Black River MEMORIAL HOSPITAL

NO SURPRISES ACT: FURTHER EXPLAINED

NEW PROTECTIONS

What are the new protections?
For consumers who get coverage through their employer (including a federal, state, or local government), through the Health Insurance Marketplace® or directly through an individual health plan, beginning **January 2022**, these rules will:

- Ban surprise billing for emergency services. Emergency services, even if they're provided out-of-network, must be covered at an in-network rate without requiring prior authorization.
- Ban balance billing and out-of-network cost-sharing (like out-of-network co-insurance or copayments) for emergency and certain non-emergency services. In these situations, the consumer's cost for the service cannot be higher than if these services were provided by an in-network provider, and any coinsurance or deductible must be based on in-network provider rates.
- Ban out-of-network charges and balance billing for ancillary care (like an anesthesiologist or assistant surgeon) by out-of-network providers at an in-network facility.
- Ban certain other out-of-network charges and balance billing without advance notice. Health care providers and facilities must provide consumers with a plain-language consumer notice explaining that patient consent is required to get care on an out-of-network basis before that provider can bill the consumer.

For consumers who don't have insurance, these rules make sure they'll know how much their health care will cost before they get it, and might help them if they get a bill that's larger than expected.

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.

UNDERSTANDING COSTS IN ADVANCE

Starting in 2022, providers, facilities, and health plans will be required to give consumers upfront information on costs ahead of a service and potential out-of-network costs. Whether you have health insurance or are currently uninsured, you'll be able to get estimated costs ahead of a service to help you avoid surprise bills. Consumers with health insurance will be able to get these estimates from their health plan. Uninsured consumers will be able to get a "good-faith" estimate from their health care providers and facilities ahead of time.

Good Faith Estimate
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). The good-faith estimate must be provided after a patient has scheduled an item or service, or upon their request. It should include expected charges for the primary item or service they're getting, and any other items or services that are provided as part of the same scheduled experience.

For example, if a patient is getting surgery, the estimate would include the cost of the surgery, any labs or tests, and the anesthesia that might be used during the operation. If an item or service is something that's not scheduled separately from the surgery itself, it should be included in the good-faith estimate. But, items or services related to the surgery that might be scheduled separately, like pre-surgery appointments or physical therapy in the weeks after the surgery, won't be included in the good-faith estimate.

Providers and facilities must:

- Provide the good-faith estimate before an item or service is scheduled, within certain timeframes.
- Offer an itemized list of each item or service, grouped by the provider or facility offering care. Each item or service has to have specific details, like the health care code assigned to it and the expected charge.
- Explain the good-faith estimate to the patient over the phone or in-person if the patient requests it, and then follow up with a paper or electronic estimate.
- Provide the good-faith estimate in a way that's accessible to the patient.

Insurance ID Cards
Starting in 2022, new pricing information will be shown on any physical or electronic plan or insurance identification card (ID) provided to patients.

This will include:

- Applicable deductibles
- Applicable out-of-pocket maximum limits
- A telephone number and website where consumer assistance will be provided

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.

GOOD FAITH ESTIMATE

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost.

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 715-284-1327.

PAYMENT DISAGREEMENTS

Payment disputes between consumers and providers.
If an uninsured (or self-pay) consumer is billed for an amount that exceeds the good faith estimate they were provided, the consumer can use a new patient and provider dispute resolution process to determine a payment amount. Consumers will be eligible to use this process if they have a good-faith estimate, a bill within the last 120 calendar days, and the difference between the good-faith estimate and the bill is at least $400.

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Through this process, consumers will also be able to request a third-party arbitrator to review the good-faith estimate, their bill, and information submitted by their provider or facility to determine if the additional charges are allowed or if the provider or facility can only charge less than the billed charge.

Insured consumer rights when a health plan denies a claim as not covered.
Starting in January 2022, consumers with health insurance will have expanded protections when they need to appeal or dispute a payment for services that their health plan denied with the reason that the item or service isn't covered, limitations on the coverage, or the plan considers the item or service as not "medically necessary". Consumers will be able to start a process for an external review of whether their health plan's denial complies with the new surprise billing and cost-sharing protections. For example, if a consumer's health plan covers emergency care and the consumer goes to the emergency room, but later the plan denies payment for the services because it doesn't believe the items or care the consumer received were "emergency services", the consumer will be able to dispute this decision using a new external review process to help determine whether their health plan needs to cover the services.

Helping to resolve disputes between providers, facilities, and health plans.
To protect consumers from surprise medical bills, starting in 2022 consumers with health insurance generally won't be responsible for balance bills or out-of-network cost-sharing when getting emergency care, or non-emergency care from out-of-network providers at in-network facilities, and air ambulance services from out-of-network providers. When this happens, instead of the consumer paying for out-of-network costs and balance billed amounts, they'll generally only need to pay their normal in-network costs. The provider and the consumer's health plan can negotiate the total payment amount to the provider.

The surprise billing rules outline the process for resolving payment disputes between a provider or facility and a health plan. When a provider or facility and a health plan can't agree on the payment amount for an out-of-network service experienced by a patient, they'll be able to initiate a new federal independent dispute resolution process. Consumers aren't involved in this process and don't have to negotiate with the provider or health plan. This new dispute resolution process for out-of-network bills will start in January 2022.

Usually, providers and facilities send a claim to a consumer's health plan for payment once the patient gets care. Once the surprise billing rules are in place, after receiving a payment from a health plan or a notice of denial, either the health plan or the provider or facility can choose to start an open negotiation period that lasts 30 business days. If the health plan and provider or facility can't agree on a negotiated rate, either can begin the independent dispute resolution process.

All information provided in this handout comes from www.cms.gov.