

Balance Billing: An Overview

Has it Happened To You

Every year in Texas, tens of thousands of patients have inpatient or outpatient surgical procedures that they believe are fully covered by their health insurance plans. And if they are responsible for a co-payment or deductible, they know what those costs are. However, some physicians are using a practice known as balance billing to force patients to pay more for their health care. This questionable practice is disrupting patients' confidence in the health system as well as placing individuals and families in financial peril because of an unanticipated medical bill. If it has not yet happened to you, there's a good chance it will.

This is how it often occurs: an individual seeks medical services at a hospital that is within his health plan's network (in-network). The medical procedure is conducted by a physician who is also within the patient's health plan network. By using an in-network facility and physician, the patient believes that he has limited his financial exposure to the predetermined amounts outlined in the health policy. Several weeks may go by, and then the recovering patient receives an unexpected bill in the mail, often from a radiologist, anesthesiologist, pathologist, or emergency room physician for additional fees that may range from \$200 to \$10,000 or more.

Typically, the patient feels angry, deceived and perhaps financially threatened—justifiably so. Balance billing amounts can be large enough to create serious financial issues for families, including credit problems and bankruptcy.

Balance Billing:

How Does It Happen?

Physicians agree to become a part of a health plan's network by accepting discounted fees for their services in return for access to the health plan's members. This arrangement not only provides a critical link between the patient and physician but also helps moderate overall health care costs.

When a patient uses an in-network physician, the patient is typically protected from balance billing. He is only charged an agreed-upon fee based on a deductible, a co-payment and/or coinsurance.

A Deceptive Trade Practice?

In every transaction in a market economy such as ours, the **price of a product or service**—a hamburger, an automobile, a tennis lesson—is based on an **agreement between buyer and seller**. We cannot conceive of receiving a bill for **extra charges** for the food, the car or the lesson weeks later. And we cannot imagine that we may be hounded by **collection agencies** and have our **credit ratings damaged** if we do not pay the bill we **never agreed to pay** and consider to be an **unfair amount**.

Most balance billing occurs when services are delivered by an out-of-network physician and the doctor believes the health plan reimbursement is inadequate. The Texas Department of Insurance offers the following explanation in its Consumer Guide to Health Care Billing: "Balance billing occurs when physicians or other medical providers and hospitals or facilities who are not contracted within your HMO or preferred provider benefit plan (often referred to as a PPO) bill you for the difference between the amount your health plan pays them and the amount the provider or facility believes to be adequate reimbursement." But the physician never asks the consumer – either before or after care – what the consumer considers to be fair reimbursement. Balance billing, many believe, is nothing less than a deceptive trade practice.

Balance Billing—Why It Occurs

The perplexing question is why certain kinds of physicians and specialists are often not a part of a health plan's network, and thus free to balance bill patients. Physicians and health plans both offer explanations. Not surprisingly their perspectives differ significantly.

Despite the fact that statistics provided by their own statewide organization indicate that an average of 79 percent of the state's doctors are under contract with six major health plans, the physician community argues that balance billing is the result of health plans failing to meet their obligation to build adequate networks for their enrollees.¹ They argue that health plans do not include them in their networks, and then deliberately let their members be exposed to unexpected and expensive bills from certain medical providers.

Texas Health Source

Health plans offer a different perspective, stating that certain physician groups position themselves to reject joining a health plan's network, allowing them to charge excessive fees that are unregulated and arbitrarily set by the doctors.

Basically, medical care is delivered to enrollees in two distinct settings. The first setting is the office of the primary care physician or in the office of a specialist. With rare exceptions, this is not the environment where balance billing occurs. In large part, this is because in-network physicians and specialists accept the arrangement of discounted rates in return for access to the volume of patients available through the health plan.

Hospitals are a different environment altogether. Many hospital-based providers, especially emergency room physicians, radiologists, anesthesiologists and pathologists, refuse to agree to negotiated rates with health plans because patients must use their services whether the physician participates in a health plan or not. Participating in numerous plans makes no difference in the amount of patients these specialists will treat over the course of a week, a month or a year.

Why is this so? Because it is the common practice for hospital-based physician groups, such as anesthesiologists, to negotiate **"exclusive privileges"** with a hospital or group of hospitals to provide all of the services needed in their area of specialty. These agreements give them monopoly-like status within the hospital setting. Given such exclusionary status, it is not unusual for these specialists to charge from 300 percent to 3,000 percent of Medicare fees.

Hospital-based doctors with exclusive privileges have little or no incentive to contract with health plans because (a) they have monopoly status and their services are essential; (b) the health plan is required by state law to pay them anyway; (c) they are free to balance bill without their patients fully understanding they are using an out-of-network provider; and (d) joining a network subjects their services to utilization review and comparison with peers.

Comparison of Rates	
Type of Physician	Range of Charges as % of Medicare (from examples)
Primary Care Physician	132-162%
Specialist	151-183%
Radiologist	415-1637%
Anesthesiologist	335-598%
Pathologist	549-2319%
Emergency Room Physician	322-524%

Hospital-based Radiologist Charges as % of Medicare		
HCPCS Code (w/Modifier)	Doctor Service	Average as % Medicare
75650	Artery x-rays, head & neck	471%
75671	Artery x-rays, head & neck	461%
75724	Artery x-rays, kidneys	415%
75743	Artery xrays, lungs	466%
75962	Repair arterial blockage	1637%

Hospital-based Anesthesiologist Charges as % of Medicare		
HCPCS Code (w/Modifier 26)	Doctor Service (Anesthesia)	Average as % Medicare
00170	Intraoral Procedures, including biopsy	379%
00630	Procedures in Lumbar Region	335%
00790	Intraperitoneal Procedures in Upper Abdomen	348%
00810	Lower Intestinal Endoscopic Procedures	598%
01961	Caesarean Delivery	346%

Hospital-based Pathologist Charges as % of Medicare		
HCPCS Code (w/Modifier 26)	Doctor Service	Average as % Medicare
88300	Surgical Path	1309%
88302	Tissue Exam	2319%
88304	Tissue Exam	1648%
88305	Tissue Exam	794%
88307	Tissue Exam	549%

Hospital-based ER Physician Charges as % of Medicare		
Doctor Service by CPT Code	Average as % Medicare	Doctor Service by CPT Code
99281	496%	99281
99282	524%	99282
99283	351%	99283
99284	338%	99284
99285	322%	99285

Current Texas law requires health plans to pay doctors directly for services a patient receives even if the physician does not participate in the health plan's network. This mandate, known as an "assignment of benefit," limits a patient's ability to negotiate a fair charge for a particular service since the doctor is paid directly by the health plan and the patient is not involved in the initial payment process. Many states have chosen to strengthen an individual's ability to negotiate a reasonable billing rate by mailing payments for services rendered out-of-network directly to the patient, who then applies the funds toward payment to the out-of-network doctor.

The practice of balance billing is also perpetuated by a Texas law that prevents hospitals from hiring physicians directly and including them in the health plan networks in which the facility participates. The ban blocks a hospital's ability to hire doctors directly and include them in the health plan networks in which the facility participates. By subcontracting with the facility rather than existing as a part of its overall operations, hospital-based doctors often use their status to charge fees in excess of what otherwise might be allowed.

The Prevalence of Balance Billing

The prevalence of balance billing in Texas is unknown. The Texas Department of Insurance has attempted to collect information on the frequency of balance billing but lacks the authority to obtain it. As a result, information on the prevalence of balance billing in Texas is not known and doctors are the only ones who are aware of how often they balance bill their patients.

However, the California Association of Health Plans commissioned a 2007 study that showed "more than 1.76 million insured Californians who visited emergency rooms in the last two years received balance bills on top of their co-pays and deductibles." The study reported that the average bill was \$300, generating \$528 million in unexpected charges to insured Californians visiting emergency rooms over a two-year period.²

Balance Billing – Are Texans Protected?

A patchwork composed of Texas laws and Texas state agencies currently affect patient exposure to balance billing.

The Texas Insurance Code requires health plans to ensure their members have access to all necessary medical services. The Texas Department of Insurance (TDI) also requires that health plans make services for primary, hospital and specialist care geographically accessible and available to their members.

Under TDI's interpretation of state law, balance billing by HMO providers is prohibited. Because HMOs are closed networks where patients are offered services on a prepaid basis and physicians agree to discounted rates, TDI has determined that HMO patients are protected from being balance billed.

PPOs have similar provisions to protect members from balance billing when they use in-network providers. However, patients may be subject to balance billing when they receive services from out-of-network providers. This is particularly important as PPO members often receive medical services from out-of-network providers even though they are using an in-network facility. In cases where providers are not available in the network or in the case of emergency services, benefits are paid by health plans at an in-network level.

In 2007, the Texas Legislature adopted SB 1731 to provide new disclosure requirements for health plans, hospitals, and physicians regarding balance billing.

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A 2007 study commissioned by the California Association of Health Plans

Average bill: \$300

\$528 million burden on insured Californians

SB-1731

Health Plan Requirements

- Must provide notice to patients that facility-based doctor or other provider may not be in the health plan network
- Must provide notice that non-network physician may balance bill
- Must clearly identify in "separate and conspicuous" way any health facilities at which facility-based providers do not participate in the health plan's network
- Must include number for TDI's consumer protection division in any explanation of payment to an enrollee that a non-network physician has been paid at the usual and customary amount

Hospital Requirements

- Must provide written disclosure at admission that provides confirmation of whether or not the facility is a network provider
- Must provide written disclosure that informs patient that a physician or health care provider at the facility may not be in their health plan's network
- Must post in the general waiting area a conspicuous notice of the availability of the hospital billing and complaint policies

Physician Requirements

If an out-of-network, facility-based physician bills a patient, the physician must provide:

- Itemized listing of services in billing statement
- Plain-language explanation that the physician does not participate in the plan network and that the plan has paid less than the full billed charge
- Telephone number at which the consumer may call to discuss the statement and/or payment arrangements
- Notice that the consumer may file a billing complaint with the Texas Medical Board
- Notice that for bills over \$200 a physician may not report the consumer to a credit agency if the patient has finalized a payment agreement within 45 days of receiving the bill

The legislation, which went into effect September 1, 2007, also requires physicians to notify patients that they may file a billing complaint with the Texas Medical Board (TMB). What impact these billing complaints to the TMB will have is difficult to assess. More than 820 complaints involving overcharging or over-treating by physicians have been filed with the board since June 2003. According to records obtained from TMB, the agency has not disciplined a single provider due to a billing complaint.

SB 1731 is a good first step to increase the awareness of balance billing because it makes our health care system more transparent. However, until the practice is prohibited by law or patients are provided options to using hospital-based, out-of-network providers the harm caused by balance billing will continue.

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To date, **the agency has not disciplined a single provider** for balance billing.”

What Changes Should the State Consider to Protect Consumers From Balance Billing and Keep Health Care Costs Down?

Here are options state leaders may want to consider:

- Limit the ability of out-of-network physicians to balance bill enrollees for services not covered by their plan
- Amend the corporate practice of medicine law which prevents hospitals from directly hiring physicians
- Create an independent review process to resolve disputes between health plans and medical providers on billing issues
- Prohibit the practice of facility-based exclusive monopoly contracts with medical providers unless they agree to participate in the same health plans as the facility
- Amend the state’s current “assignment of benefit” law to allow health plans to send payment directly to patients who then pay medical providers; this practice strengthens a patient’s ability to negotiate a fair billing rate from a physician
- Direct the Texas Medical Board to enforce the existing law limiting physician charges to an amount based on a fair market standard, and to prohibit monopoly-based charges

Ending Balance Billing.

More and more states are acting to end the practice of balance billing. Florida has created an independent dispute resolution mechanism to resolve health care billing issues. Other states have developed physician payment formulas for out-of-network providers.

TAHP believes that Texans who use in-network facilities should not be subject to balance billing by physicians. Unless action is taken to end this deceptive practice, balance billing will continue to unfairly penalize patients who think they are receiving medical services fully covered by their health plans. Without effective protections against balance billing, the practice will continue to fuel rising health care costs while creating financial burdens for patients and their families that many are unable to overcome.

Source

1. Texas Medical Association membership survey as reported to the Texas Department of Insurance SB 1731 Health Network Adequacy Advisory Committee.
2. California Association of Health Plans www.calhealthplans.org.



Our Mission: “To improve health care for all Texans by serving as an effective advocate for value, access, quality care and sound public policy in the administration of health care benefits.”