New Protections from Surprise Medical Bills

You may have heard stories from friends or in the news about balance bills or surprise bills from health care providers. New laws are in place to protect you from surprise bills in many cases. Here are the basics on the new protections, followed by examples of how they apply.

What is balance billing?

Balance billing occurs when a health care provider bills a patient after the patient's health insurance company has paid its portion. The balance bill is for the difference between the amount the provider charges and the price the insurance company sets, after the patient pays any co-pay, co-insurance, or deductible.

Balance billing can occur when a consumer receives health care services from an out-of-network provider or at an out-of-network facility.

In-network providers agree with an insurance company to accept the insurance payment in full. In-network providers agree not to balance bill.

Out-of-network providers do not have this agreement with the insurance company. Therefore, in the past they sometimes billed the patient for the amount not covered by insurance.

Some health plans, such as Preferred Provider Organization (PPO) or Point of Service (POS) plans, offer some coverage for out-of-network care, but the provider can still balance bill the patient. Other plans offer no coverage for out-of-network providers and leave the financial responsibility entirely on the consumer.

Balance billing is prohibited in both Medicare and Medicaid.

What is surprise billing?

Surprise billing occurs when a patient receives a balance bill after unknowingly receiving care from an out-of-network provider or an out-of-network facility, such as a hospital. This can occur in emergency and non-emergency situations.

Some states have enacted protections for consumers against surprise billing. However, state laws do not apply to self-insured health plans, which account for the majority of people who get coverage through an employer. Now, federal law adds additional protections.

What protections are in place?

A new federal law, the No Surprises Act, protects you from:

- emergency out-of-network medical bills including air ambulances, and
- non-emergency services at an in-network facility.

The law applies to plans starting in 2022. It applies to self-insured health plans offered by employers as well as health insurance companies.

- A facility (such as a hospital or freestanding emergency room (ER)) or a provider (such as a doctor) may not bill you more than your in-network cost sharing amount for emergency services.

  This is true even if the emergency services you received were at an out-of-network facility or performed by an out-of-network provider.
- Under your health plan, you are still responsible for cost sharing amounts that may include copays, coinsurance, and deductibles.
- You are also protected when you receive non-emergency services from out-of-network providers at in-network facilities. An out-of-network provider may not bill you more than your in-network co-pay, co-insurance, or deductible for services performed at an in-network facility.
    - You can still consent in advance to receive care from an out-of-network provider in some situations and agree to pay the provider amounts above your in-network co-pay, co-insurance, or deductible.

What else should I know?

- You must receive notice of your rights under the new law from your health plan and from the facilities and providers that serve you.
- If you think the protections have not been applied correctly, you can file an appeal with your insurance company or request external review of the company's decision.
- You can also file a complaint with the [State Insurance Commissioner] or the federal Department of Health and Human Services.
- An independent dispute resolution (IDR) process, or another process your state sets up, is available for providers and insurance companies to settle disputes about your bill without putting you in the middle. IDR is also available for individuals who are uninsured, in certain circumstances.
- Other protections in the new law require insurance companies to keep their provider directories updated and to limit your co-pays, co-insurance, or deductible to in-network amounts if you rely on inaccurate information in a provider directory.

See the next page for examples of how the protections apply.

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 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 insurance plan?

A. For emergency care, Deion is only responsible for paying his in-network deductible, copayments, and coinsurance, even if he received services from health care providers that were not in his plan network or at a facility that was also out of network. If the bills don't match his EOB, Deion can call his health plan first. If he is not satisfied with their response, he can contact [insert state agency].

Deion should be aware 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, but only once he is able to understand the information. Deion can decide if he wants to continue with the out-of-network provider, or switch 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 will be responsible for any out-of-network deductible, copayments, or coinsurance, and for the amount the provider charges over what the insurance company pays, called 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 plan, then Bill will only have to pay the in-network deductible, coinsurance, or copayment. The air ambulance company will accept their contracted amount as payment in full.

For health plans staring in 2022, the new federal law protects patients even when they are transported by an air ambulance company that does not have an in-network contract with their health insurance plan. Bill will only have to pay the deductible, copayment, or coinsurance that he would have to pay if the air ambulance were in-network. Federal law will help the air ambulance company and the health insurance company determine how to pay the rest of the bill.

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

A. Surgery for a biopsy can involve health care providers that you don't 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, her out-of-pocket costs will be at the in-network rate, including the costs for any out-of-network providers she didn't choose that participate in her care.

Q. Hannah's family is covered under her employer health plan. Hannah's employer changed insurance companies. Hannah and her husband's doctors are in-network with the new company, but their 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 is 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. [State has laws to require insurance companies to …]

Starting in 2022, health care providers must regularly update their information with insurance companies. In turn, insurance companies must verify 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 deductible, copayment, or coinsurance.