FAQ: Consumer Protections from Surprise Medical Bills

Many Virginians are already protected against surprise medical bills, thanks to a Virginia law that took effect January 1, 2021. Starting January 1, 2022, the federal No Surprises Act (NSA) provides additional protections to consumers against surprise billing for medical expenses. Most of these surprise billing protections apply to you if you get your coverage through your employer (including a federal, state, or local government), or through the individual Marketplace (HealthCare.gov), or directly through an individual market health insurance issuer that uses a provider network.

What is "balance billing"?

"Balance billing" occurs when patients enrolled in managed care health insurance plans receive care from medical service providers who do not participate in the plan's network of providers (referred as "out of network providers") and the provider bills them for more than their plan's in-network cost-sharing amounts (such as deductibles, coinsurance and copays).

What is "surprise billing"?

"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.

What protections are in place?

The federal No Surprises Act (NSA), effective **January 1, 2022**, works together with the Virginia law to protect you from:

- Balance bills for covered emergency services at a facility, such as a hospital or freestanding emergency department,
- Balance bills for emergency air ambulance services (but not ground ambulance services), and
- Surprise bills for covered non-emergency services at in-network facilities.

May a health plan require that an emergency service be approved before the service is provided for it to be covered?

No. Prior authorization is not required for emergency services.

How am I notified of my rights and protections from balance billing?

Your health plan and the facilities and providers that serve you must provide you with a Consumer Notice of your rights under federal and Virginia law.

Can a provider ask me to waive my protections?

If you are covered under a health plan protected by Virginia law, you can never be asked to give up your balance billing protections for emergency services or for non-emergency surgical or ancillary services at an in-network facility.

There are some limited situations where the NSA allows some out-of-network providers and facilities to seek your written consent to waive your protection against balance billing for post-stabilization emergency services or non-ancillary, non-emergency services at an in-network facility. Please contact the Bureau of Insurance at 1-877-310-6560 if you are ever asked to give up these protections and have questions.

What if I rely on an inaccurate provider directory?

The NSA requires insurance companies to keep their provider directories updated. The law also limits your copays, coinsurance, and deductibles to in-network amounts if you rely on inaccurate information in a provider directory.

How are balance billing disputes resolved?

Virginia law and the NSA require the provider and carrier to settle balance billing disputes. You, as the consumer, are never in the middle of settling these disputes.

What if I think I am billed too much?

If you believe you've been wrongly billed, you may:

- File a complaint with your insurance company;
- Ask your insurer for an external review of the company's decision;
- File a complaint with the SCC Bureau of Insurance at: scc.virginia.gov/pages/File-Complaint-Consumers or call **1-877-310-6560**; or
- Call the federal Department of Health and Human Services at **1-800-985-3059**; or visit https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing.

Where can I find more information?

You can visit scc.virginia.gov/pages/Balance-Billing-Protection for more information about the No Surprises Act and Virginia's balance billing laws.

Examples of Surprise Medical Bills

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 EOB, Deion can call his health insurer first. If he isn't satisfied with the insurer's response, he can contact the consumer complaint resources identified above.

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. 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. Under the NSA, 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. Under Virginia law, as long as she has her surgery at an in-network facility and the surgery is covered under her plan, even if the surgeon is out-of-network she is only responsible for her in-network cost share.