Is it ‘Balance Billing’ or ‘Predatory Underpayment’?

For too long Texas health insurance providers have controlled the healthcare narrative, attempting to vilify healthcare providers while they slowly reduce coverage for consumers and shrink their networks. On one issue in particular, balance billing, health insurance providers have been unchecked by regulation, and Texas consumers are paying the price.

TAFEC defines balance billing below:

“Balance billing is a direct consequence of insurance companies failing to pay healthcare facilities anything close to reasonable amounts. When facilities are reimbursed an unusually low percentage of billed charges, they may seek to collect the remaining balance from patients.”

As emergency care providers, we believe a more appropriate term for balance billing is “predatory underpayment,” something that ultimately hurts consumers and the healthcare system overall.

Predatory Underpayment

Because there is no established industry standard for reimbursing healthcare providers, health plans are lowering freestanding emergency center reimbursement rates to unacceptable levels. As a result of the insurance provider’s predatory underpayment, a freestanding emergency center’s only option may be to seek reimbursement for their services from the patient.

Health plans then try to pin these bills on medical care providers, arguing that FECs are increasing the cost of healthcare by remaining out-of-network. But if health insurance providers are obeying Texas law and using the nationally accepted “prudent layperson” standard, a law enacted to protect consumers seeking emergency care, then emergency room visits where a patient believes his or her life is in danger should be billed at the in-network rate. Somehow this provision is overlooked and rarely enforced, allowing insurance providers to illegally bill consumers at the out-of-network rate for emergency care received at an FEC facility.
Myth: Freestanding emergency centers (FEC) are remaining out-of-network so they can secure higher payment rates by seeking compensation from patients, thus driving up costs of healthcare.

Fact: As an industry, freestanding emergency centers would like the opportunity to contract in-network with all major insurance providers. However, the majority of FEC facilities that apply to go in-network are either rejected immediately or offered ridiculously low rates, much lower than what is offered ERs. If health insurance companies expanded their networks and offered freestanding emergency centers fair rates, more FECs would contract in-network.

Myth: Insurance companies obey Texas and national law and bill at the in-network rate for emergency care administered in a freestanding emergency center setting.

Fact: Despite national and state regulations, insurance companies are refusing to pay ER claims at the patients in-network benefit level and illegally billing at the out-of-network rate for emergency care. Texas statute and the national “prudent layperson” standard require insurance providers to bill at the in-network rate so that consumers are not discouraged financially from seeking the immediate care they need. Insurance companies in Texas have operated unchecked and continue to break the law with their billing practices, thus increasing the financial burden on consumers.

Myth: Insurance companies already reimburse freestanding emergency centers with “usual and customary” rates comparable to rates being offered to hospital-based ERs.

Fact: While a small percentage of insurance companies provide FECs with “usual and customary” reimbursement rates, a majority of insurers reimburse FECs at rates substantially lower than what they offer hospital-based ERs, or the in-network rate for treatment. Because there is no definition for “usual and customary” in Texas statutes, insurance companies have taken advantage of this ambiguous terminology and reduced FEC reimbursement to ridiculously low levels that, in many cases, do not cover the costs. This hurts patients by forcing FECs to seek additional payment for their services, up to the allowable amount.
IDENTIFYING THE CAUSES OF PREDATORY UNDERPAYMENT

To better understand balance billing and why it exists, TAFEC has identified three major issues with the current billing structure for emergency care.

1. No Definition for “Usual and Customary”

Currently, the Texas statute reads that insurance providers are required to reimburse emergency healthcare providers at the “usual and customary rate” for emergency care. However, there is no definition or uniform guidelines for insurance companies to follow, which has allowed insurers to determine their own arbitrary rates. While some insurers provide adequate reimbursement for services, others are reimbursing at a much lower percentage, leaving patients to foot the remainder of the bill. Defining a “usual and customary rate” is necessary to hold health plans accountable, ensure healthcare providers are paid sufficiently for their services, and most importantly, to reduce out-of-pocket costs for consumers.

2. Disregard for Existing Emergency Care Statutes

The Affordable Care Act defined emergency care as an essential healthcare benefit. A person cannot be penalized for receiving emergency care at a freestanding emergency center. This statute is also a component of the prudent layperson laws, which require insurance providers to pay at the in-network benefit level for emergency care when a person believes his or her life is in danger. However, many health plans are not following these regulations and pay at the out-of-network rate.

This is a direct violation of the prudent layperson standard and is not in accordance with Texas law.

3. Patient Involvement

Not only are patients being hit with high medical bills they expected to be covered by their insurance, they are also being dragged into the middle of the mediation process. Disputing medical bills and health insurance claims should involve only health insurers, billing companies, and healthcare providers, not patients. To truly fix balance billing, a solution would need to remove the patient from the equation altogether.
‘Surprise Bill’ vs. ‘Surprise Undercoverage’ - There’s a Difference

The term surprise bill seems to be a healthcare buzzword. Media coverage tends to focus on patients who receive medical treatment and then are shocked by their large bill. In many “surprise billing” cases involving FECs, the surprise bill stems from a patient’s lack of understanding of their own health insurance. Let us explain.

“Surprise billing occurs when all or part of a healthcare provider’s technical charges are not paid by the patient’s insurance because the deductible has not been met.”

Following the passage of the Affordable Care Act, where we saw a spike in high deductible plans with low premiums, many Texans are now grossly underinsured. Consumers selected these plans without fully understanding the high deductibles that must be met before insurance begins paying. It is important to understand that surprise billing in the minds of consumers does not always result from a balance bill; surprise billing often stems from patients not knowing their own insurance plan and being surprised by their lack of coverage, leaving a large amount owed in order to meet their high deductible as designated in their plan. Effectively, balance billing cannot exist if a patient has yet to meet their insurance deductible.

The Need for Education

As more Texans secure health insurance under the Affordable Care Act, it has become evident that there is a general need for education around health insurance. Patients do not appear to have a strong understanding of how their plans are structured and what is covered within their plans. Health insurance providers should take time to thoroughly review insurance terminology with patients so they are familiar with deductibles, copayments, in- and out-of-network providers, etc.

Although TAFEC believes this responsibility rests primarily on insurance providers, we are proactively spending time and resources to educate the public on health insurance. We are pleased to announce that the association is developing a website for Texas consumers that will serve as an education resource for emergency care. TAFEC is proactively working to address the education gap by providing online resources for patients. Information on insurance, Texas medical statutes, patient billing, and more can be found on our website. Also visit our FAQ page for common questions regarding FECs.
**BALANCE BILLING SCENARIOS**

Consider the following situation: A patient is seen at a freestanding emergency center (FEC) and determined to have acute bronchitis. The doctor sees the patient quickly and administers treatment, resulting in $2,000 bill from the FEC facility for its services. This bill is comparable to what would be billed by a hospital for the same treatment. Depending on the patient’s health insurance plan and how the insurance company decides to process the claim, the amount billed to the patient could vary. Below are three different scenarios that demonstrate the possible ways this might play out.

1. **Scenario 1: Surprise Undercoverage**
   
   The patient’s insurance provider pays nothing on a claim because the patient selected a high deductible plan and has not yet met his or her $5,000 deductible. Therefore the facility bills the patient for the total allowed amount (or in-network rate for the treatment administered to the patient), which is likely less than the billed charges.

   Following passage of the Affordable Care Act, many Texans have secured high deductible plans without understanding the financial repercussions these plans have when seeking care. Because there is so much confusion, TAFEC encourages patients to become familiar with their health plan and ask questions about their coverage so they can make the best decision in the event of an emergency and avoid surprise undercoverage.

2. **Scenario 2: Appropriate Reimbursement**

   Assuming the patient has met his or her deductible, the insurance company determines the total allowed amount (or the in-network rate for the treatment administered to the patient) is 70 percent of the facility’s total billed charges. The insurance company reimburses the FEC facility one hundred percent of the in-network allowed amount, which in this case would be $1,400 for its services, and the FEC facility does not deliver a bill to the patient.

   This example is an ideal case in which the FEC receives appropriate reimbursement from the insurance company, and the patient does not incur any additional out-of-pocket expenses other than their copay. If health insurance companies were obeying Texas and national law and consistently reimbursing FEC facilities at the in-network rate, there would be no need to balance bill patients. We must hold health insurance companies accountable to follow Texas statutes, otherwise Texas consumers pay the price.

3. **Scenario 3: Predatory Underpayment**

   The insurance company determines the total allowed amount (or the in-network rate for the treatment administered to the patient) is 70 percent of the facility’s total billed charges. However, the insurance company decides to reimburse the FEC facility for 40 percent of the total allowed amount, or $560 (only a portion of the in-network rate for the treatment administered to the patient). The FEC facility then seeks the remaining compensation for its services from the patient, up to the allowed amount, which in this case is $840.

   For emergency care, insurance providers are legally required to reimburse FEC facilities at the in-network rate (also known as “usual and customary” rate). Because the “usual and customary” rate has not been defined, health insurance companies are exploiting this ambiguous terminology and illegally reimbursing FECs at lower rates. This practice is harmful to patients because they may be billed for the remainder of the medical charges up to the allowed amount. We must define “usual and customary” in order to protect Texas consumers from predatory underpayment.
SOLVING BALANCE BILLING

Solving Balance Billing

TAFEC would like to present a potential solution that will take the patients out of the crossfire and eliminate the need to balance bill altogether. The solution involves defining a “usual and customary” reimbursement rate that takes into consideration the average charges for specified procedures by FEC providers, and then assigns a uniform reimbursement percentage by insurers to those providers.

Once all stakeholders agree upon reimbursement rates, these newly defined rates would then be enforced for both insurers and healthcare providers. The Texas statute updated to reference these newly defined “usual and customary” reimbursement rates. As long as the established reimbursement rates are met, FEC facilities and out-of-network providers that accept the rate would no longer need the right to balance bill a patient.

This proposed solution will reduce the time and resources associated with mediation and remove patients from the process altogether. By taking this initiative to start a dialogue, we hope that insurance plans and legislators will come to the table in good faith to eliminate this grey area and make meaningful changes that protect Texas consumers.

TAFEC encourages consumers to review their health plans and hold providers accountable to cover what is listed in their plans. We also encourage legislators to truly explore this issue and not simply accept the framing of the health insurance companies, which blame healthcare providers while shrinking coverage for Texans. There is a reasonable solution in which medical care providers are adequately reimbursed for the services they provide and consumers are protected from exorbitant out-of-pocket expenses.

TAFEC looks forward to being a part this conversation.

Connecticut Balance Billing Legislation

Connecticut recently passed legislation that prohibits a health insurer from charging an insured patient a higher coinsurance, deductible, or other out-of-pocket amount for emergency services provided by an out-of-network provider than would be charged if the services were provided by an in-network provider. In the event that an out-of-network provider renders emergency services to an insured person, this legislation requires the health insurer to reimburse such a healthcare provider at the greater of:

1. The in-network rate;
2. The usual, customary, and reasonable rate; or
3. The Medicare reimbursement rate.

The Connecticut legislation defines “usual, customary and reasonable rate” as the 80th percentile of all charges for the service provided in the same geographic region by a same or similar specialty, as determined by reference to a database designated by the insurance commissioner.