Out-of-Network Billing
Balance Billing

• A bill to a consumer from a provider for the difference between an insurer’s payment to the provider and the provider’s charges
• Occurs when consumers receive covered services from out-of-network providers
• Carrier payment to out-of-network providers based on “usual, customary, and reasonable rates”
“Surprise Billing”

- Balance bills occurring even though consumers did everything they reasonably could to remain in network
- Prevalent with emergency care
  - Consumer may not have time to determine which hospital is in-network
  - An ambulance driver decides to take the patient to out-of-network facility
  - Emergent needs require consumer to go to nearest facility
- Frequently occurs within in-network facility for services provided by out-of-network providers
  - Hospitalists
  - Anesthesiologists
Figure 1: Percentage of In-network Texas Hospitals with No In-network Provider Type, by Physician Specialty

Source: Center for Public Policy Priorities (CPPP), Surprise Medical Bills Take Advantage of Texans (Sept. 2014)
Figure 2: Average Percentage of Dollars Billed Out-of-network at In-network Texas Hospitals, by Physician Specialty

- Emergency Room:
  - Blue Cross: 41%
  - Humana: 42%
  - United: 68%

- Anesthesiology:
  - Blue Cross: 7%
  - Humana: 23%
  - United: 25%

- Radiology:
  - Blue Cross: 8%
  - Humana: 17%
  - United: 15%

- Pathology:
  - Blue Cross: 2%
  - Humana: 9%
  - United: 24%

- Neonatology:
  - Blue Cross: 2%
  - Humana: 2%
  - United: 0%
Balance Billing Protections

- No protections currently exist in Nevada or federal law
- Network providers are prohibited by the terms of the contracts with carriers from balance billing the consumer
- Some states have enacted balance billing laws
  - CA, TX, NY, IL, FL, CT, MD, CO, MN, WV, and UT
- NAIC Network Adequacy Model Act (November 2015) addresses “surprise billing” by establishing a mechanism for consumers to deal with bills for services provided by out-of-network facility-based providers while receiving treatment at an in-network facility
NAIC Model Approach

• Focuses on transparency and consent
  – Health carriers and facilities provide “conspicuous written disclosure” of network status and to warn that out-of-network physicians might balance bill
  – allows patients to request a full list of network participation for all providers based at the facility

• In non-emergency situations, if consumers receive a balance bill of more than $500, they may opt for mediation
  – Consumer pays in-network cost sharing and forwards the bill to the health carrier
  – Health carrier uses mediation process with provider
  – Under mediation process, consumer’s costs may be eliminated

• In emergency situations, consumers have to pay only what they would pay for care from in-network providers
  – Bills of more than $500 are forwarded to health carrier
  – Health carrier uses mediation process with provider
  – Consumers do not have to take any additional steps and are guaranteed protection from the bill
FL Surprise Billing Law

- Prohibits surprise billing in emergency situations.
- Requires that insurers “are solely liable for the payment of fees” minus any applicable cost-sharing amounts and prohibits out-of-network providers from balance billing.
- Requires increased transparency and notice to consumers about the possibility of being treated by an out-of-network provider.
- Requires hospitals to post on their websites the health plans with whom they are in-network, and put consumers on notice that patients may be seen by out-of-network providers.
- Creates a binding independent dispute resolution process in order for health carriers and medical providers to resolve payment issues.
CA Surprise Billing Law

- Adopts informed financial consent for private insurance
- Creates a binding independent dispute resolution process in order to facilitate resolution to claims disputes between a carrier and an out-of-network provider
- Out-of-network providers can bill full amounts for out-of-network services at in-network facilities only if the patient consents in writing at least 24 hours in advance, after receiving an estimate of the costs and notice that in-network options are available
- Requires plans and insurers to reimburse providers of surprise bills the greater of the average contracted rate or 125 percent of the Medicare payment for the same service in that geographic region