

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. Starting in 2022, a new law will protect you from many types of surprise bills. Here are the basics about the new protections and some examples of how they can protect consumers.

What is balance billing?

Balance billing happens when a health care provider (a doctor, for example) bills a patient after the patient's health insurance company 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, after the patient has paid any 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 (a hospital, for example).

In-network providers agree with an insurance company to accept the insurance payment in full, and don't balance bill. Out-of-network providers don't have this same agreement with insurers.

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 of 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 balance bill after they receive 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.

Some states have laws or regulations that protect patients against surprise billing. However, state laws generally don't apply to self-insured health plans, and most people who get coverage through an employer are in self-insured health plans. Now, a new federal law protects consumers in self-insured health plans as well as consumers in states that don't have their own protections.

What protections are in place?

A new federal law, the No Surprises Act, protects you 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 insurance 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 (ER)) 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. You also can 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 to settle bills. Providers and insurance companies 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.
- You can get more information and make complaints to federal agencies by calling 1-800-985-3059.

See the next page for examples of how the No Surprises Act 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 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 insurance 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 insurer first. If he isn't satisfied with the insurer's response, he can contact KY Department of Insurance.

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 insurance company 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 plan, 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 new federal No Surprises Act protects patients even if the air ambulance company doesn't have an in-network contract with their health insurance plan. Bill will only have to pay the deductibles, copays, or coinsurance that he would have to pay if the air ambulance were in-network. Federal law will help the air ambulance and the health insurance companies 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 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, all of 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.

Starting in 2022, federal law 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.