No Surprises Act: Surprise Medical Billing Legislation
Frequently Asked Questions

On December 28, 2020, the No Surprises Act became law. The Arthritis Foundation spent nearly two years supporting and fighting for legislation to protect patients from surprise medical bills. Here is what you need to know about the law and what it means for arthritis patients.

What are the highlights?

- Patients only pay in-network cost-sharing rates for medical care, emergency services and air ambulance services that are provided by out-of-network service providers or facilities without the patients' informed consent. That means the out-of-network providers can't send a "surprise medical bill" or balance bill patients for the out-of-network charges.
- Patients are provided more information when out-of-network providers are being used, greater access to external review processes to appeal surprise bills, and an Advance Explanation of Benefits 3 days before services are provided.
- Patients with complex needs get up to 90 days of protection at in-network rates when transitioning to an out-of-network facility.

Does it cover all insurance types?

No. Importantly, it covers people with federally regulated insurance, which includes:

- The roughly 135 million Americans with self-funded employer-sponsored insurance.
- Those with Federal Exchange (Affordable Care Act) plans or other health plans regulated at the federal level, including small group market and individual market plans.

What if I have state-regulated insurance?

If you have insurance regulated by the state (e.g., fully insured employer plans, state-based Exchange plans), then state law would determine protections against surprise bills (NOTE: if you have insurance through your employer and are not sure if it is fully or self-insured, contact your HR or benefits manager to find out). Currently 17 states have laws with comprehensive protections and 15 states have partial protections. To find out if your state has surprise billing protections, click on this resource from the Commonwealth Fund. If your state does not have a law and you want to advocate for one, please visit our Action Center to learn more about how you can advocate.

What if my state has a surprise medical billing law in place?

In cases where a state has a surprise billing law in place, the payment rates set by the state would take effect, rather than the payment rates set by the federal law. In other words, this law does not override state law, and this applies to future state laws as well.

When does it go into effect?
Most provisions of the law will go into effect Jan 1, 2022. In the meantime, there will be a rule-making process throughout the year on how to implement the law, and determine the dispute resolution process.

How does it protect patients financially?
It ensures that patients will not pay more than the in-network rate when they see out-of-network providers, and it bars providers from charging patients higher amounts. It covers:

- **Emergency services**, both facilities and providers, until the patient is stable and can consent to being transferred to an in-network facility.
- **Non-emergency services** provided at in-network facilities by out-of-network providers (NOTE it does allow patients to waive the federal protection if they knowingly choose to use an out-of-network provider).
- **Air ambulances** (NOTE it does NOT include ground ambulances but does call for the creation of an advisory committee to make recommendations on how to protect patients from surprise bills from ground ambulances).

Does it help make information about provider networks and costs more transparent?
Yes, it does several important things to help patients find accurate information about their provider networks and cost-sharing responsibilities, including:

- Allowing patients to access an Advanced Explanation of Benefits before health care services are delivered. This would include a good-faith estimate of costs and cost-sharing, whether providers are in-network, and how to find in-network providers if not.
    - **NOTE:** if a provider gives a good faith estimate and final charges are substantially higher than the patient expected, he/she can initiate an independent dispute resolution challenging the higher amount
- Requiring insurers to provide price comparison information and make it available in multiple formats, including by phone and web.
- Requiring insurers to maintain up-to-date provider directories.