

Spotlight

The End of Unexpected Health Care Bills? Implementation of the “No Surprises Act” Is Key

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A 51-year-old man with comprehensive health insurance through his employer suddenly comes down with wrenching abdominal pain. Acting swiftly, his wife rushes him to the nearest emergency room, where he receives emergency surgery for acute appendicitis. His recovery goes smoothly—until, that is, weeks later, when he receives a bill for more than \$20,000. Unfortunately, the nearest hospital was out of his health insurance plan’s network.

Meanwhile, a 64-year-old woman with coverage through her state’s health insurance Marketplace undergoes a jaw surgery she had scheduled weeks prior, carefully making sure that the hospital was in her health plan’s network. The bill she gets handed following the surgery: \$8,000. Although the hospital and surgeon were both in-network, one of the doctors involved in the procedure, the anesthesiologist, turned out to be out-of-network, causing her out-of-pocket cost to soar.

These scenarios represent situations that happen to people every day. A study of 2017 insurance claims showed that nearly one in every five emergency visits and one in every six in-network hospital stays had at least one out-of-network charge, leaving millions of consumers at risk for surprise medical bills.¹

Surprise medical bills occur when a consumer receives an unexpected bill for care they received from a health care provider or facility that is not a part of their health insurance plan’s network.

Surprise billing has long been a costly loophole in health insurance coverage, exposing

Key Takeaways

- ✓ A new federal law called the No Surprises Act has the potential to protect individuals, including older adults, from surprise medical bills.
- ✓ Many states have already taken action to protect consumers against surprise medical bills. As of January 1, 2022, 33 states have surprise-billing laws in place, though there is significant variation between them.
- ✓ As the No Surprises Act is implemented, policy makers and key stakeholders must carefully ensure that the shared goal of protecting consumers from surprise medical bills is fully realized, including navigating complex interactions between the new federal law and existing state laws.

individuals to high, and often unaffordable, unanticipated health care costs. Fortunately, many states, and now the federal government, have taken action to close this gap. At the end of 2020, the federal government enacted the No Surprises Act.² As of the law’s effective date, January 1, 2022, 33 states have also adopted laws that address surprise billing.

These federal and state laws have tremendous potential to protect consumers—particularly older adults who are not yet eligible for Medicare—from unanticipated health costs.³ Older adults rely heavily on many health care services that often result in surprise-billing

Key Related Terms

In-network	Providers or facilities that contract with an insurer or health plan to provide services. They agree to an amount to provide services and agree not to bill the insured consumer for any amount above the contracted plan's required cost sharing. May also be referred to as <i>participating</i> providers or facilities.
Out-of-network	Providers or facilities that do not contract with an insurer or health plan. Some health plans may cover some out-of-network services; others do not offer out-of-network coverage. May also be referred to as <i>nonparticipating</i> or <i>noncontract</i> providers or facilities.
Balance billing	The broad term referring to the practice of charging consumers the difference between a health care provider's fee for services and the amount that the consumer's health insurance plan will allow. Some types of balance billing may be allowed, such as when a consumer knowingly decides to seek out-of-network care. In other situations, balance billing may be prohibited or limited by law or by terms of the health insurance contract.

situations, such as inpatient procedures, surgeries, and emergency care.⁴

Yet despite these important developments, implementation is also critical. To ensure that consumers, including older adults, benefit fully from the federal No Surprises Act and relevant state laws, policy makers will need to take deliberate steps to implement the new federal law and integrate the new protections with existing state surprise-billing laws.

The Problem of Surprise Medical Billing

Surprise billing occurs when a consumer receives an unexpected medical bill for out-of-network care. It can happen in emergencies, when the consumer does not have a true opportunity to select providers, or in nonemergency situations where the consumer believes they are making a reasonable effort to select less expensive in-network care.

A typical scenario for a surprise bill in a nonemergency situation is when a person with health insurance chooses to receive care at an in-network facility but one of the providers (e.g., an anesthesiologist during an outpatient surgical procedure) involved in the care turns out not to be in the plan's network. While the individual expects to pay the insurer's in-network rate, one or more out-of-network

providers bills the consumer for their portion of the balance for services.

In an emergency, surprise billing can happen when an individual is unable to choose an in-network emergency room (e.g., a person rushes to the nearest hospital, which turns out not to be in their plan's network) or is seen at an in-network emergency room by an out-of-network provider. It can also happen when a person needs an air ambulance, since a consumer in that situation is often in no condition to specify a particular air ambulance provider for their transport.

According to recent reports, millions of Americans receive surprise medical bills each year. In 2016, one in seven privately insured consumers got a surprise medical bill despite obtaining care at an in-network facility.⁵ A 2020 survey showed that one in five insured adults received a surprise medical bill within just the past two years, and that 18 percent of emergency room visits resulted in a surprise bill.⁶

Among Americans, including older adults, concern about surprise medical bills is high. In a 2019 survey 60 percent of respondents expressed worry that they or a family member would receive a surprise medical bill that would be hard to pay.⁷ Another recent survey showed that more than half of adults ages 60

and older and more than two-thirds of adults ages 45 to 60 were worried that they or a family member would receive an expensive surprise medical bill.⁸

Driving this concern is the fact that surprise medical bills can greatly exceed the amounts that a consumer would have to pay if they had been treated by an in-network provider or at an in-network facility. These bills are typically for hundreds or thousands of dollars, but examples in the hundreds of thousands also abound.⁹ When a person has not explicitly chosen to see an out-of-network provider, surprise bills can be more than shocking—they can be financially overwhelming.

The No Surprises Act Protects Consumers from Unexpected Health Care Costs

The new federal law, the No Surprises Act, protects a wide group of consumers with private health insurance coverage and holds them harmless from surprise bills. The law protects consumers with private health insurance, including group health insurance coverage through an employer and nongroup (individual) coverage through Health Insurance Marketplaces or off-Marketplace (including plans grandfathered under the Affordable Care Act).¹⁰ Unlike state surprise-billing laws, this federal law includes protection for individuals enrolled in self-insured employer-based health insurance plans regulated by the federal government and the Federal Employee Health Benefits Program.¹¹ As of 2019, an estimated 47 million adults ages 50 to 64 enrolled in such private coverage and therefore could benefit from the law's protections.¹²

The No Surprises Act contains several key provisions to protect consumers who find themselves in situations that could result in surprise bills as well as those who receive surprise bills through no fault of their own. It also requires insurers and providers to share information about these protections with consumers.

Consumer Protections in Surprise-Billing Situations

- **Emergency Services:** Providers delivering emergency care, regardless of whether they are in-network, may only charge consumers an in-network cost-sharing amount. In addition, any consumer cost-sharing responsibilities must count toward in-network deductibles and out-of-pocket maximums.
- **Post-Stabilization Services:** Services needed to stabilize a consumer *after* an emergency are subject to the same protections as emergency services. Post-stabilization services include outpatient observation services or an inpatient or outpatient stay following emergency care. The law maintains prohibitions on balance billing and limitations on cost sharing for post-stabilization services furnished by an out-of-network provider or out-of-network emergency facility to the in-network amount.
- **Nonemergency Services:** When nonemergency services are furnished by out-of-network providers at in-network health care facilities, the No Surprises Act prohibits surprise billing and limits a consumer's cost sharing to the in-network rate unless approved in advance by the consumer.
- **Referrals for Out-of-Network Services:** The nonemergency protections also extend to referrals for consumers to see other types of providers during a protected visit.

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So, for example, if during a visit to an in-network provider, a consumer receives a referral to an out-of-network lab, the out-of-network provider may not balance bill or impose cost sharing beyond the in-network rate. Furthermore, if during a course of treatment an in-network provider transitions to an out-of-network provider, a consumer can continue to see that provider and pay in-network rates for 90 days.

Consumer Protections When Surprise Billing Occurs

- **Removing Consumers from Payment Disputes:** At the root of surprise billing are reimbursement rate disputes between health care providers and insurers. Prior to the passage of state and federal laws, consumers often found themselves caught in the middle of these disputes and asked to pay all or a portion of the difference between what a provider billed and what an insurer would reimburse. The No Surprises Act removes consumers from disputes by providing a resolution process for providers and health insurers to work out payment issues.
- **Exceptions for Notice and Consent:** The law does provide opportunities for consumers to consent to receive out-of-network care, but it puts in place strong guardrails to prevent surprise billing.
 - *Out-of-Network Providers:* To provide protected services, an out-of-network provider or facility must notify an insured consumer at least three days before the date of the appointment and obtain consent from the consumer. For a service that is to occur on the same day, providers and facilities must provide notice at least three hours prior to furnishing services.
 - *Out-of-Network Providers at In-Network Facilities:* The No Surprises Act does not allow notice and consent exceptions for “ancillary” services, such as care provided by an anesthesiologist or

radiologist, when provided by out-of-network providers at in-network facilities.¹³

More Information Shared with Consumers

The No Surprises Act requires health insurers and providers to make certain information available to consumers about the protections available under the law.

- **Advance Notice:** Prior to services, a facility or provider must provide a consumer with written or electronic advance notices that make clear the network status of the facility and all providers involved in the care; a good-faith estimate of the amount that an out-of-network provider or facility will charge for services; and information on any applicable utilization management requirements.
- **Advanced Explanation of Benefits:** An insured consumer who schedules a protected service in advance will also receive an advanced explanation of benefits (EOB) from their health insurer with the network status of the provider or facility, the provider’s good-faith estimate of the charges for the items or services, and information on any applicable utilization management requirements. The EOB must also include an estimate of expected cost sharing, the amounts the insurer will pay, and the amount that the consumer has already paid toward deductibles or out-of-pocket maximums.
- **Good-Faith Estimate for Uninsured Individuals:** When an uninsured individual schedules an appointment in advance, providers and facilities must provide a good-faith estimate that includes an itemized list of items and services and expected charges for a defined period of care as well as information on a dispute resolution process available if a consumer is charged amounts that substantially exceed those estimates.

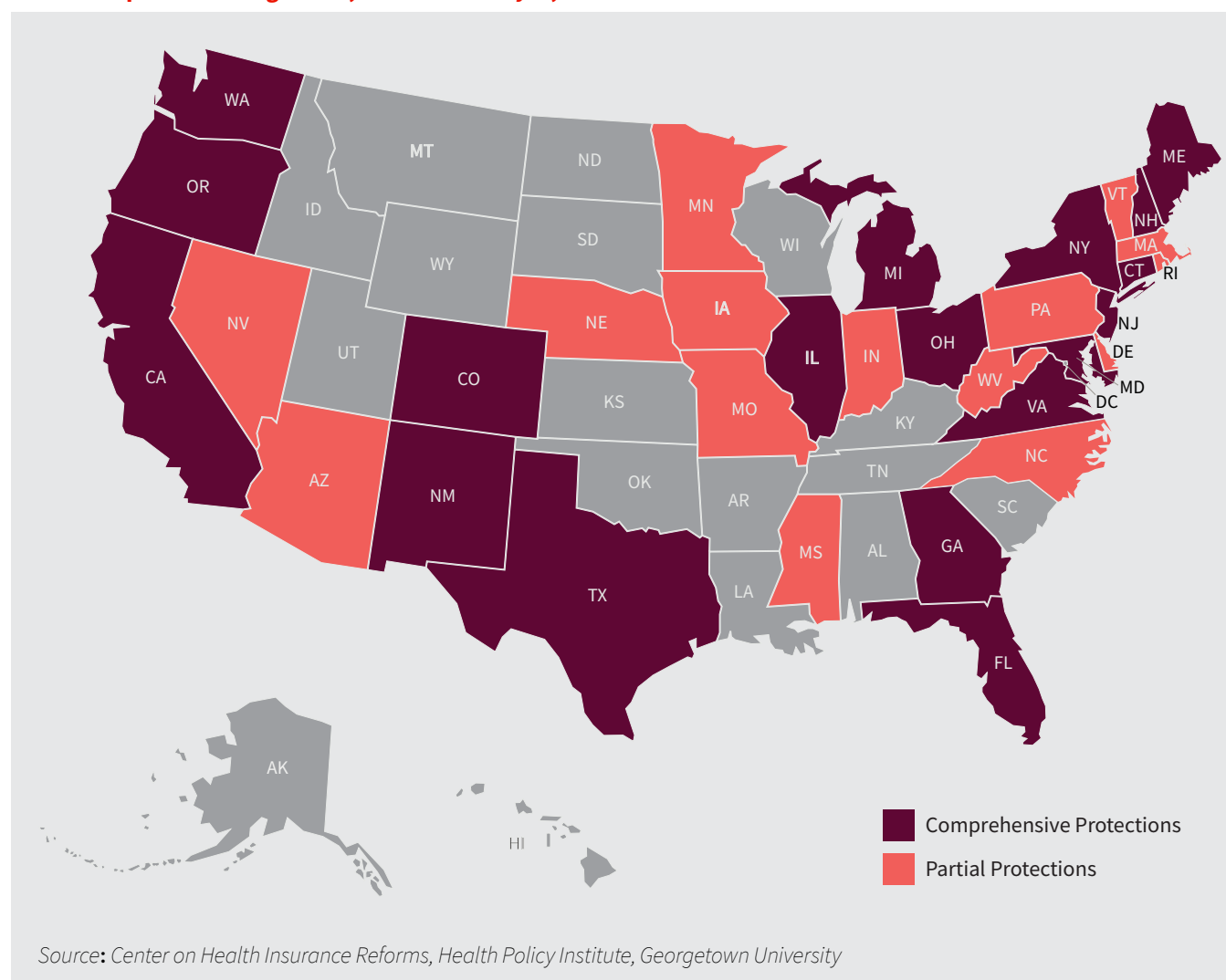
How State Laws Will Interact with the New Federal Law

As of January 1, 2022, the effective date of the No Surprises Act, 33 states have enacted a surprise-billing law.¹⁴ Although many of the state laws are comprehensive, others offer partial protection from surprise bills (figure 1). Even within these two categories, the state laws may also differ in other aspects, such as protected health care services; the type of plans, providers, and facilities affected; and the manner and mode of

dispute resolution. Because of this variation, the interactions between the new federal law and state laws are complex.

The federal No Surprises Act establishes a minimum set of protections applicable across all states and all commercially insured consumers. In states where both state and federal laws offer protections for the same types of services, circumstances, and providers, the federal law is deferential to state laws. Federal protections apply where no state protections exist.

FIGURE 1
State Surprise-Billing Laws, as of January 1, 2022



State Spotlight: Texas and New York's Comprehensive Law Interacting with Federal Law

Both Texas and New York have enacted comprehensive protections against surprise out-of-network billing. In these two states, the protections apply to emergency care and certain nonemergency care when provided by an out-of-network provider or facility without the consumer's consent. Both states' laws, however, have certain gaps that the federal protections will fill. Neither of the states' laws, for example, apply to coverage offered by employers who self-fund or self-insure their coverage. In addition, New York exempted certain hospitals that disproportionately serve low-income communities from changes that limit reimbursement for emergency services.¹⁵

Aspects of the states' laws also extend beyond the federal protections. In Texas, people treated at in-network birthing centers—a type of facility not included in the federal protections—by out-of-network providers are protected against surprise out-of-network billing.¹⁶ In New York, although the state law doesn't apply to employment-based self-funded plans, an enrollee in such plans can directly initiate dispute resolution proceedings and the provider is bound to the decision.¹⁷

States with weak or partial protections will look to the federal law to fill out protections for consumers. If a state's law is narrow, the No Surprises Act may, for example, cover additional groups of insured individuals, cover nonemergency situations, or add additional requirements for providers and health insurers to disclose information about the costs of services.

Even states with comprehensive laws have gaps that the federal No Surprises Act will fill. Foremost among them is that state laws do not apply to employment-based health coverage where companies self-insure or self-fund their health benefits. State laws are preempted from applying to those plans, and therefore the No Surprises Act protections, not state laws, will apply. Another common gap in state laws is that they often do not apply to air ambulance transports, which is addressed by the No Surprises Act.¹⁸

What's Next: Necessary Steps to Realize Full Protections from Surprise Billing for Older Adults

The federal government has taken the first steps toward integrating state and federal surprise-billing protections. In 2021, federal

officials sketched a blueprint for implementing the No Surprises Act in a series of rules. The first rule set forth the conditions for the ban on surprise billing in emergency and nonemergency situations, codified key consumer protections, and outlined provider requirements concerning balanced billing.¹⁹ A second rule identified plans to operationalize the dispute resolution process between insurers and providers.²⁰ The Centers for Medicare & Medicaid Services (CMS) has signaled that other rules may be forthcoming. States may also continue to consider legislation to strengthen current surprise-billing protections.

So far during the initial stages of implementation, it appears that establishment of the dispute resolution process is a key focus for stakeholder attention. While setting up an effective dispute resolution process that removes consumers from any balanced billing negotiations is one critical element, successful implementation will also need to include careful attention to a broader set of policies. As the No Surprises Act is integrated with individual state laws, stakeholders should monitor certain key areas to ensure that the law is implemented in the way most protective

of consumers, including older adults. Key areas include:

- **Quick and Seamless Coordination of State and Federal Laws:** Implementation of the federal law in coordination with the existing 33 state laws, as well as any subsequent state efforts to strengthen state surprise-billing laws, will be administratively complex. In November 2021, Washington was one of the first states to take the difficult first step of making implementation determinations.²¹ Through formal guidance to insurers, Washington state outlined which state requirements were different from the federal law, how certain provisions of the state law changed on account of the federal law, and how the state would manage its enforcement of certain provisions. Similarly, other states should act quickly to provide stakeholders with clear guidance about how the No Surprises Act will interact with their own surprise-billing laws; in addition, where integration of state and federal law is ambiguous, states should ensure that implementation prioritizes consumer protections.

CMS has issued a series of letters to states, which outline the complex interaction and enforcement of federal and state surprise billing laws.²² Federal officials should help execute the anticipated collaboration spelled out in these state letters and consider how to be responsive and offer timely support to states as they issue and enforce guidance on existing and future state surprise-billing laws in 2022 and beyond.

- **Effective Communication of New Protections to Consumers:** During implementation, as states build toward successful integration of state and federal laws, some surprise billing may happen. Consumers should have information about applicable protections to make informed choices and take action if they receive a surprise bill. Unfortunately,

communication to consumers about health insurance is notoriously opaque—either not reaching consumers or being included in dense documents.²³ Federal officials have begun communication efforts and created a dedicated website and help desk where consumers can find information, ask questions, and field complaints.²⁴ Insurers and providers must collaborate to disseminate information about the No Surprises Act and relevant state laws, through familiar methods and in plain language.

- **Access to Meaningful Complaint and Appeals Processes:** Consumers must have access to resources to act if and when they believe they have received a bill in violation of the law. The No Surprises Act sets forth a consumer complaint process, and most state laws also provide an avenue for consumers to file grievances. States must ramp up enforcement of these processes, so that consumers have assurances that if they receive a surprise bill, they can report it without difficulty.
- **Removal of a Consumer's Responsibility to Enforce Hold Harmless Protections:** Although consumers should be made aware of new protections and alerted to complaints and appeals processes, the burden of ensuring the success of the new law should not rely upon consumers. Implementation should ensure that prohibited surprise bills never reach the consumer.
- **Maintain Meaningful Consumer Access to Care:** Several provider groups that stand to see reduced payments under surprise-billing laws have opposed these laws. They warn that negotiated payments for out-of-network providers could limit access to specialty care or could disincentivize providers from contracting with health plans. The potential result of these warnings is for plans to offer more narrow provider networks and consumers to have

access to fewer in-network providers. Analyses of state laws, however, suggest that these warnings are unlikely to come true.²⁵ Nevertheless, state departments of insurance should continue to monitor and regulate network adequacy and ensure that plans offer meaningful access to consumers for all manner of providers, including specialists. Additionally, state officials should reevaluate licensing requirements to help incentivize providers to be part of plan networks.

Capturing the Benefits of the No Surprises Act

Integration of state and federal laws can be complicated. The implementation of the No Surprises Act and state surprise-billing laws has the potential to be just that; however, older adults—and all consumers—should receive the full benefits of these laws. Execution of the first steps in the federal implementing rules, careful planning by states, and sustained oversight of the provisions of the state and federal laws can help ensure that surprise bills are a loophole of the past.

- 1 Karen Pollitz et al., *An Examination of Surprise Medical Bills and Proposals to Protect Consumers from Them* (Washington, DC: Pearson-KFF: Health System Tracking, February 2020), <https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them-3/>.
- 2 The No Surprise Act was part of the 2021 Consolidated Appropriations Act. See the full law at [Public Law 116-260](#).
- 3 The federal No Surprises Act and state surprise-billing laws do not address Medicare. Medicare rules already limit many surprise-billing practices. See Karen Pollitz, *Surprise Medical Bills* (Washington, DC: Kaiser Family Foundation, March 2016), <https://files.kff.org/attachment/issue-brief-surprise-medical-bills>. However, other types of surprise billing that expose consumers unknowingly to high unexpected costs may occur in Medicare, such as the use of observation status. See T. Edelman, “Observation Status and Surprise Medical Bills,” Center for Medicare Advocacy, July 11, 2019, <https://medicareadvocacy.org/observation-status-and-surprise-medical-bills/>.
- 4 For information on surgeries with anesthesia by age and year, see *2021 Anesthesia Almanac*, American Society of Anesthesiologists (September 2021): 68. For emergency department visits by age and year, see “Interactive Biannual Early Release Estimates,” Centers for Disease Control and Prevention’s National Center for Health Statistics, accessed February 1, 2021, https://wwwn.cdc.gov/NHISDataQueryTool/ER_Biannual/index_biannual.html.
- 5 Kevin Kennedy, Bill Johnson, and Jean Fuglesten Biniek, “Surprise Out-of-Network Medical Bills during In-Network Hospital Admissions Varied by State and Medical Specialty, 2016,” Health Care Cost Institute, March 2019, <https://healthcostinstitute.org/out-of-network-billing/oon-physician-bills-at-in-network-hospitals>.
- 6 Karen Pollitz et al., “US Statistics on Surprise Medical Billing,” *JAMA* 323, no. 6 (2020): 498, doi:10.1001/jama.2020.0065.
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- 9 Karan R. Chhabra et al., “Out-of-Network Bills for Privately Insured Patients Undergoing Elective Surgery with In-Network Primary Surgeons and Facilities,” *JAMA* 323, no. 6 (2020): 538–47, doi:10.1001/jama.2019.21463.
- 10 The No Surprises Act does not apply to Medicare and Medicaid, which have separate prohibitions against balance billing and cost-sharing protections. The No Surprises Act also does not apply to excepted benefit plans, such as Medicare supplement plans, stand-alone dental or visions plans, or health flexible spending accounts.
- 11 The federal government regulates self-insured employer-based health insurance plans under the Employee Retirement and Income Security Act of 1974 (ERISA).
- 12 AARP Public Policy Institute analysis of 2019 American Community Survey (ACS) data.
- 13 Ancillary services specified in the law for which notice and consent exceptions are prohibited include emergency medicine services; anesthesiology; pathology; radiology; neonatology; and services provided by assistant surgeons, hospitalists, and intensivists. Also included are diagnostic services, such as radiology and laboratory services, and items and services provided by an out-of-network provider when there is no in-network provider who can furnish the item or service at the facility.

- 14 Maanasa Kona, “State Balance-Billing Protections,” Commonwealth Fund, accessed February 1, 2022, doi:[10.26099/0x7j-7731](https://doi.org/10.26099/0x7j-7731).
- 15 Ibid.
- 16 “Health Facility Compliance Guidance Letter: GL 19-2004-A,” Texas Health and Human Services Commission, April 15, 2021, <https://www.hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/facilities-regulation/memos/gl-19-2004.pdf>.
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- 18 The No Surprises Act does not cover all services, including ground ambulance services. See Krutika Amin et al., *Ground Ambulance Rides and Potential for Surprise Billing* (Washington, DC: Pearson-KFF: Health System Tracking, June 2021), <https://www.healthsystemtracker.org/brief/ground-ambulance-rides-and-potential-for-surprise-billing/>.
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- 25 Sabrina Corlette and Olivia Hoppe, *New York’s 2014 Law to Protect Consumers from Surprise Out-of-Network Bills Mostly Working as Intended: Results of a Case Study* (Washington, DC: Georgetown University Health Policy Institute’s Center on Health Insurance Reforms, May 2019), http://chirblog.org/wp-content/uploads/2020/02/Georgetown_StateBased-NY-Billing_May2019.pdf.

Spotlight 1345301, March 2022

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<https://doi.org/10.26419/ppi.00160.001>

