

The Truth About “Surprise Bills”

***How Health Insurance Company Practices Leave You
Without the Coverage You Thought You Bought***



Physicians Caring for Texans

THE TRUTH ABOUT “SURPRISE BILLS”

How Health Insurance Company Practices Leave You Without the Coverage You Thought You Bought

Health insurance is just a way to help finance your health care. Insurance companies are financial institutions. They collect your premiums in return for a promise to make payments when you have certain losses, such as for medical care. Sometimes the details of that promise get lost in fine print and in complicated insurance industry practices. That leaves patients like you wondering what exactly happened to the coverage you thought you bought.

This happens mostly when insurance companies:

1. Limit which physicians and providers they consider “in network,” and
2. Limit how much they pay for services provided “out of network.”

Before 1986, preferred provider benefit plans (we call them “PPOs” in this paper) were arguably illegal in Texas. They were considered unjust policies that deceived the public.¹ The Texas State Board of Insurance voted to legalize PPOs in 1986. The Texas Legislature passed a law in 1997 incorporating those regulations.²

PPOs are managed care products that offer a **basic level of coverage** to patients no matter who provides the care. That basic level of coverage is what many call an “out-of-network benefit.” PPOs also offer a different level of coverage when a “preferred provider” delivers the care. That’s “in network.” When patients go to an in-network hospital, they expect they will receive that highest level of benefit for all services. That doesn’t always happen, however, because the PPO benefit they bought is a limited form of financing. Insurance companies create networks to manage costs. Those networks don’t always reflect how physicians, hospitals, and health care providers in communities come together to deliver their services, especially in a hospital setting.

Unfortunately, Texas patients are discovering the limitations of their PPO coverage when they need it most, especially in emergencies; they receive a bill for services that the insurer has not paid. The bill surprises patients who expected total coverage.

Physicians can have contracts with a health insurer for *some* of the plans it offers, only to be excluded by that insurer from other plans. So a physician may be in network for some patients and out of network for others — all at the health insurer’s option. And often, physicians don’t even know which networks they’ve been left out of.

Insurance companies save money by severely limiting which physicians, hospitals, and providers they include in their networks. These are called “narrow networks,” something insurers are using more and more often, especially in Texas. A recent study rated 45 percent of the Affordable Care Act (ACA) networks in Texas as “x-small” and 27 percent as “small.”³ With narrow networks, patients now face greater financial exposure, more often.

Also, PPOs don’t settle claims based on the actual amount you may owe to the doctor. Instead, they use an “allowed amount,” which the insurance companies themselves determine. Outside of emergencies, this “allowed amount” sometimes has little relationship to the amount the physician or provider billed. This causes confusion over the amount left unpaid by the PPO — not to mention confusion over why the patient has to pay at all.

¹ See, generally, 11 TexReg 2810, adopting 28 Tex. Admin. Code §§3.3701-3.3705, to be effective July 1, 1986.

² Acts 1997, 75th Legislature, Ch. 1024, §1, effective June 19, 1997.

³ “State Variation in Narrow Networks on the ACA Marketplaces,” Leonard Davis Institute of Health Economics, the University of Pennsylvania, August 2015. <http://ldi.upenn.edu/sites/default/files/rte/state-narrow-networks.pdf>.

PART I: NARROW NETWORKS

Why Are Some Physicians Out of Network?

Insurance companies use networks to control costs. They sign contracts with physicians, hospitals, and providers to be in their networks. That usually means those physicians, hospitals, and providers agree to accept a smaller payment for their services. In return, the insurance company agrees to advertise who is in its network and send more patients to them for treatment and services. The company might also make it easier for them to get their bills paid.

Many physicians *want to be* in network with the big insurance companies in their communities, and most physicians are in at least one network. However, sometimes physicians who want to be in network find the company won't let them in at all, or it offers to pay the doctors less than it costs them to provide the care. In a recent TMA survey, about one in four physicians said they tried to join a network. Of that group, 29 percent got no answer to their request, 32 percent got a payment offer that was too low for them to accept, and 39 percent received a contract to join the network.

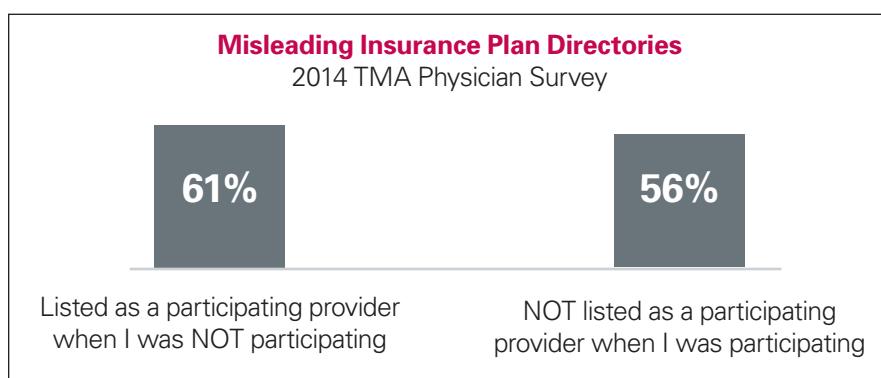
Interestingly, a physician may have a contract with an insurance company, but then only be included in the networks for *some* of the company's plans. For example, UnitedHealthcare took a large number of physicians out of its Medicare Advantage plans, but kept those doctors in network for some commercial plans.⁴ This means a physician can have a contract with UnitedHealthcare **but still be out of network** for some UnitedHealthcare patients. Because of narrow networks, the practice of including contracted physicians in some networks but not others has become much more common. This increases the chance that patients will pay more out of pocket because the physician is out of network.

Patients are in the middle of this because it's not made clear to them what they are purchasing. Having narrow networks with too few doctors is like buying a warranty on a car and finding out there's only one shop in the entire town where you can take your car.

How Do I Determine Who Is in Network and Out of Network?

The insurance company must publish a directory of contracted physicians who participate in their plans. However, these directories have been found to be notoriously inaccurate.

A recent survey of Texas physicians found that most know of times where a health insurance company's directory listed them incorrectly. Based on TMA's 2014 survey findings, health insurance company directories frequently misrepresent the plan's network. In fact, the survey found that **61 percent of physicians had found times they were listed as being in the network when really they were not. And 56 percent had detected cases where they were not listed in a plan but should have been.** The inaccurate directories may mislead patients when they buy a PPO and try to use the benefits they have purchased.



⁴ "UnitedHealthcare cuts many Medicare Advantage physicians," *Houston Chronicle*, Jan. 30, 2014.

Insurance companies claim they can't keep their network directories up to date because network physicians don't tell them about their network status. This couldn't be further from the truth. When a physician signs a network contract, the plan must put that information into its computers for both payment and directory listings. The opposite happens when a physician leaves or is forced out of a network. Since only the insurance companies can use the computers that add or remove a physician from the directory, it is solely the companies' job to make sure their directories are correct and up to date. This means the companies should shoulder the responsibility for maintaining and updating any printed or electronic directory they make available for physicians, and their current or potential customers.

Are Networks Inadequate in Texas?

TMA has collected information on network hospitals and the facility-based physicians who practice in those hospitals or in the various hospitals of a large hospital system. In late 2014, we found:

- In about 54 percent of its in-network Texas hospitals, Humana Health Plan has no contracts with emergency department physicians. It has no network radiologists in 31 percent of its in-network hospitals. It has no contracts with anesthesiologists in 36 percent of those hospitals.
- UnitedHealthcare is the insurer for most state employees in Texas. At about 40 percent of its in-network hospitals, United has no in-network emergency physician or physician group.

It is no longer so simple to measure the strength of networks for insurance companies in Texas. The numbers of separate health insurance products and networks have grown so quickly, it is becoming harder and harder for patients and physicians to tell exactly who is in what specific network. One large physician practice had to make an 11-page handout for its office staff just for Aetna insurance plans. The handout uses photos of Aetna insurance ID cards to help the staff decide if a patient's plan matches up with the Aetna networks the doctors are in. Even the insurance company staff are sometimes confused when doctors or patients call for help.

As of Dec. 15, 2015, 19 insurance companies were offering 543 different plans on the ACA marketplace, or exchange, in Texas for 2016.⁵ Each plan is offered on a county-by-county basis. This chart shows the emergency services provided at the eight Austin-area hospitals that are in network with three large insurance companies in Texas for the silver plan sold on the ACA health insurance exchange. It only includes hospitals that are in network with *all three* companies.

This chart, for a single city served by the three carriers, illustrates the problems that plague network coverage and directories in Texas.

Hospital	City	In-Network Emergency Services Provider by Health Plan		
		Humana	Blue Cross and Blue Shield	UnitedHealthcare
Dell Children's Medical Center	Austin	None	Seton Healthcare	Dell Children's Med Center
Seton Medical Center Hays	Austin	None	None	Capitol City Emergency Staff, PA
Seton Northwest Hospital	Austin	None	None	Capitol City Emergency Staff, PA
Seton Southwest Hospital	Austin	None	None	None
Seton Highland Lakes Hospital	Burnet	None	None	None
Cedar Park Regional Medical Center	Cedar Park	None	None	Capitol Emergency Associates
Seton Medical Center Hays	Kyle	None	None	Capitol Emergency Associates
Seton Medical Center Williamson	Round Rock	None	None	Capitol City Emergency Staff, PA

⁵ U.S. Centers for Medicare & Medicaid Services, www.healthcare.gov/health-plan-information/.

- **Inadequate networks.** Patients covered by Humana in Austin have absolutely no network hospitals where in-network emergency services are available. Yet Humana is allowed to sell a network product in Austin. **Is this the coverage its customers expect?**⁶
- **Physicians are willing to contract; some insurers are unwilling to contract.** The vast majority of physicians and physician groups prefer to be in network. Insurance companies are forcing physicians out of network by reducing payments to the point where they frequently do not cover the doctors' costs. Note that UnitedHealthcare has network agreements with the emergency medicine groups in Austin that Humana and Blue Cross have kept out of network. That shows these same physicians are willing to contract with an insurance company in each network hospital when the contract offer has value. Those companies seem unwilling to offer a reasonable contract like the ones these physicians have agreed to with other insurers. The question in Austin then is, **"Why can't those two insurance companies come to an agreement with physicians where the other company has managed to do it?"**

Does the State Measure Network Adequacy?

Like any other state agency, the Texas Department of Insurance (TDI) enforces the law and regulations by following up on complaints. TDI now also requires PPOs to file a network adequacy report on April 1 of every year. That started in 2014. The first year, the insurance companies did not seem to take it very seriously. In December 2014, the *Houston Chronicle* reported that a majority of the industry still had not reported:

According to insurance department records, however, reports for only 25 of the 140 preferred provider plans offered in Texas were submitted by an April 1 deadline. And after more than seven months in which regulators have not levied any sanctions, only three more providers have submitted reports.

Even more troubling, "We can't verify that (the insurance companies) do, indeed, have an adequate network, and that's concerning," acknowledged Debra Diaz-Lara, director of TDI's managed care quality assurance office.⁷

For 2016, Ms. Diaz-Lara told the Senate Business and Commerce Committee that only 60 percent of insurance companies reported that information on time. One key senator said he is concerned that the state is not using its full authority over the insurance companies to make sure they have adequate networks. In addition, Ms. Lara informed the House Insurance Committee that only three TDI staff members, including herself, actually review the networks for adequacy for all of Texas.

Consumers need active oversight and continuous monitoring of health maintenance organization (HMO) and PPO networks. The Office of Public Insurance Counsel (OPIC) is an independent agency that represents the interests of individuals and small companies that buy insurance. Currently, OPIC issues regular report cards on Texas HMOs — but not PPOs. In both its 2014 and its 2015 HMO report cards, OPIC found a growing number of consumer complaints over "failure to properly disclose provider networks" and "improperly expecting additional payment."⁸

⁶ Humana's self-reported hospital-based physician reports, April 2016. Accessed at <http://apps.humana.com/marketing/documents.asp?file=2280317> and <http://apps.humana.com/marketing/documents.asp?file=1870245>.

⁷ "Most insurance companies not complying with billing transparency law," *Houston Chronicle*, Dec. 10, 2014.

⁸ "Guide to Texas HMO Quality," Office of Public Insurance Counsel, www.opic.texas.gov/health/guide-to-texas-hmo-quality.

Health Insurance Terms

A **health insurance premium** is what an insurance company charges each month for insurance coverage. Insurance is a contract. The company agrees to protect the insured person against the risk of loss or liability when specific things happen.⁹

Before managed care, most health insurance was indemnity insurance. Under **indemnity health insurance**, the insurance company would pay for actual losses due to health-related expenses from illness or injury. The key term is “actual losses.” The coverage in indemnity insurance was based on the actual loss the insured person suffered — the charge for the care he or she received. It did not matter who provided the service.¹⁰

That is not the case today in managed care coverage. A premium paid to a managed care plan is not a payment to protect against actual losses. A managed care plan is much more limited. **Managed care** is a system of coverage in which patients agree to visit certain physicians and hospitals for which an administrator (your insurance company) monitors the cost of treatment.¹¹ Managed care companies have contracts with physicians, health care providers, hospitals, and the like to provide care for members at reduced costs. How much of your care the insurance company will pay for depends on the company’s rules and your policy.¹² In other words, the coverage patients are buying never was intended to cover “actual losses”; it was and is intended to reduce (by some amount) only a portion of the actual medical loss patients must bear.

An **HMO** is a managed care plan that arranges for prepaid health care services.¹³ The catch in this type of plan is that the person covered in an HMO must receive services *only* from physicians and providers in the HMO delivery network. Otherwise, the HMO won’t pay (except in emergencies or when the HMO refers the patient out of network because its network does not include the appropriate physician or provider).

HMOs work just like gym memberships. In a gym, members pay a monthly fee ahead of time for the unlimited use of the exercise machines at that gym or its branches. There is no additional fee to use the machines, but members can’t use the equipment at other gym companies. In exchange for your monthly premium, an HMO arranges for the basic health care services you may need. But you can *only* see the physicians and providers within the HMO network.

A **PPO** is another type of managed care. It is an actual insurance product. It is not “prepaid health care” like an HMO. Texas law defines a PPO as a “benefit plan in which an insurer provides, through its health insurance policy, for ... a level of coverage that is different from the basic level of coverage provided by the health insurance policy if the insured person uses a preferred provider.”¹⁴

That definition shows that PPOs are somewhat like indemnity plans. When a person buys PPO coverage, he or she is buying a “basic level of coverage” that is applicable **in every medical setting. There is no such thing as an out of network benefit — it’s the basic benefit!** In addition to the basic benefit, you receive a “level of coverage that is different” when you use a preferred provider. That is the in-network benefit. So, in Texas, when patients buy PPO coverage, they are buying a basic level of coverage *with an additional in-network benefit*. It is the different level of coverage (an incentive to use preferred providers) that changes the insurance product enough to consider it managed care rather than indemnity coverage.

The PPO basic level of benefits (those benefits that provide coverage even out of network) does not provide full coverage (as shown in How Does a PPO Determine Coverage? in Part II). Patients are surprised by the coverage and payment limits in PPOs when they receive an outstanding bill for services.

A **network** is a group of contracts an insurance company has with physicians and other providers. In those contracts, physicians and providers agree to accept a specific payment rate in exchange for a listing in plan directories, quicker payments, and better customer service from the companies. When PPO patients receive services from physicians and providers who agreed to those contracts, the patients get an increased insurance benefit. *An HMO requires patients to receive services from a contracted physician or provider in order to have any coverage at all.*

⁹ Black’s Law Dictionary, Eighth Edition.

¹⁰ Indemnity Plans vs. Managed Care, www.miller-miller.com/content/health/indemnity.

¹¹ CMS Data Navigator Glossary of Terms, www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/Downloads/DataNav_Glossary_Alpha.pdf.

¹² National Institutes of Health, Medline Plus, www.nlm.nih.gov/medlineplus/managedcare.html.

¹³ Texas Insurance Code §843.002(14).

¹⁴ Texas Insurance Code §1301.001(9).

PART II: UNFAIR “ALLOWABLE AMOUNTS”

If a Managed Care Plan Doesn’t Protect Against Actual Losses, How Does a PPO Determine Coverage?

When a person seeks medical care from a physician, the bill for services always belongs to the patient. In some cases, managed care companies have negotiated payment rates for out-of-network services, but not always. That is when the limited financing the policy provides under the out-of-network benefit can leave a patient with a balance to pay.

Why Do Patients Receive a Bill?

Patients receive a bill because they have received care the insurance company didn’t cover completely. Why do insurance companies leave their customers with bills to pay? Well, that is a more complicated answer and is a clever insurance company tactic.

Remember, your health insurance is just a method of financing — just like your credit card (except with insurance, you make your payments *before* you use it). Suppose a person goes to the grocery store and decides to pay with her credit card. She is \$100 from hitting her credit limit on that card. When she tries to buy \$150 of groceries, the credit card will pay for only \$100 worth. She must pay the grocery store the \$50 balance out of pocket if she wants to walk out of the store with all of her groceries. If you want to increase your credit limit, you don’t ask the grocer; you must ask the credit card company.

Let’s use another analogy. You pay automobile insurance premiums every month to finance repairs to your car if you are in an accident. You also have a deductible that you have to meet before the financing kicks in. Your auto insurer will then decide what it will pay toward repairs, which affects what you have to pay out of your own pocket. If you are unhappy with how your auto insurer settled your claim (because you think it should have paid more), you complain to your insurer or the department of insurance, not the body shop owner.

It is very similar with health insurance. When a patient has insurance and receives a bill for out-of-network medical care, it is because the health insurance company determined what it was willing to pay for the out-of-network care, and left the rest for the patient to pay. So, when the patient receives \$150 in medical services out of network but the financing only pays for \$100, the remaining \$50 is for the patient to pay. If the patient thinks the insurer should pay more, then she should ask her insurer to pay more.

Managed care companies use several different methods to determine how much they will pay for out-of-network services.

What Is Health Insurance? OR What Am I Really Buying?

When a patient buys health insurance, he or she is not buying health care or access to health care. Rather, the patient is purchasing financing and payment when illness strikes. Health insurance isn’t a guarantee that the patient will have nothing to pay out of pocket for health care. It is only a promise that the insurance company will consider paying *something* under certain circumstances described in the insurance policy.

A way to think about insurance is to think about a credit card. **Both a credit card and insurance are forms of financing purchases.** The credit card company does not provide the products you buy, and a health insurance company does not provide the health care you need. They both finance your ability to pay for those purchases. (Of course, with insurance, you pay for it ahead of time; with a credit card, you pay for it later.)

Before the arrival of managed care, if you bought health insurance, you bought what was called indemnity coverage. That meant you got the same level of financing for care provided by any physician or hospital you chose. Insurance paid a fixed amount or fixed share of any health care expense, and you paid the rest.

Those days are long gone. Managed care introduced the concept of networks, which limit the financing available to patients when they don’t use a network doctor or provider. Managed care plans do not guarantee a patient will always be treated by a network physician or provider. The plans, however, allow for different levels of financing for coverage of in-network and out-of-network services.

Typically, they base it on either:

- The contract rate they would pay for the same services provided by an in-network physician or provider; or
- An internally developed amount called the “allowable amount.”

An allowable amount is the most a third party or an insurance company will pay a physician or provider for a specific service.¹⁵ It may have no connection to the actual charge for a medical service. The allowable amount is the dollar amount the company will pay and *consider* the bill as paid in full, at least from its perspective. It’s the amount at which the company will *consider* that it has met its obligations.¹⁶

This sleight of hand limits what insurance companies have to pay and forces patients to pay more. This is how it works:

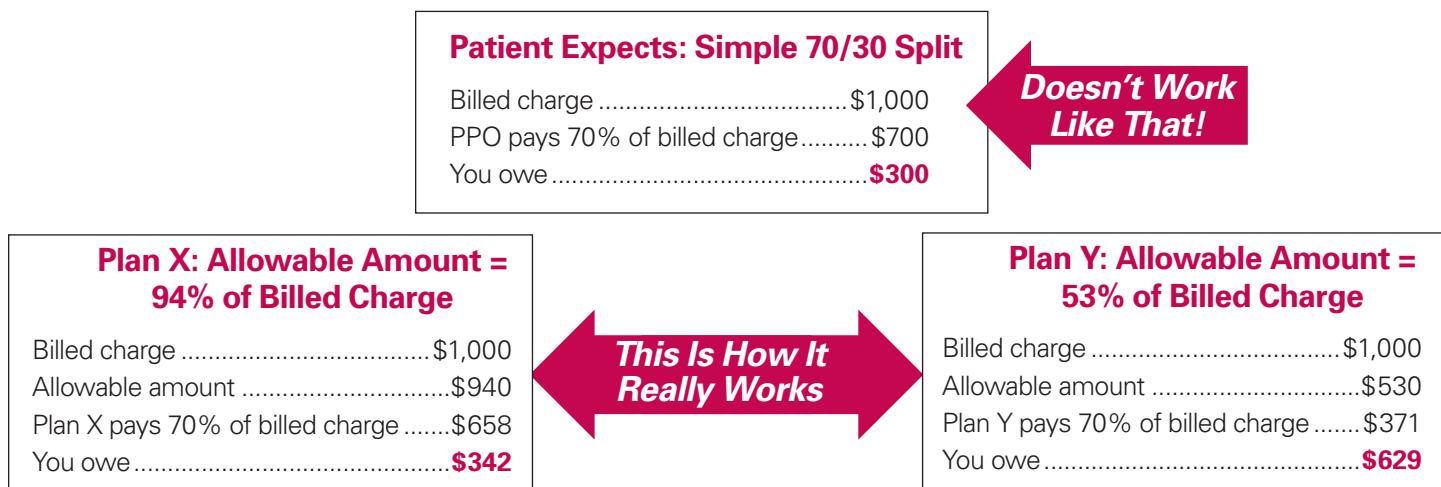
Suppose your health insurance coverage for out-of-network services has a 70/30 coinsurance. You might think that means the PPO would pay 70 percent of the amount billed for a medical service, and the patient would pay the remaining 30 percent. For example, when your physician files a \$1,000 claim for an out-of-network service, you assume the health insurance company will pay \$700 (70 percent) and you will pay \$300 (30 percent). Not so.

A managed care plan pays its percentage based on the “allowable amount” for that particular medical service. Each company sets its own allowable amount. In 2008, insurance companies reported to the Texas Department of Insurance how their allowable amounts compare, on average, to the doctor’s actual charge.¹⁷ Those numbers varied from a high of 94 percent to a low of 53 percent.

Let’s use the companies at the high and low end of the range as examples, both with 70/30 coinsurance. (To keep it as simple as we can, we’re leaving out your copay and deductible.)

- If you were lucky enough to buy the plan that sets its allowable amount at 94 percent of the billed charge, the allowable amount for your \$1,000 charge would be \$940. (That’s 94 percent of \$1,000.) The PPO would pay 70 percent of that — or \$658 — and you would be responsible for the remaining \$342.
- If, however, you were unfortunate enough to buy the plan whose allowable amount is 53 percent of the billed charge, you would see a big difference. Your PPO’s allowable amount would be just \$530. (That’s 53 percent of \$1,000.) Your plan would pay 70 percent of that — just \$371. And you would be responsible for the \$629 remaining.
- Note that in no case is it as simple as the company paying \$700 and you paying \$300.

In summary, you have a plan that requires the insurance company to pay 70 percent for out-of-network medical care. But 70 percent of *what*? Because the company alone determines that allowable amount, the insurer substantially limits its own losses and shifts the rest to you.



¹⁵ United HealthOne Learning Center, www.goldenrule.com/glossary-terms/allowable-charge/.

¹⁶ Id. (emphasis added).

¹⁷ Report of the Health Network Adequacy Advisory Committee, Senate Bill 1731, Section 11, 80th Legislature, Regular Session, 2007.

What Can I Do if I Think My Health Insurance Company Should Have Covered My Loss?

If you are a health insurance customer and are unhappy with the amount left for you to pay for an out-of-network service, call TDI's complaint line at (800) 252-3439. Tell TDI you believe your insurer has not fairly settled the claim. If you think your network doesn't have as many physicians or hospitals as it should, you can file a complaint about that as well. Just tell the agency you think the network is inadequate for what you paid in premiums.

Also, if you get coverage from your employer, complain to your employer's human resources department.

State Regulations on Out-of-Network Claim Settlement

TDI has adopted regulations to better protect patients from unfair PPO claim settlement. These regulations say when an out-of-network physician or provider provides services because a network physician or provider is not reasonably available (which includes emergency care), the insurer must:

- Pay the claim, at a minimum, at the usual or customary charge for the service, less any patient coinsurance, copayment, or deductible responsibility under the plan. This means instead of the health plan paying just any amount it wants, it has to look at the value of the medical service based on what physicians and providers in that same geographic area charge for the same or similar service.
- Pay the claim at the same coinsurance level as for in-network claims. Let's look at an example where your *in-network* coinsurance is split so that the health plan covers 80 percent and you cover 20 percent. In that case, the insurer will pay 80 percent of the allowable for this out-of-network expense, instead of the out-of-network percentage that is usually less.
- Credit any out-of-pocket amounts that were more than the allowed amount toward the insured's deductible and annual out-of-pocket maximum for in-network services. This is an important improvement because in the past, when an out-of-network physician billed you for emergency care, **you did not receive any credit** for the balance that your insurer didn't cover. Today, under Texas regulation, if you show your insurer what you paid to the out-of-network physician, **your insurer must credit that amount toward your in-network deductible and annual out-of-pocket maximum.** When you report these out-of-network balances to your insurer, you reach your in-network deductibles and out-of-pocket maximums sooner.

TDI has — at least once — fined an insurer for setting “allowable” amounts for noncontracted facilities at unreasonably low rates.¹⁹

What Is a Hospital? OR Isn't a Hospital a Single Business?

A hospital is an institution. It is a building or set of buildings set up for the care and recovery of patients. Professionals, typically physicians, provide the medical services. A hospital provides a location under one roof that supports the practice of medicine and offers a safe place for patient care. Hospitals, physicians, and other health care practitioners have separate functions and responsibilities. In Texas, they are most often separate businesses.

Some have compared a hospital to a restaurant, where everyone waiting on you works for the same company. That's why you just get one bill from the restaurant. But a hospital is not like a restaurant. It's more like a shopping mall. A mall offers a “campus under one roof” for many different vendors or stores to sell their products or services. You pay separately at each store. For example:

A customer enters the mall planning to use a particular brand of credit card. The customer might be surprised to learn that some of the merchants at the mall do not accept that credit card. Customers who want to buy something from that store will have to pay for it out of pocket. Just because you shop at a single location doesn't mean everyone at the location will accept the same financing. **That is true in a hospital as well. Some of the physicians and technicians, the hospital itself, and other providers may accept different insurance.** So, an insurance company may have network arrangements with many practitioners in a hospital, but not *all* of them — just like a mall may have *some* retailers who accept particular credit cards and some who don't.

¹⁹ TDI Order 08-0514.a.

Insurance Tips for Patients From Doctors

- Don't budget just to pay your premium each month. Put some extra money aside in case you have to pay for a service until you meet your deductible. Remember that even after you meet your deductible, you will still have to pay copayments and coinsurance until you reach your out-of-pocket maximum for the year. In addition, the insurer likely will not cover every kind of care from every doctor or provider you might see.
- Don't pick a plan just because the monthly premium is low. You may end up paying more out of pocket when you actually need medical care because of a higher deductible and coinsurance.
- Know what doctors and hospitals are in the network being offered. If that specialist you need to see regularly is not in the network, you may want to pick a plan that has a higher premium but has your specialist in network.
- Don't assume that if physicians or hospitals say they "accept all insurances," they are in your health plan's network. If they are out of network, that usually means they will take your insurance information and will bill the insurer. They will then bill you for the amount not paid by the insurer. Remember, health plans often allow physicians and hospitals to be in only some of networks for the various insurance products they sell, but not all. **You need to give the physician or hospital your exact policy number and information and then ask specifically, "Are you in network for my policy?"**
- When you can, give the physician or hospital the complete information on your insurance card and pin down the physician's or hospital's network status before you receive treatment.

The agency found the "rates are unreasonably low in light of representations made by the company in its advertising and its policies." Without admitting it did anything wrong, the company settled for \$3.9 million. It also agreed to change how it determines the allowable for certain facilities. Is that new method based on patients' cost for medical services? No. It is based on at least 75 percent of the company's average contract rate for the same services provided by an in-network physician or provider. The patient is responsible for the rest.

Why Wasn't I Informed That My Managed Care Plan Covers Only Allowable Amounts, Not the Actual Charges I May Have to Pay?

Actually, there may have been several attempts to inform you about the limitations of your coverage. It just might not have been as obvious as you think it should be.

First, when a consumer shops for insurance, that person is provided a Summary of Benefits and Coverage (SBC). An SBC is a supposed to be a plain-language description of the plan you may be considering. The government's most recent sample SBC links to a glossary that includes this definition of "allowed amount":

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."²⁰

Also, Texas law²¹ requires hospitals to tell patients that a physician or provider in the facility may not be in network with the same insurers or other payers as the facility. Texas law also requires an insurer to let patients know that physicians or other health care practitioners may not be included in the insurance company's provider network even at a network hospital and that the practitioner may bill the enrollee for amounts not paid by the insurance company. The insurer must display this information on its public health plan websites.

²⁰ U.S. Department of Labor, April 2016. www.dol.gov/ebsa/pdf/sbc-template-final.pdf.

²¹ Acts 2007, 80th Legislature, Regular Session, Ch. 997 (Senate Bill 1731), §3, effective Sept. 1, 2007.

PART III: RECOMMENDATIONS

The Texas Legislature has looked at the problem of surprise billing and enacted many different fixes over the years. The physicians of the Texas Medical Association will ask the 2017 legislature to take these steps to further protect patients and their doctors from insurance company abuse:

- Increase state agency oversight of the adequacy of all of an insurer's networks, especially for the insurers that patients often bring to mediation.
- Expand the current mediation process (for PPO plans and certain state employee health benefit plans) to include:
 - Services provided by an out-of-network physician or health care professional at an in-network hospital;
 - Emergency care provided by an out-of-network physician or health care professional at a hospital or freestanding emergency medical care facility/department, regardless of the network status of the hospital or freestanding facility/department;
 - Emergency services provided by an out-of-network hospital or freestanding emergency medical care facility/department; and
 - Out-of-network ambulance services.
- Maintain the current \$500 mediation threshold (after copayments, deductibles, and coinsurance) and the patient's role in the mediation process.
- Prior to any preauthorized elective services, require the insurer to inform the patient about the network status of physicians and others who may bill for services as part of any prior authorized procedure.
- Require physicians and providers to use a standard disclosure form to remind patients about which physicians and providers may be involved in their care and how to contact them.
- Require insurers selling PPOs to include "a clear and conspicuous notice regarding the implications of using or receiving services from an out-of-network physician ... and the potential for balance billing" on their websites, policy documents, and directories.
- Require insurance brokers and agents to educate consumers on the basic limitations of the plans they buy, especially their out-of-pocket responsibilities for care provided both in and out of network. This will reduce their surprise when consumers actually seek services.



Physicians Caring for Texans

(800) 880-1300 • 401 W. 15th St. • Austin, TX 78701-1680 • knowledge@texmed.org • www.texmed.org