

# Illinois Insurance Facts

Illinois Department of Insurance



## Out-of-Network Benefits – Proceed with Caution

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Note: This information was developed to provide consumers with general information and guidance about insurance coverages and laws. It is not intended to provide a formal, definitive description or interpretation of Department policy. For specific Department policy on any issue, regulated entities (insurance industry) and interested parties should contact the Department.

Many, if not all, health insurance plans use provider networks to help contain costs. Health Maintenance Organizations (HMOs) require members to use a primary care physician to direct all care and it must be within the HMO's contracted provider network unless special circumstances occur. HMOs do not pay any benefit for out of network providers unless a referral is issued by the primary care physician and approved by the HMO, or it is an emergency situation.

Preferred Provider Option plans (PPOs) are considered by many as more desirable because the member has the flexibility to see any provider they wish and receive a benefit. Unfortunately, many people do not read or understand the policy language which governs the out-of-network benefit.

This fact sheet provides information to help consumers understand how to read their policy and understand the true out-of-network benefit available.

### Summary of Benefits

Carriers make available a Summary of Benefits for each plan they market. The Summary of Benefits compares costs incurred if a member uses an in-network provider against costs incurred if a member uses an out-of-network provider. Below is an example of a page from a Summary of Benefits:



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the health plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- The plan may encourage you to use Participating **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 copay/visit	40% coinsurance	No benefits will be provided for services which are not, in the reasonable judgment of [redacted] medically necessary
	Specialist visit	\$55 copay/visit	40% coinsurance	---none---
	Other practitioner office visit	\$55 copay/visit	40% coinsurance	Acupuncture not covered. Chiropractic services are limited to 25 visits per calendar year.
	Preventive care/screening/immunization	No Charge	40% coinsurance	---none---
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	---none---
	Imaging (CT / PET scans, MRIs)	20% coinsurance	40% coinsurance	---none---

This plan requires the member to pay a \$35.00 copayment for a primary care office visit if the member uses in-network or participating provider. The member is required to pay 40% coinsurance if an out-of-network or non-participating provider is used. Most readers of this document assume that the member pays 40% of billed charges for the out-of-network provider. However, a close review of the information above the chart reveals that the coinsurance is the member's share of the cost of a covered service, calculated as a percent of the **allowed amount** for the service. It also states that the member will be balance billed for charges over the allowed amount. The term "allowed amount" is not defined on the Summary of Benefits. However, a buyer may click on the glossary button and find the universal definition of allowed amount under the Affordable Care Act is:

**Allowed Amount** - Maximum amount on which payment is based for covered health care services. This may be called "**eligible expense**," "**payment allowance**," "**maximum allowance**" or "**negotiated rate**." If the provider charges more than the allowed amount, the member may have to pay the difference.

It is imperative that the member reviews the definition of "allowed amount" in the plan document or policy in order to understand the full repercussions of using an out-of-network provider. Plans use a variety of methodologies including, but not limited to, basing the allowed amount on a percentage of Medicare rate or basing it on the contracted rate they have with in-network providers.

Prior to the use of provider networks, carriers paid claims based on "usual and customary" which is defined as the charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area. When Preferred Provider Option policies were first introduced, out-of-network benefits were based on a percentile of usual and customary. Some older policies may still use that methodology. However, the out-of-network benefit methodologies have evolved over the years.

**BEWARE:** Allowed amounts, eligible expenses, payment allowances, and negotiated rates are seldom if ever based on usual and customary fees and are never based on billed charges unless the billed charge is less than allowed amount.

Here are two examples to illustrate how claims are paid for out-of-network providers:

**Example 1:**

A consumer used an PPO in-network hospital for an outpatient surgery. She used an out-of-network physician for the surgery. The hospital charged \$874.00; the surgeon charged \$10,500.

The summary of benefits are:

**Deductible:**

In-Network Deductible \$2,500  
 Out-of-Network Deductible \$5,000

**Surgical Benefit:**

In-Network 100% of contracted after deductible – provider writes off contracted amount  
 Out-of-Network 80% of **eligible charge** after deductible – provider does not write off amount in excess of eligible charge

**Hospital Benefit:**

In-Network: 100% of contracted after deductible – provider writes off contracted amount  
 Out-of-Network 80% of **eligible charge** after deductible – provider does not write off amount in excess of eligible charge

**Out of Pocket Maximum:**

In –Network \$3,500  
 Out-of-Network \$6,000

The plan states that eligible expenses are determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.

This chart illustrates how the bills were processed:

Provider	Charge	Discount	Eligible Amount	Deductible	Amount Member owes
Hospital	\$874.00	\$305.90	\$568.10	\$568.10 In-network	\$568.10
Surgeon	\$10,500	None	\$2,761.06	\$2,761.06 Out-of-network	\$10,5000

The hospital was an in-network or preferred provider so the charge was reduced to \$568.10 which was applied to the member’s in-network deductible. The remaining balance was written off by the provider pursuant to the provider contract.

Because the surgeon is an out-of-network or non-participating provider, the plan determines the “eligible expense” for the procedure (110% of Medicare rates) is \$2,761.

Summary of claims:

- \$568.10 applied to in-network deductible and out-of-pocket maximum;
- \$2,761.06 applied to out-of-network deductible and out-of-pocket maximum;
- \$7,738.94 not covered and not accrued to either deductible or out-of-pocket maximum.

**Example 2:**

Consumer had back surgery which was pre-authorized by her carrier. The surgery was performed by an out-of-network surgeon. The surgeon’s bill was \$38,532.60. The carrier paid \$539.41. The consumer thought her plan paid 50% of the billed charge. However, her policy states that it pays 50% of the **eligible expense** which is defined as the lesser of: (1) Fees that are negotiated with the provider; (2) 110% of Medicare rate; (3) billed charges; or (4) fee schedule which company develops.

Provider	Charge	Discount	Eligible Amount	Deductible taken	Amount Paid	Amount Member owes
Surgeon	\$38,532.60	None	\$5,079.61	\$4,000.79	\$539.41	\$37,993.19

Because the surgeon is an out-of-network provider, the plan determined the eligible expense for the procedure (Maximum Non-Network Reimbursement Program) at \$5,079.61.

Summary of claim:

- \$4,000.79 applied to out of network deductible;
- \$4,540.20 applied to out of pocket maximum
- \$539.41 paid
- \$33,992.60 not covered and not accrued to deductible or out-of-pocket maximum.

**What protections are provided in Illinois?**

**Emergency Services:**

For HMOs and PPOs, if emergency treatment is provided by an out-of-network provider, the member shall be no more out of pocket for the charges than had the treatment been provided by an in-network provider.

**Network Adequacy:**

For PPO plans, Illinois Administrative Code states “whenever a beneficiary has made a good faith effort to utilize preferred providers for a covered service and it is determined the administrator does not have the appropriate preferred providers due to insufficient number, type or distance, the administrator shall ensure, directly or indirectly, by terms contained in the payor contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider.” (50 IL Admin Code 2051.310).

**Disclosure:**

For non-participating provider claims 215 ILCS 356z.3 and 215 ILCS 5/370i(c) requires PPO policies to include the following disclosure in the policy:

"WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon

the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. **YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.** Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts.”

For More Information:

Call our

Office of Consumer Health Insurance toll free at (877) 527-9431  
or visit us on our website at <http://www.insurance.illinois.gov/>

**Related Topics:**

Provider Network Adequacy