TEXAS DEPARTMENT OF INSURANCE

Balance Billing

Glossary of Terms

Allowed amount - The maximum amount on which payment is based for **covered health care services**. From the health plan's perspective, this is the fair price for a health care service. This may be called "eligible expense," "payment allowance," "contracted rate," or "negotiated rate." If your doctor or hospital charges more than the allowed amount, you may have to pay the difference. This is called **balance billing**.

Balance billing - When a doctor or hospital bills you for the difference between their charge and the **allowed amount**. For example, if their charge is $100 and the allowed amount is $70, they may bill you for the remaining $30. A **preferred provider** may not balance bill you for **covered services**.

Coinsurance - Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. In most plans, after meeting your **deductible** , you must pay coinsurance until you reach your **out-of-pocket limit**. For example, if your plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20 percent would be $20. The health plan pays the rest of the allowed amount. Coinsurance usually does not apply to **HMOs**.

Deductible - The amount you must pay **out-of-pocket** for **covered services** before your plan begins to pay its portion of your medical expenses. You usually must meet a deductible each year. For example, if your deductible is $1,000, your plan won't pay anything until you've paid $1,000 out-of-pocket for covered health care services subject to the deductible. If you have a family plan that covers your spouse or dependents, you may have one deductible for the entire family, or you may have to meet a separate deductible for each family member.

Exclusive provider organization (EPO) - A type of health plan where services are covered only if you go to **preferred providers**. **Out-of-network** care is only covered in an emergency, or if you can't access the care you need **in-network**. EPO plans are similar to **HMO** plans, but EPOs are offered by insurance companies, which are regulated differently than HMOs.

Health maintenance organization (HMO) - A type of health plan that usually limits coverage to care from **preferred providers. Out-of-network** care is only covered in an emergency, or if you can't access the care you need **in-network**. In an HMO plan, your care is managed by your **primary care provider** and you need a **referral** in order to see a **specialist**. HMO plans are similar to **EPO** plans, but HMOs are regulated differently than insurance companies.

Non-preferred provider - Any **provider** outside an insurer's **network**. Visiting a non-preferred provider can incur **balance billing -** synonymous to an **out-of-network** provider.

Out-of-pocket maximum or limit - The most you will have to pay during a policy period (usually a year) before you no longer have to pay **cost-sharing** for **covered health services**. Once you've reached your out-of-pocket maximum, your health plan generally pays 100 percent of your covered essential health benefits. You are still

responsible for paying your **premium**. This maximum or limit does not include your premium, **balance-billed** charges, spending for non-essential health benefits, or spending for **non-covered services**.

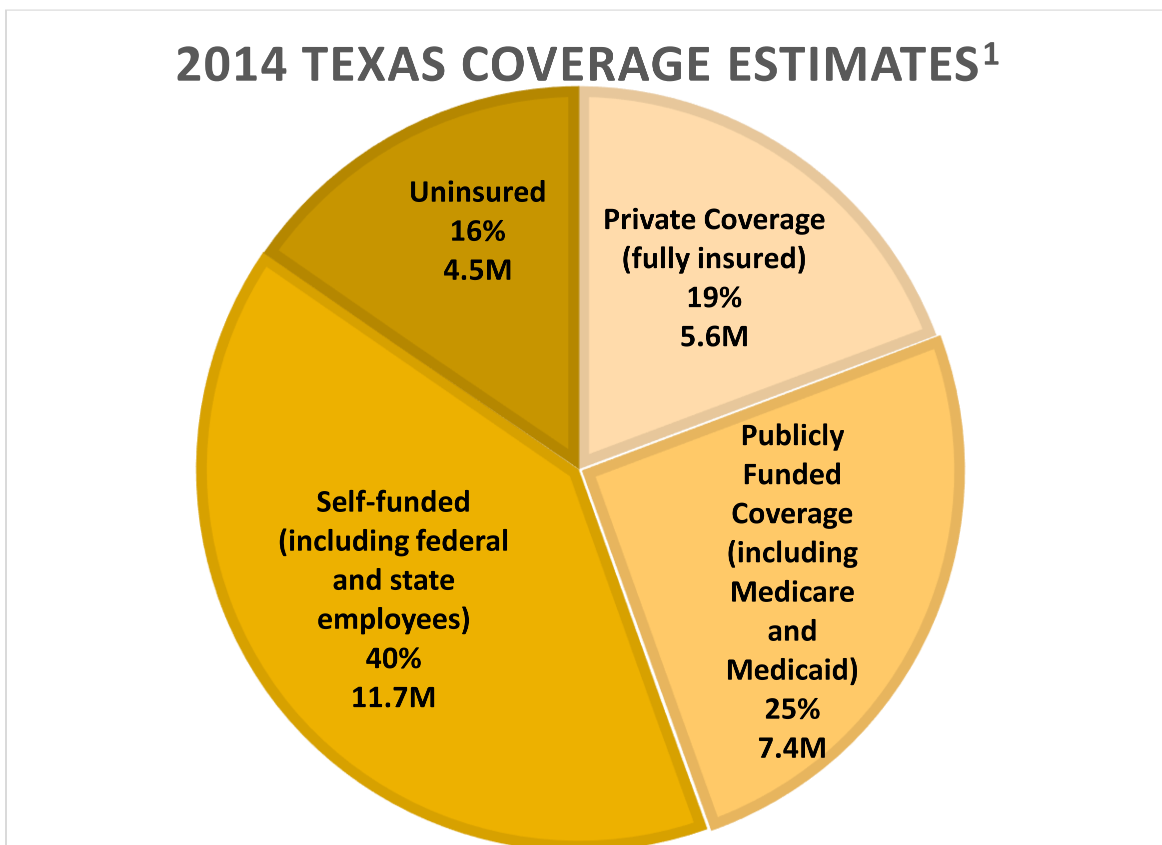
Preferred provider organization (PPO) - A type of health plan that contracts with doctors and hospitals to create a network of **preferred providers** that can provide care to **enrollees** at a discounted cost. PPOs will cover some **out-of-network** costs, but you will pay more and may be **balance billed**.

Self-funded plans - Plans funded strictly from employer contributions and employee premiums. These plans are authorized by the federal Employee Retirement and Income Security Act (ERISA) of 1974 and are regulated by the U.S. Department of Labor. State regulation of these plans is limited. Although an insurance company may be hired to administer the plan, the insurance company assumes no risk. (Also known as ERISA plans.) The state may regulate state employee self-funded plans and multiple employer self-funded plans.

Usual and customary charges - The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The usual and customary charge amount sometimes is used to determine the allowed amount.

Market Overview

TDI regulates private fully insured coverage, as shown below.



1 Note that some individuals have multiple coverages.

Balance Billing Laws and Regulations

Transparency Requirements – Insurers (non-HMOs) must:

- use language in insurance policies that:
  - is readable and understandable;
  - discloses how reimbursements of non-preferred providers will be determined and the insured's financial responsibilities for out-of-network services;
  - if usual and customary charges are used, discloses the source of the data, how the data is used in determining reimbursements, and the existence of any reduction that will be applied; and
  - if anything other than full billed charges is used, discloses the possibility of balance billing, provides a description of the payment methodology, and provides a method for consumers to obtain a real-time estimate of how much a non-preferred provider will be paid;

- use provider directories that are:
  - updated at least every month;
  - identify hospitals that facilitate the use of preferred providers;
  - identify all in-network, facility-based physicians at network facilities and specifically identify facilities without any contracts with different types of facility-based physicians; and
  - identify, for each contracted hospital, the percent of the total dollar amount of out-of-network claims filed by facility-based physicians, broken down by specialty;

- provide consumers notices of their rights and of substantial decreases in the availability of facility-based physicians at contracted hospitals and provide policyholders annual detailed notices regarding any inadequacies in their network.

Network Standards – Insurers must:

- meet qualitative and quantitative network adequacy requirements;
- not market where they have an inadequate network unless they obtain a TDI waiver on a showing of good cause, giving providers an opportunity to respond;
- file a detailed network adequacy report with the department each year; and
- if an EPO, meet rigorous prior approval and examination processes, with standards for quality improvement programs.

Payment Standards – Payments to non-preferred providers must:

- be calculated pursuant to an appropriate methodology that:
  - if based upon usual and customary charges, is based on generally accepted industry standards and practices for determining the customary billed charge for a service and that fairly and accurately reflects market rates, including geographic differences in costs;
  - if based on claims data, is based on sufficient data;
  - is updated no less than once per year;
  - does not use data that is more than three years old; and
  - is consistent with nationally recognized and generally accepted bundling edits and logic.

- take into account emergency, inadequate network, and inaccurate provider directory situations by:

- paying those claims, at a minimum, based on the usual or customary charge, less any coinsurance, copayment, or deductible;
- paying those claims at the in-network coinsurance percentage;
- in addition to any amounts that would have been credited had the provider been a preferred provider, crediting any out-of-pocket amounts paid to the non-preferred provider above the allowed amount toward the insured's deductible and annual out-of-pocket maximum applicable to in-network services; and
- if an EPO, protecting the consumer from balance billing.

Mediation

- HB 2256 created a mediation process for balance billing issues in 2009.
- TDI began accepting mediation requests in 2010 and has seen a gradual increase over time as more consumers and providers become aware of the program.
- The scope of the statute is limited to balance bills by facility-based non-preferred physicians incurred at preferred (in-network) facilities.
- In 2015, SB 481 lowered the dollar threshold to balance bills of more than $500 (not including applicable coinsurance, copays, or deductibles).
- Most mediation requests are settled informally prior to actual mediation.

MEDIATION REQUEST SUMMARY							
	CY 2009	**CY 2010**	**CY 2011**	**CY 2012**	**CY 2013**	**CY 2014**	**CY 2015**
Total Number Received	5	14	21	7	146	893	1,062
Mediation Billed Amount*							$1,220,554.44
Mediation Paid Amount**							$190,720.82
Total Referred to SOAH	0	0	0	0	3	126	82
Number Received - $1,000 and over							1,000
Number Received - $500-$999***							46
Number Received - $499 amount or below							7
Number Received - Did not qualify****							9
Total Number Received							1,062

*The Mediation Billed Amount is the amount entered on the Mediation Request form submitted to TDI.

**The Mediation Paid Amount is the amount paid by the carrier to the provider as a result of the informal settlement telephone conference. This does not include mediation settlements.

***The mediation request threshold changed from $1,000 to $500 on 9/1/2015.

****These mediation requests did not qualify because 1) they involved a self-funded or other type of health plan that is not eligible for this program or 2) the requester did not provide sufficient information.