Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia,

pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

Please see attached for Massachusetts state law provisions.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed you may contact the Massachusetts entities listed in the notice attached.
Visit www.hhs.gov for more information about your rights under federal law.

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Learn more about "Patients First" – a new law which requires your health care provider to give you more information about charges for hospital stays, medical procedures, health care services, or referrals

On January 1, 2021, Governor Baker signed *An Act Promoting a Resilient Health Care System that Puts Patients First* ("*Patients First*") into law which makes significant changes to the state's healthcare laws. **This letter is about your rights under the law.**

- Your health care provider now must tell you how much you will pay for planned hospital stays, medical procedures, health care services, and referrals – based on your specific health insurance plan.
- These requirements begin on January 1, 2022.
- These requirements also authorize the Massachusetts Department of Public Health (MDPH) to fine providers who fail to comply with a penalty up to $2,500 for each instance of non-compliance. These penalties will take effect July 1, 2022.

1. Impacted Health Care Providers

These requirements apply to health care providers. When using the term provider below, this refers to:

- Doctors (primary care doctors, specialists, psychiatrists, etc.)
- Dentists
- Nurses
- Social workers
- Chiropractors
- Psychologists
- Pharmacists
- Hospitals
- Clinics (such as community health centers)
- Nursing homes

2. Notice Requirements

As a patient or potential patient, your provider must inform you either verbally or in writing whether they take patients in your health insurance plan, when you are scheduling a hospital stay, medical procedure, or health care service related to a non-emergency medical condition.
After your provider gives you this information the first time, you can choose not to receive the information again when you schedule follow-up hospital stays, medical procedures, or health care services with that same provider.
The law also has additional requirements based on whether your health care provider accepts your health insurance plan.

When your provider DOES accept your health insurance plan ("in-network")
Requirements for Providers: At the time of scheduling a hospital stay, medical procedure or health care service that is not for an emergency medical condition, **a health care provider must notify you that:**

- The health care provider accepts your health insurance plan.
- **You can request the following information**: You have the right to know how much your health insurance plan will pay for that hospital stay, medical procedure, or health care service. This is called the "allowed amount." You also have the right to know what if any facility fees you will be charged for that hospital stay, medical procedure, or health care service. Facility fees are sometimes charged when a procedure is done at a hospital or clinic, rather than a doctor's office. You must be provided this information within two days of your request.
- If a health care provider is unable to tell you a specific amount (because they cannot predict what specific treatment will be needed), they must tell you the *estimated* maximum amount that your insurance will pay and tell you about any facility fees.
- You can get additional information about out-of-pocket costs (such as deductibles, co-pays and co-insurance) from your health insurance plan's toll-free number or website.

When your provider DOES NOT accept your health insurance plan ("out-of-network")
Requirements for Providers:

- If your appointment was scheduled **more than 7 days in advance,** your health care provider must inform you that they do not accept your health insurance plan, verbally and in writing, at the time that you schedule the appointment (at least 7 days before your appointment).
- If your appointment was scheduled **less than 7 days in advance**, the health care provider must verbally inform you that they do not participate in your health insurance plan, at the time of scheduling (at least two days, or as soon as possible), before your appointment. The provider must also give written notice when you arrive for your appointment.
- Your health care provider must tell you about any expected costs for you, at the time you schedule your appointment.

- Your health care provider must tell you that you will be responsible for any costs for you which are not covered by your health insurance plan.
- Your health care provider must inform you that you may be able to get the hospital stay, medical procedure or health care service at a lower cost from another health care provider, who participates in your health insurance plan.

The law also has requirements for when your health care provider refers you to another health care provider. This is called a "referral."

Your provider is required to:

- Tell you if the provider you are referred to is part of the same "provider organization" as your provider. This would mean that the two providers are in same physician organization, physician-hospital organization, independent practice association, provider network, accountable care organization or another organization that contracts with health insurance companies.
- Give you enough information about the provider you are referred to so that you can figure out if this provider is "in network," which means the provider is covered by your insurance plan.

  Your health insurance plan has a toll-free telephone number and website where you can find out: (1) if a provider is in your network (2) the estimated or maximum "allowed amount" or charge for a hospital, medical procedure or health care service, and (3) the estimated amount you will be responsible to pay for a hospital stay, procedure or service.
- Tell you that if the provider you are referred to is not in-network, there may be out-of-network costs that apply.
- Tell you to confirm whether the provider you are referred to participates in your health insurance plan by calling the provider and/or your health plan before making an appointment or agreeing to use their services.

If your health care provider is directly scheduling, ordering, or arranging health care services for you with another provider, **your provider must:**

- Verify whether the provider you are referred to is in-network for your plan.
- Notify you if the provider you are referred to is not in-network or that your provider cannot verify whether or not the provider you are referred to is in-network.

3. Penalties

The law authorizes the Massachusetts Department of Public Health (MDPH) to fine health care providers who fail to follow these requirements, with a penalty of up to $2,500 in each case. These penalties will begin on July 1, 2022.

If you have not received any of these required notifications from your health care provider, you may submit a complaint, in writing, to the health care provider's professional licensing board, or in the case of a licensed facility, to the Massachusetts Department of Public Health.

All health care providers must provide you with information on how to file a complaint with the Massachusetts Department of Public Health if you do not receive all required notices.

To file a complaint with the MDPH Bureau of Health Professions Licensure (BHPL):

- Nursing complaint instructions: https://www.mass.gov/how-to/file-a-complaint-about-a-nurse
- Nursing complaint form: https://www.mass.gov/doc/nursing-complaint-form-1/download
- Pharmacy complaint instructions: https://www.mass.gov/how-to/file-a-complaint-with-the-bureau-of-health-professions-licensure
- Pharmacy complaint form: https://www.mass.gov/doc/pharmacy-complaint-form/download

To file a complaint with the MDPH Bureau of Health Care Safety and Quality (BHCSQ):

- Hospital complaints: https://www.mass.gov/how-to/file-a-complaint-regarding-a-hospital
- Long Term Care Facility and other MDPH licensed health care facility complaints (including clinics): https://www.mass.gov/how-to/file-a-complaint-regarding-a-nursing-home-or-other-health-care-facility

To file a complaint against a licensee from the Division of Occupational Licensure (DOL):

You have the right to file a complaint if you think a licensee or unlicensed individual has violated the standards of professional conduct:https://www.mass.gov/how-to/file-a-complaint-against-a-division-of-occupational-licensure-licensee

To file a complaint with the Board of Registration in Medicine's (BORIM) Consumer Protection Division:

All complaints and reports to BORIM: https://www.mass.gov/submit-a-complaint
Patient or patient representative complaints against physicians: https://www.mass.gov/service-details/submit-a-complaint-against-a-physician

Frequently Asked Questions

1. What is an emergency medical condition?

A medical condition (physical, behavioral, related to substance use disorder, or mental) with severe symptoms (for example, severe pain), that an average person would reasonably believe could result in serious harm or danger, if medical attention is not quickly received.

2. If I need a series of hospital stays, medical procedures or health care services as part of my treatment, does the health care provider need to continue to inform me that they do not take my health insurance plan after the first one?

You may decide not to receive such notice for any future hospital stays, medical procedures, or health care services. It is your choice whether to do so.
However, even after you decide not to receive the notice, a health care provider **must inform you of any changes in the health insurance plans they take** during your course of treatment.

3. What is the "allowed amount"?

The maximum amount paid by a health insurance plan to a health care provider for a service.

4. What is a "facility fee"?

A facility fee is sometimes charged when a procedure is done at a hospital or clinic, instead of a doctor's office. Facility fees may not be covered by your health insurance plan or may only be partially covered.

5. What if the provider is unable to predict what specific treatment I may need?

If a health care provider is unable to quote a specific cost in advance because they cannot predict the specific treatment you will need, they must tell you the *estimated* maximum allowed amount for the hospital stay, medical procedure or health care service. They must also tell you about any facility fees that will be charged.

6. What happens if a health care provider does not comply with these requirements?

Beginning January 1, 2022, the Commissioner of the Massachusetts Department of Public Health is allowed to fine health care providers who fail to follow these requirements. The fine can be as high as $2500.00 for each case of non-compliance. Healthcare providers will be held liable for payment of these penalties.

7. What happens if a health care provider does not participate in my health insurance plan (is "out-of-network") and does NOT provide verbal and written notice to me within the required time frames for a hospital stay, medical procedure, or health care service?

That health care provider **can only bill you** for the amount that you would have been required to pay as a copayment, coinsurance, or deductible if that health care provider **had** been covered by your health insurance plan.