



Consumer Alert: No Surprises Act – What You Need to Know

January 20, 2022 - The federal Consolidated Appropriations Act, which includes the [No Surprises Act](#), went into effect on January 1, 2022. The No Surprises Act protects consumers from balance billing on certain types of care and services, as well as creates new requirements that apply to health insurance plans/issuers, healthcare providers (including air ambulance providers), and facilities regarding cost-sharing rules, notice and consent requirements, and requirements related to disclosures about balance billing protections.

In this Consumer Alert, we detail what this new act means for you, and what to do if you receive a surprise balance bill.

What is balance billing?

- Balance billing happens when a healthcare provider (a doctor, for example) bills a patient after the patient's health insurance issuer has paid its share of the bill. The balance bill is for the difference between the provider's charge and the allowed amount by the insurance issuer set after the patient has paid any copays, coinsurance, or deductibles.
- Balance billing can happen when a patient receives covered, emergency healthcare services from an out-of-network provider or an out-of-network facility (a hospital, for example).

What is surprise billing?

- Surprise billing happens when a patient receives an unexpected balance bill after they receive care from an out-of-network provider or at an out-of-network facility. It can happen for both emergency and non-emergency care. Typically, in emergency care, patients don't know the provider or facility is out-of-network until they receive the bill.

What protections are in place?

- Consumers are protected from surprise bills for covered emergency out-of-network services, including air ambulance services (but not ground ambulance services).
- Consumers are protected from surprise bills for covered non-emergency services at an in-network facility.
- The act applies to health insurance plans starting in 2022 and is not retroactive. It applies to individual and group insurance plans offered by health insurance issuers as well as self-insured and grandfathered plans.
- A facility (such as a hospital or freestanding emergency room) or a provider (such as a doctor) may not bill you for more than your in-network coinsurance, copays, or deductibles for **emergency** services, even if the facility or provider is out-of-network.
- If your health plan requires you to pay copays, coinsurance, and/or deductibles for in-network care, you're responsible for those.
- The new act also protects you when you receive non-emergency services from out-of-network providers (such as an anesthesiologist for a non-emergency surgery) at in-network facilities. An out-of-network



provider may not bill you more than your in-network copays, coinsurance, or deductibles for covered services performed at an in-network facility.

- You **should not** be asked to waive your protections and agree to pay more for out-of-network care at an in-network facility **for care related to emergency** medicine, anesthesiology, pathology, radiology, or neonatology — or for services provided by assistant surgeons, hospitalists (doctors who focus on the care of hospitalized patients), and intensivists (doctors who care for patients needing intensive care), or for diagnostic services including radiology and lab services.
- You **can agree in advance** to be treated by an out-of-network provider in some situations, such as when you choose an out-of-network surgeon knowing the cost will be higher. The provider must give you information in advance about what your share of the costs will be and receive your consent for out-of-network care at least 72 hours before the scheduled medical event. If you choose to go out-of-network, you'll be expected to pay the balance bill as well as your out-of-network coinsurance, deductibles, and copays.

What to do if you receive a surprise bill:

- Your health plan, the facilities, and the providers that serve you must send you a notice of your rights under the new act.
- If you've received a surprise bill that you think isn't allowed under the new act, you can file an appeal with your insurance issuer or ask for an external review of the issuer's decision.
- You can [file a complaint](#) with our Office of Consumer Services or email your complaint to consumers@doi.sc.gov. You may also call the Office of Consumer Services at **803-737-6180**.
- You also can file a complaint with the federal government by visiting [CMS.gov/nosurprises](https://www.cms.gov/nosurprises) or by calling **1-800- 985-3059**.

Other things to know:

- An independent dispute resolution (IDR) is available to settle bills. Providers and insurance issuers can use this process to settle disputes about your bill without putting you in the middle. A similar dispute resolution process is available for uninsured individuals, in certain circumstances, such as when the actual charges are much higher than the estimated charges.
- Other protections in the new act require insurance issuers to keep their provider directories updated. They also must limit your copays, coinsurance, or deductibles to in-network amounts if you rely on inaccurate information in a provider directory.

Please visit doi.sc.gov/NoSurprisesAct to learn more, in-depth details about the No Surprise Act and what it means for you.