



# Connecticut Consumers Receive Added Protections from Surprise Medical Bills

*Information Provided by the Connecticut State  
Insurance Department*

## ***New Federal Laws Expand Existing Protections***

Since 2015 Connecticut consumers with fully insured health plans regulated by the Connecticut Insurance Department have received protection from surprise medical bills.

Beginning January 1, 2022, a new federal law will offer additional protections from many types of these surprise bills to self-insured, employers sponsored health plans.

### **What is a 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 consumers in self-insured employer sponsored plans under ERISA as well as plans from health insurance companies beginning January 1, 2022, 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.
- A facility (such as a hospital or freestanding emergency room (ER) or a provider (such as a doctor) may not bill you more than the plan's in-network coinsurance, copays, or deductibles for emergency services, even if the facility or provider is out-of-network.
- If your health plan requires copays, coinsurance, and/or deductibles for in-network care, consumers are responsible for paying those.
- The new law also covers non-emergency services from out-of-network providers (such as an anesthesiologist) at in-network facilities. An out-of-network provider may not bill for more than the 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.

*Find more information and FAQs:*

***Requirements Under the Federal No Surprises Act***

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# Connecticut Consumers Receive Added Protections from Surprise Medical Bills Cont.

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## **What protections are in place, continued:**

- \* 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 about the federal Surprise Medical Bill law?**

- 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 this Department or the federal Department of Health and Human Services.
- An independent dispute resolution (IDR) process 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.

## **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 do not 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 do not 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.