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Surprise Medical Bills Take Advantage of Texans:
Little-known practice creates a "second emergency" for ER patients

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Most of us will end up in an emergency room at some point. And when we do, we'll probably have no choice which physicians treat us and no ability to ensure they are part of our insurance company's network of preferred providers. Texas consumers may reasonably expect that if treated in an in-network hospital in an emergency, the physicians practicing within that hospital would also be in that same network. This is too often not the case, leaving consumers vulnerable to surprise medical bills, known as "balance bills," from out-of-network physicians based at hospitals. While the practice is little-known to consumers, those who have received surprise medical bills often recount in anger how much money they paid and the frustrations of trying to understand and resolve billing issues with doctors and insurers. This report analyzes what leads to unexpected balance bills and explores recommendations to correct this practice.

What is "balance billing"?

"Balance billing" occurs when a consumer receives out-of-network health care services and is directly billed by the provider for the balance of what the insurer didn't pay – in other words, the difference between the provider's billed charge and the amount the insurer pays. This difference, as illustrated in Figure 1, can be quite large.

Why does balance billing happen?

In many cases the physicians practicing within a hospital are not employees of the hospital and do not necessarily participate in the same insurance plans as the hospital. This may come as a surprise to many consumers since hospital-based care is delivered and billed for under a different model than most consumer services. Imagine going out to eat and receiving separate bills from the restaurant, host, waiter, cook, and busboy, some of whom were willing to negotiate discounts or accept coupons, while others were not.

Hospitals commonly make arrangements with individual physicians and/or a physician group(s) to provide medical services within the hospital. For example, a hospital may contract with one or more groups of emergency room physicians to provide services within the emergency room. Similar arrangements may be made with outside groups of doctors to provide anesthesiology, radiology, pathology, and neonatology services within the hospital. These groups of physicians, who are not hospital employees, decide independently which insurance plans to participate in and often do not participate in all of the same insurance plans that the hospital does. In practice, this means a trip to the emergency room will likely result in multiple separate bills from different providers and may result in receiving (and being billed for) out-of-network physician services even if a consumer goes to an in-network hospital. This is one way consumers who think they are using an in-network provider still end up with an unexpected balance bill.

Most Texans with private insurance are enrolled in Preferred Provider Organization (PPO) plans, in which consumers save money if they get their care within a specified network of providers. If you stay in-network, you will have a lower deductible and copayments. You can see doctors outside of the network, but your out-of-pocket costs will be higher.

Providers within an insurer's network have agreed to accept the insurer's reimbursement as payment in full. But out-of-network providers have not agreed to accept an insurer's rates and may expect to receive their full billed charges.

Texas has some protections in place that lessen the impact of surprise bills stemming from emergency room visits, but these protections do not prohibit balance bills. The best solution for consumers in a medical emergency is to stay out of billing disputes between insurers and out-of-network providers. The Texas Legislature can remove consumers from the billing disputes by patching the gaps in Texas' successful, but tightly limited, balance-billing mediation process.

Figure 1: Illustration of a Consumer's Cost for In- and Out-of-network Care

	In-network	Out-of-network
Billed amount from ER doctor	$940	$940
Insurer's in-network contracted amount agreed to in advance	$350	n/a
Insurer's "allowed amount" paid out-of-network	n/a	$190
What your insurer pays	80% coinsurance $350*.8 = **$280**	70% coinsurance $190*.7 = **$133**
Your coinsurance/cost sharing	20% coinsurance $350*.2 = **$70**	30% coinsurance $190*.3 = **$57**
Balance bill *Difference between billed charge and allowed amount out-of-network*	n/a	$940 - $190 = **$750**
Total amount you owe *Your coinsurance plus any balance bill*	**$70**	$57 + $750 = **$807**

Illustration assumes annual deductible has been satisfied. ER doctor billed charges and insurer's allowed amount for out-of-network services based on actual medical bills from 2014.

Threat to family financial security

Surprise medical bills that can run into the hundreds or thousands of dollars are difficult for most families to afford. But for low-income families, an unexpected medical bill can threaten the family's economic security. It could mean getting behind on other financial obligations or being sent to collections and the related, long-lasting damage to a person's credit history. Or it could be the final

straw that triggers bankruptcy. With more low-income families moving into private insurance through the Affordable Care Act, it becomes even more important that Texas continues working to find meaningful solutions to stop balance billing.

How common is balance billing?

Texas Department of Insurance (TDI) regulations that took effect in July 2013 direct Texas insurers to – for the first time – publish PPO plan out-of-network service data by network hospital for specific hospital-based physician types, including emergency room doctors. Specifically insurers must publish the **percentage of dollars billed as out-of-network by emergency room physicians within each in-network hospital** as well as **identify any in-network hospitals that have no in-network emergency room physicians at their hospital.**

These new data, summarized in Table 1 for the three largest insurers in Texas, do not *directly* showcase the magnitude of balance billing in Texas. They *can*, however, help illustrate the likelihood of a consumer being treated by an out-of-network physician at an in-network emergency room – and potentially getting a surprise bill as a result.

Table 1: Out-of-network Emergency Room Physician Services at In-network Hospitals

Insurer	Average Percentage of Dollars Billed Out-of-network for Emergency Room Physician Services at In-Network Hospitals	Percentage of In-network Hospitals with No In-network Emergency Room Physicians
United Healthcare	68%	45%
Humana	42%	56%
Blue Cross Blue Shield	41%	21%

CPPP analysis of data supplied by Texas' three largest health and accident insurers by market share according to the Texas Department of Insurance, *2013 Annual Report*, "Part II," p. 49, www.tdi.texas.gov/reports/documents/13annualdata.pdf. Data reflect billing and providers associated only with in-network hospitals that offer emergency room services, as indicated by insurers. Average share of out-of-network billing calculated as the mean percentage of dollars billed out-of-network by each in-network hospital.

Sources: Blue Cross Blue Shield, "Provider Finder: Important Message About Hospital-Based Physicians, Blue Choice PPO," accessed July 2014 at www.bcbstx.com/onlinedirectory/hospital_based_physicians.htm. Average percentage of dollars billed over the course of 2013; percentage with no in-network provider current as of July, 2014. United Healthcare, "Texas Facility Based Physician Contract Status," 05 March 2014, accessed 14 August 2014 at https://www.providerlookuponline.com/UHC/po7/pdfs/EPO_Texas_Hospital_English.pdf. Data provided in March, 2014. Date ranges or "current as of" information not provided. Humana, "Hospital Based Physicians, Texas PPO – English," accessed 14 August 2014 at https://www.humana.com/about/legal/health-provider-notice. Average percentage of dollars billed over the course of 2012; percentage with no in-network provider current as of October 2013.

What does this mean for consumers?

- Whether you get a balance bill after an emergency room trip is a roll of the dice for consumers. Insured consumers face a decent chance that they will be treated by an out-of-network emergency room physician, even if they go to an in-network hospital.
- Emergency room physicians at in-network hospitals bill a significant portion of services out-of-network, increasing out-of-pocket costs for consumers and the likelihood of unexpected balance bills.
- Of the state's three largest insurers, United Healthcare and its network hospitals top the list with an eye-opening average of 68 percent of emergency room physician charges billed out-of-network for services delivered at an in-network hospital.

- A staggering percentage of in-network hospitals with emergency rooms have NO in-network emergency room physicians available**,** guaranteeing that all emergency physician treatment will be performed by out-of-network doctors. For example, a hospital might be in an insurer's PPO network, but NONE of the dozens of emergency physicians practicing within the emergency room have contracted to accept the insurer's reimbursement rates.
- Of the state's three largest insurers, Humana and its network hospitals top the list with 56 percent of network hospitals having NO in-network emergency room physicians. Even with Blue Cross Blue Shield, the best performing of the three in this category, one-in-five network hospitals have no in-network emergency physicians.
- Disturbingly, 8 percent of hospitals (23 of 276 hospitals) that contract with ALL 3 insurers have NO in-network emergency room physicians with any of the three insurers—meaning emergency room physicians at these hospitals (listed in Table 2) are not in the PPO networks of any of Texas' three largest insurers. As a result, a large percentage of insured patients who use these hospitals' emergency rooms may get unexpected doctor bills that are substantially higher than the emergency room co-payments they would expect under the terms of their insurance plan.

Table 2: Hospitals In-network with Each of Texas' Three Largest Insurers, but with No In-network Emergency Room Physicians for Any of the Three Largest Insurers

Hospital	City
METHODIST HOSPITAL FOR SURGERY	Addison
CARE REGIONAL MEDICAL CENTER	Aransas Pass
CORPUS CHRISTI MEDICAL CENTER - BAY AREA	Corpus Christi
CORPUS CHRISTI MEDICAL CENTER DOCTORS REGIONAL	Corpus Christi
BAYLOR UNIVERSITY MEDICAL CENTER	Dallas
WISE REGIONAL HEALTH SYSTEM	Decatur
TEXOMA MEDICAL CENTER	Denison
FORT DUNCAN MEDICAL CENTER	Eagle Pass
DALLAS MEDICAL CENTER, LLC	Farmers Branch
HARLINGEN MEDICAL CENTER, LP	Harlingen
VALLEY BAPTIST MEDICAL CENTER	Harlingen
SOUTH TEXAS REGIONAL MEDICAL CENTER	Jourdanton
DOCTORS HOSPITAL OF LAREDO	Laredo
MEMORIAL MEDICAL CENTER – LIVINGSTON	Livingston
MEMORIAL MEDICAL CENTER LUFKIN	Lufkin
WOODLAND HEIGHTS MEDICAL CENTER	Lufkin
RIO GRANDE REGIONAL HOSPITAL	McAllen
PARKVIEW REGIONAL HOSPITAL	Mexia
MIDLAND MEMORIAL HOSPITAL	Midland
OAKBEND MEDICAL CENTER	Richmond/Sugar Land
MEMORIAL MEDICAL CENTER - SAN AUGUSTINE	San Augustine
METHODIST HEALTH CENTER SUGARLAND	Sugarland
TOMBALL REGIONAL HOSPITAL	Tomball

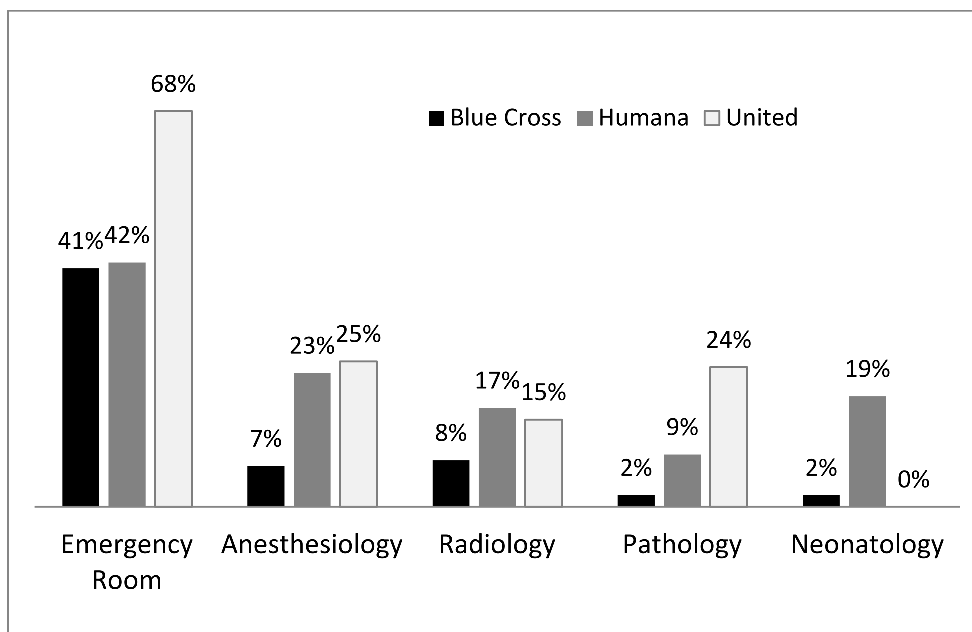
CPPP analysis of data supplied by Texas' three largest health and accident insurers by market share according to the Texas Department of Insurance. Data include only hospitals that offer emergency room services, as indicated by insurers. Source notes for insurer data listed in Table 1.

Why focus on emergency room doctors?

Of the five hospital-based provider types for which insurers must report PPO out-of-network service data to TDI—anesthesiologists, emergency room physicians, neonatologists, pathologists, and radiologists—emergency room physicians had by far the highest share of out-of-network billing at in-network hospitals, as shown in Figure 2. Texas' three largest insurers had an average of 41 to 68 percent of emergency room physicians' charges billed out-of-network at in-network hospitals, compared with 7 to 25 percent for anesthesiologists, the physician type with the next highest out-of-network billing share. In-network hospitals were also more likely to entirely lack any in-network emergency room physicians compared to the other hospital-based physician types, as shown in Figure 3. The average share of in-network hospitals with no in-network emergency room physician available ranged from 21-56 percent across insurers, compared with 1-38 percent for anesthesiologists.

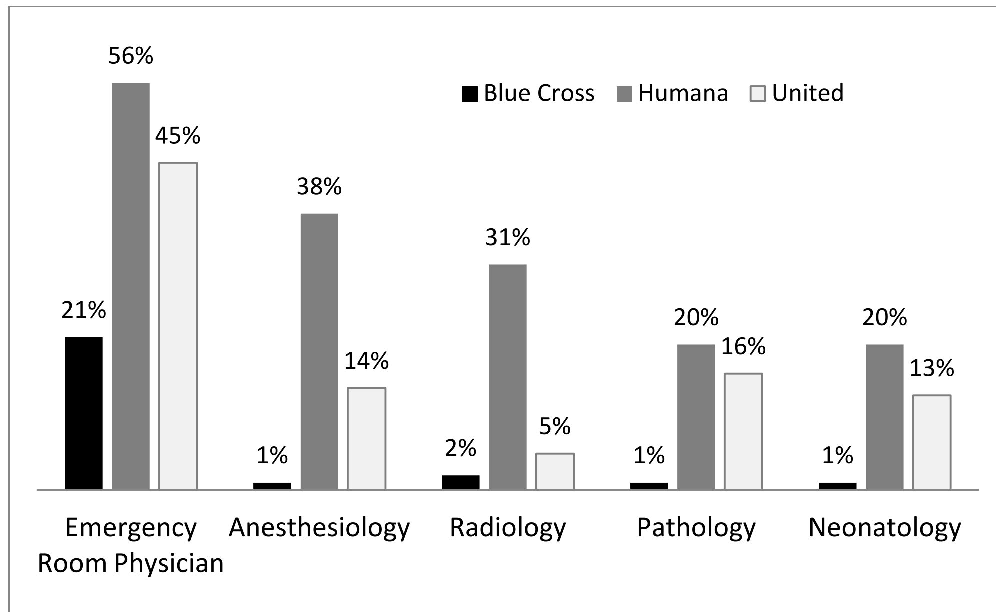
In addition, in an emergency, consumers have no control over which emergency room physician treats them and no ability to request or ensure that they receive services in-network, making network status of emergency care providers more of a concern for consumers.

Figure 2: Average Percentage of Dollars Billed Out-of-network at In-network Hospitals, by Physician Specialty



CPPP analysis of data supplied by Texas' three largest health and accident insurers by market share according to the Texas Department of Insurance. Data reflect billing associated only with in-network hospitals that offer the hospital-based physician specialty service, as indicated by insurers. Average share of out-of-network billing calculated as the mean percentage of dollars billed out-of-network by each in-network hospital. Source notes for insurer data listed in Table 1.

Figure 3: Percentage of In-network Hospitals with No In-network Provider Type, by Physician Specialty



CPPP analysis of data supplied by Texas' three largest health and accident insurers by market share according to the Texas Department of Insurance. Data reflect in-network hospital-based provider types associated only with in-network hospitals that offer the hospital-based physician specialty service, as indicated by insurers. Source notes for insurer data listed in Table 1.

Balance billing outside of the emergency room

Balance billing is not limited to physicians or emergency situations. There are several other medical scenarios where consumers have a limited ability or no ability to select in-network providers and are therefore vulnerable to unexpected balance bills. Consumers can get an unexpected balance bill from a facility, such as an out-of-network hospital or free-standing emergency room, if that is their nearest provider or where the ambulance takes them in an emergency. Consumers are also balance billed by ambulances for emergency transport, and of course have no ability to select an in-network ambulance when making a 9-1-1 call. Consumers also receive unexpected balance bills following scheduled procedures, especially when out-of-network providers are brought in without the consumer's advance knowledge or meaningful consent. Even diligent consumers who ask all of the right questions leading up to outpatient procedures report being unable to ensure that they will only be treated by in-network providers. For example, a consumer getting a colonoscopy may ensure that their gastroenterologist and facility are in-network, but have an out-of-network anesthesiologist assigned at the last minute or have a biopsy sent off to an out-of-network pathologist that the consumer does not choose.

Existing balance billing protections for HMOs

For Health Maintenance Organizations (HMOs), the Texas Department of Insurance (TDI) has long maintained that in an emergency or when an in-network provider is not reasonably available, consumers should have to pay no more for out-of-network care than they would have for in-network care. In other words, consumers are not *liable* for balance bills, and the HMO has the responsibility

of fully reimbursing the provider. This protection on paper, however, may not always translate into practice. State law does not prohibit an out-of-network provider from sending a balance bill to a consumer enrolled in an HMO, even though the HMO should be on the hook to resolve it. HMOs must instruct consumers to call the HMO if they get bills for out-of-network services, but neither HMO disclosures nor provider bills are required to explicitly say that the HMO, not the consumer, is liable for balance bills resulting from emergency care. Due to the convoluted nature of these protections, consumers in HMOs could receive balance bills stemming from emergencies and pay them, never knowing they are not technically responsible for the bill. TDI plans to amend state HMO rules soon and will have the opportunity to make existing “hold harmless” consumer protections explicit, so that they are meaningful for consumers.

Existing balance billing protections for PPOs

For Preferred Provider Organization plans (PPOs), state rules that took effect in July 2013 require plans to pay “usual and customary charges” when no in-network provider is reasonably available, including in emergencies. This should have reduced the amounts and frequency of balance bills to consumers, since a reimbursement based on the “usual and customary charge” is likely higher than an insurer’s general allowed amount for out-of-network services. State rules, however, do *not* end nor prohibit balance billing when a consumer involuntarily gets out-of-network care.

Insurers determine their own “usual and customary charge” calculations within state standards, and consumers can still be balance billed for provider charges that exceed an insurer’s calculation. Varying insurer calculations likely mean some consumers are better protected from balance bills than others. In addition, a recent consumer complaint reviewed by CPPP calls into question whether an insurer is adhering to new state protections, indicating more oversight may be needed.

Rule changes last year also require PPO plans to credit balance bills actually paid to in-network deductibles and out-of-pocket maximums. This appears to be another area where a consumer protection technically exists in Texas insurance law, but consumers are not informed of their rights or how to get amounts credited by either insurers or TDI. Many consumers may not benefit from the protections that are technically the law.

Since 2009, Texas has allowed some consumers with PPO plans and Texas state employee insurance to take certain balance bills to mediation, which could reduce or eliminate the consumer’s balance bill. This recourse, while meaningful, is not available to many consumers, as discussed later in this paper.

Transparency alone is not enough

Meaningful transparency about network status of providers, out-of-network reimbursement methodologies, estimated charges, etc., are all important consumer protections and areas in which Texas has made significant progress. Transparency alone, however, does not provide a real solution for ending surprise balance bills, because consumers do not proactively or knowingly choose to get health care out-of-network in many cases. For example, the most clear disclosure and data imaginable would be entirely useless to a person suffering a heart attack and being rushed to an emergency room by an ambulance. The meaningful consumer protections described below are needed in situations where disclosure and transparency cannot benefit a consumer.

Furthermore, it is worth acknowledging the limits of transparency and disclosure even when consumers have access to information when they are not suffering medical emergencies. The newly released data highlighted in this report are intended to help consumers minimize out-of-network costs by indicating the likelihood of being treated by an out-of-network hospital-based physician at in-network hospitals. While the data are interesting to regulators and consumer advocates, as currently reported and posted, the data are not very useful to many consumers aiming to prevent surprise medical bills. Some of the data are a year or two old and thus not reliable for making decisions in real-time. Also these data were not generally easy to find or recognize on insurers' websites, and were contained within reports or spreadsheets that ran up to 77 pages long. The one notable exception was United Healthcare's data on in-network hospital-based provider types available at in-network hospitals, which is incorporated into the insurer's online PPO provider director in a user-friendly fashion as part of each hospital entry. United Healthcare's out-of-network billing data is available in a separate 38-page report.

What is the best solution for consumers?

When consumers get care out-of-network involuntarily – in an emergency or if their network lacks needed specialty care, for example – they shouldn't have to pay any more out-of-pocket than they would have had the care been in-network. On top of that, these consumers should be freed from the resulting billing tug-of-war between insurers and out-of-network providers. If insurers think physicians' billed charges are too high and/or if physicians think insurers' allowed payments amounts are too low, these parties (and not the consumer) should resolve their disputes in mediation. Importantly, this solution would mean consumers are held harmless – they wouldn't incur higher costs; they wouldn't get unexpected balance bills; they wouldn't have to spend hours on the phone with billing departments or possibly get turned over to collections; and they would not have to trigger or participate in the mediation.

Texas already has the foundation for this mediation system in place, and it is working well for the limited share of consumers who have *eligible* balance bills and elect to take advantage of the system. Consumers with state-regulated PPO plans or state employee insurance through the Employee Retirement System can request mediation if they receive an eligible balance bill and were not told in advance that services would be out-of-network. To be eligible for mediation, a balance bill must top $1,000 (on top of any deductibles or copayments also owed) and be from an out-of-network anesthesiologist, emergency physician, neonatologist, pathologist, or radiologist for services delivered at an in-network hospital.

The Texas Department of Insurance reports that nearly all requests for mediation have resulted in an agreement between doctors and insurers without mediation taking place, meaning that the system, when accessed, is working well. There have been relatively few requests for mediation, however, possibly because access to the process is tightly restricted to only certain balance bills or because of limited consumer awareness. Consumers are the only party that can initiate mediation today.

Gaps in the current mediation process keep it from protecting consumers as well as it could. For example, a consumer could receive multiple balance bills from one emergency room trip (i.e., one each from an emergency room physician, anesthesiologist, and pathologist), which total well over $1,000, but be unable to access mediation if none of the bills from any one physician is over $1,000. Or a consumer could have a $900 balance bill from one provider with no available recourse. Consumers also can't seek mediation for balance bills from hospitals, free-standing emergency

rooms, ambulances, or provider types other than the five allowed hospital-based physician types. Finally, the system today doesn't guarantee relief for consumers—insurers and physicians do not have to reach an agreement, but even if they do, a consumer may still be on the hook for part of the balance bill.

Texas has the opportunity to create a truly consumer-centric solution to end surprise balance billing by building on the existing mediation process by making the following changes:

- Affirm that consumers who are treated out of network in an emergency or without advance written consent to receive out-of-network services will have to pay no higher out-of-pocket costs than they would have had with in-network care.
- Prohibit providers from sending balance bills to patients treated out-of-network involuntarily, removing consumers from provider/insurer billing disputes.
- Require insurers and providers to directly take their billing disputes for out-of-network care in these situations to mediation, which the insurer or the provider can initiate when they feel the bill or paid rate is inappropriate.
- Ensure that mediation is available to all consumers treated out-of-network involuntarily regardless of the treating provider type, dollar amount of billing dispute, or plan type (PPO or HMO).

This solution provides a real guarantee that people who have had emergencies or other non-elective out-of-network care won't face staggering, unexpected medical bills or be pulled into the middle of intractable billing disputes. It would also provide a real incentive for insurers and providers to reach mutually agreeable network contract terms up front, instead of mediating disputes case-by-case after the fact.

For more information or to request an interview, please contact Oliver Bernstein at bernstein@cppp.org or 512.823.2875.

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