

Balance Billing

Has It Happened to You?

What Is Balance Billing?

Each year millions of Texans turn to their health insurance coverage to help them ensure access to health care. Most insured Texans are comforted by the fact that their health coverage protects them and their families from the financial uncertainties of a health crisis. Unfortunately, a trend by certain health care provider groups is forcing many patients to absorb unanticipated, hidden, out-of-pocket costs in excess of what these expenses are intended to be under their health plan.

This phenomenon known as balance billing, involves the practice, by certain physicians, of billing a patient for more than the usual and customary amount paid by the member's health plan. When a patient uses a network physician, the patient is protected from balance billing and is only charged their portion (co-payment and deductible) of the fee agreed to between the physician and the health plan. However, when a patient receives services from an out-of-network physician (even when receiving services while a patient is in an in-network hospital) the health plan pays the physician the usual and customary rate. **Balance billing** occurs when the physician charges the patient in excess of that usual and customary rate paid by the health plan.

The Delivery (A Balance Billing Example)¹

On Jan. 16 it finally happened, the labor pains began. Sandra was rushed to the hospital as she and her family shared in the excitement and anticipation of a new baby. The hospital she selected was the hospital that had been pre-designated by her obstetrician and was in her health plan's network. During the labor, it was determined that Sandra would require a Caesarian section. This procedure was successful, and Sandra delivered a healthy baby boy. Sandra felt blessed with her healthy son. She also had peace of mind that a healthy baby and an uncomplicated C-section wouldn't create extra financial hardship due to any unanticipated out-of-pocket costs from her health insurance.

Then it came...Weeks after the delivery, Sandra received a bill from the anesthesiologist who provided the anesthetic during her procedure. The bill was in excess of what her out-of-pocket expenses were expected to be under her health plan. Alarmed and confused, Sandra called the anesthesiologist and the health plan to discover, for the first time, the reason for this bill – while the hospital, and other medical staff were a part of her health plan's network, the anesthesiologist was not...and he was requiring her to pay the remainder of his fee for the procedure beyond what the health plan had already paid.

Sandra and her family were devastated by the excessive fee. She had unknowingly become a victim of balance billing.

Balance Billing: How it Happens

Many physicians who provide unique and required hospital-based health care services join their colleagues in organizing their practices by specialty groups. These specialty groups are often given exclusive practice rights by the hospitals where they practice. By establishing these "exclusive arrangements" with particular hospitals, the specialty physician groups have access to a constant and assured source of patients. While health plans make every effort to contract with these providers, this exclusive arrangement with the hospital encourages physicians within their group to refuse to join a health plan's network, empowering them to charge arbitrary and often excessive fees for the services offered. These fees often exceed the usual and customary rates paid in the region by as much as 200 percent and are usually not known by a patient until well after care has been provided. Radiologists, anesthesiologists, and pathologists (RAPs), as well as emergency room physicians, are most often the hospital-based providers who balance bill their patients.

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EXCLUSIVE ARRANGEMENTS

Health plan networks are organized to provide members with a broad list of physicians from which they can seek care, at a predetermined discounted rate billed directly to and paid in full by the health plan. In developing their networks, health plans have noticed increasing refusal by specialty physicians to join networks, depriving patients of the ability to receive care at rates negotiated for a large group, discounted from the much higher “retail” price. These physicians refusal to contract with a network-based health plan is facilitated by the “exclusive arrangements” offered by hospitals to these specialty groups. Since these physician groups have no competitor within a given hospital, any incentives for physicians to contract for a health plan’s members are nonexistent. These factors leave the patient with no choice but to enlist that physician for critical and often life-saving care.

Many believe an implied extension of the contract between the hospital and the health plan should exist in the exclusive agreement between physicians and the hospital. Such a contract would bind a physician practicing within an in-network hospital to the same “hold harmless” requirement, to which that network hospital is bound. This would mean that members are not liable for the fees in excess of usual and customary rates paid by the health plan and the designated member out-of-pocket co-payments. In 2002, the Texas Department of Insurance (TDI) agreed in a letter to Texas Attorney General Greg Abbott, “TDI does not suggest that non-network physicians providing care to enrollees in network facilities do so without compensation, just that their compensation must come from a source other than the enrollee. In such a situation, Article 20A.09 (f) requires the HMO to reimburse a non-network physician or provider at the usual and customary rate (emphasis added).”² While the attorney general did not rule on the merits of balance billing, it was determined that TDI lacked the authority to enforce the HMO Act to prohibit a physician from balance billing an enrollee of an HMO.

UNREASONABLE AND ARBITRARY RATES

Even though many specialty physicians may currently choose to not be a part of a health plan’s network, patients have the right to expect the fees they are charged by these providers to be reasonable. Unfortunately, rates ranging from 300 percent to 3,000 percent of Medicare fees are not unusual for these hospital-based specialty physicians practicing through their exclusive arrangements with the hospital.

EXAMPLE OF BALANCE BILLED CHARGES COMPARED WITH MEDICARE

Type of Provider (Hospital-Based)	Description of Services Provided	Billed Charges Compared With Medicare (Percentage)
Radiologist	Arterial blockage procedure	988%
Anesthesiologist	Anesthesia for Caesarean delivery only	463%
Anesthesiologist	Anesthesia for intraoral procedures including biopsy – not otherwise specified	440%
Anesthesiologist	Anesthesia for lower intestinal endoscopic procedures, endoscopic intro	429%
Pathologist	Surgical path, gross	1,230%
Pathologist	Tissue exam by pathologist	1,649%

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Under most circumstances, physicians who are out of network are paid the usual and customary rate. This rate refers to the average prevailing fees paid by most insurance carriers for similar services in the region where the service is being provided. The fee is considered reasonable if it falls under the same parameters of the average charges for that community.

LACK OF TRANSPARENCY

A poll released in 2005 by Harris Interactive showed that on average, individuals were able to identify the price of a Honda vehicle within \$300, but when asked to identify the price of a four-day stay in a hospital, those responding missed the mark by an average of \$8,100.³ The results were not surprising given the overwhelming lack of knowledge by consumers of the charges they incur for health care services.

This lack of knowledge is partly attributable to the absence of transparency in medical costs and the confusion regarding out-of-network fees being charged at an in-network facility. These factors make patients easy prey for price-gouging practices such as balance billing. Increased transparency in medical costs are a key component to eliminating balance billing but will need to be combined with other measures providing patient protection or alternatives to care when predatory pricing is discovered.

The Surgery (A Balance Billing Example)¹

Mary had been devastated by the news of her illness. Surgery would be required in an attempt to save her life, and even then her chances for survival were not certain. She approached the surgery date with reluctance and fear, but once it arrived she knew it was her only hope.

Mary checked into the hospital, which was in her health plan's network and where her surgeon was affiliated. The surgeon, as well as most of the other medical staff, were also within her health plan's network.

The surgery was a success. While challenging, Mary's recovery was full. She was grateful for the care she received and for the health coverage that made the life-saving surgery possible. Mary would be able to resume a normal and peaceful life.

But then it changed. A month after her surgery, Mary received two bills. The bills were from the radiologist and anesthesiologist who had participated in her surgery and hospital visit. Both bills were in excess of what was expected to be Mary's out-of-pocket expenses for this procedure. After consulting with both physicians, she learned that neither was in her health plan's network even though they participated in the procedure at a hospital and with primary surgeons who were in-network.

Mary also learned that even if she had been made aware of their out-of-network status prior to the surgery, their exclusive arrangement with the hospital would have left her no alternatives for the services they provide.

Because of her fixed income, Mary faced significant financial challenges in paying the bills. When she communicated her financial status to the physician's offices, Mary was informed that her accounts would be turned over to a collection agency if payments were not received within two budget cycles.

Mary was being balance billed – living alone, she was not sure where to turn.

Description of Radiology Charges	Billed Amount	Example of Usual and Customary Rate (U&C)	Percentage Difference*	Medicare Allowable
Echoencephalography	\$112.00	\$36.63	205%	\$33.30
CT scan abdomen	\$216.00	\$134.54	60%	\$63.63
CT scan pelvis	\$198.00	\$131.99	50%	\$58.14
CT scan thorax	\$210.00	\$137.18	53%	\$61.79
MRI lower extremity joint	\$1,439.00	\$502.31	186%	\$451.37
MRI brain	\$1,468.00	\$517.51	183%	\$466.86
MRI spine	\$1,488.00	\$523.96	184%	\$472.66

* Percentage Difference Between Billed Amount and U&C

Source: Texas Association of Health Plans, Example of Facility Based Radiology Charges Compared to Medicaid, Medicare and HMO U&C Rates. Billed charges received by one hospital-based health plan.

Protecting the Patient

Through developing an exclusive arrangement to deliver specialty care within an in-network hospital, and then by refusing to join the health plan's network because of that exclusive arrangement, these hospital-based physicians are creating higher medical costs by balance billing unsuspecting patients. Through these arrangements, some physicians are taking advantage of the trust and vulnerability of patients who have turned to them in their time of need.

From a patient's perspective, their condition requires specific care beyond that provided by the attending physician, such as lab work and X-rays; they have no say in the choice of physicians because of the specialty provider's exclusive arrangement with the hospital; and the lack of transparency also contributes to the patient not knowing they will be balance billed following their hospital stay.

According to a Harvard study published in 2005, nearly half (46.2 percent) of the individuals who filed for bankruptcy did so because of medical costs.⁴ Many believe that balance billing contributes to patients being financially injured by the very physicians whose help they seek. There is also concern that balance billing allows individuals to be victimized by a health care provider and a process in which they place their trust and their lives. Because of these concerns, there is a growing movement to protect patients by reexamining the practice of balance billing and proposing restrictions to eliminate abusive practices. Such innovation would help ensure that the public's faith in health care and health care coverage is never in doubt.

The Emergency Room (A Balance Billing Example)¹

What was planned to be a time of celebration turned out to be a day of embarrassment and pain for John. A day he will remember not so much for the excitement, but for the unanticipated costs to follow.

As his son's 10th birthday present, John was installing a new basketball goal. A classic neighborhood game was to follow only to be halted by an unexpected fall from the ladder by John.

X-rays confirmed what John had suspected. His right arm was broken during the fall. He would be fine, but the injury required serious medical attention that John would receive at a nearby emergency room. After treatment, John and his family returned home where his broken arm and ego would ultimately heal. He was fortunate that a more severe injury had not occurred, and he was comforted that his health care coverage minimized the expense associated with his careless fall. Unfortunately, he would learn otherwise.

The emergency room where he was treated was located at a hospital in-network for his family's health plan. He would find out several weeks later that the emergency room physician and radiologist that treated him were not. Their bills would require payment of fees in excess of John's expected out-of-pocket expenses because of their out-of-network status. John was confused since the hospital was listed as in-network and had accepted his co-payment for treatment during his visit. The unpleasant memory of spending his son's birthday in the emergency room turned into a nightmare of unexpected expenses that would take John and his wife almost a year to pay.

The specialty care these physicians provided and their exclusive arrangement with the hospital left John and his family as victims of balance billing.

The Texas Association of Health Plans is committed to working with members of the Texas Legislature to end the practice of balance billing.

Sources

- ¹ These examples are not reflective of actual incidents, but demonstrate how balance billing can occur in Texas.
- ² Letter from the Texas Department of Insurance, Legal and Compliance to Susan Gusky, Chair, Opinions Committee, Office of the Attorney General, "RE: Whether the Health Maintenance Organization Act, Chapter 20A of the Texas Insurance Code, authorizes the Texas Department of Insurance to enforce its provisions against physicians that are not under contract with an HMO (Request No. 0597-JC)." November 4, 2002.
- ³ Goodman, John C., National Center for Policy Analysis, *Transparency in Health Care, Brief Analysis No. 548*; March 29, 2006. Retrieved May 26, 2006, from <http://www.ncpa.org/pub/ba/ba548/ba548.pdf>.
- ⁴ David U. Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, MarketWatch: Illness and Injury as Contributor to Bankruptcy, Health Affairs Web Exclusive (February 2, 2005): W5-63-W5-73. Retrieved May 30, 2006 from <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.63v1>.



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