What You Pay Out-of-Network Depends on What's 'Reasonable'

These days, even people with comprehensive health insurance are getting pinched by higher medical expenses. In a multipart package, Co-Pay Blues, the Online Journal this week looks at the financial burdens facing insured consumers and offers advice. In today’s installment, we look at how getting treated out of network may be more expensive than you’d expect.

If you participate in group health insurance coverage through your employer, it’s a given that you’ll pay more to see a doctor who isn’t in your plan’s network of participating physicians. Exactly how much more may floor you.

I recently staggered back to my feet after opening a pair of health-care bills, following a routine physical at my doctor’s office and an unexpected visit to the local hospital’s emergency room. Prior to the visits, I was unaware that both recently had opted out of participating in my health insurer’s preferred provider organization (PPO), so I unwittingly became liable for higher out-of-network costs.

Under my plan, as I had understood it, insurance coverage through your employer, patients to resolve insurance problems. In today’s installment, we look

Doctors and Insurers Square Off

So exactly what is reasonable? The insurance industry isn’t telling.

Most major insurers, including Aetna Inc. and Cigna Inc., license data and tools from the Prevailing Healthcare Charges System, a billing database operated by Ingenix Inc., a unit of UnitedHealth Group Inc. in Minneapolis, Minn., to help insurers create “reasonable and customary” reimbursement tables.

But individual insurers generally don’t make these tables available to consumers, arguing they are proprietary and that making the tables public would encourage doctors who would otherwise charge less to raise fees.

“If physicians and consumers are informed about the usual and customary rate before the treatment is received, that [rate] will act as a floor, not as a ceiling, in terms of charging the patient,” says Karen Ignagni, president of the America’s Health Insurance Plans, a trade association of health-insurance plans in Washington, D.C.

Naturally, doctors have their own beef with how insurers come up with these tables. The American Medical Association in Chicago has filed class-action lawsuits against a number of insurers, including UnitedHealthcare, charging that insurance companies use unreliable or insufficient data to determine rate schedules, according to Dr. Donald Palmisano, former president of the AMA. A spokesman for UnitedHealth declined to comment, citing the ongoing litigation.

More recently, some insurers have started to break away from using traditional formulas to create customary and reasonable rate tables. Some are using their own in-house billing data to develop their own schedules in an effort to further limit payouts, says Barry Schilmeister, a senior consultant in Mercer Human Resource Consulting in New York.

“Some insurance carriers are even defining their level of coverage as a percentage of what Medicare would allow for the same services, which is far less than what plans would normally cover,” he says.
When reasonable and customary rates are lower than the average cost of medical services, employees end up paying more for out-of-network care.

Avoiding Insurance Sticker Shock

Staying within your network is the most cost-effective solution to the problem. But if you must go outside your network — or already have received services without realizing the doctor or facility was in the network — here are some suggestions for containing costs.

Negotiate lower fees in advance. If you’re considering an out-of-network physician for any kind of significant treatment, spend some time with your doctor going over what procedures are likely to be involved, and ask for a rough breakdown on the cost. Ask if the doctor is familiar with your insurer, and if he or she can give you some idea about how much of the cost is likely to fall under the category of "reasonable." Then ask whether the doctor is willing to accept a lower fee to make the treatment more affordable for you.

"Some doctors may not be in your network, but they may be in another network and could be willing to accept the lower charge imposed by that network as an acceptable payment for services rendered," says Dr. Leibowitz of Health Advocate.

Review your bill. If you’ve already received medical care and now are facing a daunting bill, you may still be able to trim your costs — but it will take time and a bit of detective work.

If your bill already has been processed by your insurer, ask for a re-evaluation to ensure it was processed correctly. "It’s not so uncommon that if someone gets a bill for $1,000, they really should have paid only $300 because there was a mistake in the coding when the doctor submitted the claim," says Ron Fontanetta, a consultant at human-resources consulting firm Towers Perrin in New York.

Also, thoroughly check hospital bills for errors or charges for services that were never received. For example, during my recent ER visit, I was billed for receiving intravenous medication that I had specifically asked the doctor not to administer. After I disputed the bill with the hospital, the hospital resubmitted the claim. Ultimately, I owed less. If you’re uncertain about what the charges on your bill cover, sit down with a billing representative at the hospital and carefully go over each line item.

Turn to outside help. If you’ve negotiated with your doctor and your insurer to no avail, speak to your employee-benefits department and explain your situation. Some larger firms employ companies to serve as mediators between the company and the insurer to work out problems or financial hardships that arise from claims.

If your bills are in danger of going into the collection process, it may pay to turn to an independent negotiator for help. You can find referrals to claims-mediation experts in your area at the Alliance of Claims Assistance Professionals in West Chicago, Ill.

Mediation firms typically charge a flat fee or a percentage of the amount of money they save you on the bill, typically between 25% to 50%, so make sure you understand in advance what you’re getting for your money. If the cost is prohibitive, your state’s consumer protection office may be able to help.

Use tax-advantaged savings accounts. Many employers offer workers the ability to sock away money for copays and other out-of-pocket health-care costs with health-care flexible spending accounts. The money is exempt from federal, state and payroll taxes if used to pay for IRS-approved medical expenses. And because monies invested in FSAs are pre-tax, it lowers your overall taxable income for the year, too.

FSAs also can serve as an advance on your income to cover health-care costs, says Robert Natt, chief executive officer of MBI, an issuer of employee-benefits debit cards that can be used to access funds in FSAs. Though you make contributions to your FSA in small chunks every paycheck, the entire amount you request to be withheld for the year is available to you right away. "Since you have access to those funds as of Jan. 1st of the year, you don’t have to worry about building up the account to have funds to pay big charges," he says. But FSAs come with a use-it-or-lose it provision: If you don’t spend down the entire account by year end, you lose any remaining savings.

The new "health savings accounts" play a similar role, though as this article explains, the Treasury Department’s delay in issuing administrative rules on these account prompted many employers to put off offering them to their employees during this year’s open-enrollment period. And if it’s likely you’ll be using out-of-network providers often, ask your human-resources department to consider adding HSAs to the company’s benefits package.