Consumer tips to protect yourself from surprise medical bills

Imagine you go to a hospital for a routine procedure. You've made sure your hospital and doctor are covered by your insurance. The procedure goes well and you head home to recover. Two weeks later, you get the bill, but instead of the copay you expected, you get a bill for nearly $4,000. Turns out, the anesthesiologist who assisted with your procedure was "out of network" and your insurance won't cover that bill as expected. You've received a surprise medical bill and now owe the difference between what your insurance will pay the out-of-network anesthesiologist and what you were billed.

What is a "surprise" medical bill?

You receive a surprise medical bill when, through no fault of your own, you are treated by providers outside of your insurance network. These out-of-network providers can charge exorbitant rates only revealed when the bill arrives in the mail. The average emergency room surprise medical bill is around $600, but these bills can range into the tens or even hundreds of thousands of dollars. When out-of-network providers charge these high rates, it drives up costs for everyone. Consumers are burdened with higher bills that they had no way to avoid. And when insurers have to pay their share of this higher charge, they're likely to pass on that cost to everyone by raising premiums.

If you have insurance through Medicare, the Arizona Health Care Cost Containment System (AHCCCS), or are on Veterans Affairs Health Care, you are fully protected from surprise medical bills. This tip sheet is for people covered under any other type of insurance.

How to prevent a surprise medical bill

The best way to prevent a surprise medical bill is to do everything you can to avoid being treated by an out-of-network provider. Here are a few important steps you can take.

1. Check with your insurer to make sure you are choosing a hospital, health care facility (lab, diagnostic center, surgery center), and doctors that are in your insurance network before receiving treatment.
2. When planning hospitalizations at an in-network facility, check with the facility to be sure that all providers (surgeons, anesthesiologists, and others), lab services (such as blood work) and imaging services (such as X-rays, MRIs) are covered by your insurance plan. When scheduling your hospitalization, ask that all services you may need are covered by your insurer. If certain services are not covered as in-network by your insurer, you may be able to work with your insurer for a discounted payment.
3. Know where your nearest in-network emergency room is for those times when it is possible to choose.

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Arizona PIRG Education Fund

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Know your rights

Arizona has a law that allows patients to dispute a bill from an out-of-network provider for treatment at an in-network facility if it amounts to $1000 or more, after subtracting your cost-sharing amounts (copay, coinsurance and deductibles). If you get a surprise medical bill, you can file a request for dispute resolution (arbitration) with the Department of Insurance and Financial Institutions (DIFI). The request for arbitration must be filed within one year of receiving the bill.

NOTE: Only Arizona residents on certain plans that are regulated by the state Department of Insurance and Financial Institutions (DIFI) may use this arbitration process. If you are unsure whether your plan is state-regulated, you can contact your insurer to find out. If you have a limited benefits plan, a HMO or health and accident coverage for state employees, you cannot use the arbitration process to fight a surprise medical bill.

Know which bills you can fight

You can request arbitration for a bill sent by an out-of-network provider who treated you at an in-network facility in one of the following situations:

1. You received the treatment from an out-of-network provider without your written consent.
2. You received the treatment from an out-of-network provider because there were no in-network providers available.
3. You received the treatment from an out-of-network provider during an emergency.

Other important items to know

1. If you received multiple bills from different out-of-network providers, you must file separate requests. Each bill must be over $1,000 to qualify.
2. The bill must be for treatment that is normally covered by your insurance plan.
3. You cannot file a request for arbitration on a bill if you have sued the provider or insurer over the same bill.

Filling out a request for arbitration

You must go online to fill out the request to fight your bill. You can find instructions at the Arizona Department of Insurance and Financial Institutions and fill out this form. Gather the documents you need and take photos of the following documents:

1. The bill that you are fighting.
2. Both sides of your insurance card.
3. The "Explanation of Benefits" (EOB) letter you should have received from your insurer. This letter should give information about what the provider billed for your treatment and what the insurer paid. Your EOB may also be linked to your account on your insurer's website.

There are a few additional things you can send that can help you prove your case. They are not required.

1. Proof of any payment you made to the provider for any part of the bill (copay, co-insurance, deductible).
2. All emails, letters, notices, and other documents you received from the provider or that you sent to the provider regarding either your medical treatment or the bill.

What are the next steps?

The Arizona Department of Insurance may contact you for additional information. Respond swiftly to all communications and provide any additional information requested throughout this process. If your request for arbitration is granted, the Department will set up a call with you, your insurer and your provider to try to reach an agreement. This is called the informal settlement teleconference (IST). You may choose to have a representative take your place, but either you or your representative must join the call. If you miss the first IST, you may ask to reschedule one time. If you or a representative participate in this call, even if no agreement is reached, you cannot be billed for more than your copay, coinsurance, or deductible. If your insurer had already sent you money to pay the out-of-network provider, you will also have to send that amount to the provider. At this point, your part in this dispute is complete. However, if you choose, you may participate in the additional arbitration if no agreement was finalized during the phone call, but you are not required to do so.

NOTE: If your request for arbitration is accepted, the provider cannot send your bill to debt collections. Once the arbitration process has finished, you are responsible for any copay, coinsurance, or deductible you owe, as well as any money that your insurer may have sent you to pay the out-of-network bill.

Voluntarily choosing an out-of-network provider

Many insured Arizona residents are covered by an HMO plan which does not cover out-of-network services. But if you do have a plan that has an out-of-network benefit, you can still choose an out-of-network provider at an in-network facility. However, requesting an out-of-network provider will result in a higher copay and additional costs your insurer will not cover.

If you want to use an out-of-network provider, Arizona law requires the provider to give you a written document within a reasonable time in advance of your treatment. This disclosure document must include the following information:

1. The name of the provider and the fact that the provider is not in your insurance network.
2. An estimate of the total cost the out-of-network provider will bill for the services.

NOTE: You are not required to sign this cost estimate disclosure in order to receive medical care. If you do sign this disclosure, you will lose the right to request arbitration. Out-of-network providers cannot give you this form in emergency situations.

Tips for lowering a medical bill

If your bill does not qualify for arbitration or your plan is not protected by state law, you should still try these tips to lower a medical bill:

1. Ask for an itemized bill and check that you are not being mistakenly billed for treatment you did not receive.
2. Compare the itemized bill to your Explanation of Benefits to see whether your insurer is paying its share. Sometimes patients are billed for services the insurer covers because their provider sent the wrong billing code to the insurer.
3. Contact your provider and ask about anything you don't understand.
4. Contact your insurer to see if any mistakes were made on their end.
5. If there are no mistakes, try negotiating with your provider. Many hospitals have patient advocate departments to help you negotiate the bill.
6. Contact the Department of Insurance and Financial Institutions at (602)364-2399. They may have additional tips to help you fight the bill.
7. Keep careful notes of all conversations you have. Get the names of the people you are speaking to. Keep your files in one place for easy access.
8. Be patient and clear in your requests.

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Special information during the COVID-19 pandemic

Testing for COVID-19 is free of charge for both insured and uninsured consumers if it is medically necessary. This means that if you have symptoms or have been exposed to someone with COVID-19, you can get a free test. Even though the test is free, many people have been billed for other fees associated with their visit. Before being tested, contact your insurer to confirm the testing site is in-network and ask about cost-sharing. When you choose a testing site, call and ask about other fees.

In Arizona, you may also be tested at no cost at CVS, Walgreens, Walmart and local independent pharmacies such as eTrueNorth and Health Mart. You do not need a referral to be tested at these pharmacies, but you will have to complete a questionnaire to determine that your test is medically necessary. To find out more about COVID testing in your state, use this resource.

More consumer protections are coming in January 2022

In a victory for consumers, Congress passed the Arizona PIRG-supported No Surprises Act to expand surprise medical billing protections to all insured Americans. This means that Arizona residents on federally regulated plans who are currently without protections will be protected from surprise medical bills. The federal protections will go much further than Arizona's current laws to protect consumers. As of January 2022, you will not have to file a request for arbitration to fight a surprise medical bill. Instead, providers will be banned from sending these unfair bills. That means that you will not have to pay a surprise out-of-network bill of any amount. These protections will also protect you from surprise bills for air ambulance services and emergency treatment at out-of-network facilities.

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