Issue brief: Balance billing

What is balance billing?

Balance billing happens when a patient's health insurance company pays an out-of-network physician or other health care provider less than the amount the physician charges for the care. Because the physician and the health plan have not agreed upon payment through a contract, the physician bills the patient for the remainder of the costs.

A commonly used term – "surprise billing" – references a type of balance billing where a patient receives care at an in-network facility (e.g. hospital), but the care is provided by an out-of-network physician or other health care provider, without the patient knowing the provider is out-of-network. This happens because physicians and hospitals contract with health insurance companies separately, and with dozens of health insurance products in a market, it is rare that a physician is asked to participate with all the same products as each hospital where the physician provides care. So-called "surprise billing" can also refer to emergency care provided by an out-of-network provider.

This type of balance billing has become a focus for many policymakers over the last several years, as stakeholders offer solutions to protect patients from these unanticipated costs. The American Medical Association (AMA) is committed to advocating for policy solutions to address these situations and ensure that patients receive fair coverage for their health care needs when they purchase a health insurance product.

Why does balance billing happen?

Balance billing is predominantly a symptom of a much larger set of problems that have resulted from the way provider networks are assembled and regulated.

Many states do not require that provider networks be evaluated for adequacy using measurable standards, including standards that evaluate access to in-network physicians at in-network hospitals. As a result, the product a patient purchases may not provide reasonable in-network access to care for covered services in a hospital.

Meanwhile, health insurance companies are decreasing the size of provider networks as a way to hold down costs. These narrower networks mean that patients have access to fewer in-network physicians and, therefore, a greater chance of receiving care from a physician outside of their network when at a hospital.

Additionally, even when patients have some out-of-network coverage (e.g. a PPO), insurance companies are attempting to decrease their costs by paying out-of-network physicians arbitrarily low amounts for the care provided to their enrollees. For example, a patient may purchase a product with

"70 percent" out-of-network coverage. But what is often unclear to a patient is that the health insurance company will only pay 70 percent of the amount the company wants to pay for the care, not 70 percent of what the physician charges for providing the care. Unfortunately, the less the insurance companies' payments correlate to the cost of providing the care, the more likely the patient will be left to fill in the financial gap. Moreover, these low payments mean that insurance companies have little incentive to bring physicians into their networks, since they can pay them less (and the patient pays more) if they remain outside of their network.

What policies can prevent balance billing?

To best address the root causes of the problem and protect patients from these unanticipated out-of-pocket costs, policymakers must ensure that all health insurance companies provide adequate access to in-network physicians, including physicians that practice in hospitals, and that insurance companies provide coverage as promised when a patient goes out-of-network.

1. Strong network adequacy standards

The first line of defense against balance bills should be a regulatory framework that fosters adequate networks and provides patients with timely access to and choice of providers. Critical to this are strong, measurable network adequacy standards that include evaluation of patients' ability to access in-network physicians at in-network hospitals.

Too often an insurance company will be able to meet provider network requirements under the federal or state standards without showing coordination of physicians and hospitals in their network, or while having an insufficient number of physicians in their network. For example, a health insurance company may have hospitals A, B and C in their network and 20 anesthesiologists contracted with the plan, with only two of those anesthesiologists contracted to treat patients at hospital C. As a result, it is likely that a patient who is taken to hospital C will receive care from an out-of-network anesthesiologist.

Therefore, special attention should be paid, and specific adequacy measurements should be applied, to a health insurance product's ability to offer access to in-network care that patients need at in-network hospitals.

2. Transparency in out-of-network coverage

Transparency in out-of-network coverage is an essential step in helping patients determine whether it is cost-effective for them to pay higher premiums for out-of-network coverage, and if they will receive the coverage advertised.

Patients who purchase PPO health insurance products pay more in premiums to have coverage for out-of-network care. Unfortunately, that coverage is rarely as comprehensive as believed and patients end up paying for large gaps in out-of-network payments to providers and the costs of providing the care.

Health insurance companies should be required to standardize the way in which they market and describe their out-of-network coverage, with comparisons to a realistic baseline derived from charge data from a source independent of insurance companies. That way, patients can have a clear idea of how much of the physician's bill the health insurer will pay and how much of that bill will remain the patient's financial responsibility.

3. Reasonable coverage of out-of-network care

In addition to providing transparency in out-of-network coverage, it is important that health insurance companies fulfill their obligation to patients for coverage of out-of-network services by correlating their physician payments (i.e. allowables) to what physicians charge for the care. This includes using charge data sources independent of insurers to help establish allowables.

Other commonly used payment alternatives – a percentage of Medicare rates or the average in-network rates – do not accurately reflect the cost of care. When used as the basis for out-of-network allowables, the result is a cost-shift onto patients. Moreover, below-market payments to out-of-network physicians remove incentives for insurance companies to offer contracts to these physicians and build comprehensive provider networks.

4. Transparency in network and benefit design

Patients must have all relevant coverage information prior to purchasing a health insurance product. Restrictive networks are quickly replacing more robust networks, providing patients with lower-premium options but potentially less coverage and higher out-of-pocket costs. For example, patients may not be aware that they have purchased a plan with a very limited network. As a result, a patient may inadvertently seek care from an out-of-network provider or be forced to deliberately access one when similar in-network care is unavailable. Either way, patients may be left with hefty out-of-pocket costs.

Health insurance companies should use a standardized definition of alternative networks, such as a "narrow network" or "small network" and label the network as such in all patient-facing materials. Moreover, there must be transparency in marketing tools, coverage descriptions, and provider directories about restrictions on the plans' network and benefits. Now, more than ever, patients should have all of the information available about a plan's network and coverage so that they can make an informed decision about their health insurance and so that out-of-pockets costs are rarely a surprise.

5. Patient out-of-network costs count toward out-of-pocket maximum

Patient costs associated with out-of-network care should count toward any out-of-pocket maximums established by the health insurance company. Current federal law provides important stopgaps for out-of-pocket costs to patients, establishing individual and family maximums. Additionally, the federal government has recently taken steps to require that some patient costs associated with out-of-network care count toward these out-of-pocket maximums. However, under many plans, these maximums still do not include patient out-of-pocket costs for out-of-network care, leaving the patient vulnerable to significant, unanticipated health care expenses. Given the shift toward narrow networks that result in

more frequent use of out-of-network providers, it is important to allow for these expenses to count toward health plan out-of-pocket maximums.

What should physicians do to protect patients from balance billing?

In addition to working with stakeholders to advocate for the policies above, physicians should also take steps to address patient concerns:

1. Disclosure of fee schedules

Physicians should discuss their charges with patients whenever possible. Physicians should have a fee schedule that they can provide to patients prior to care and upon request. This helps patients determine their financial responsibilities, depending on the out-of-network coverage their health insurance plan provides.

2. Transparency in network status

Physicians should be knowledgeable and transparent about the health insurance products with which they participate, and be able to offer that information to patients and hospitals at any time. Although a physician may be contracted with numerous health insurance companies and even more individual products offered by those companies, making every effort to disclose their network information to patients prior to care will help patients make informed decisions and reasonably anticipate out-of-pocket costs.

3. Discourage outliers

Most physicians make every effort to be part of networks and if not possible, to bill in a way that reflects the cost of providing care. There is no place in medicine for the rare physician who inappropriately bills patients. Physicians should make clear that they oppose these outlier and unethical practices.

4. Work with patients to reduce financial hardships

Physician practices are taking steps every day to help patients manage out-of-pocket costs. Regularly physicians forgive balances, reduce payments, or work out payment plans with patients to lessen the financial impact of limited health insurance coverage. Physicians should continue to work with patients to reduce the impact of these unanticipated costs whenever possible.

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