No Surprises Act

Dear Current and Potential Future Clients,

Congress has enacted the “No Surprises Act” which went into effect 1/1/2022. The act is described as “new federal protections against surprise medical bills that take effect in 2022. **Surprise medical bills** arise when insured consumers inadvertently receive care from out-of-network hospitals, doctors, or other providers they did not choose” (please see **https://www.kff.org/health-reform/issue-brief/no-surprises-act-implementation-what-to-expect-in-2022/**).

It is highly unlikely this could affect our work together. There will be no situation in which you would “inadvertently” receive care from one of our therapists or with no choice. Also, the final rules about how to implement this in a practice such as ours have not even been written yet by the federal government. We are “out of network” for all insurance companies.

You may read more about this at **https://www.cms.gov/nosurprises**.

If we currently work together, you are already aware of our charges and your costs. If you are considering working with us, available information on the requirements of the “No Surprise Act” suggests your psychotherapist might need to provide you with a diagnosis before you even meet, which of course would be both unethical and impossible without a meaningful evaluation of your circumstances. Currently, multiple professional organizations are scrambling to understand the details of this law, to whom it applies and how to apply it. Guidance so far is uncertain and, in many cases, conflicting. In compliance with the “No Surprises Act,” you will receive a “Good Faith Estimate” of costs involved with your therapy. There will be no surprises whatsoever, since you are always informed of our fees for each service you request in advance of the appointment or service.

Rest assured that we will be transparent with you about the costs of the services we agree on together. You will have “no surprises” here. This transparency is required by ethical standards by which we, as licensed professionals, have abided by our entire careers and simply because it is necessary for us to work well together.

In the meantime, you may certainly ask us at any time about any costs about which you may be unsure, and you will be provided clear information.

Please feel free to contact us if you have any related questions. Our contact information is available under the CONTACT menu on this website.

Your Rights and Protections Against Surprise Medical Bills

Effective: January 1, 2022

What is “balance billing” (sometimes called “surprise billing”)?

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

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, 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 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.

You are 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 the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). 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 balance billed for these post-stabilization services.

New Jersey law also protects you from being billed for out-of-network services provided on an emergency or urgent basis in an amount more than your in-network cost-sharing amount (*i.e.*, the amount your deductible, copayments, or coinsurance would have been if the same services were provided on an in-network basis).

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 may be out-of-network. In these cases, the most those providers may 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 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 care out-of-network. You can choose a provider or facility in your plan's network.

New Jersey law also protects you from being billed for inadvertent out-of-network services (services at an in-network facility provided by out-of-network providers) in an amount in excess of your in-network cost-sharing amount (*i.e.*, the amount your deductible, copayments, or coinsurance would have been if the same services were provided on an in-network basis).

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (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 deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Centers for Medicare & Medicaid Services, Department of Health and Human Services at 1-800-985-3059.

For services rendered in New Jersey, you also may contact the New Jersey Department of Banking and Insurance at 609-292-7272 or file an online complaint at:

https://www.state.nj.us/dobi/consumer.htm.

For more information about your rights under federal law, visit: https://www.cms.gov/nosurprises/consumers.For more information about your rights under New Jersey law, visit: https://www.state.nj.us/dobi/index.html.