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Balance Billing in Private Health Insurance Plans

What is balance billing?

Balance billing is when a health care provider bills a consumer for charges (other than cost sharing) that exceed the health insurance plan's payment for a covered service.

Key Terms

Charge: The dollar amount a provider sets for services rendered before negotiating any discounts.

Negotiated Payment: The maximum amount on which payment is based for covered health care services. The payment may be negotiated by the health plan or the consumer.

In-Network: The facilities, providers, and suppliers with which a health plan has contracted to provide health care services.

Out-of-Network: The facilities, providers, and suppliers with which a health plan has not contracted to provide health care services.

Premium: The amount paid for health insurance, often on a monthly basis.

Cost Sharing: Also referred to as out-of-pocket costs for the consumer. The amount an insured consumer pays for health care services according to the terms indicated in the health plan. A plan's cost-sharing requirements may include deductibles, coinsurance, and co-payments.

Coinsurance: The share of costs, figured in percentage form, an insured consumer pays for a health service.

Co-payment: A fixed amount an insured consumer pays for a health service.

Usual, Customary, and Reasonable (UCR) Fee: The amount determined by the plan to be paid for a medical service based on what providers in the area usually charge for the same or similar service.

How does the billing process work for consumers with private health insurance?

Many privately insured consumers are covered through some type of managed care organization (MCO), such as a health maintenance organization (HMO) or preferred provider organization (PPO). MCOs contract with a wide range of providers that consequently are regarded to be in a plan's network. These providers accept the plan's *negotiated payment* in full for services to the plan's consumers. This group of providers is *in-network*; providers that have not contracted with the plan are *out-of-network*.

In addition to paying their health insurance *premium*, consumers often are required to pay an amount for health care services (i.e., *cost sharing*) via *coinsurance* or a *co-payment*.

The cost-sharing amount often is dependent on the network infrastructure. In general, health insurance plans want consumers to utilize in-network providers because those providers have met the plan's standards and give the plan a discount. Thus, consumers typically have lower cost sharing for covered services obtained in-network.

Consumers who seek care out-of-network likely have higher cost sharing because out-of-network providers have not agreed with the plan's negotiated payment.

In addition to the higher cost sharing for out-of-network services, a plan may pay only its *usual, customary, and reasonable (UCR) fee* for such services. Some plans may not offer any out-of-network benefits and thus would not pay for any *charges* associated with out-of-network services.

Why does balance billing occur?

When a plan's negotiated payment or UCR fee is less than the provider's charge for a given health care service, some providers, if allowed under federal or state law, may bill a consumer for the amount of that difference. This payment differential is known as *balance billing*. In-network providers often are contractually prohibited from balance billing health plan consumers.

What does balance billing mean for consumers?

Balance billing also can be attributed to the difficulty of determining which provider is in a plan's network. For example, providers may leave a plan's network mid-year. Accordingly, provider directories available from the plan may be out-of-date. Additionally, a physician group may be in-network while some individual physicians in the group may be out-of-network. A physician also may be part of multiple practices, and those practices in turn may accept different insurance plans.

What are some examples of balance billing?

There are a number of scenarios that result in balance billing. The following are two illustrative balance billing scenarios:

Illustrative Scenario One: An insured consumer chooses to receive care from an out-of-network provider. In addition to the higher cost sharing, as a result of going out-of-network the provider balance bills the consumer for the remaining charge. (See **Table 1** for an illustrative example of such a scenario.)

Illustrative Scenario Two: An insured consumer checks a health plan's website to verify that a hospital was in-network and thus assumes that the health care services

received at the hospital will be included in the plan's in-network covered benefits. The consumer receives care from an out-of-network physician at the in-network hospital. The out-of-network physician who provided care during the service may bill the consumer for the remaining charges.

Table I. Illustrative Example of Balance Billing
(20% coinsurance for in-network services and 40% coinsurance for out-of-network services)

	In-Network Provider	Out-of-Network Provider
Provider Charge	\$50,000	\$50,000
Plan's Negotiated Payment	\$30,000	No negotiated discount because provider is out-of-network
Plan's Usual, Customary, and Reasonable (UCR) Fee	N/A	\$35,000
Plan Pays	\$24,000 <i>(80% of plan's negotiated payment)</i>	\$21,000 <i>(60% of plan's reasonable and customary fee)</i>
Consumer Pays	\$6,000 <i>(20% of plan's negotiated payment)</i>	\$14,000 <i>(40% of plan's UCR fee)</i>
Balance Billed Amount	N/A	\$15,000 <i>(provider charge minus plan's UCR fee)</i>
Total Amount Paid by Consumer	\$6,000 <i>(coinsurance)</i>	\$29,000 <i>(coinsurance plus balance billed amount)</i>

Source: CRS illustrative example.

Notes: Coinsurance rates for in-network and out-of-network services may vary by plan type. Some plans do not offer out-of-network benefits and thus do not pay for charges associated with out-of-network services.

What is the relationship between balance billing and surprise medical bills?

Balance billing often is cited as a reason for *surprise medical bills*. A surprise medical bill is any bill for which a health plan paid less than a consumer expected. However, not every balance bill is a surprise medical bill. While a variety of circumstances may make a consumer vulnerable to unexpected medical expenses, surprise medical bill scenarios generally are a result of not understanding a plan's provider network and inadvertently using out-of-network services.

Who has jurisdiction over balance billing?

Private health insurance is regulated primarily at the state level. Individual states have established standards and regulations overseeing the business of insurance. Despite the states' role as the primary regulators of health insurance, federal requirements may overlap. However, federal laws often establish federal minimum requirements while generally giving states the authority to enforce and expand those requirements.

What are some state approaches to balance billing?

Approaches to address balance billing vary from state to state, may differ depending on the type of plan, and may make distinctions between emergency and nonemergency situations.

One of the most comprehensive state approaches to balance billing is in New York. In April 2014, New York enacted the Emergency Medical Services and Surprise Bills law. The law bans balance billing for out-of-network emergency care. For out-of-network nonemergency services, the law requires plans to let consumers see out-of-network providers at in-network costs when an in-network provider is unavailable. New York also established an independent arbitration process to review balance billing discrepancies. Furthermore, the law includes additional provisions related to provider network disclosure. MCOs in New York now are required to provide comprehensive contact information in their provider directory lists and update those lists regularly. According to the law, health care providers must provide consumers with plan and hospital affiliation information at the time of the appointment for nonemergency services.

How does federal law address balance billing?

Federal law does not prohibit balance billing in the private health insurance market. The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) addresses cost-sharing issues as they relate to emergency health services obtained out-of-network for all non-grandfathered private health insurance plans. In an emergency situation, consumers do not need to obtain prior authorization, regardless of whether the provider is in-network or out-of-network.

For out-of-network emergency situations, health plans must pay the greatest of the following three amounts: the amount the plan would pay in-network; an amount that is calculated using the same method the plan uses to determine payments for out-of-network services, excluding co-payments or coinsurance; or the amount Medicare would pay for the service. Nonetheless, a consumer may be required to pay, in addition to the in-network cost sharing, the balance bill.

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