Surprise Medical Bills – Your Rights and Protections

The No Surprises Act, 2021& Texas Senate Bill 1264 (SB 1264), 2019

"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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

"Balance billing" means the practice of charging an enrollee in a health benefit plan that uses a provider network to recover from the enrollee the balance of a non-network health care provider's fee for service received by the enrollee from the health care provider that is not fully reimbursed by the enrollee's health benefit plan. Amounts charged are likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

Out-of-network providers may be allowed to bill you for the difference between what your plan pays, and the full amount charged for a service. "Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services.

A. You're protected from balance billing for:
   1) Emergency services: If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
   2) Texas citizens covered by state-regulated PPO, EPO, HMO and Employee Retirement System/Teacher Retirement System plans and certain nonprofit agricultural organizations. Balance billing is prohibited for amounts due beyond cost sharing amounts for:
      i. Emergency care,
      ii. Care provided at an in-network facility by an out of network provider, and
      iii. Labs & imaging (in connection with in-network care)
   3) Certain services at an in-network hospital or ambulatory surgical center. When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount.
      i. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services.
      ii. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.
      iii. If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

B. You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

C. SB 1264 prohibits balance billing to health benefit plan enrollees, expands the Texas Department of Insurance (TDI) mediation program between health benefit plans and out-of-network facilities, creates an arbitration system between health benefit plans and out-of-network providers that are not facilities, and requires health plans to cover certain out-of-network services at the usual and customary rate.
   1) An out-of-network provider or a health benefit plan issuer or administrator may request mediation of a settlement of an out-of-network health benefit claim through a portal on the department's Internet website if:
      i. there is an amount billed by the provider and unpaid by the issuer or administrator after copayments, deductibles, and coinsurance for which an enrollee may not be billed; and
      ii. the health benefit claim is for:
         a. emergency care;
         b. an out-of-network laboratory service; or
         c. an out-of-network diagnostic imaging service.

D. When balance billing isn't allowed, you also have these protections:
   1) You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
   2) Generally, your health plan must:
      i. Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
      ii. Cover emergency services by out-of-network providers.
      iii. Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
      iv. Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

➲ If you think you've been wrongly billed, contact 1-800-252-3439 (Texas Department of Insurance).

➲ Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law and you may also visit www.tdi.texas.gov/consumer/health-insurance.html for more information about your rights as a citizen of Texas.