BALANCE BILLING **IN IDAHO** 2019

BOISE STATE UNIVERSITY
IDAHO POLICY INSTITUTE

BALANCE BILLING IN IDAHO
EXECUTIVE SUMMARY

There is growing concern about the financial burden of balance billing, or surprise billing, on individuals with private health insurance plans. Idaho has limited provisions concerning balance billing, but none that protect patients who are unaware they are receiving services outside their insurance carrier's network. Idaho residents receiving emergency care or major surgeries often do not choose their treating physicians, putting them at risk of being charged staggering amounts for out-of-network services. Research shows that balance billing disparities exist between geographic areas and service type which may point to private health insurance network inadequacies.

Half of states have full or partial protections for patients experiencing balance billing situations and legislation is currently being considered by Congress. The purpose of this report is to examine balance billing in Idaho. This study analyzes claims data provided by Idaho's major insurance carriers and a survey of physicians throughout the state. The findings confirm Idaho experiences similar trends in balance billing as other states. The results of this study could provide indication of overall network adequacy. The report concludes:

- In Idaho, roughly 1% of claims for Idaho residents are out-of-network. This figure jumps to over 2% for emergency out-of-network services.
- The results show there are noticeable differences in rates of out-of-network claims based on region, urban/rural designation and service type.
- In general, emergency service claims are more likely to be out-of-network compared to overall claims, a finding that is largely consistent when the data is broken down by region, urban/rural designation and service type.
- Rural counties tend to have higher rates of out-of-network claims overall, but urban areas have more issues with emergency services being out-of-network.
- Although some physicians indicate they balance bill patients, qualitative responses reveal some insurance carriers and physicians are willing to work with patients who are at risk of being balance billed.
- Actions taken to curb balance billing include engaging in case-by-case negotiations for out-of-network claims, offering income-based rates to ease the financial burden on patients and providing patients with referrals to other physicians.

WHAT IS BALANCE BILLING?

A balance billing charge is the difference between a health care provider's charge for medical services and the maximum amount of coverage paid by the insurance carrier.[1] An out-of-network claim occurs when a patient receives care from a physician that is outside their insurance carrier's provider network. Claims for out-of-network services can result in patients being balance billed, which potentially leads to staggering financial liability for patients.[2] Balance billing is also called surprise billing because patients are often not aware that medical services received are outside their insurance carrier's network. Research shows that balance billing is more likely for major surgeries and time sensitive emergency services.[3] "In some cases, use of an out-of-network provider is not an informed or voluntary choice."[4] Even Idahoans with private health insurance plans are at risk of being financially burdened by out-of-network medical bills. In emergency situations, patients do not choose which physicians care for them. If emergency physicians happen to be outside a patient's insurance network, charges for those out-of-network services may not be covered by a patient's insurance plan. Even if patients are able to choose an in-network hospital for non-emergency services, patients have no guarantee that every treating physician is in a particular network.

BALANCE BILLING LEGISLATION IN IDAHO

The state of Idaho has few regulations concerning balance billing. Balance billing of patients enrolled in managed care organizations, in cases where the provider has accepted a referral, is prohibited under Idaho administrative code. "Balance billing refers to the practice whereby a provider bills an individual covered under the benefit plan for the difference between the amount the provider normally charges for a service and the amount the plan, policy, or contract recognizes as the allowable charge or negotiated price for the service delivered."[5] Additionally, Idaho Code §§ 72-102(2) prohibits balance billing in regard to workers' compensation cases: "charging, billing, or otherwise attempting to collect directly from an injured employee payment for medical services in excess of amounts allowable in compensable claims."[6] However, these regulations do not apply to most out-of-network claims received by insurance carriers.

In the 2018 session of the Idaho Legislature, House Bill No. 495, the Health Care Billing Equity Act, was introduced and referred to the House Health and Welfare Committee.[7] HB 495 was intended to prohibit balance billing of patients for out-of-network services at in-network hospitals and emergency services. The bill defined balance billing as "the billing to a covered person by a health care provider of more than the coinsurance, copayment or deductible amounts owed by the covered person for covered benefits."[8] In the end, the bill stalled in committee.

BALANCE BILLING LEGISLATION NATIONWIDE

There are no balance billing limitations at the federal level. However, a bipartisan group of U.S. senators introduced the Lower Health Care Costs Act in June 2019 in order to address balance billing nationwide.[9] The bill was referred to the Senate Committee on Health, Education, Labor, and Pensions.[10] It was reported out of committee on July 8, 2019 and is awaiting action by the full Senate. The bill appears to have strong bipartisan support, including President Trump.[11]

States take various approaches to address balance billing. Nine states prohibit balance billing and another 16 have partial protections.[12] For instance, New York enacted legislation in 2014 that protects patients from out-of-network charges "in cases of emergency or circumstances in which the patient did not have a reasonable choice between an in-network and out-of-network provider."[13] While some states prohibit balance billing outright, other approaches include providing mediation for balance billing situations and creating all-payer claims databases used for research purposes.

OBTAINING DATA FROM PRIVATE HEALTH INSURANCE CARRIERS AND HEALTH CARE PROVIDERS

For this study, data about balance billing was collected in two ways: claims data provided by private insurers and a survey of health care providers. The insurance carriers included in this study are Aetna Health of Utah, Aetna Life Insurance Company, Blue Cross of Idaho, SelectHealth, Mountain Health CO-OP, PacificSource, Regence Blue Shield and United Health Care. Overall, seven insurance carriers are included in the claims data—accounting for 96.6 percent of all major medical claims submitted for Idaho residents in 2018—while eight carriers submitted open responses. Note that the largest insurance carrier accounts for roughly two-thirds of all claims included in this report.

The Idaho Department of Insurance requested that each major carrier submit data for all claims received for Idaho residents in 2018. Out-of-network claims were reported at the provider level. Carriers reported the total number of out-of-network claims, as well as the total amount billed and total allowed amounts for each out-of-network provider. Data submitted included the following information for each out-of-network provider: provider name, address, city, county, zip code, National Provider Identifier (NPI) and provider specialty. Each claim was categorized into one of the following nine service types: evaluation and management, medicine, pathology and laboratory, pharmacy and drugs, radiology, anesthesiology, surgery, transportation and supplies, or other (see appendix A for information about each service type). The same information was collected for in-network claims but at the county level. Carriers were asked to break out data for emergency services for both out-of-network and in-network claims. The data encompasses services received by Idaho residents in Idaho and neighboring states.[14]

Along with the claims data, carriers were also asked a series of open ended questions about how they determine allowable amounts for out-of-network services, policies on dealing with situations of balance billing and the number of balance billing complaints they receive.

Additionally, a survey of health care providers was administered in order to learn how health care professionals respond to balance billing situations, as well as their general thoughts about balance billing.[15] The survey was distributed to approximately 1,330 health care providers throughout Idaho that are members of the Idaho Medical Association. A total of 44 complete responses were gathered from the survey. The authors speculate the low response is due to providers not personally handling billing and the difficulty of tracking the information.

There are two primary data limitations that may influence the results. First, the seven carriers that submitted claims data account for 96.6 percent of all claims received for Idaho residents in 2018. However, the claims data does not encompass all private health insurance claims in Idaho. Smaller carriers were not included in this study and some claims data from major carriers could not be utilized due to incomplete information. Second, there is no way to determine the extent of financial liability that rests with patients. Survey responses indicated that some health care providers try to help patients in balance billing situations by offering discounts or income-based charges. This report does not include data about health care providers' charges.

SERVICES RECEIVED BY IDAHO RESIDENTS IN- AND OUT-OF-STATE

This report includes data for all claims from Idaho residents. The majority of claims are for services received in Idaho. However, some Idahoans receive health care services in other states, often because they live on the border near cities like Spokane, WA, Ontario, OR or Jackson, WY. This section includes data for out-of-state services used by Idaho residents in states bordering Idaho in order to reflect the full extent of residents' health care options.

The total number of claims for Idaho residents in each state is shown in Table 1, as well as the percent of claims for out-of-network services. Over 9 million claims were submitted to major carriers in Idaho in 2018 and just under one percent (73,351) were for out-of-network services. Just over 300,000 Idaho claims were for emergency services, while just over two percent were out-of-network. Idaho has a higher percent of out-of-network claims for emergency services than out-of-network claims in general. This suggests that Idaho follows the greater national trend of emergency services being overrepresented among out-of-network claims.

Table 1 suggests a similar trend when Idaho residents seek medical care outside the state. Residents seeking medical care outside Idaho are more likely to utilize an out-of-network provider, particularly for emergency services. Claims for Idaho residents occurring in Nevada have the highest proportion of out-of-network claims, possibly due to the lack of a population center near the Idaho-Nevada border. Neighboring states with larger population centers near Idaho have lower rates of out-of-network claims, namely Washington and Utah.

TABLE 1: TOTAL CLAIMS AND THE PERCENT OF OUT-OF-NETWORK CLAIMS BROKEN DOWN BY STATE (IDAHO RESIDENTS ONLY)

State	Total Claims	% Out-of-Network Claims	Total Claims for Emergency Services	% Out-of-Network Claims for Emergency Services
Idaho	9,028,216	0.8%	309,974	2.1%
Montana	11,980	5.6%	895	13.1%
Nevada	3,503	18.2%	415	35.4%
Oregon	68,415	7.3%	2,937	11.0%
Utah	202,232	1.9%	5,618	7.7%
Washington	431,765	1.8%	10,135	5.3%
Wyoming	6,917	4.9%	513	10.7%

Table 2 displays the total allowed amounts for out-of-network services divided by the total billed amounts, as well as the same calculation for emergency claims. In Idaho, 53 percent of the total amount of out-of-network claims were covered, compared to 65 percent for emergency services. Insurance carriers and health care providers may be more willing to alleviate a patient's financial burden for emergency claims. However, this trend is reversed in most other bordering states (except Montana) with lower allowable rates for emergency services than for out-of-network claims in general.

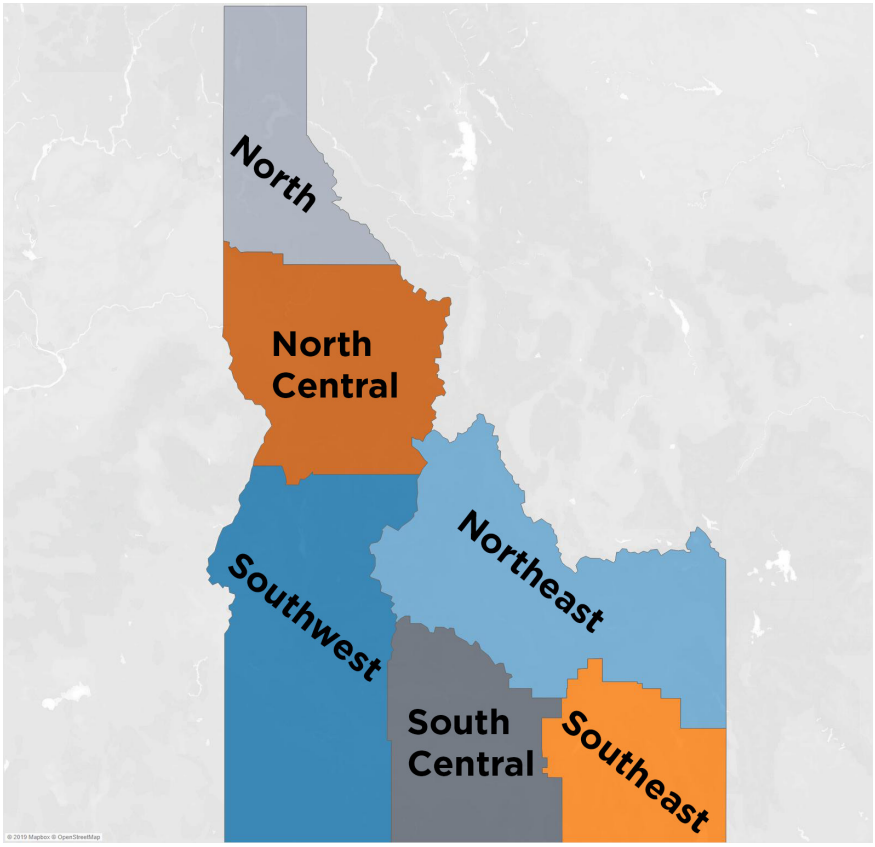
TABLE 2: PERCENT OF TOTAL CHARGES ALLOWED BY CARRIERS BROKEN DOWN BY STATE (IDAHO RESIDENTS ONLY)

State	% Allowed for Out-of-Network Claims	% Allowed for Out-of-Network Claims for Emergency Services
Idaho	53%	65%
Montana	77%	81%
Nevada	39%	30%
Oregon	82%	36%
Utah	51%	37%
Washington	56%	43%
Wyoming	60%	48%

REGIONAL DIFFERENCES

Some regions of Idaho have a higher percent of out-of-network claims than others, as shown in Table 3. Figure 1 displays the six regions of Idaho, as defined by the Idaho Department of Insurance. The North Central region has the highest percent of out-of-network services, while the Northeast region has the lowest percent. This reflects trends found in other states and nationally. "For some specialties and some geographic areas, access to in-network providers may be limited, making some patients feel compelled to use an out-of-network provider."[16]

FIGURE 1: IDAHO DEPARTMENT OF INSURANCE REGIONS



In terms of emergency services, the Southwest and Southeast regions have a notably high percent of out-of-network services, seen in Table 3. The Southwest region has the largest proportion of out-of-network claims for emergency services. Data for each county in Idaho can be found in appendix B. Along with regional differences, rates of general and emergency out-of-network claims vary by county. It is difficult to pinpoint the cause of these differences, but high percentages of out-of-network claims could indicate insurance network inadequacies.

TABLE 3: TOTAL CLAIMS AND THE PERCENT OF OUT-OF-NETWORK CLAIMS BROKEN DOWN BY REGION

Region	Total Claims	% Out-of-Network Claims	Total Claims for Emergency Services	% Out-of-Network Claims for Emergency Services
North	905,244	0.8%	39,900	1.1%
North Central	470,535	1.3%	22,790	1.2%
Southwest	4,474,141	0.8%	148,378	2.9%
South Central	775,776	1.0%	33,992	1.1%
Southeast	795,140	0.8%	21,477	2.6%
Northeast	1,607,380	0.6%	43,437	1.2%

TABLE 4: PERCENT OF TOTAL CHARGES ALLOWED BY CARRIERS BROKEN DOWN BY REGION

Region	% Allowed for Out-of-Network Claims	% Allowed for Out-of-Network Claims for Emergency Services
North	40%	53%
North Central	26%	53%
Southwest	58%	73%
South Central	44%	45%
Southeast	47%	33%
Northeast	59%	70%

Table 4 shows that the Southwest and Northeast regions had nearly 60 percent of out-of-network costs covered by insurance carriers, as opposed to only 26 percent in the North Central region. Similar to the statewide results, the allowed amount for emergency services was higher than for out-of-network claims overall in all regions except the Southeast.

DIFFERENCES BETWEEN URBAN AND RURAL AREAS

Research shows that urban and rural areas face different problems in terms of health insurance network adequacy. Table 5 confirms this trend. Urban counties have the lowest percent of out-of-network claims, while Counties with Extreme Access Conditions (CEAC) have the highest percent of out-of-network services. However, when emergency claims are isolated, the pattern reverses and urban counties have the highest percent of emergency out-of-network claims. Urban counties face more issues with emergency services, while rural counties have more instances of out-of-network claims broadly. A breakdown of these statistics can be found for each county in Idaho in appendix B.

TABLE 5: TOTAL CLAIMS AND THE PERCENT OF OUT-OF-NETWORK CLAIMS BROKEN DOWN BY URBAN/RURAL DESIGNATION

Urban/Rural Designation	Total Claims	% Out-of-Network Claims	Total Claims for Emergency Services	% Out-of-Network Claims for Emergency Services
Urban	7,522,242	0.8%	235,812	2.3%
Rural	965,940	0.9%	41,945	1.2%
CEAC	540,034	1.2%	32,217	1.6%

Table 6 shows that a higher proportion of emergency claims were covered by insurance carriers for urban and rural counties. CEACs saw greater coverage of general out-of-network services than emergency services. Again, this data suggests a trend that emergency services seem to be a more acute problem for urban counties. Notably, rural counties reported the lowest total allowed amounts of the three categories. Counties with the rural designation only saw 33 percent of out-of-network charges covered, as well as 47 percent for emergency service claims.

TABLE 6: PERCENT OF TOTAL CHARGES ALLOWED BY CARRIERS BROKEN DOWN BY URBAN/RURAL DESIGNATION

Urban/Rural Designation	% Allowed for Out-of-Network Claims	% Allowed for Out-of-Network Claims for Emergency Services
Urban	55%	67%
Rural	30%	47%
CEAC	58%	52%

SERVICE TYPE

Table 7 shows the percent of out-of-network services varies by service type. Anesthesiology, medicine, and transportation and supplies have relatively high rates of out-of-network claims. The percent of emergency out-of-network claims is generally higher for each service type, except transportation and supplies. Emergency anesthesiology claims show a high percentage of out-of-network claims, but total number of claims in this category is very low compared to other service types.

TABLE 7: TOTAL CLAIMS AND THE PERCENT OF OUT-OF-NETWORK CLAIMS BROKEN DOWN BY SERVICE TYPE

Service Type	Total Claims	% Out-of-Network Claims	Total Claims for Emergency Services	% Out-of-Network Claims for Emergency Services
Anesthesiology	62,859	1.4%	37	13.5%
Evaluation and Management	1,973,840	1.1%	154,370	2.4%
Medicine	2,666,465	1.7%	42,681	2.7%
Pathology and Laboratory	2,187,928	0.4%	43,722	2.6%
Pharmacy and Drugs	439,061	0.4%	8,017	3.0%
Radiology	779,229	0.5%	26,895	3.2%
Surgery	911,210	0.5%	30,326	1.9%
Transportation and Supplies	287,963	1.5%	18,640	1.4%
Other	444,473	0.1%	5,799	2.1%

There is significant variation in the allowable amounts for different service types. Anesthesiology and transportation and supplies claims had over two-thirds of the total out-of-network charges covered, whereas less than one-third of charges were allowed for medicine claims. In terms of emergency claims, pharmacy and drugs claims were covered at a rate of 86 percent, whereas medicine claims, again, were covered at a rate of less than one-third. Two interesting extremes to note are the general versus emergency allowed amounts for pharmacy and drugs and transportation and supplies. General out-of-network claims for pharmacy and drugs were covered at a rate 28 percent less than out-of-network emergency claims. However, for transportation and supplies, 71 percent of billed charges were covered versus only 28 percent for emergency service claims.

TABLE 8: PERCENT OF TOTAL CHARGES ALLOWED BY CARRIERS BROKEN DOWN BY SERVICE TYPE

Service Type	% Allowed for Out-of-Network Claims	% Allowed for Out-of-Network Claims for Emergency Services
Anesthesiology	68%	61%
Evaluation and Management	60%	68%
Medicine	29%	32%
Pathology and Laboratory	49%	49%
Pharmacy and Drugs	57%	86%
Radiology	60%	59%
Surgery	45%	48%
Transportation and Supplies	71%	28%
Other	85%	84%

MAJOR HEALTH INSURERS CURRENT PRACTICES

In order to identify current balance billing practices, an open ended questionnaire was distributed to eight major insurance carriers in Idaho. The questionnaire asked how insurers determined allowed payments, if differences existed between plan types, any exceptions, steps taken to reduce the likelihood of balance billing, claim totals, dollar totals and the outcomes of complaints. The following section summarizes their responses.

ALLOWED PAYMENTS

When asked how their organization determines allowed payment amounts for out-of-network claims, several of the major insurance carriers indicated that the out-of-network allowed amounts were either the same as the in-network allowed amounts or were a rate specified in a third-party industry database (such as Multiplan's Data iSight or FAIR Health). Federal standards, such as Medicare and the Affordable Care Act, also come into play for multiple insurers in determining allowed payment amounts.

Other relevant dimensions include the type of service, geography of the area, availability of the service in-network and emergency status. All of the major insurers indicated that there would be no difference in pricing between types of plans (such as managed care vs. PPO plans or group vs. individual plans), although some variation in the types of benefits offered would occur.

EXCEPTIONS TO STANDARD OUT-OF-NETWORK CALCULATIONS

There was variation among insurance carriers in exceptions to standard out-of-network payment calculations. Some indicated they require prior authorization before an out-of-network service occurs. This process may require an administrative review that includes

the rationale for the request, a determination of medical necessity and follow-ups handled by participating providers, among other factors.

Multiple insurers noted compliance with state or federal requirements as another area in which exceptions are allowed. Others indicated negotiations, either directly with out-of-network providers or through a third party that sets different rates.

That being said, two major insurers indicated that there were no exceptions to their standard out-of-network payment calculations.

REDUCING THE LIKELIHOOD OF BALANCE BILLING

Generally, there are three points at which insurers may take action to reduce the likelihood of balance billing: 1) before the service occurs, 2) before payment is made and 3) upon receiving a complaint from a customer. Insurers were asked to identify any methods they employed to reduce the likelihood of balance billing at each stage.

BEFORE SERVICE

Prior to the service occurring, the most commonly reported method used by insurers was to provide detailed information to customers on in-network providers and covered benefits. Another common response was to provide comprehensive information on how to obtain authorization for an out-of-network service before it occurs. This information could be relayed through a variety of methods, including printed literature, the insurers website or a customer service telephone line.

While not as widely reported, other alternatives include providing access to a national network, one-time-service contracts and prohibitions on contracted providers balance billing. Some insurers also reported providing additional training for both insurance brokers and health care providers to help reduce the likelihood of balance billing.

BEFORE PAYMENT

When asked about methods used to reduce the likelihood of balance billing after the service has occurred but before payment has been made, several insurers indicated taking no measures, as it is viewed as the member's responsibility at that point if they did not obtain prior approval. Some indicated that they may not even be aware of the service or provider involved at this point.

Several of the remaining carriers indicated that they work to have the out-of-network provider accept their fee schedule or otherwise negotiate a one-time cost.

UPON CUSTOMER COMPLAINT

When it comes to reducing the likelihood of balance billing following a customer complaint, several insurers indicated that they negotiate with providers in order to mitigate costs. Others indicated that they would investigate complaints and correct any errors discovered.

CLAIMS RECEIVED AND COMPLAINTS

As shown in Table 9, for 2018, responding insurers reported 13,039,174 claims in Idaho.[17] These claims resulted in $5,382,234,493 total dollars spent. Dollars spent per claim at the insurer level ranged from $370 to $932, with an average across insurers of $548.[18]
In terms of complaints, insurers reported receiving 261 total complaints in 2018, with 196 of those complaints resulting in lower bills for patients. Among six carriers that reported receiving complaints, an average of 52 percent resulted in lower bills.

TABLE 9: SUMMARY OF INSURANCE CARRIER OPEN RESPONSES

Measure	Value
Total Claims Received, 2018	13,039,174
Total Dollar Amount of All Claims, 2018	$5,382,234,493.00
Average Dollars Spent per Claim, 2018	$547.80
Total Complaints Received	261
Number of Complaints Resulting in Lower Bills	196
Average % of Complaints Resulting in Lower Bills	52.4%

RESULTS OF THE HEALTH CARE PROVIDER SURVEY

In order to better understand the role of health care providers in balance billing situations, a survey was distributed that asks health care providers contracting with insurance carriers how they determine whether to balance bill patients. A total 44 usable responses were recorded. Table 10 displays responses classified by the respondent's self-reported major

TABLE 10: SURVEY RESPONDENTS BY SPECIALTY

Specialty	Response Counts
Dermatology	3
Emergency Care	9
ENT	2
Gastroenterology	1
Nephrology	1
Neurosurgery/Neurology	4
Obstetrics/Gynecology	3
Orthopedics	6
Pain Management/Anesthetics	4
Pediatrics	1
Plastic/Cosmetic Surgery	2
Psychiatry	3
Pulmonology	1
Radiology	1
Urology	3
Total (15 specialties)	**44**

specialty. A total of 15 specialties were identified. The most common specialties include emergency care (9 responses), orthopedics (6), neurosurgery/neurology (4) and pain management/anesthetics (4).

Table 11 shows by specialty whether a respondent or their practice has been in a situation where they could not contract with an insurer due to disagreement on the insurer's proposed compensation/reimbursement rate for health care providers' services. Overall, out of a total 44 responses, 29 replied "Yes," suggesting they have disagreed with an insurance carrier's proposed compensation/reimbursement rate. As for the four major specialties with higher representation in the sample, seven out of nine in emergency care replied "Yes", five of six in orthopedics and four of four in both neurosurgery/neurology and pain management/anesthetics.

TABLE 11: HEALTH PROVIDER SURVEY RESULTS, UNABLE TO CONTRACT BROKEN DOWN BY SPECIALTY

Specialty	No	Not sure/Do not know	Yes	Total
Dermatology	1	1	1	3
Emergency Care		2	7	9
ENT			2	2
Gastroenterology	1			1
Nephrology			1	1
Neurosurgery/ Neurology			4	4
Obstetrics/ Gynecology	1	2		3
Orthopedics	1		5	6
Pain Management/ Anesthetics			4	4
Pediatrics	1			1
Plastic/Cosmetic Surgery			2	2
Psychiatry		1	2	3
Pulmonology		1		1
Radiology	1			1
Urology		2	1	3
Total (15 specialties)	**6**	**9**	**29**	**44**

Question: "Have you or your practice been in a situation where you could not contract with an insurer due to disagreement on the insurer's proposed compensation/reimbursement rate for physician services?"

Table 12 shows a simplified version of the previous table by reducing the 15 specialty categories to just two: emergency care and other. Out of the total nine responses in emergency care, seven replied that they have been in the situation of disagreement with an insurer's proposed compensation/reimbursement rate. On the other hand, 22 responses out of a total 35 responses in "Other" replied that they have been in the situation of disagreement with an insurer. Among survey respondents, more health care providers giving emergency care may have experienced instances of disagreement with an insurance carrier's proposed rates.

TABLE 12: HEALTH PROVIDER SURVEY RESULTS, UNABLE TO CONTRACT BROKEN DOWN BY EMERGENCY CARE

Emergency Status	No	Not sure/Don't Know	Yes	Total
Emergency Care		2	7	9
Other	6	7	22	35
Total	6	9	29	44

Question: "Have you or your practice been in a situation where you could not contract with an insurer due to disagreement on the insurer's proposed compensation/reimbursement rate for physician services?"

When asked what criteria they apply when determining whether to send a bill for the remaining cost of out-of-network services to the patient or to accept the allowed payment, respondents indicated they consider: 1) providing patients with information about the possibility of balance billing if rejected by the insurers, 2) making referrals to other providers in the patient's network, 3) balance-billing the remaining cost to patients and/or 4) making discounts/adjustments based on patients' ability to pay.

One noteworthy open ended response suggests that the role of balance billing gives providers leverage in negotiations with insurers. In the respondent's view, balance billing is the only leverage that providers have to encourage insurers to contract with them. If balance billing is completely eliminated, the respondent suggests insurers "can lowball us...and we are either stuck with that contractual payment, or we go out of network and thereby have some leverage for them to come back to the table with a better offer when their customers start receiving balance bills."

CONCLUSION

Idahoans with private health insurance plans face the possibility of being balance billed for out-of-network services, often without their prior knowledge. This report reveals that this is especially true for emergency services in parts of the state. The trends in balance billing in Idaho generally reflect those detected across the country by research in other states. This study found that in Idaho rural areas tend to have more out-of-network services, but urban areas have somewhat higher rates of out-of-network claims for emergency services. There are differences between regions with North Central Idaho seeing the least overall coverage for out-of-network claims. This research also points to significant differences between service types, particularly the low percentage of allowable payments made for medicine claims. This study points to some willingness of insurance carriers and physicians to help patients in instances of balance billing, especially in emergency care situations. However, it is difficult to know the extent that these practices result in lower bills for patients. Although more research and robust data collection is required for more nuanced analysis of balance billing in Idaho, this report sheds light on the trends in balance billing occurrences for Idaho residents with private health insurance plans.

APPENDIX A: SERVICE TYPE CATEGORIES

Anesthesiology encompasses all claims associated with anesthesia.

Evaluation and Management encompasses all claims related to the administration of services, such as record keeping, documentation and evaluation of operations.

Medicine encompasses all claims associated with a patient interacting with a provider for any medical services that fall outside of the other categories. Examples include clinic services, physical therapy, occupational therapy, home health, outpatient procedures, preventative care, therapeutic services, vision and dental, among others.

Pathology and Laboratory encompasses all claims associated with any pathology or testing, such as bloodwork or other diagnostic services that require specialized laboratory evaluation.

Pharmacy and Drugs encompasses all claims related to pharmaceuticals or intravenous (IV) injections.

Radiology encompasses all claims related to administering and evaluating x-rays or medical imaging diagnostics, including magnetic resonance imaging (MRI) and electrocardiograms (EKG), among others.

Surgery encompasses all claims in which the patient has received surgical services, including the surgical procedures themselves, operating room services, intensive care services, surgical care administered in an ambulance and organ transplants.

Transportation and Supplies encompasses all claims associated with direct transportation of the patient (such as in an ambulance) as well as the provider's supplies. These supplies include medical equipment, such as wheel chairs or heat lamps, room and board, oxygen stores, blood supplies, and any other supplies necessary for the provider's facility to function.

Other encompasses any claims that did not fall into one of the other listed categories.

APPENDIX B: COUNTY INFORMATION

TABLE B1: COUNTY TYPES BY POPULATION AND DENSITY

County Designation	Population	Density
Large Metro	≥ 1,000,000	≥ 1,000/mi^2
-	500,000 – 999,999	≥ 1,500/mi^2
-	Any	≥ 5,000/mi^2
Metro	≥ 1,000,000	10 – 999.9/mi^2
-	500,000 – 999,999	10 – 1,499.9/mi^2
-	200,000 – 499,999	10 – 4,999.9/mi^2
-	50,000 – 199,999	100 – 4,999.9/mi^2
-	10,000 – 49,999	1,000 – 4,999.9/mi^2
Micro	50,000 – 199,999	10 – 99.9 /mi^2
-	10,000 – 49,999	50 – 999.9/mi^2
Rural	10,000 – 49,999	10 – 49.9/mi^2
-	<10,000	10 – 4,999.9/mi^2
Counties with Extreme Access Conditions (CEAC)	Any	<10/mi^2

Source: Table 3-1: Population and Density Parameters in CMS, Medicare Advantage and Section 1876. https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/2018-Network-Adequacy-Guidance.pdf (Accessed May 5, 2019), p.8.

TABLE B2: COUNTY TYPES IN IDAHO

County Designation	#	Counties
Metro (Urban)*	3	Ada; Canyon; Kootenai
Micro (Urban) *	5	Bannock; Bonneville; Madison; Payette; Twin Falls
Rural	12	Benewah; Bingham; Bonner; Franklin; Gem; Gooding; Jefferson; Jerome; Latah; Minidoka; Nez Perce; Teton
CEAC	24	Adams; Bear Lake; Blaine; Boise; Boundary; Butte; Camas; Caribou; Cassia; Clark; Clearwater; Custer; Elmore; Fremont; Idaho; Lemhi; Lewis; Lincoln; Oneida; Owyhee; Power; Shoshone; Valley; Washington
Total	44	

Source: CMS, HSD_2019_Reference_File_2018-08-01, (2019) https://www.cms.gov/medicare/medicare-advantage/medicareadvantageapps/index.html (Accessed May 5, 2019).

* In the preceding analysis, Metro and Micro categories were collapsed into a single Urban category.

TABLE B3: TOTAL CLAIMS AND THE PERCENT OF OUT-OF-NETWORK CLAIMS BROKEN DOWN BY COUNTY

County	Total Claims	% Out-of-Network Claims	Total Claims for Emergency Services	% Out-of-Network Claims for Emergency Services
Ada	3,697,209	0.8%	104,750	2.2%
Adams	2,222	0.8%	38	0.0%
Bannock	512,956	1.0%	12,659	4.0%
Bear Lake	16,029	0.6%	914	0.0%
Benewah	20,132	0.6%	1,412	1.5%
Bingham	203,728	0.4%	4,963	0.3%
Blaine	122,999	0.9%	6,162	0.0%
Boise	2,182	2.2%	69	8.7%
Bonner	130,557	1.1%	5,253	3.3%
Bonneville	1,274,907	0.5%	32,248	1.3%
Boundary	20,365	0.8%	1,076	0.3%
Butte	14,350	0.1%	595	0.0%
Camas	647	0.2%	4	0.0%
Canyon	620,137	0.7%	32,316	5.8%
Caribou	22,649	0.3%	1,011	1.8%
Cassia	80,472	2.7%	2,842	11.8%
Clark	*	*	*	*
Clearwater	27,812	2.4%	1,981	1.8%
Custer	4,213	0.7%	38	0.0%
Elmore	32,720	0.4%	2,523	0.4%
Franklin	20,762	0.3%	706	0.1%
Fremont	8,918	0.9%	196	0.0%
Gem	22,371	0.5%	1,914	1.4%
Gooding	28,100	1.7%	2,816	0.1%
Idaho	49,094	0.3%	3,704	0.8%
Jefferson	50,547	0.3%	104	1.0%
Jerome	38,629	0.3%	3,507	0.1%
Kootenai	715,844	0.7%	30,491	0.8%
Latah	163,091	1.3%	7,752	1.5%
Lemhi	22,583	1.9%	1,781	2.4%
Lewis	488	17.8%	25	0.0%
Lincoln	2,812	1.7%	20	0.0%
Madison	203,813	0.5%	7,046	0.8%
Minidoka	29,924	1.1%	2,761	0.7%
Nez Perce	230,050	1.3%	9,328	1.1%
Oneida	9,455	0.6%	542	0.0%
Owyhee	5,061	3.9%	77	0.0%
Payette	25,183	1.2%	422	0.9%
Power	9,561	1.2%	682	1.0%
Shoshone	18,346	2.9%	1,668	0.2%

TABLE B3 (CONT.)

County	Total Claims	% Out-of-Network Claims	Total Claims for Emergency Services	% Out-of-Network Claims for Emergency Services
Teton	28,049	1.7%	1,429	1.4%
Twin Falls	472,193	0.8%	15,880	0.1%
Valley	48,232	0.8%	4,879	0.1%
Washington	18,824	0.5%	1,390	1.7%

* Claims data indicates no claims were made in Clark County, Idaho.

TABLE B4: PERCENT OF TOTAL CHARGES ALLOWED BY CARRIERS BROKEN DOWN BY COUNTY

County	% Allowed for Out-of-Network Claims	% Allowed for Out-of-Network Claims for Emergency Services
Ada	57%	73%
Adams	50%	*
Bannock	45%	34%
Bear Lake	41%	*
Benewah	49%	36%
Bingham	59%	45%
Blaine	64%	93%
Boise	68%	79%
Bonner	43%	48%
Bonneville	60%	72%
Boundary	58%	86%
Butte	59%	*
Camas	27%	*
Canyon	70%	73%
Caribou	54%	17%
Cassia	58%	44%
Clark	**	**
Clearwater	84%	97%
Custer	17%	*
Elmore	52%	32%
Franklin	74%	44%
Fremont	79%	*
Gem	53%	40%
Gooding	80%	40%
Idaho	44%	42%
Jefferson	51%	78%
Jerome	71%	77%
Kootenai	39%	59%
Latah	62%	68%
Lemhi	77%	60%
Lewis	92%	*

TABLE B4 (CONT.)

County	% Allowed for Out-of-Network Claims	% Allowed for Out-of-Network Claims for Emergency Services
Lincoln	64%	*
Madison	67%	65%
Minidoka	60%	52%
Nez Perce	17%	33%
Oneida	66%	*
Owyhee	67%	*
Payette	70%	55%
Power	58%	28%
Shoshone	72%	76%
Teton	73%	56%
Twin Falls	37%	64%
Valley	71%	48%
Washington	76%	64%

* Claims data indicates no Emergency Claims were made in these counties.
** Claims data indicates no claims were made in Clark County, Idaho.

ENDNOTES

1 Kyanko, K., Curry, L., & Busch, S. (2013). Out-of-Network Physicians: How Prevalent Are Involuntary Use and Cost Transparency? HSR: Health Science Research, 48(3), 1154-1172.

2 Kyanko, K., Pong, D., Bahan, K., & Curry, L. (2013). Patient Experiences with Involuntary Out-of-Network Charges. HSR: Health Science Research, 48(5), 1704-1718.

3 Gomez-Aquinaga, B., Sanchez, G., Griego, E. and Howarth, S. (2017). Surprise Medical Billing in New Mexico. Center for Health Policy at the University of New Mexico. <http://healthpolicy.unm.edu/sites/default/files/OSI_RWJF_Surprise_Medical_Billing_Study_12.20.17.pdf>

4 Kyanko, K., & Busch, S. (2013). The Out-of-Network Benefit: Problems and Policy Solutions. Inquiry, 49, 352-361. Page 353.

5 Rule to Implement the Managed Care Reform Act. IDAPA 18.04.04.002.02 (2019) <https://adminrules.idaho.gov/rules/current/18/180404.pdf>

6 Also see Idaho Code §§ 72-432(6).

7 Idaho Legislature Website. (2019). House Bill No. 495. <https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2018/legislation/H0495.pdf>

8 Idaho Legislature Website. (2019). See note 7 above.

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14 Idaho's neighboring states are Montana, Nevada, Oregon, Utah, Washington and Wyoming.

15 Survey of health care providers was distributed in collaboration with the Idaho Medical Association.

16 Kyanko and Busch (2013), p. 353. See note 4 above for citation.

17 The total number of claims reported in this section differs from total claims in previous sections because some carriers count individual claims under multiple service codes. Additionally, some claims data was excluded from analysis due to incompleteness of data.

18 In order to better capture the variation across insurers, each insurer's dollars spent per claim was used to calculate the average dollar amount.

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