

Types of Out-of-Network Reimbursement

Most health plans have a “network,” a group of doctors, hospitals and other healthcare providers who agree to take your insurer’s rate. Some plans may not cover any services you get from providers who are not in the network. Others cover part of your care when you get services from other providers. But, plans may differ in how they decide how much they will pay out-of-network providers. Many of them develop their own “usual, customary and reasonable” (UCR) charges to help work out what they will pay out-of-network providers. Others use Medicare’s payment (fee) schedule.

- **UCR charges.** Most plans pay for out-of-network care based on a percentage of UCR charges. Those reflect what providers typically charge for a specific procedure in a given geographic area. Health plans make their own decisions about what is usual and customary. They may use resources such as FAIR Health, however, to help them make these decisions.
- **Medicare fee schedules.** Medicare’s payments are usually lower than payments from commercial health insurers. Some insurance plans use Medicare fees as a basis for reimbursing service for out-of-network providers. They then multiply that fee by a certain percentage to set the maximum amount that they will pay for that procedure.

The rate is often less than what your doctor charges. If you go out of network, your insurer may pay for part of the bill. You will pay the rest.

If your insurer uses the Medicare fee schedule to set its out-of-network reimbursement rates you can use the FH Medical Cost Lookup to estimate your out-of-pocket costs. Just select the “Medicare-Based” button on the right-hand side of your results page.

You may have the option to choose between plans—one that reimburses based on a percentage of UCR charges, and one that reimburses based on a percentage of Medicare fees. If so, you can compare your estimated out-of-pocket costs for services you receive out of network for both plans by using the FH Medical Cost Lookup. Select the “Compare Both” button on the right of the results page.

What is Medicare?

Medicare is the federal health insurance program that covers tens of millions of elderly and disabled Americans, helping to pay for the care that they need. In fact, Medicare covers so many Americans that it currently pays for almost 30% of the hospital care and 20% of the physician and clinical services in our country.

Medicare also plays an important role for health insurers. Since the program pays for such a large share of medical care in the U.S., some insurance plans use its rates to help them determine how much they will pay for out-of-network care for their own members. This can affect your out-of-pocket costs.

How Does Medicare Make Payments?

Medicare pays a fixed amount for most hospital, medical, and physician services. This amount depends on the severity of the treatment, the geographic area where the service was provided, and other factors. Some types of hospitals can receive extra payments, such as teaching hospitals and hospitals that may treat many uninsured, low-income patients.

Medicare fees for each procedure may differ depending on whether the procedures are provided in a facility setting (e.g., hospital, surgery center) or doctor's office, and the geographic area where the procedure was provided. Fees may also reflect national policy and budgetary decisions.

Medicare's fee schedules are reviewed regularly by the Medicare Payment Advisory Commission (MedPAC). MedPAC is an independent agency made up of experts from every area of the healthcare industry. It advises Congress on many issues affecting Medicare. The commissioners study the fee schedules for services like inpatient hospital care, outpatient care, and doctors' visits, and recommend changes to Congress.

Follow the link to find a detailed description of [MedPAC's responsibilities, and all the current payment schedules and recommendations.](#)

How Does Medicare Affect My Plan?

Some types of plans, like a PPO or POS, cover some portion of your care if you receive services from providers outside your plan's provider network. Since Medicare is such a large, established plan, many insurers use the program's payment schedules to help determine what they will pay out-of-network providers.

Medicare's payments are usually lower than payments from commercial health insurers. So, some insurance plans use Medicare's fee for a specific medical procedure as a base, and then multiply it by a certain percentage to develop the maximum amount that they will pay for that procedure.

For example, if you visit an out-of-network doctor, your insurer may agree to pay 130% of the rate Medicare would normally pay for the visit. This means that if Medicare would normally pay \$100 for an office visit, your insurer would agree to pay up to \$130.

What Does That Mean for My Out-of-Pocket Costs?

Even if your plan's out-of-network rate is higher than Medicare's fee schedule, it could still be less than what your doctor charges. This is particularly true for some specialties like surgery and anesthesiology, and outpatient services like radiology and lab visits. If you go out-of-network, your insurer may reimburse a small percentage of the total cost and you may be responsible for paying the balance out of your own pocket.

So, for example, if your insurer agrees to pay 130% of Medicare's fee schedule for an out-of-network doctor's visit, and Medicare's rate is \$100, your insurer will pay up to \$130. But, if the provider charges \$200 for that visit, you may need to pay the remaining \$70 yourself.

Remember, this is only for out-of-network care. When you stay in your plan's contracted network, your plan will often cover most of the costs for your care. That is because those providers have agreed to accept your insurer's contracted rate as payment in full. You will usually just owe your deductible, copayment or coinsurance. (You can read more about these out-of-pocket costs here.)

If your insurer uses the Medicare fee schedule to set its out-of-network reimbursement rates, you can estimate your out-of-pocket costs using the FH Medical Cost Lookup by selecting the "Medicare-Based" button on the right hand side of your results page. Note that other plans may reimburse for out-of-network care based on a percentage of usual, customary, and reasonable (UCR) charges based on FAIR Health data that reflect what providers typically charge for a specific procedure in a given geographic area. These UCR-based charges are the default on the FH Medical Cost Lookup.

If you are trying to choose between plans - one that reimburses based on a percentage of the Medicare fee , and another that reimburses based on a percentage of UCR charges, such as FAIR Health data - you can compare your out-of-network benefits for both plans using the "Compare Both" button on the right of the results page.

Why Go Out-of-Network?

There are some very good reasons patients go out-of-network for their care. If you or a loved one is facing a serious illness, you may want more provider options than are available in your plan's network. Sometimes that means choosing a hospital that does not participate in your plan, or a specialist who is not a part of your network.

Sometimes patients go out-of-network by accident. For instance, your primary care physician might refer you to a specialist who doesn't participate in your network. Or, you may go to an in-network hospital, but receive care there from a surgeon or anesthesiologist who is not contracted with your plan. (You can find more information on in-network and out-of-network care here.)

Your Action Plan: Understand Your Plan

There are times when you cannot avoid going outside your network for care. But, you should know what to expect and be prepared for the bills you receive. It's very important to understand how your plan calculates its reimbursement rates before your visit.

Follow these tips to help manage your out-of-pocket costs:

- Ask your provider to refer you to in-network providers first unless there is a specific reason why you want to go out-of-network. If you are having a complex procedure, ask if all of your providers are in the network.
- If you choose to go out-of-network, ask the provider's staff how much he or she will charge before your visit. Then, talk to your insurer to find out how much of the service your plan will cover.
- If your plan tells you they will pay a percentage of the charge based on Medicare's fee schedule, ask how that will translate into a dollar amount.

- If your plan reimburses out-of-network care based on a percentage of Medicare, look up your out-of-pocket costs in advance by selecting the Medicare-based button on the results page of the FH Medical Cost Lookup.
- If you're unclear about how your plan calculates out-of-network rates, or what services are covered, look on your insurer's website, check your plan documents – or call your insurer and ask!

And most importantly – remember that you are your own best resource. Speaking up and asking your provider and insurer these questions up front will help you manage your out-of-pocket expenses.