

Why Did I Get That Medical Bill?



Most of us hate surprises, especially bills we don't expect. The fine print in insurance policies and confusing practices of health insurance companies have left more and more Texans with medical bills they never expected.

The physicians of the Texas Medical Association wrote this guide to help you understand why.

A surprise bill is the unexpected difference between what the doctor charges and what the insurance company pays. Here are some common causes of surprise bills.

The health plan's benefits don't cover the medical service you received.

This is pretty straightforward. Health insurance plans don't cover every service a patient may get from a doctor. They may not cover cosmetic procedures. They may not cover experimental treatments. They may cover only a limited number of certain kinds of visits or procedures. They may cover only certain drugs or kinds of drugs.

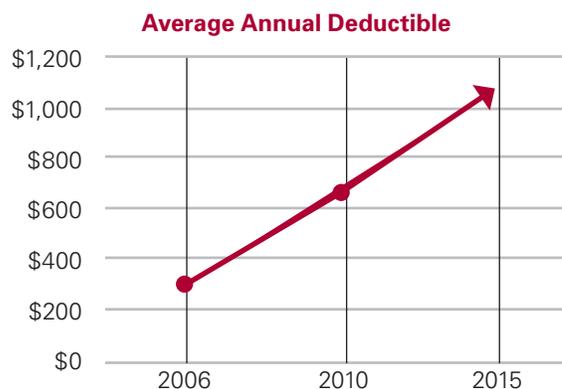
Unfortunately for patients, the list of "exclusions" is growing. When that information is hidden in the small type of the insurance policy and no one explains that you may have to pay extra, you get a surprise bill for services you thought would be covered.

You haven't met your annual deductible.

Medicare and most PPO health plans come with a deductible. That's how much you have to pay first, every year, before your insurance starts to cover any of your health care costs.

Routine office visits and most prescription drugs are usually covered even if you haven't met your deductible. Patients just have to pay their office visit or medicine copay. Insurance companies usually won't pay anything for other services — even those you get in a doctor's office — before you meet your deductible.

The size of deductibles is growing. That means you have to spend more out of pocket before your insurance kicks in. One study looked at people who get health insurance through their work. It found that average deductibles were \$303 a year in 2006. That grew to \$646 in 2010, and \$1,077 in 2015. The average deductible for someone with a silver plan through the Affordable Care Act ("Obamacare") in 2016 is \$3,117.



Physicians Caring for Texans



The physician is not “in network.”

Surprise bills often involve medical services provided by doctors who aren't part of your health plan's network. A network is all the physicians who have a contract with an insurance company to provide care for a specific payment rate to patients in that plan. An insurance company can have different networks for the different products it sells. It may want a physician in its HMO network but not in its PPO network.

Many physicians *want to be* in network with the big insurance companies in their areas. Most are in at least one network. Sometimes physicians who want to be in network find the company won't let them in at all. Other times, the insurance company offers to pay the doctors

less than it costs them to provide the care. In-network doctors have agreed to accept the insurance company's rates as payment in full, after you have paid your copay, coinsurance, and deductible. Out-of-network doctors have to ask the patient to pay the difference.

Insurance companies save money by severely limiting which physicians and hospitals they include in their networks. These are called “narrow networks.” Insurers are using them more and more often, especially in Texas. A recent study rated 45 percent of the Affordable Care Act networks in Texas as “x-small” and 27 percent as “small.” More narrow networks mean more physicians are out of network. That means 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.

This is the most complicated and best-disguised cause of a surprise medical bill. It starts with something called the “allowable amount.” This amount is the most an insurance company will pay an out-of-network physician for a specific service. It may have no connection to the actual value of the service. And it is a number the insurance companies themselves decide.

The allowable amount comes into play when deciding your coinsurance for a medical service. That is how you and the insurance company split the cost after you meet your deductible each year. A common coinsurance is 70/30. That means the insurance company pays 70 percent and you pay 30 percent. But — watch closely here — the insurance company pays 70 percent of *the allowable amount*, not 70 percent of the doctor’s actual bill.

When the insurance company sets the allowable amount really low, you get left with a bill that’s really high.

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 your 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.

	BILLED CHARGE	ALLOWABLE AMOUNT	INSURER PAYS	YOU OWE
Patient Expects: Simple 70/30 Split	\$1,000	—	PPO pays 70% of billed charge: \$700	\$300

Doesn’t Work Like That!

	BILLED CHARGE	ALLOWABLE AMOUNT	INSURER PAYS	YOU OWE
Plan X: Allowable Amount = 94% of Billed Charge	\$1,000	\$940	Plan X pays 70% of allowable amount: \$658	\$342
Plan Y: Allowable Amount = 53% of Billed Charge	\$1,000	\$530	Plan Y pays 70% of allowable amount: \$371	\$629



Tips to Remember:

- Don't budget just to pay your premium each month. Put some extra money aside in case you have to pay for a service until you meet your deductible.
- Don't pick a plan just because the monthly premium is low. You may end up paying more out of pocket when you actually need medical care because of a higher deductible and coinsurance.
- Know what doctors and hospitals are on the network being offered. If that specialist you need to see regularly is not in network, you may want to pick a plan that has a higher premium but has your specialist in network.
- Don't assume that if a physician practice or hospital says it "accepts all insurances," it is in your health plan's network. If it is out of network, that usually means it will take your insurance information and will bill the insurer. The physician or hospital will then bill you for the amount not paid by the insurer. Remember, health plans often allow physicians and hospitals to be in only some of the networks they offer, but not all. When you can, give the physician practice or hospital the complete information on your card and pin down its network status before you receive treatment.



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