

New protections starting Jan. 1, 2022, from surprise medical bills

You may have heard stories from friends or in the news about receiving a surprise medical bill from health care providers and facilities. Starting Jan. 1, 2022, a new law will protect you from many types of these surprise bills. If you receive a surprise medical bill, it may be prohibited by this new law. These bills typically are sent by your health care provider for the remaining charges for services you received and are not covered by your insurance. You are protected from receiving these types of bills for either of the following:

- Emergency services provided out of network, including air ambulance services (but not ground ambulance services)
- Nonemergency services provided by an out-of-network provider at an in-network facility

If you believe you have received a surprise medical bill from a provider for the services specified above, contact the U.S. Department of Health and Human Services and file a complaint by calling 800-985-3059 (toll-free) or going to <https://www.cms.gov/nosurprises/consumers>.

If you have received a surprise bill you believe is not allowed under the new law, you can file an appeal with your insurance company, then ask for an external review of the company's decision after the initial appeal is completed with your plan. You may also contact Oregon's Division of Financial Regulation to speak with a consumer advocate or file a complaint any of the following ways:

- Phone: 888-877-4894 (toll-free)
- Email: DFR.InsuranceHelp@dcbs.oregon.gov
- Website: <https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx>

For more information on surprise medical bills and the new law effective in 2022, below are some frequently asked questions:

What is surprise billing or a surprise medical bill?

Surprise billing happens when a patient receives an unexpected 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 nonemergency care. Typically, patients don't know the provider or facility is out of network until they receive the bill. The practice that creates the surprise bill is called balance billing.

What is balance billing?

Balance billing happens when a health care provider bills a patient after the patient's health insurance company has paid its share of the bill per a consumer's benefits. The balance bill is the difference between the provider's charges, what the insurance carrier paid for the services, and the patient cost sharing (co-pay, co-insurance, or deductible) as required by the plan.

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

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 include some coverage for out-of-network care, but the provider may still balance bill the patient if state or federal protections do not apply. Other plans do not include coverage for out-of-network services and the patient is responsible for all of the costs of out-of-network care.

What protections are in place?

A new federal law, the No Surprises Act, protects you from surprise medical bills when you receive these types of health care services at certain facilities:

1. Surprise bills for covered out-of-network emergency services, including air ambulance services (not applicable to ground ambulance services)
 - i. This means 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 co-insurance, co-pays, or deductibles for emergency services as outlined in your plan documents, even if the facility or provider is out of network. However, if your health plan requires you to pay co-pays, co-insurance, or deductibles for in-network care, you are still responsible for the cost-share amounts as specified in your plan.
2. Surprise bills for covered nonemergency services provided by an out-of-network provider at an in-network facility.
 - i. The new law also protects you when you receive nonemergency 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 co-pays, co-insurance, or deductibles for covered services performed at an in-network facility.

What health insurance plans are protected under the new law?

The law applies to the majority of health insurance plans starting in 2022, including plans offered by an employer. It includes group health plans and health insurance issuers of group and individual health coverage. It also applies to grandfathered health plans, ERISA plans, and self-insured government plans. Medicare and Medicaid have their own protections against balance billing.

I am uninsured, do I have any protections under this new law?

There are some protections provided in the new law for people without insurance and pay for care with cash. Health care providers and facilities are required to give you a good faith

estimate of the cost of a specific requested service or before an appointment. If the bill you receive is substantially higher than the estimate provided, you may engage in a process with the federal government to work with the health care provider or facility to determine a payment amount.

For example: "In the instance of a knee surgery, a good faith estimate could include an itemized list of items or services in conjunction with and including the actual knee surgery (such as physician professional fees, assistant surgeon professional fees, anesthesiologist professional fees, facility fees, prescription drugs, and durable medical equipment fees) that occur during the period of care."

What happens if I am asked to agree to balance billing by an out-of-network provider?

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 can still 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. After this, you must give consent to these higher costs. If you gave consent for the higher cost, you are expected to pay the balance bill and your out-of-network co-insurance, deductibles, and co-pays.

What else should I know?

- Your health plan and the facilities/providers that serve you must send you a notice of your rights under the new law.
- Other protections in the new law require insurance companies to keep their provider directories updated. Also, they must limit your co-pays, co-insurance, or deductibles to in-network amounts if you rely on inaccurate information in a provider directory.

Examples of surprise bill protections

Example 1: Emergency room care and services

Question: Deon 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 and surgery. Now, bills are coming in. What is he responsible for paying? How can he get help if he does not understand the bills he is receiving or receiving bills that don't match the Explanation of Benefits (EOB) from his health insurance plan?

Answer: Under the new protections, for emergency care he received, Deon is responsible only for paying his applicable in-network deductibles, co-pays, and co-insurance, 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), Deon can first call his health insurer to verify coverage and claims processing accuracy. From there, he may contact the billing office of the provider/facility to reconcile the discrepancy. If he is not satisfied with his insurer's response, he may contact the Oregon Division of Financial Regulation to speak with a consumer advocate or file a complaint.

If Deon 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. He must be stabilized and able to understand the information about his care and out-of-pocket costs, and is safe to travel to an in-network facility using nonemergency transportation before providers may ask for his consent. If those conditions are met, Deon 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 will be responsible for any out-of-network cost shares as outlined in his plan and he will be responsible for the amount the provider charges beyond what the insurance company pays (the balance bill).

Example 2: Air ambulance services

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

Answer: If the air ambulance company has an in-network contract with Nancy's health insurance plan, then Nancy will have to pay only the in-network deductibles, co-insurance, or co-pays (cost shares). The air ambulance company will accept the insurance company's contracted amount as payment in full.

Starting in 2022, the new federal No Surprises Act protects patients even if the air ambulance company does not have an in-network contract with their health insurance plan. Nancy will have to pay only the deductibles, co-pays, or co-insurance she would have to pay if the air ambulance was in network. Federal law will help the air ambulance and the health insurance companies determine how to pay the rest of the bill.

Example 3: Out-of-network health care providers

Question: Sam is scheduled for a biopsy, a service that their health plan covers. Their hospital and surgeon are in network with their 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 Sam have unexpected charges?

Answer: Surgery for a biopsy can involve health care providers you don't get to choose, such as an anesthesiologist and a pathologist. Starting in 2022, when Sam chooses an in-network facility and surgeon for their procedure, all of their out-of-pocket costs will be at the in-network rate. That includes the costs for any out-of-network providers Sam did not choose who participate in their care.

Example 4: health care provider directories

Question: 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?

Answer: 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. Oregon law requires insurance companies to keep provider directories accurate and updated monthly.

Starting in 2022, federal law requires health care providers to update their information with insurance companies when there is a change. Insurance companies must verify that the information in their provider directories is complete and current.

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, co-pays, or co-insurance.