NO SURPRISES ACT

The federal No Surprises Act became effective Jan. 1, 2022. The law aims to help patients understand health care costs in advance of care and to minimize unforeseen or surprise medical bills.

OVERVIEW

What is balance billing/ surprise billing?

Your plan may assign an out-of-pocket responsibility for when you see a doctor or other health care provider. Because of this, you may owe a copay, coinsurance and, or, a deductible. Your responsibility might increase when you visit a provider or facility that is outside your plan's network.

Balance Billing occurs when Out of Network providers bill you for the difference between "what your plan agreed to pay and the full billed amount and is considered unexpected.

How are Patients Protected?

For certain scheduled care with out-of-network providers, patients must be given advance notice and give approval, where applicable, to be billed for any related out-of-network fee or amount. Patients are protected from balance billing resulting from emergency services and for certain scheduled services at an in-network hospital or ambulatory surgery center. Self-Pay Patients, patients without insurance or who do not wish to use their plan for coverage of services, have a right to receive a good faith estimate of their potential bill for medical services when scheduled at least three days in advance.

Individuals with Medicare, Medicare Advantage, Medicaid, Indian Health Services, VA health care, or TRICARE insurance plans are not covered under the No Surprises Act because these federal insurance programs have existing protections in place to minimize large, unforeseen bills.

The No Surprises Act will reduce instances where patients face unexpected medical bills due to receiving care from an out-of-network facility or provider during an emergency. Similarly, patients are protected from receiving surprise bills for certain scheduled services for which they could not reasonably know the network status of a provider.

MARYLAND SPECIFIC BALANCE BILLING PROTECTIONS

Patient enrolled in a health maintenance organization (HMO) governed by Maryland law, may not be balance billed for services covered by their plan, including ground ambulance services. Patient enrolled in a preferred provider organization (PPO) or exclusive provider organization (EPO) governed by Maryland law, hospital-based or on-call physicians paid directly by the PPO or EPO (assignment of benefits) may not balance bill for services covered under the patient's plan, and they cannot ask them to waive their balance billing protections.

Get a Cost of Care Estimate

You have the right to receive a good faith estimate ahead of scheduled non-emergency health care services, if you are an uninsured or self-pay patient. A good faith estimate shows the cost of items and services that are reasonably expected for your scheduled visit based on information known at the time the estimate was created. If you would like to receive a good faith estimate, please contact our office.

For details about the law, visit the No Surprises Act site from the Centers for Medicare and Medicaid Services.