TCEP Messaging Points on Surprise Billing

Why care provided by physicians in the Emergency Department (ED) is unique.

- Patients rarely have time to determine whether if the provider is in network with their insurance in emergency situations.

- EDs have a legal requirement to treat all patients regardless of their insured status or ability to pay (Emergency Medical Treatment and Labor Act (EMTALA) enacted by US Congress in 1986).

- The 24 hour availability of physicians in the ED often correlates with increased severity and broader diversity of conditions being treated than those presented for treatment in a clinical environment.

- The pressure of treating unknown patients, often with time constraints, and the sheer number of billing codes necessary to treat ED patients makes estimating and disclosing costs for services virtually impossible in advance of delivering emergent care.

- Complex treatment in an ED often mean separate bills from hospital and ED providers as well as bills for services from other physicians, including radiology, pathology, anesthesia, etc.

- Because more billing and International Classification of Disease (ICD) codes are used in the ED than other places, disclosure lists of relevant pricing information for potential ED services would be too long and cumbersome to provide a meaningful benefit to the patient.

Why do patients end up with "surprise bills?"

- The patient's health plan benefits may not cover every service received from a doctor. Ex. The plan may only cover a limited number of a certain kind of office visit or procedure.

- Their annual deductible has not been met. (This is how much a patient has to pay first, every year, before insurance starts to cover any health care costs.) The deductible amount of many plans is growing, meaning more out of pocket costs before insurance kicks in.
    - Ex. The average silver plan through the Affordable Care Act in 2016 is $3,117.

- The physician is out of network. A network is made up of all the physicians who have a contract with an insurance company to provide care for a specific payment rate to patients in that plan.
    - *Many physicians want to be in network with the big insurers in their areas, but sometimes the insurance company does not want them in their network or offers to pay the doctors less than the actual cost of care provided.
    - Insurance companies can save money by limiting which physicians and hospitals are included in their networks. The number of "narrow networks" is increasing, meaning more physicians may end up out of network, resulting in more bills for patients.

- The health plan decides what it is willing to pay for out-of-network care and leaves the patient to pay the balance.
    - Let's use two companies as examples. Both have 70/30 coinsurance. Plan X sets its allowable amount at 94 percent of the physician's bill, Plan Y at 53 percent. (These are real numbers from real Texas insurance companies.) To keep this as simple as we can, we're leaving out the copay and deductible. For this example, the doctor's bill is an even $1,000.
        - Plan X sets its allowable amount at 94 percent of the billed charge. The allowable amount for your $1,000 charge is $940. (That's 94 percent of $1,000.) Plan X pays 70 percent of that — or $658. You are responsible for the remaining $342.
        - Plan Y sets its allowable amount at 53 percent of the billed charge. That makes a big difference. The allowable is now just $530. (That's 53 percent of $1,000.) Plan Y pays 70 percent of that — just $371. And you are responsible for the $629 remaining.

TCEP supports a multi-prong approach to "surprise billing."

- Require adequate insurance networks to cover the care of patients across our state, including in emergency situations. Increase network adequacy oversight by the Texas Department of Insurance.

- Continuing education requirements for insurance brokers and agents to include health literacy component.

- Require insurers offering PPO products to include a clear and conspicuous notice regarding the implications of using or receiving services from an out-of-network physician or provider.

- For elective services prior-authorized by the insurer at an in-network or out of network facility, require the insurer to contact and inform the patient before the date of service about the network status of the facility-based physicians and others who may participate in their care and bill for services. Also, inform of out-of-pocket responsibility.

- Expand current mediation process to all out-of-network physicians, health care professionals, and vendors regardless of the network status of the facility.

- Expand current mediation to any out-of-network hospital, outpatient hospital, ASC, FSED, and ground ambulance services.

- Use standard disclosure form to disclose to patients the identity of other physicians or non-physician practitioners typically practicing in the facility where planed services, surgical procedure, or labor/delivery will occur.