

## Balance Billing and Out-of-Network Providers Basic Facts for Consumers

**When a medical provider is not in an insurer’s network, there is no contract between the insurer and provider for set prices. This leaves the patient open to “balance billing,” which can be an unwelcome surprise.** If you are covered by a preferred provider option policy (PPO), then you must use participating providers to obtain the best benefit available under the policy. While the PPO allows you flexibility to use out-of-network providers, this flexibility may come at a great out of pocket cost which you may not realize when reviewing your benefits.

**Some insurers sell more than one plan, with different networks for different plans.** To avoid surprises, contact your insurer directly to ask whether a provider is in-network for your particular plan. If you ask your medical provider whether it is in-network, be sure to ask about your particular plan. The medical provider might be in-network for one of your insurer’s plans, but out-of-network for your particular plan.

**Insurers pay for out-of-network providers’ services based on an amount the insurer sets, which might be significantly less than the dollar amount billed by the provider.**

### Comparison of In-Network and Out-Of-Network Costs and Payment

Network Status	Insurer Pays	Who Determines the Amount Owed to Provider	Who Determines the Insurance Payment Amount	Who Pays the Remaining Balance of Provider’s Bill	Insured’s Out-of-Pocket Costs
<b>In-Network</b>	Provider directly	Provider agrees to accept a negotiated price per service	Insurer agrees to pay a negotiated price per service	Because there is a negotiated price, there is no remaining balance	Deductible, co-payments and coinsurance as stated in the insurance policy
<b>Out-of-Network</b>	Insured Patient, who then pays the provider	Provider, using charges that apply when there is no insurer contract	Insurer, using their own formula to arrive at a value of the service provided (formulas are discussed in more detail in the FAQs following this chart)	Insured Patient, if the provider does not agree to write off the additional amount	Deductible, co-payments and coinsurance (deductible) as stated in the policy, plus the balance of the provider’s bill

## Frequently Asked Questions

### **What is the relationship between an in-network medical provider and an insurer?**

For in-network providers, the insurer and provider have agreed to the price per service. When a provider becomes part of a network, the provider agrees to accept a negotiated price for medical services. Providers agree to lower negotiated prices because in-network status means they will have more patients as part of the insurer's network. Providers that are part of the insurer's network are paid directly by the insurer.

### **What is the relationship between an out-of-network medical provider and an insurer?**

For out-of-network providers, there is no negotiated contract between the provider and the insurer. This means the provider has not agreed to accept payment from the insurer as payment in full. The insurer pays an amount referred to as the "allowed amount" or "recognized charge" or "maximum benefit allowance." You could be billed for the difference.

### **How do insurers determine what they will pay for out-of-network medical services?**

For in-network medical providers, the insurer and provider have agreed to the value of the provider's services in a contract. For out-of-network medical providers, insurers use formulas to determine the dollar amount they will pay for medical services. This methodology may be referred to as "usual and customary charges," "reasonable and customary charges," "maximum benefit allowance," or "prevailing rate in the community." Insurers' pricing formulas often rely on Medicare reimbursement rates (increased by a percentage) and prices charged by other providers in the same area.

### **Can my out-of-network medical provider send me a bill for the amount the insurer did not pay?**

Out-of-network providers have the option to require patients to pay any amounts that remain due after the insurer issues payment. This practice is called "balance billing" and it is legal.

### **Can an out-of-network provider balance bill for emergency services?**

Yes. The federal Public Health Service Act, section 2719A, provides that emergency services in the emergency department of a hospital must be covered without regard to whether the provider is in network for those services. This means that your copayment and coinsurance for emergency services in an emergency department of a hospital will be at the in-network rates. However, the statute does not require insurers to pay amounts that out-of-network providers may "balance bill," and the statute does not prohibit providers from balance billing. You can be balance billed for emergency services.

### **My insurer pays 80% of the cost for out-of-network providers – is that 80% of the provider's bill or 80% of the price the insurer sets?**

Insurers calculate your coinsurance obligation after reducing the billed amount. First, insurers take the provider's "retail" charge and reduce that billed amount using a formula to determine the usual, reasonable and customary charges or prevailing rate in the community. Insurers may refer to this reduced charge as the "allowed amount," "recognized charge" or "maximum benefit allowance." Then the coinsurance percentage is applied to the reduced charge.

### **Do the amounts paid for balance billing count toward my deductible or out-of-pocket maximum?**

No. What you pay when you are balance billed does not count toward your deductible. Also, amounts paid for balance billed charges are not part of any cap your plan might have on how much you pay out-of-pocket for covered services.

### **What can I do about this bill from my out-of-network provider?**

The same way an insurer negotiates with a provider, an individual patient can negotiate with a provider. You can ask your provider to accept a lower dollar amount as payment in full. Consumer advocacy organizations and attorneys are good resources with experience helping people negotiate medical bills.

### **What if the insurer's payment is so low it seems unfair and unreasonable?**

Your insurance contract contains specific language stating the basis for reimbursement of out-of-network providers. If you believe the insurer is not paying as promised in the contract, you can ask the insurer to reconsider the amount it paid. Sometimes an insurer will adjust the benefit after receiving additional information that justifies a higher charge. You can file a complaint with the Department of Insurance's Consumer Affairs Division if you believe the insurer's payment is unfair or unreasonably low. However, the Department does not have jurisdiction to order an insurer to pay a specific dollar amount on a particular claim; only the courts have that power. Therefore, you should consider consulting with an attorney if you believe the insurer's payment is unreasonable.

### **Going forward, what are my options?**

Check with your provider to confirm in-network or out-of-network status. Some out-of-network providers may agree to accept out-of-network payment from an insurer as payment in full. You can ask your provider if he or she will sign an agreement to waive any balance due after the insurer pays its out-of-network rate. If your provider will not agree to waive balance billing, you have the option to reevaluate your insurance to determine if your provider would be in-network with a different insurance company.

### **Is there a way to find out my balance billing exposure before I seek out-of-network treatment?**

Yes. You can obtain a good faith estimate of the dollar amount the insurer will pay for a medical service. The specific steps to obtain this estimate should be included in your health insurance policy. In order to obtain an estimate for out-of-network provider reimbursement, the insurer will need information from the health care provider including the medical procedure code number or diagnosis related group and the provider's estimated charge. See Neb. Rev. Stat. § 44-712(1) and your policy for details.

### **How can I avoid getting surprised by a balance bill in the future?**

There are times when going outside your network is simply unavoidable. But, the choice should be up to you, and you should make that choice an informed one. Follow these tips to help manage your costs:

- Ask your provider to refer you to in-network first unless there is a specific reason why you want to go out-of-network.
- Before scheduling an appointment with a new provider, ask if he or she participates in your plan (and your network through that insurer).
- If you are having a complex procedure, like a surgery, ask your doctor if **all** of your providers participate, including the hospital, assistant surgeon if used, lab and anesthesiologist. Your doctor may be able to change your care to in-network providers for those services.
- If you choose to go out-of-network, ask the provider's staff how much he or she will charge before your visit. Then, talk to your insurer to find out how much of the cost your plan will cover.

**Most importantly, remember that you are your own best advocate. Speaking up and asking questions up front will help you avoid being surprised at what you may owe.**

### **More Information**

If you have insurance-related questions, please contact the Nebraska Department of Insurance at 402-471-2201, or call our toll-free consumer hotline at 1-877-564-7323. Additional information is available on our website at **[www.doi.nebraska.gov](http://www.doi.nebraska.gov)**.