

# Keep Balance Billing From Biting Your Customers

BY JANE COOPER

**E**VEN SOPHISTICATED GROUP PLAN MEMBERS WHO understand co-payments, deductibles and coinsurance rates may discover to their horror that they know nothing about balance billing.

Group plan members who intentionally seek out-of-network care—or inadvertently end up getting care from out-of-network anesthesiologists, testing laboratories or other providers while in the hospital—often end up with bills that shock them.

One way to keep employer clients happy is to help educate their plan members about the risk of balance billing and give them tools they can use to minimize that risk.

## EVERYTHING CHANGED

Back in the 1990s, the typical managed plan gently reminded consumers of the cost of medical care by charging flat co-payments for in-network services, such as \$50 for an emergency room visit or \$15 for a doctor's office visit. Some patients paid a small, flat co-payment for every day in the hospital. But, for patients, it didn't seem to matter what the services actually cost. No matter how high or low the total bill was, the patient paid a relatively small amount.

Over the past five years, the situation has changed dramatically. Health care premiums have more than doubled. Employers find themselves unable to absorb those high cost increases year after year. So, employers are shifting away from flat co-payments toward deductibles and coinsurance features that give employees more responsibility for sharing the cost of paying for care. Under a plan with a deductible and coinsurance, the employee

▶ **Jane Cooper** is president and CEO of Patient Care, Milwaukee, a national health care advocacy company. She can be reached at [jcooper@patientcare4u.com](mailto:jcooper@patientcare4u.com).

## DRIVER ED

### What To Tell Employees About Driving Their Care

- ▶ **Recommend that plan members** ask about the cost of elective procedures before being treated. Even if the providers will not give exact quotes, patients may be able to get a range of expected costs.
- ▶ **Advise plan members** to ask their insurers or benefit administrators about any reasonable and customary schedules that will apply to claims.
- ▶ **Encourage plan members** who expect to receive large balance bills to try to negotiate discounts based on prompt payment of the bill.
- ▶ **Make sure patients** who may not really be responsible for balance-billed charges have the knowledge and courage to question the charges.

pays the entire deductible amount, which often ranges from \$750 to \$1,500, and then a percentage of the remaining bill (possibly 10% to 30%) until costs reach the plan's out-of-pocket maximum. When costs reach the out-of-pocket maximum, the typical plan pays 100% of the bill until benefits are exhausted.

For an individual who uses a hospital or doctor outside the provider network, the out-of-pocket costs may be much higher.

An "in-network provider" is a doctor who has signed a contract agreeing to offer network patients discounted fees in exchange for a chance to get a steady flow of network patients. A key section of the network contract will require the provider to accept the payment rates specified in the contract as full payment for the services rendered.

Consider Dr. Smith, who normally charges \$230 for exams but has a contract with ACME Insurance Company that

pays only \$160 for exams. If Wilma Worker, an ACME plan member, goes to Dr. Smith for the exam, Dr. Smith will discount Wilma Worker's bill to \$160, from \$230. He also will "write off," or not bill, either ACME or Wilma Worker for the remaining \$70. To bill the patient or ACME for the remaining \$70 would violate the network contract. That practice is known as "balance billing."

If a consumer uses an out-of-network physician or hospital, no contract discount will apply. However, to save money, ACME will apply a schedule of "reasonable and customary" charges to the out-of-network claims.

Suppose Wilma Worker goes to Dr. Johnson, an out-of-network physician, for an exam. Dr. Johnson charges \$230, but ACME may decide that the R&C amount for the \$230 exam is \$180. ACME will process the claim using the assumption that Dr. Johnson's exam should cost \$180. The out-of-network physician, who has no contract with ACME, then has the right to balance bill the patient for the remaining \$50. Wilma Worker must pay that \$50 in addition to her deductible and her coinsurance bill.

## COPING

Few consumers ask what health care services cost before using them, and few consumers ask what their insurance company's R&C payment levels will be for out-of-network claims.

The result: Consumers often end up with large, unexpected bills.

How can group plan members protect themselves? How can you help them?

The truth is that it is a difficult problem to solve. Patients often have a hard time finding out whether specific providers balance bill or what the total charges might be. Medical office receptionists and managers are trying to keep track of so many provider network contracts that they may not know whether a particular patient will be balance billed.

Benefits agents and brokers may be able to help by hiring ombudsmen who can help patients understand their medical bills. Other benefits firms hire outside "patient advocacy" firms to address these issues. ■