

SURPRISE MEDICAL BILLING

A Glossary of Terminology



Allowed amount

For an in-network medical bill, the allowed amount should reflect the fee schedule negotiated by the health insurer and provider. This is also referred to as the “in-network rate.” Of this amount, a patient may still owe a portion through their co-pay and/or deductible, as determined by the plan. For out-of-network claims, this amount is determined by the insurance carrier, and varies depending on the terms of the specific plan and policy.

Alternative dispute resolution (ADR)

An independent objective system for resolving payment disputes between plans and providers that is intended to produce the most reasonable payment rate. This completely removes the patient from the middle of the dispute.

Balance billing

The difference between the amount charged by the provider for medical services provided and the amount an insurance company will reimburse for out-of-network services. This is the patient’s potential responsibility for an out-of-network medical bill.

“Baseball-style” arbitration

A negotiation process in which providers and insurance companies submit their “final offers” for payment along with supporting data and information to an independent third-party arbitrator. This third-party then makes a decision based on specific criteria relevant to the commercial insurance market. Economic research has shown that this produces rates approximating market levels.

Bundling

A policy that would prohibit hospital-based physician practices from separately contracting with health plans as they do today (or alternatively set their out-of-network reimbursement at artificially low levels, which would cause the cancellation of all current network agreements). The hospital would bear the burden of providing substantial financial support to the physicians practicing at their facility. In theory, this may be partially offset by the hospital negotiating for higher prices from the health plans for their facility fee. This system would require unprecedented government intervention in the private contracting between two independent business entities (hospitals and hospital-based physicians) that have different contracts and payment systems within Medicare, Medicaid, as well as the private, commercial, and ERISA marketplaces.

Employee Retirement and Income Security Act (ERISA)

A federal law that governs the health insurance plans offered by large employers. The majority of Americans receiving coverage through an employer-sponsored health insurance plan are part of an ERISA plan. Since these plans are regulated under federal law, state laws regulating insurance plans are limited in their ability to affect ERISA plans.

FAIR Health

A national, independent, nonprofit database of private and public health insurance claims for medical and dental services that was established in 2009 after an investigation by New York State into insurance industry practices for determining out-of-network reimbursement. FAIR Health was established when Ingenix, a subsidiary of United-Health Group, was found to have a major conflict of interest and was using data that lacked transparency for providers and patients.

In-network

Providers who have negotiated a contract with insurance companies to be within their provider network, at mutually agreed rates. Network participation offers providers a reliable patient volume and more predictable, faster payments for the care they deliver. It also offers physicians and health plans the opportunity to work together and implement measures and incentives that improve quality and outcomes.

Interim direct reimbursement (IDR)

As part of a broader ADR framework, this would be a payment by the insurer to the out-of-network patient's provider based on contracted rates in the geographic region. Either the provider or the plan could initiate binding arbitration if they are not satisfied with the interim payment. By making an interim payment based on market rates (including referencing the plan's and provider's most recent contracted rate with one another, if applicable), it would reduce the incentive of either providers or plans to utilize arbitration and would provide an efficient system for paying low volume or "incidental" out-of-network claims. It also ensures that small, often rural, physician practices do not face financial ruin when negotiating against well-funded insurance companies.

Medicare rate

The Medicare program was established for the purpose of reimbursing medical services for an age-specific population. As a result, rates do not appropriately reflect key under-65 health services, such as obstetrics and pediatrics. Reimbursement rates are based on federal budgetary and regulatory constraints and, too often, on major political considerations. This can result in significant budget cuts which can, in turn, impact access to care. Medicare rates were never designed to represent the fair market value of health care services or to cover provider costs; they are consistently set below market rates.

Out-of-network

There are two scenarios under which a provider is not in a particular health plan's network: (1) when the health plan has a limited or no presence in a certain geographic market, such that a provider in that area would rarely treat one of their members (for example, a member of a regional health plan in Pennsylvania who gets hurt or sick on vacation and visits an emergency department in North Carolina) or (2) when an agreement cannot be reached during negotiations between providers and insurers. This can happen when insurers offer insufficient rates that do not reflect the cost of that care, or when the plan deliberately and significantly restricts the number of providers in their network (a "narrow network"). A small number of providers have also taken advantage of out-of-network billing to earn outsized economics relative to responsible, predominantly in-network, physician groups.

Surprise billing

A scenario in which a patient receives an unexpected bill for medical care. This can be the result of either unplanned or emergency care from an out-of-network provider, or a patient being unaware of their plan's cost-sharing responsibilities.

Usual, customary and reasonable rate (UCR)

The usual rate charged by similar providers for the same service in the same geographic region. UCR can be used to determine allowed amounts or out-of-network reimbursement when tied to an independent, non-profit, and non-conflicted database.

80th percentile benchmark

The value at the point where 80 percent of the charges are equal to or lower than the particular value and 20 percent are higher. By designing it to address bad actors, this benchmark prevents excessive payments while still allowing for payments to reflect experience, quality, and intensity of health care services provided. The 80th percentile of charges, until recently, was the methodology insurers used for determining out-of-network reimbursement.