a surprise bill and can cost hundreds, if not thousands, of dollars.

These bills don't just happen in emergency settings. Americans have been receiving balance bills from in-office visits or even when they unknowingly see an out-of-network provider at an in-network facility.

New Protections Starting January 1

No more surprise bills from emergency rooms.

No more surprise bills from out-of-network providers at in-network facilities. This extends to anesthesiologists, radiologists and even labs, all of which were previously a big source of surprise bills.

No surprise bills from air ambulances.

90-day coverage if your provider moves out-of-network. If your provider moves out-of-network, your insurer must provide 90 days of coverage for that provider at the in-network rate, giving your 3 months to find a new provider for your needs.

New, more accurate provider directories. Not only must your insurer maintain and update their provider directory every 90 days, but if they give you inaccurate information and falsely tell you that a provider is in-network when they are not, they must still provide in-network coverage. Further, they must respond to all requests for this information within one day.

Advance notice on costs

- From your insurer: If you submit a request to your insurer, they must reply within 3 business days about whether a provider is in-network, along with a good faith estimate of what the plan will pay and what your out-of-pocket costs will be.

- From a provider: You must receive written 72-hours notice from any out-of-network provider or facility which includes a good faith estimate of out-of-network charges and provides a list of other in-network providers at that facility. Keep in mind, though, that radiologists and anesthesiologists must stay at the in-network rate. If you receive such a notice from these providers, please notify your insurer.

What can you still expect to pay? You will still be responsible for your normal, in-network copay, coinsurance or deductible.

Who does this apply to? Most Americans are covered by these laws, except for those who are on short-term plans or in a sharing ministry rather than insurance. If you get your insurance from your employer, if you buy it on the Marketplace, even if your plan is a pre-ACA grandfathered plan…you're covered! And if you are on Medicare or Medicaid, your plan already prohibited balance billing.

What's Still Missing

You can still receive a balance bill from:

- Ground ambulances
- Non-emergency services provided in urgent care facilities
- Non-emergency services by certain types of providers to whom you have given informed, written consent at least 72 hours before a procedure. Not all providers are given this exception; for instance, radiologists and anesthesiologists must be covered as in-network.

What You Should Do If You Receive a Surprise Bill

Importantly, the law specifies that providers can not send you a balance bill. If you receive a bill in the mail that you suspect could be a balance bill, you should call your insurer and report the issue.

A bill might be a balance bill if:

- It is a different amount than what your Explanation of Benefits specified that you would owe
- It comes directly from your provider but is a different amount than your normal copay or coinsurance – especially if you have already reached your deductible

- It includes language about your insurer paying the out-of-network rate
- It is from an out-of-network provider to whom you did not provide written consent

If this applies to you, call your insurer and ask them to clarify how much you owe. Report the bill to your insurer. Providers and facilities can be charged up to $10,000 for each violation of this law.

Terms Used In This Guide

Explanation of Benefits: a packet your insurer will send to you that confirms they have received a claim on your behalf and tells you how much you will owe

Copay: a fixed amount you pay for each service after you have met your deductible (for instance, $20 for an office visit at your primary care provider)

Coinsurance: an amount you pay as a percentage of the bill after you have met your deductible (for instance, if a bill is $1000 and your coinsurance is 20%, you would owe $200)

Deductible: the amount you pay for covered services after which your insurance starts to pay. For instance, if you have a $2000 deductible, you must pay that amount before you are only responsible for a copay, except for certain preventative services that must come at no cost to you, like your annual wellness visit.

Network: a group of providers and facilities that are covered at reduced rates by your insurance and who cannot bill you outside of those agreed-upon rates