TAHP
The Texas Association of Health Plans

*Representing health insurers, health maintenance organizations, and other related health care entities operating in Texas.*

# What is Balance Billing?

Balance billing is a growing practice occurring in Texas and across the country that has become synonymous with "surprise medical bills." Surprise balance billing occurs when insured patients receive out-of-network care, and the non-network doctor, facility or other health care provider who treats them bills them for fees that exceed the amount covered by their insurance.

In these out-of-network instances, there is no contract between the provider and the health plan, meaning there is no negotiated rate. Therefore, the health plan will pay their out-of-network reimbursement rate to the provider. In most cases, at this point, consumers believe their bill has been paid. But, because there was no negotiated rate, the provider will send a second bill (balance bill) for the difference between what the health plan paid and the facility/provider's "billed charges." Billed charges are the price a facility or provider sets for their services. There is no legal limit to the price they can set, and these charges often have no connection to underlying market prices, costs, or quality.

## Understanding Balance Billing: Two Patients with Sprained Ankles 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<br>$500 x 0.8 = $400 | 80% Coinsurance<br>$600 x 0.8= $480 |
| Your coinsurance/cost sharing (same in-network and out-of-network) | 20% Coinsurance<br>$500 x 0.2 = $100 | 20% Coinsurance<br>$600 x 0.2=$120 |
| **Balance Bill:**<br>*Difference between what the insurer paid (usual and customary) and what the physician charged* | None | $1,050 - $600 = $450 |
| **Total amount you owe:**<br>*Your coinsurance and balance bill* | **$100** | $120+$450 = **$570** |

*The most surprising balance bills occur when consumers unknowingly receive out-of-network care in emergency situations or when they are treated by an out-of-network physician at an in-network hospital*

# Situations When Surprise Balance Billing Most Often Occurs

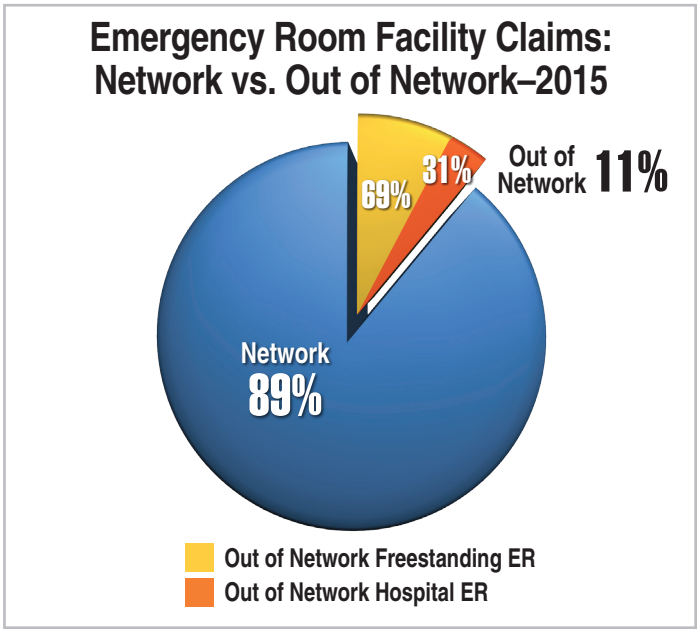
## *Emergency Situations:*

A large number of freestanding ERs and emergency care physicians have adopted a business model of not being in any health plan networks because they are taking advantage of a financial incentive that exists as a result of current TDI rules.

When consumers in emergency situations visit a facility that is not in their insurance network, their health plans are required by law to pay out-of-network providers a rate that is based on "billed charges," or the "usual or customary charge" for the region. This means the State has set reimbursement rates for these situations based on an **average of what providers *bill* in the region—*not* on the average rate that providers are actually *accepting*** in that same region. This financial incentive encourages ER facilities and providers to remain out of network.

As a result, consumers often receive surprise balance bills in emergency care situations.

While mediation protection exists for consumers who are billed by an out-of-network ER physician who treated them at an in-network hospital ER, there are currently no mediation protections for consumers who receive emergency care from an out-of-network ER facility, including freestanding ERs, and the out-of-network physicians who practice there.




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

## *No Network Provider Available*

As mentioned, surprise balance bills also result from a consumer being treated by an out-of-network physician at an in-network facility. These facility based physicians include ER doctors, radiologists, pathologists, anesthesiologists, neonatologists, and assistant surgeons, who typically have exclusive access agreements with hospitals. An exclusive access agreement means the hospital can only exclusively contract with one large physician practice. Exclusive access agreements between hospitals and facility based physicians effectively create a monopoly, which discourages competition that would benefit consumers.

Mediation protection is available in these situations if the balance bill exceeds $500 for the above-mentioned six facility based physicians. However, new hospital based providers who are not currently listed in statute have begun balance billing consumers (e.g., hospitalists).

## History of Balance Billing Mediation in Texas

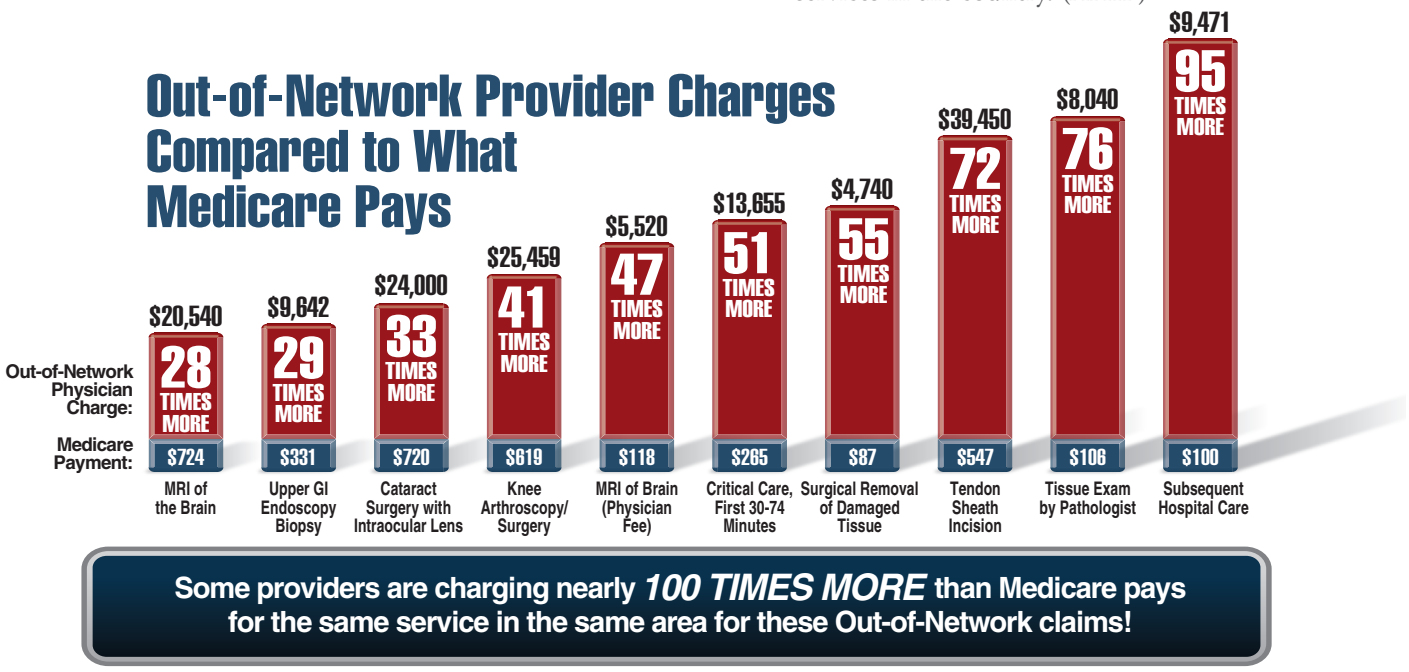
*HB 2256 (2007) established a new mediation process for consumers who were balance billed more than $1000 by a non-network facility-based physician. Mediation is available to consumers who are covered through a fully-insured PPO or EPO plan or the State ERS plan.*

*Prior to the passage of House Bill 2256 in 2007, there was no remedy for unexpected balance bills other than the patient attempting to set up a payment plan with the facility-based physician. HB 2256 established a new mediation process for consumers that are balance billed. Physicians are no longer allowed to collect a "balance" bill from consumers once they have received notice that mediation has been requested. SB 481 (Sen. Hancock) from last session expands options for mediation by reducing the claim threshold from $1000 to $500 and adding assistant surgeons to the list of providers subject to mediation and required to notify consumers about the option of mediation. The bill also strengthened the required notifications to consumers that mediation is an available option to resolve a balance-billing dispute.*

*Health plans and providers are responsible for informing consumers of the potential of balance billing by hospitals and non-network facility-based physicians. Providers are responsible for notifying consumers that mediation is a protection available to them on the "balance" bill.*

# Did You Know?

- ✓ Economists and advocates estimate that **consumers pay almost $1 billion a year due to balance billing.**
- ✓ Health plans and consumers routinely receive bills from doctors that are **10 to 20, or sometimes 100 times,** what Medicare pays, which is widely used as the national benchmark for determining accepted rates for medical services. (AHIP)
- ✓ 23 Texas hospitals that have contracts with the state's largest PPO plans do not have any emergency room doctors who contract with those plans. (CPPP)
- ✓ 21%-56% of in-network hospitals in Texas have no in-network ER doctors with the three largest health plans. (CPPP)
- ✓ There is no limit to what providers can bill for health care services. Billed charges often have little or no connection to actual underlying costs or market prices. But balance bills are based on billed charges and so there is no limit to what non-network providers can bill consumers, even after being paid the health plan benefits.
- ✓ Balance billing is a growing problem in the U.S. but especially in Texas where some consumers are receiving **ER bills for high acuity care that are 650% higher than Medicare.** (AHIP)
- ✓ **Texas has the 5th highest out-of-network provider charges** for life-threatening emergency services in the country. (AHIP)




**Some providers are charging nearly *100 TIMES MORE* than Medicare pays for the same service in the same area for these Out-of-Network claims!**

(This graphic comparison is not even to actual scale as the difference would be difficult to interpret on a single page.)

## Mitigating the Effects of Balance Billing—TAHP Recommendations

- **Increase Consumer Access to Mediation:** Mediation is working for consumers when it is available. In the past year, mediation has saved consumers millions of dollars. Virtually all claims have been settled. A more expansive use of mediation will bring a higher degree of fairness to the situation and, ultimately, better protect Texans from surprise debt.
  - Eliminate or reduce the current $500 threshold for claims eligible for mediation.
  - Expand mediation protection for consumers to all emergency care situations, including freestanding ERs.
  - Expand mediation to include other hospital-based providers not currently mentioned in statutes who are increasingly balance billing consumers (hospitalists)
- **Boost Transparency:** When consumers are empowered with information, they are better able to care for themselves and their families without breaking their bank accounts.
  - Require Out-of-Network Facility-Based Providers' contract status and fees to be disclosed to consumers.
- **Streamline emergency care protections, so they are consistent across all product types and do not create an incentive for providers to stay out-of-network and inflate billed charges (freestanding ERs, large ER physician groups).**

# Out-of-Network Payments: Current Requirements

## *Mediation in Texas*

Currently, an individual may request mediation of a non-network balance bill if all of the following are met:

- The member has coverage through a fully-insured PPO or EPO plan **or the State ERS plan.**
- The medical service was provided by a non-network hospital-based physician at a network hospital.
  - a radiologist, an anesthesiologist, a pathologist, an emergency department physician, a neonatologist,or an assistant surgeon
- The "balance bill" amount owed by the consumer is more than $500.
- The consumer was not notified of projected costs, or the amount billed to the consumer exceeds the projected amount.

## *Transparency at Freestanding ERs in Texas*

In 2015, Gov. Abbott signed into law SB 425, TAHP-supported legislation that requires emergency care facilities to be forthcoming regarding the fees and other charges patients might incur at freestanding emergency rooms. There is currently no mediation option for consumers who use freestanding ERs.

SB 425 requires freestanding ERs to post a prominent notice—and also include this notice on their web site—that clearly includes the following information:

- The facility is an emergency room.
- The facility charges rates comparable to a hospital emergency department, including a possible facility fee.
- The physician may bill separately from the facility.
- The facility and facility-based physicians may not be participating providers in an individual's health plan network.

# Federal and State Protections Ensure that Providers Already Receive a Fair Payment: They "Balance" Bill Above These Paid Amounts:

**Consumer and Provider Payment Protection for Out- of-Network Care**—TDI's protections ensure consumers receive in-network levels of coverage in emergencies and if a network provider is not "reasonably available." In this situation, TDI rules require health plans to:

- **Pay the claim at the "usual or customary CHARGE" for the service area** (less any patient coinsurance, copayment, or deductible responsibility under the plan);
- **Pay the claim at the in-network level of benefits (same as the in-network coinsurance level); and**
- **Credit any "balance billing" amount paid by the consumer to the non-network deductible and annual out-of-pocket maximums.** (28 TAC 3.3708.)

- **Federal Requirements for Out-of-Network Emergency Services**—Federal rules require that a "reasonable" amount be paid for out-of-network emergency services using the higher of the following possible amounts:
  - the rate negotiated with in-network providers for emergency services (example: median in-network rate);
  - the Medicare rate for emergency services; or
  - the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable rate or amount).

(Medicare rates are available to the public at: http://www.cms.hhs.gov/ MedicareAdvtgSpecRateStats/downloads/oon-payments.pdf.)

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