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Insurance Bulletins are issued when the Commissioner renders formal opinions, guidance or expectations on matters or issues, explains how new statutes or rules will be implemented or applied, or advises of interpretation or application of existing statutes or rules.

► New Consumer Protections from Surprise Medical Bills ◄

Starting in 2022, a new federal law called the No Surprises Act (NSA) will protect consumer from many types of surprise medical bills. The Offices of the Insurance Commissioner (OIC) is issuing this Insurance Bulletin to provide basic information to consumers about the new surprise billing protections and to provide some examples of how consumers are protected.

What is balance billing?

Balance billing happens when a health care provider bills a patient after the patient's health insurance company or health plan has paid its share of the bill. The balance bill is for the difference between the provider's charge and the price the insurance company set, or agreed to pay, after the patient has paid any applicable copays, coinsurance, or deductibles.

Balance billing can happen when a patient receives covered health care services from an out-of-network provider or an out-of-network facility.

In-network providers agree with a health plan to accept the health plan's payment in full and don't balance bill. Out-of-network providers don't have this same agreement with health plans.

Some health plans, such as Preferred Provider Organization (PPO) or Point of Service (POS) plans, include some coverage for out-of-network care, but the provider may still balance bill the patient if state or federal protections don't apply. Other plans don't include coverage for out-of-network services and the patient is responsible for all the costs of out-of-network care. Medicare and Medicaid have their own protections against balance billing.

What is surprise billing?

Surprise billing happens when a patient receives an unexpected, or surprise, balance bill after he or she receives care from an out-of-network provider or at an out-of-network facility, such as a hospital. It can happen for both emergency and non-emergency care. Typically, patients don't know the provider or facility is out-of-network until they receive the bill. This oftentimes occurs when a facility (such as a hospital) is in-network with a health plan, but a provider within the facility (such as a radiologist, pathologist, anesthesiologist, or emergency medicine doctor, etc.) is out-of-network with the same health plan.

Some states have laws or regulations that protect patients against surprise billing. However, state laws generally do not apply to self-insured health plans, also called ERISA plans. The No Surprises Act (NSA) will now protect consumers in self-insured health plans as well as consumers with commercial insurance plans in states that don't have their own protections.

What protections are in place?

The No Surprises Act (NSA) protects consumers from:

- Surprise bills for covered emergency out-of-network services, including air ambulance services (but not ground ambulance services), and
- Surprise bills for covered non-emergency services at an in-network facility.
- The law applies to health plans starting in 2022. It applies to the self-insured health plans that employers offer as well as plans from health insurance companies.
- A facility (such as a hospital or freestanding emergency room) or a provider (such as a doctor) may not bill you 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 law also protects you when you receive non-emergency services from out-of-network providers (such as an anesthesiologist) 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 can never 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 care of hospitalized patients), and intensivists (doctors who care for patients needing intensive care), or for diagnostic services including radiology and lab services.
- You still 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. If you did that, you'd be expected to pay the balance bill as well as your out-of-network coinsurance, deductibles, and copays.

What else should I know?

Your health plan and the facilities and providers that serve you must send you a notice of your rights under the new law.

If you've received a surprise bill that you think isn't allowed under the new law, you can file an appeal with your insurance company or ask for an external review of the company's decision with the OIC. You also can file a consumer complaint with the OIC or with the federal Department of Health and Human Services.

An independent dispute resolution (IDR) process is available to settle bills. Providers and health plans can use this process to settle disputes about your bill without putting you in the middle. A similar dispute resolution process is available for individuals who are uninsured, in certain circumstances, such as when the actual charges are much higher than the estimated charges.

Other protections in the new law require insurance companies 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. West Virginia also has a state law regarding provider directories that can be located at W.Va. Code §33-55-4. State law also requires insurers to electronically post accurate provider directories.

Examples of Surprise Bill Protections

Q. Deion fell off a ladder, hitting his head and breaking his arm. He was taken to the nearest emergency room. He needed covered imaging and radiology services as well as surgery. Now bills are starting to come in. What is he responsible for paying? How can he get help if he's receiving bills that don't match the explanation of benefits (EOB) from his health plan?

A. For emergency care he received, Deion is only responsible for paying his in-network deductibles, copays, and coinsurance, even if health care providers who were not in his plan network treated him or he was taken to a facility that was out-of-network. If the bills don't match his explanation of benefits (EOB), Deion can call his health plan first. If he isn't satisfied with the health plan's response, he can contact the OIC.

If Deion is admitted to the hospital after he receives care in the emergency room, he should know that any out-of-network health care providers at the facility may ask him to consent to continuing care and to agree to pay higher amounts. They can only ask for his consent to receive out-of-network care once he is stabilized, able to understand the information about his care and out-of-pocket costs, and it is safe to travel to an in-network facility using non-emergency transportation. If those conditions are met, Deion can decide if he wants to continue with the out-of-network provider, or travel to a provider who participates in his health plan's network. If he stays with the out-of-network provider and consents to out-of-network billing, he'll be responsible for any out-of-network deductibles, copays, or coinsurance. He'll also be responsible for the amount the provider charges that is more than what the health plan pays (the balance bill).

Q. Bill had chest pains and went to his local hospital's emergency room. The doctors there said he had to be transported to a hospital in a major city for full treatment and he had to go by air ambulance to make it in time. Bill was flown to the larger hospital and is now doing well. Bill's wife, Nancy, has heard scary stories about air ambulance costs and is starting to worry. Are there any protections for someone who is transported by air ambulance in an emergency?

A. If the air ambulance company has an in-network contract with Bill's health insurance company, then Bill will only have to pay the in-network deductibles, coinsurance, or copays. The air ambulance company will accept their contracted amount as payment in full.

Starting in 2022, the No Surprises Act (NSA) protects patients even if the air ambulance company doesn't have an in-network contract with their health insurance company. Bill will only have to pay the deductibles, copays, or coinsurance that he would have to pay if the air ambulance were in-network. A federal IDR process will help the air ambulance and the health plan determine how to pay the rest of the bill.

Q. Elena is scheduled for a biopsy, a service that her health plan covers. Her hospital and surgeon are in-network with her health plan, but the hospital uses anesthesiologists and pathologists that are not in-network. Does this mean everything will be covered as in-network, or could Elena have some unexpected charges?

A. Surgery for a biopsy can involve health care providers that consumers do not get to choose, such as an anesthesiologist and a pathologist. Starting in 2022, when Elena chooses an in-network facility and surgeon for her procedure, all her out-of-pocket costs will be at the in-network rate. That includes the costs for any out-of-network providers she didn't choose who participate in her care.

Q. Hannah changes jobs and her family is covered under a new employer health plan. Hannah and her husband's doctors are in-network with the new company, but their child's pediatrician is not. How can they find an in-network pediatrician? Can they rely on the online provider directory for accurate information?

A. Hannah can review her new health plan's online provider directory or call the insurance company to get information. An insurance company may have different networks for different health plans. It's important to look at the directory for your specific health plan. Most people rely on their health plan to give them accurate information about in-network health care providers. Since 2020, health plans have been required to follow the state law for electronically posting accurate provider directories. West Virginia's state law can be found at W.Va. Code §33-55-4. Starting in 2022, federal law also requires health care providers to update their information with insurance companies when there is a change. In turn, insurance companies must verify that the information in their provider directories is complete.

If Hannah calls the insurance company to ask for a list of in-network pediatricians, the insurance company has one business day to give her a list. If Hannah relies on inaccurate information from the insurance company that a provider is in-network, then Hannah will be responsible only for the in-network deductibles, copays, or coinsurance.

In West Virginia, the OIC is responsible to enforce the applicable provisions of the No Surprises Act (NSA) against health insurers, medical providers, and health care facilities per W.Va. Code §33-2-24. Whenever the OIC believes, based upon satisfactory evidence, that any insurer, medical provider, or health care facility is violating the applicable provisions of the NSA, the OIC may assess a fine, not to exceed $10,000 per violation, after notice and hearing pursuant to W.Va. Code §33-2-13. In addition to the administrative penalty, the OIC may cause a complaint to be filed in the appropriate court of this state seeking to enjoin and restrain the insurer, medical provider, or health care facility from continuing the violation or engaging therein or doing any act in furtherance thereof. The OIC may seek assistance from any other state government agency regarding regulatory enforcement of this section against medical providers or health care facilities. The OIC may also call upon the Attorney General for legal assistance and representation as provided by law.

You may reach out to the OIC's Consumer Services Division at 1-888-TRY-WVIC (1-888-879-9842) or OICConsumerServices@wv.gov for assistance with surprise medical bills or other questions concerning the No Surprises Act (NSA). You may also visit our website at www.wvinsurance.gov/no_surprises_act.

You can get more information, initiate payment disputes and make complaints to federal agencies regarding the No Surprises Act (NSA) by calling the "No Surprises Helpdesk" at 1-800-985-3059 or visiting www.cms.gov/nosurprises.

Please e-mail any questions concerning this Insurance Bulletin to OICBulletins@wv.gov.

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