Topic Two: Health Insurance 101 and Balance Billing:

1. **What is a provider?**
   The term "provider" means a health care professional such as a doctor, a nurse practitioner, or behavioral health professional. A "primary care provider" is the provider you would see the most and help keep track of your health over time.

2. **What is a network?**
   A Network is the collection of facilities, providers, and suppliers your health insurer has contracted with to provide health care services. You should contact your insurance company to find out which providers are "in-network." These providers may also be called "preferred providers" or "participating providers." It may cost you more to see a provider who is "out-of network". Networks can change. Check with your provider to see if he or she is in your network each time you make an appointment, so you know how much you will have to pay.

3. **What is a deductible?**
   A Deductible is the amount you owe for covered health care services before your health insurance or plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

4. **What is Co-insurance?**
   Co-insurance is your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

5. **What is a Copayment?**
   A Co-payment or co-pay is an amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A co-payment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit, lab work, or prescription. Co-payments are usually between $0 and $50 depending on your insurance plan and the type of visit or service.

6. **What is a premium?**
   A Premium is the amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly. It is not included in your deductible, your co-payment, or your co-insurance. If you don't pay your premium, you could lose your coverage.

7. **What is out of pocket maximum?**
   Out-of-pocket maximum is the most you pay during a policy period (usually one year) before your health insurance or plan starts to pay 100% for covered essential health benefits. This limit includes deductibles, co-insurance, co-payments, and any other expenditure required of an individual for a qualified medical expense. This limit does not have to include premiums or spending for non-essential health benefits.

8. **What is an E.O.B.?**
   Explanation of Benefits (or EOB) is a summary of health care charges that your health plan sends you after you see a provider or get a service. It is not a bill. It is a record of the health care you or individuals covered on your policy received and how much your provider is charging your health plan. If you have to pay more for your care, your provider will send you a separate bill.

Balance Billing

1. **What is Balance Billing?**
   Balance Bills are surprise medical bills that charge patients for the difference between what an out-of-network provider charges and what your insurer actually pays the provider. Usually this occurs when a consumer inadvertently sees an out-of-network provider in an emergency situation. Because insurers do not pay out-of-network providers the full amount of the service charges, some providers try to collect from the patients the remaining amount of their fees.

2. **Why is balance billing important**?
   About 1 in 5 Mississippi adults has medical debt in collections, meaning their past due medical debt has been sold to collection agencies. Once a collection agency is involved, the debt can harm a person's credit score.

3. **What is an example of balance billing?**
   A patient visits his usual physician who participates in the patient's insurance network. The physician orders blood work and send the patient's sample to an out-of-network laboratory for testing. The patient's insurance covers 50% of out-of-network care. The lab's total charges are $500, and the insurance network rate is $300. The patient's insurance pays $150, which is 50% of the network rate, and expects the patient to pay the remaining $150 as outlined in the patient's policy. But the lab adds on the $200 difference between its charge ($500) and the network rate ($300) to the bill sent to the patient. Even though the physician was in the patient’s network, the laboratory was not. The patient receives a bill of $350 from the lab - the $150 usual co-pay plus the $200 (balance) bill for the different rate. This is a "Balance Bill" - where a healthcare provider bills a patient for the amount of fees or charges that insurance does not cover.

4. **What can a person do if they get a surprise medical bill?**
   Remember: The Mississippi Insurance Department enforces the law to protect consumers against surprise balance billing. If you get a Balance Bill, follow these steps and be sure to reach out to the Mississippi Insurance Department:
   - Make sure it is a Balance Bill. (remember you owe co-pays and deductibles)
   - Call your insurance company to make sure it's not a mistake and that the provider has accepted your Assignment of Benefits.
   - Call the Mississippi Insurance Department. (1-800-562-2957)

5. **How can the Mississippi Insurance Department assist with balance billing?**
   Mississippi law prohibits balance billing. Under MS Code 83-9-5 (1)(i), if an out-of-network healthcare provider accepts a patient's insurance assignment, then the insurance company will pay the provider directly for the patient's treatment. That payment is considered payment in full to the healthcare provider - this means the provider cannot bill the patient later for any amount more than the payment received from the insurance company, other than normal deductibles or co-pays. You may ask what an assignment is. Assignment means that your physician agrees to accept your insurance company's rates as full payment for services covered by insurance.

6. **What are the effects of air ambulance bills on Mississippians?**
   Consumers are being balance billed tens of thousands of dollars because air ambulance providers are not contracting with insurance carriers. The median cost of an air ambulance bill is $36,000.00.

7. **Are there any Federal laws protecting consumers from air ambulance bills?**
   No, The Airline Deregulation Act of 1978 (ADA) prohibits states from regulating air ambulance prices. State laws are preempted by the ADA; therefore the only way to obtain legislation to control surprise billing from an air ambulance company is through federal legislation. The Federal Aviation Administration (FAA) Reauthorization Act of 2018 includes a provision to appoint an advisory and patient billing committee on air ambulances to resolve these issues but to date no one has been appointed to the committee.

8. **What has the Mississippi Insurance Department done to help?**
   Mississippi is one of 32 states that have pushed back against air ambulance providers by submitting letters to the Senate health committees supporting the FAA Reauthorization Act of 2018. We also encourage companies, like Blue Cross and Blue Shield of Mississippi, to negotiate network agreements with the air ambulance companies and provide protections for policyholders.

9. **Has the Mississippi Insurance Department been successful in helping consumers with large air ambulance bills?**

   Yes, a patient experiencing respiratory distress was transported from a hospital in Gulfport, MS to a research hospital in Mobile, Alabama using an air ambulance. The insurance carrier paid $8,960.49 of the $41,063.79 bill. The air ambulance company balance billed the patient the difference between the insurance carrier's payment and the billed charge. To protect the patient, we worked with the air transport company to have the balance bill of $32,000 waived. The family was only responsible for their $200 copayment amount.