Reimbursement rates for out-of-network hospitals are likely to become a major issue when health insurance exchanges from the Affordable Care Act (ACA) go live. Many health insurers are shrinking their networks for health insurance exchange programs in an attempt to secure deeper discounts from participating hospitals. Consequently, the number of out-of-network hospitals is likely to rise, and the number of payment disputes for these emergency services will increase. One of the lesser known provisions of the ACA attempted to establish payment metrics for services provided in out-of-network hospital EDs.

The ACA regulations apply to providers who furnish emergency services in hospital EDs. However, this applies only to insurance plans that provide benefits for emergency services. The regulations do not apply to grandfathered insurance plans, that were in effect prior to the ACA.
Cost-Sharing Requirements

Patients treated at out-of-network EDs are protected from higher co-payments and co-insurance than what’s required for treatment at in-network emergency rooms. Also, insurance companies can’t impose higher deductibles or out-of-pocket maximums for out-of-network emergency services than what’s required for other out-of-network services.

The regulations establish a baseline reimbursement level that health insurers must pay to out-of-network emergency providers. Insurers are required to pay an amount equal to the greatest of:

1. The median amount health insurers pay in-network providers for emergency services furnished;
2. An amount based on the same methods used by health insurers generally used to pay for out-of-network services (eg, usual and customary amounts); or
3. The amount Medicare would pay for emergency services provided.

Challenges of Balance Billing

The minimum payment required from health insurers is intended to be a floor to protect patients from excessive balance billing that results from low ball, out-of-network reimbursement. Once minimum payment amounts are made, out-of-network emergency providers can balance bill patients with the difference between its billed charges and the amount paid by the insurance.

In states where balance billing is prohibited, the minimum reimbursement amounts may not apply, and emergency providers can look to recover greater amounts directly from insurance companies. Also, depending on the benefits designs of insurance plans, insurance companies may be exposed to billed charges when members have met their out-of-pocket maximum but are still obligated to pay the balance of the provider’s charges.

Seizing Opportunities Provided by the ACA

As health insurance exchanges go live, hospitals and emergency providers should take advantage of the protections provided by the ACA. There are payment metrics that must be met. Providers should not leave money on the table, but rather hold payors accountable for meeting these legal obligations.