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Seeing Double: The Practice of Balance Billing
Food For Thought

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Billed Charges vs. Negotiated Rates

Billed Charges

- The price facilities or providers set for their services
- There is no legal limit to the price providers can set. Texas does not regulate billed charges
- These charges often have no connection to underlying market prices, costs, or quality
- Billed charges are not transparent

Negotiated Rates (contract rate)

- The "agreed to" rate a health plan negotiates with a provider who is part of the health plan's provider network
- This is the amount a contracted provider agrees to accept as payment in full
- A contracted or network provider cannot balance bill above the negotiated or contract rate

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The Problem With Billed Charges

- Billed charges are self-determined by providers and generally much higher than payments accepted by providers in the market (contracted rates) and have large variation
- Average hospital billed charges in Texas are more than double-to-triple what is generally paid and accepted in the market and often more than five times higher than what Medicare pays
- The highest hospital billed charges in Texas are often more than five-to-six times higher than the contracted rate the same providers are willing to accept in the same market
- Providers do not expect to collect full billed charges from health plans, and it is rare for anyone to pay the full charges billed

"I know of no research or other evidence to suggest that these enormous price differentials reflect different levels of quality or value of services." – Uwe E. Reinhardt, Princeton economist, discussing health care pricing.

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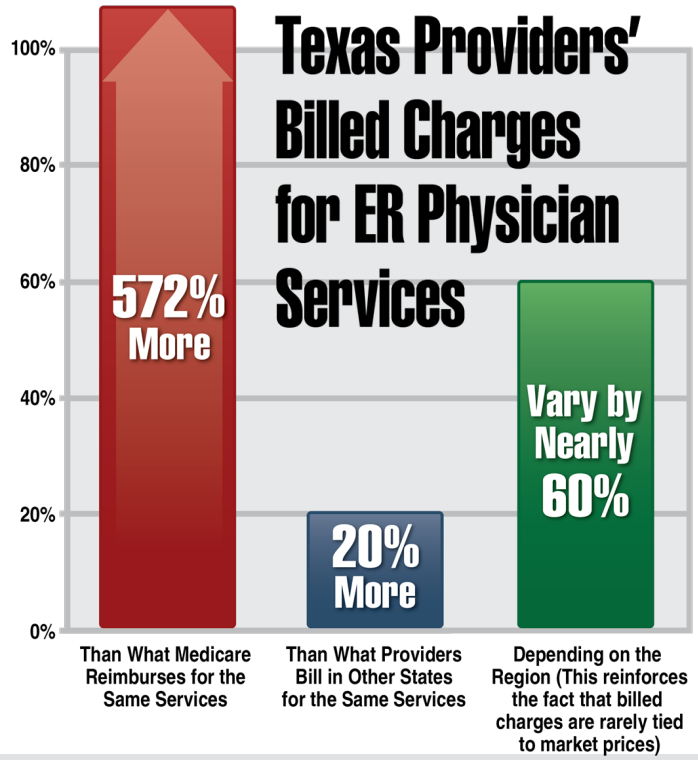
Concerns About Billed Charges

- **Example: Texas providers' billed charges for a high acuity ER visit:**
  - 572% more than what Medicare reimburses for the same services
  - 20% more than what providers bill in other states for the same services
  - Can vary by nearly 60% depending on the region, reinforcing the fact that billed charges are rarely tied to market prices (25th vs. 75th percentile)



Source: Charges Billed by Out-of-Network Providers: Implications for Affordability, AHIP. Sept 2015

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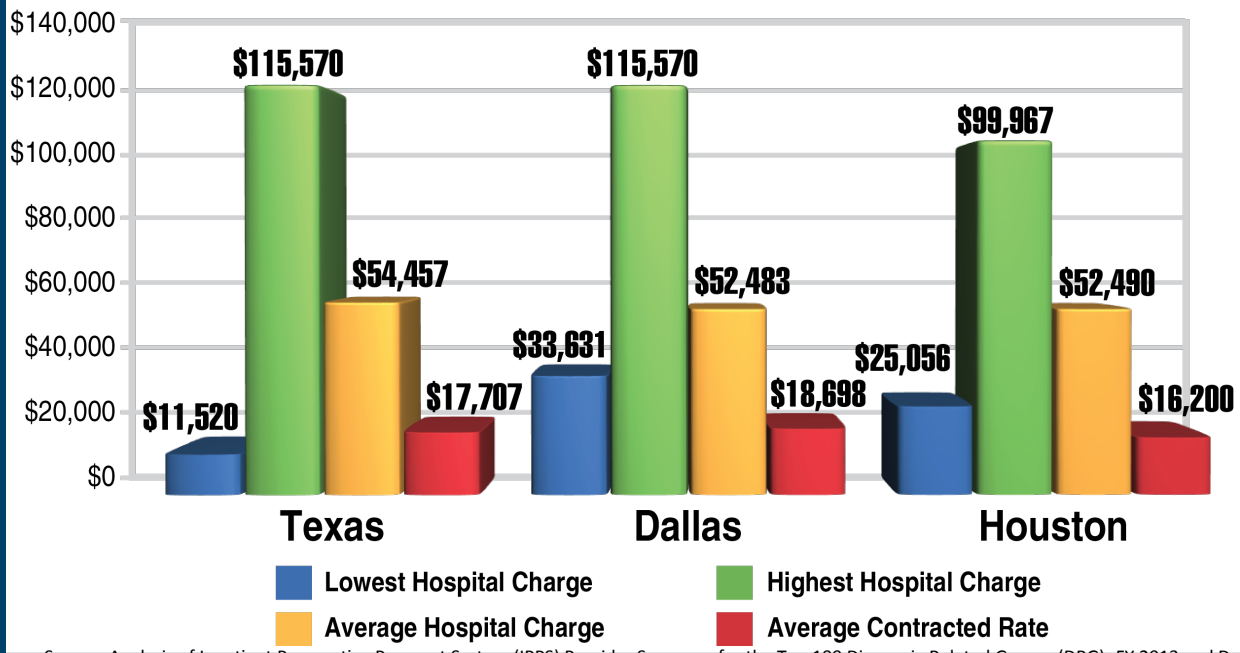
Concerns About Billed Charges

Heart Failure: 2013 Hospital Inpatient Billed Charges & Contracted Rates



- More than 900% price difference in Texas
- More than 250% price difference in Dallas
  - Average charges almost 3x higher than contracted rates
  - Highest charge more than 6x higher than contracted rates

Source: Analysis of Inpatient Prospective Payment System (IPPS) Provider Summary for the Top 100 Diagnosis-Related Groups (DRG)- FY 2013 and Data From a Large Texas Health Plan – 2013 PPO. DRG Code: 291 Heart Failure & Shock with Major Complication & Comorbidity

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Understanding Surprise Billing

Out-of-Network Care	• Consumer receives out-of-network care (often unknowingly) - No contract or negotiated rate is available
Provider Billing	• Provider bills health plan at "billed charges" • Health plan pays amount covered by out-of-network benefits (if out-of-network benefits are available)
Surprise Bill	• Consumer has paid copay and believes full payment has been made for services • Consumer receives a bill for the difference between the health plan's out-of-network payment and the provider's "billed charges" (The balance of the remaining bill or a "balance bill")

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Understanding Balance Billing: Two Patients With A Broken Arm Enter The ER Of An In-Network Hospital

	In-Network	Out-of-Network
Billed Amount From ER Doctor	$1,050	$1,050
Insurer's in-network contracted amount agreed to in advance	$500	N/A
Insurer's required out-of network payment based on what is usual and customary	N/A	$600
What your insurer pays	80% Coinsurance $500 x 0.8 = $400	80% Coinsurance $600 x 0.8= $480
Your coinsurance/cost sharing (same in-network and out-of-network)	20% Coinsurance $500 x 0.2 = $100	20% Coinsurance $600 x 0.2=$120
Balance Bill: *Difference between what the insurer paid (usual and customary) and what the physician charged*	None	$1,050 - $600 = $450
Total amount you owe: *Your coinsurance and balance bill*	**$100**	$120+$450 = **$570**

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Key Considerations: Surprise Billing

- Consumers expect provider services at a network hospital or outpatient facility to be in their health plan's network
- Most physicians at hospitals are independent contractors who work ***at*** the hospital, but not ***for*** the hospital
- Hospital and facility based providers are the biggest concern
- Hospital based providers and freestanding ERs represent most of the "surprise billing"
- Patients who go to a network hospital or seek emergency care are in no condition to "shop around"

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Out-Of-Network Disputes Cause Surprise Billing

- **Additional network adequacy standards will not address surprise billing - Texas has some of the strongest network adequacy standards in the country – all plans must meet network adequacy**
- **Surprise billing most often happens when there is an adequate network**
- **Surprise billing is generally isolated to two types of network dispute situations:**
  - **Out-of-network hospital-based providers practicing at a network hospital**
    - Often involving exclusive arrangements
    - Large provider groups - very little competition
  - **Emergency Care Services**
    - Emergency care providers/Freestanding ERs
- **These out-of-network provider/health plans disputes occur regardless of plan or network size – systemic issue**

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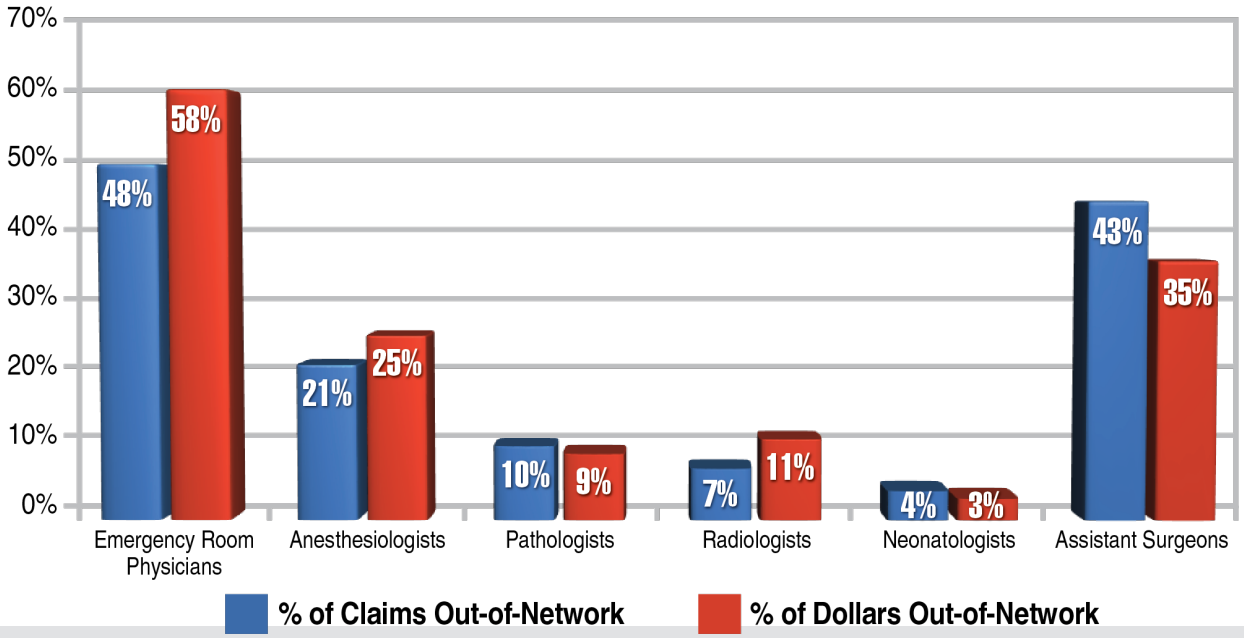
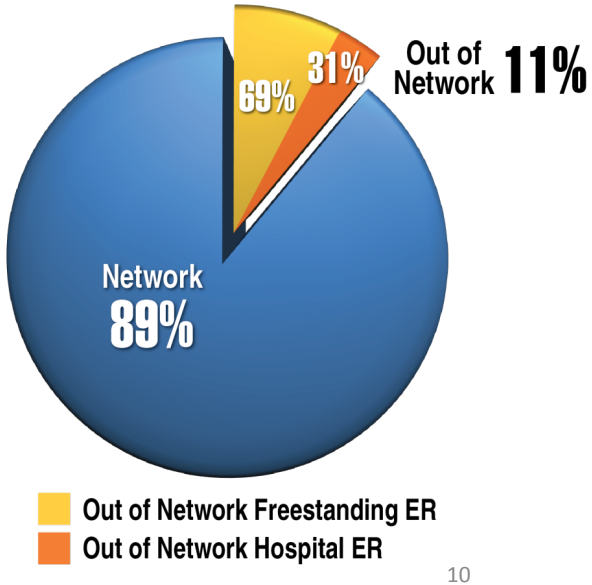
Emergency Services Are The Largest Problem

Percent of Claims & Dollars Out of Network: Hospital Based Physicians–2015



Emergency Room Facility Claims: Network vs. Out of Network



Source: TAHP Out-of-Network Claims Survey and Analysis of Three Large Texas Health Plans: 2015 Claims; May 2016

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Incentive for ER Providers to Stay Out of Network

- Emergency care payment protections are inconsistent & create an incentive to stay out of network
- TDI requires health plans to pay out-of-network providers based on billed charges - "Usual or Customary Charge" rule mandating health plans pay out-of-network ER providers based on "billed charges" has created an incentive for providers to stay out of network, exacerbated the out-of-network ER problem, and exposed more consumers to balance billing
  - Problem with "billed charges:" Often have very little connection to underlying costs, quality, or market prices
  - Creates a financial incentive for providers to stay out of network - Milliman predicted an increase in health care costs and the loss of hospital-based network providers due to the incentive to make more money out of network
  - Many ER providers have left health plan networks since U&C was adopted - 12 large ER provider groups terminated their contract with BCBSTX, citing it as a "business decision" after the 2013 rule implementation
  - Freestanding ERs tend to be out of network
  - 21% to 56% of in-network hospitals in Texas have no in-network ER docs for the three largest health plans in TX
- Providers can still balance bill patients in excess of the "usual or customary charge" payment - No regulation in Texas of billed charges

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Out-Of-Network Protections: Payments, Benefits, and Surprise Billing

Type of Plan	Out-of-Network Coverage	Out-of Network Payment Requirements (Texas)	Out-of-Network Payment Requirements (Federal)	Out-of-Network Benefit Coverage Protection	Balance Billing Protection
HMO	• Emergency Services • No Network Provider Is Available	• Usual and Customary Rate	• Emergency Only: Highest of In-Network Median Rates, Medicare, or Usual Allowable Rates	• Emergency & No Network Provider is Reasonably Available: In-Network Benefit Level (co-insurance percentage ex. 80/20)	• Hold Harmless
PPO	• All Covered Services	• Emergency Services & No Network Provider is Reasonably Available: Usual or Customary Charge (TDI Rule) • All Other Services: Allowable Rates	• Emergency Only: Highest of In-Network Median Rates, Medicare, or Usual Allowable Rates	• Emergency & No Network Provider is Reasonably Available: In-Network Benefit Level (co-insurance percentage ex. 80/20); credit balance billing amounts paid by enrollee to network deductible and out-of-pocket max • All Other Services: At Least 50% Benefit Coverage	• Physician Services Only: Mediation For OON Hospital Based Physicians (6 types) – Balance Bill Over $500 • No Additional Balance Billing Protection for Any Other Services
EPO	• Emergency Services • No Network Provider is Reasonably Available	• Usual and Customary Rate	• Emergency Only: Highest of In-Network Median Rates, Medicare, or Usual Allowable Rates	• Emergency & No Network Provider is Reasonably Available: In-Network Benefit Level (co-insurance percentage ex. 80/20)	• Hold Harmless
ERISA Self-funded Plans	• N/A	• N/A	• Emergency Only: Highest of In-Network Median Rates, Medicare, or Usual Allowable Rates	• Emergency: In-Network Benefit Level (co-insurance percentage ex. 80/20)	• No Additional Federal Balance Billing Protection

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Surprise Billing: Current Mediation Protection

- **Individuals may request mediation of a non-network balance bill, if:**
  - PPO or EPO plan or the State ERS plan (TRS is not included)
  - Hospital was in-network
  - Non-network hospital-based physician
    - Radiologist, anesthesiologist, pathologist, emergency department physician, neonatologist, or assistant surgeon
  - "Balance bill" amount (per claim) is more than $500 (not including applicable copay, coinsurance or deductible amounts)
  - No notification of projected costs occurred, or the amount billed to the consumer exceeds the projected amount
- **Provider is required to notify consumer of mediation protection on the "Surprise Bill"**
- **Plans are also required to provide notice of mediation (on EOB)**
- **Mediation forms on TDI's website: http://www.tdi.texas.gov/forms/consumer/mediationform.pdf**
- **History:** Mediation protection passed in 2009. In 2015, dollar threshold lowered from $1,000 to $500 and assistant surgeons added

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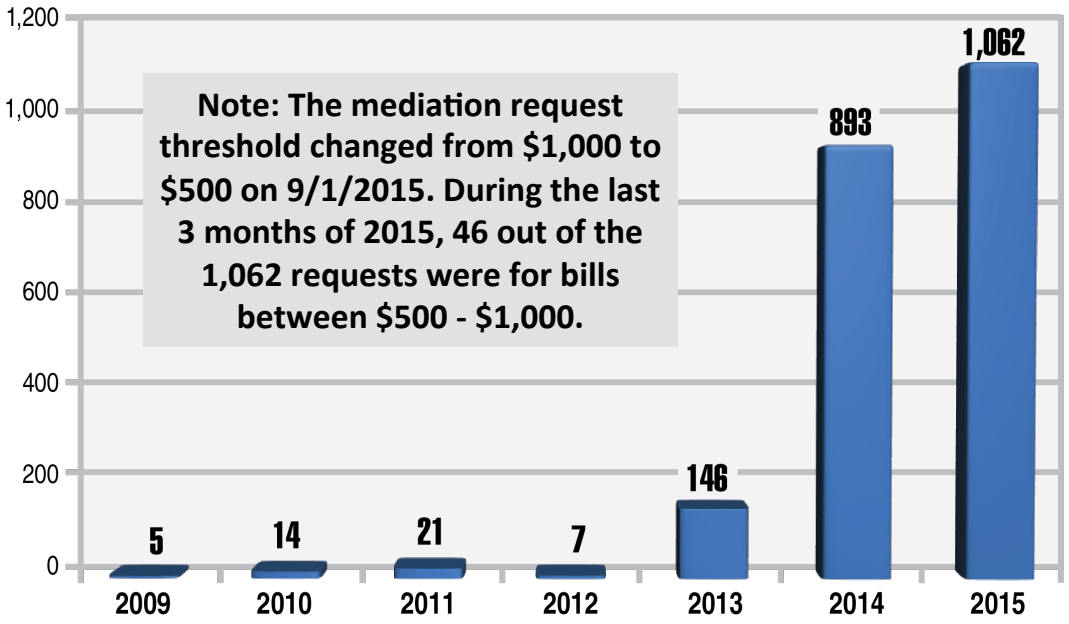
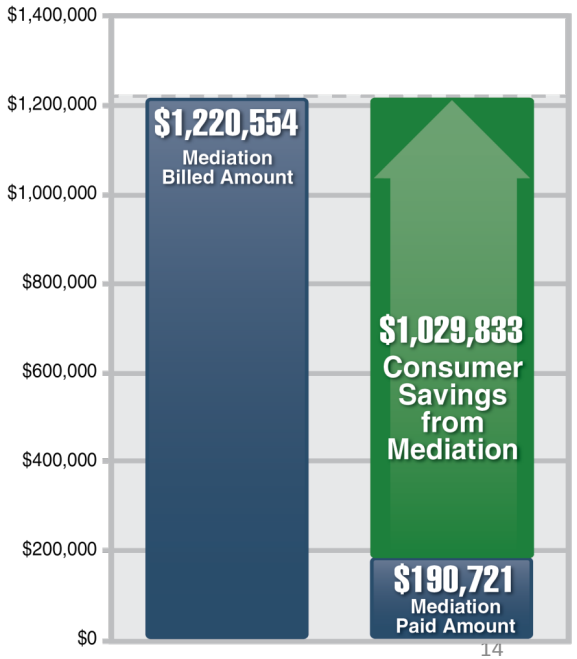
Mediation Is Working When Available

Total Number of Mediation Requests Received by TDI



Mediation Savings Impact to Consumers: 2015



Source: TDI Data On Out Of Network Mediation Requests , April 2016

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Recommendations

- **TAHP believes in a balanced approach that accomplishes three goals:**
  - Protect patients from bills they are not responsible for paying
  - Provide for fair and reasonable payment to out-of-network providers
  - Provide for a dispute process when providers feel they have not been accurately or adequately paid
- **Expand mediation and surprise billing protections for consumers for all out-of-network emergency care services – physicians, providers, and facilities**
- **Expand mediation protection for consumers who receive services from any out-of-network providers working at a network hospital**
- **Expand mediation to bills lower than the current $500 threshold**
- **Set reasonable out-of-network payment standards for emergency care that do not create an incentive for providers to stay out of network – NAIC model recommendation (Highest of a X% of Medicare or Contracted Rate)**

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Recommendations

- **Increase transparency of health care prices (billed charges) and network status:** System is still too confusing for consumers; more transparency is needed on network status and prices (billed charges)
- **Some states have prohibited balance billing –** 14 states have explicit prohibitions
- **Consumer should receive advance notice and consent to out-of-network charges and care prior to a provider being able to balance bill**
- **Provide regulatory oversight for unfair billing patterns and price gouging –** Review patterns of balance billing or excessive charges and make a determination if there are excessive or unfair billing patterns that could prompt action by a state agency with jurisdiction

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Appendix: Additional Information Related To Health Plan Networks And Balance Billing Protections

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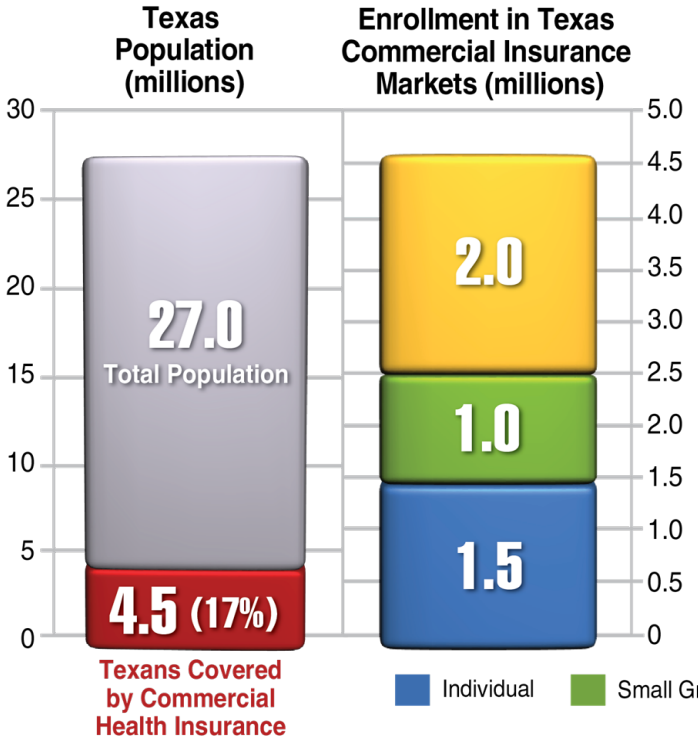
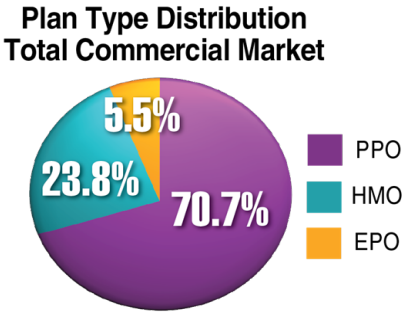
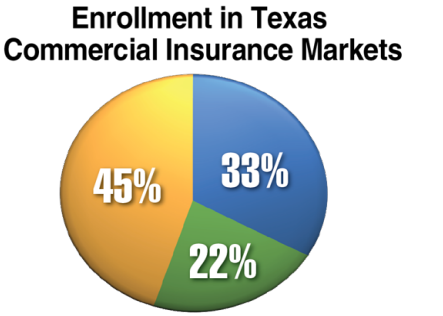
Commercial Health Insurance Market In Texas (2015)

- Regulated by TDI
- Mainly Employer- Sponsored
- PPO
  - Most Purchased
  - Higher Premiums
  - Out-of-Network Benefits
  - Referrals not Required
- HMO
  - No Out-of-Network Benefits (Except ER & When Network Provider not Available)
  - May Include PCP Referrals
- EPO
  - No Out-of-Network Benefits (Except ER & When Network Provider not Available)
  - No PCP Referral Requirement







Source: TAHP Enrollment Survey 2015, Miliman Dec. 2015 & TAHP Addendum to 2015 Enrollment Survey, Milliman, April 2016

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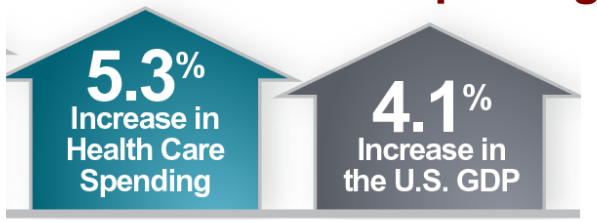
Why Health Plan Networks Are Important

- **Rising Health Care Costs: $3.1 Trillion Spent on Health Care in US in 2014**
  - 5.8% growth per year for the next decade
  - 2014: $1 in $6 was spent on health care
  - By 2024: $1 in $5 will be spent on health care
- **Health Plan Premiums Directly Track Health Care Costs**
- **Health Plan Networks**
  - Drive Competitive Price Negotiations
  - Hold Down Costs
  - Promote Quality
  - Protect Consumers From Surprise Billing and Inflated Billed Charge

2014 U.S. Health Care Spending



Source: National Health Spending, Health Affairs, January 2016

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Consumer Health Plan Trends

- Majority of consumers are satisfied with their health plans, costs, and their provider networks (Kaiser Family Foundation, May 2015)
- Nearly 90% of consumers are satisfied with the selection of providers from their health plans (Kaiser Family Foundation, January 2016)
- Only 12% of consumers have had to change providers in last 12 months (50% stated it was not a problem) (Kaiser Family Foundation, January 2016)
- 7 out of 10 exchange consumers said they had no financial difficulty paying for out-of-pocket medical expenses in the past year (Deloitte study, May 2016)
- A majority say their plan is an excellent or good value for what they pay for it (Kaiser Family Foundation, January 2016)
- A majority say they would have been unable to get or pay for that treatment without their new coverage (Commonwealth study, May 2016)

9 out of 10 Insured Adults
are Satisfied with Health Plan Networks

Source: Kaiser Health Tracking Poll January 2016

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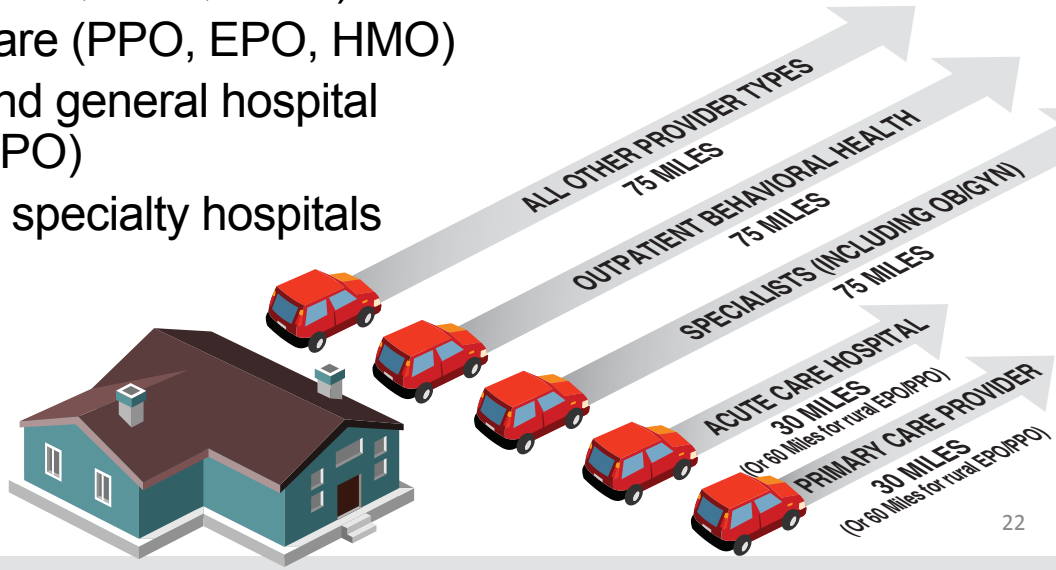
Texas Department Of Insurance: Wait Times

- **EPO & PPO Wait Times**
  - ER - 24 hours a day, 7 days a week
  - Non-emergency, urgent care - within 24 hours
  - Preventive care - within 2 months for a child and 3 months for adults
  - Appointment for medical condition - within 3 weeks
  - Appointment or behavioral health conditions - within 2 weeks
- **HMO Wait Times**
  - ER Care - 24 hours a day, 7 days a week
  - Preventive health - within 2 months for a child, 3 months for an adult, and 4 months for dental services
  - Routine care - within 3 weeks for medical services, 8 weeks for dental conditions, and 2 weeks for behavioral health conditions
  - Urgent care - within 24 hours for medical, dental, and behavioral health conditions

Texas Department Of Insurance: Distance Requirements

- **Maximum distance from any point in a health plan's service area:**
  - 30 miles for primary care (PPO, EPO, HMO)
  - 30 miles general hospital care (PPO, EPO, HMO)
  - 60 miles for primary care and general hospital care in rural areas (PPO, EPO)
  - 75 miles for specialists and specialty hospitals (PPO, EPO, HMO)



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Health Plan Transparency Requirements

- **Estimate of Payment**
  - Any deductibles, copays, coinsurance, or other costs (upon request of consumer, within 10 days)
- **Written notice to consumers that:**
  - Facility based providers may be out-of-network, even though they are at an in-network facility
  - Consumers may be charged the difference between what the health plan paid and the provider's full billed charges
- **Health plan provider directory and web site must clearly identify network hospitals in which facility-based physicians are not in the network**
- **Must identify payment to a non-network physician (EOB)**
- **Health plans report aggregate reimbursement rates, billed charges, aggregate contracted rate (for in-network providers) and aggregate allowed amount (for non-network providers) to TDI**
- **NOTE: Very few provider transparency requirements related to billed charges (prices) or network status**

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Consumer Out-of-Network Requirements

- **If a network provider is not reasonably available or for emergency care, PPO plan must:**
  - Pay usual or customary charges
  - Pay in-network level of benefits (in-network coinsurance level)
  - Credit any "balance billing" amount to the non-network deductible and annual out-of-pocket maximums
  - **Provider can still send a balance bill**
- **TDI enforces "hold harmless" protections against balance billing for EPO and HMO plan enrollees**

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Example of Freestanding ER Website Notification

FIRST CHOICE EMERGENCY ROOM

THE NATION'S OLDEST AND LARGEST FREESTANDING EMERGENCY ROOM SYSTEM.

INSURANCE: HOUSTON/AUSTIN/SAN ANTONIO

First Choice Emergency Room is a free-standing emergency room. We function just like a hospital based emergency room. We will accept your ER co-pay at the time of service, and emergency room claims will be submitted to your insurance carrier.

We are not currently contracted with your insurance company. However, in the state of Texas, all emergency visits are to be processed as in-network regardless of the network status. What that means is your visit will be processed under your in-network benefits. Your insurance may not process it correctly the first time but our patient accounts department will work with them to have your claims reprocessed until they are processed under your in-network emergency room benefits. We accept all major, commercial insurance carriers like, but not limited to, AETNA, BCBS, Cigna, Humana, and United Healthcare.

If you have specific questions about your bill, please call our patient accounts team at the appropriate phone number below, weekdays between 8am and 5pm.

Houston/Austin/San Antonio (844) 564-2177

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Example of Freestanding ER Website Notification