Out-of-network providers: What's changing and what you need to know

Beginning June 1, we're changing our out-of-network reimbursement policy for the new American medical plans. That means that if you visit or use a provider (be it a doctor, hospital, clinic, lab or imaging center) who is out of our network, the company will limit the allowable amount – meaning the amount of fees we will consider to pay the provider – to 140 percent of Medicare's published rates for that service.

What does "140 percent of Medicare" mean?
Each year, Medicare establishes rates, or fees, that providers are allowed to bill for specific services. So, an MRI costs x number of dollars, gastric bypass surgery costs x number of dollars, and so on. It is a way to establish a reasonable billing environment.

Through our healthcare administrators (United Healthcare and BlueCross), American, along with many other large companies, then takes those published Medicare rates and multiplies them by 140 percent to come up with a benchmark for what is reasonable to pay out-of-network providers for their services to our employees and their dependents.

This 140 percent approach is standard among many other companies, including Delta and Southwest.

Why are we making this change?
Here's what's happening: We're seeing more and more of our employees being charged outrageous amounts for services performed by out-of-network providers. This is unfair to our employees and to American. It is unfair to the employee because often, you aren't told that you are being sent to an out-of-network provider and your cost share is higher when you use an out-of-network provider. Also some providers are not in-network because they are not high quality providers. And it is unfair to American because our healthcare plans are self-funded (meaning after your co-pay, deductible, or co-insurance is paid, American pays the remainder of the bill). So when American incurs those higher out-of-network costs, those costs get spread across all of the rates the following year (and are one reason the rate jumps are so high from year to year).

Some of this, indeed a large portion of these questionable and extreme billing practices, consists of borderline fraud being enacted on our co-workers. And for those employees with legitimate out-of-network needs, there is a process by which one can achieve that service through a Network Gap process which is explained in greater detail below.

Lastly, a really small number of people are using out-of-network providers today (approximately 5 percent) yet that usage is driving 14 percent of our $1 billion annual healthcare spend. We don't want to simply pass on the cost to all employees in the form of higher contributions or deductions from your paycheck because most employees are not using out-of-network providers.

And, not all out-of-network providers have questionable billing practices, but it's done enough for us to need to make a change to the way we handle out-of-network reimbursements.

The good news is more than 90 percent of all hospitals and 80 percent of all doctors in the United States are in-network for our Blue Cross Blue Shield and United Healthcare administrators. These providers include specialists who are high quality and with whom we have negotiated reasonable rates. So the true need to go out-of-network should be limited.

What does this change mean to you and your dependents?

Here's a real example of what happened to one of our pilots: You visit your doctor (who is in-network) and he says you'll need an MRI. He says there is a convenient imaging center right down the hall you can go to today! You don't bother to ask if the imaging center is in-network because your doctor was in network and he recommended the imaging center. Once you receive the bill from the imaging center, you realize it is out-of-network.

What's more is while an MRI typically costs $500 to $2,000, this out-of-network imaging center charged $30,000 for the MRI. Hypothetically, let's say Medicare's rate for MRIs is $1,000. With the 140 percent of Medicare methodology that we will use, the new allowed bill amount would be $1,400. Our benefit plan would cover 60 percent of the billable amount, so that's $840, and you would pay the remaining amount of $560.

Where it gets tricky and frustrating is that the out-of-network provider can then bill you for the difference between the original $30,000 bill and the $1,400 that our benefit plan allows. So, in addition to the $560 you would be responsible for, you could also end up owing your out-of-network provider $28,600. And that's happening more and more.

How out-of-network extreme billing practices affect our employees

Take a look at a local DFW FOX news story which will give you a better idea of how the extreme billing practices of out-of-network providers can affect our employees. (Note: Internet access is required to view the news story.)

What steps can you take?

The best thing you can do for yourself and for your dependents is to become an informed healthcare consumer. That means you should start asking questions before you visit a provider. Confirm with your healthcare administrator (Blue Cross Blue Shield or United Healthcare) that the provider is in-network before you visit and before services are provided. Don't rely on the provider and don't assume.

What if you have no choice but to go out-of-network?

Our policy isn't meant to restrict from the care you need. We're committed, as we've always been, to providing you with quality healthcare. And, that means our plans allow for limited exceptions to the out-of-network reimbursement policy. The Network Gap exception can be requested through your healthcare administrator *prior* to receiving the care.

And know that if you're faced with a true emergency, always go to the nearest emergency room, no matter if the hospital is in- or out-of-network. If you have a true emergency which results in an out-of-network emergency room claim, the claim will be paid at 100 percent of billed charges.