# CAN MY DOCTOR BALANCE BILL ME?

## *UNDERSTANDING PAYMENT LEVELS*

### BY ED GAELICK

In the simplest of terms, health insurance plans can be broken down into two categories: Network Only Plans or Network and Non-Network Plans.

**Network Only Plans** such as an HMO or EPO cover eligible services when they are performed by a participating provider. Such providers agree to contracted rates so you would only be required to pay for your cost share responsibility (e.g., copayment, deductible, coinsurance). You may not be balance billed beyond that. If you choose to go outside the network, you would be responsible for 100 percent of the total charges unless you experience a true emergency.

**Network and Non-Network Plans** such as a POS or PPO offer you the freedom to choose any provider you want. This means that you would have some level of benefit for eligible services regardless of a provider's network affiliations.

As with Network Only Plans, participating providers agree to contracted rates. However, non-participating providers have no such agreement with a carrier.

For example, let's say a sick office visit costs $200. A Network provider may accept a contracted rate of $100. Depending on the benefit level, you would only be responsible for $100 or possibly less if your plan only requires a copayment. A Non-Network provider could charge you the full $200, but only a portion may be applied to your deductible. So what happens to the rest?

Since Non-Network providers are not contracted with a carrier, they can charge whatever they deem appropriate. In order to control expenses, carriers use various formats to calculate non-network payment levels. Some of the most common methodologies are listed below:

• A percentage of Medicare approved charges, i.e. 110 percent, 140 percent

• Maximum Allowable Charge (MAC) which typically matches the in-network payment level

• UCT – A third party vendor determines usual customary and reasonable amounts for services rendered in a specific geographic area for a specific treatment.

Any amounts balance billed above the non-network payment level are not factored into your Non-Network deductible or maximum out of pocket. This exposes you to greater out of pocket expenses when using non-participating providers.

**TIP:** Most people will ask a provider if they "take my insurance". Many billing offices will submit a patient's claim even if they are not contracted with a carrier. So they will "take your insurance" but it will be a Non-Network charge. So if you have an HMO or EPO (In-Network Only) 100 percent would be out of pocket! The correct question should be, "Do you participate with my network". Be sure to reference the network's name as many carriers will have more than one available to their members.

While using Network providers will minimize your out of pocket exposure, you may prefer to seek services from a Non-Network provider. These are some cost saving ideas that you should consider.

Ask provider if amounts above the non-network payment level will be "forgiven"

Negotiate with provider to reduce the balance

Submit an appeal to the carrier with additional information to substantiate the higher charge.

Having a discussion with your provider about their billing practices beforehand should avoid "sticker shock" when you receive your bill. Be sure to ask for written confirmation of your responsibility if an agreement is made with your provider.

*Ed Gaelick established PSI Consultants, LLC, where he specializes in company sponsored employee benefits, business planning and personal insurance. Throughout his career, Ed has received many of the highest professional honors awarded in the insurance industry. His dedication, integrity and fortitude have earned him great respect from his clients, staff and peers.*

www.psi-consultants.com