ALTARUM
HEALTHCARE VALUE HUB

Glossary: Surprise Medical Bills

Across a number of surveys, approximately 1/3 of privately-insured Americans report receiving medical bills for which a health insurer paid less than the patient expected. Both States and the Federal government are looking at a range of solutions to address the problem – particularly the situation where a patient receives an unexpected bill from an out-of-network provider when they thought they were receiving in-network care or had to get emergency care. This glossary lists some terms you may encounter when reading about this issue.

Term	Acronym	Definition
Balance Billing		When you receive services from a doctor or hospital that does not participate in your insurer's network, that provider is not obligated to accept the insurer's payment as payment in full and may "balance bill" you for the remaining, unpaid amount.
Employee Retirement Income Security Act	ERISA	A 1974 federal law that sets minimum standards for most retirement and health plans in private industry in order to provide uniform, federal regulation of these plans. The upshot of ERISA is that states cannot regulate health plans where the employer is the ultimate insurer (self-funded plans) but can regulate health plans that are full funded.
Fully Funded Plan		A plan where the health plan bears the risk for covering the claims of the enrolled population. These plans are regulated by state regulators and typically are purchased by individuals and small employers.
Health Maintenance Organization	HMO	A type of health plan that provides healthcare coverage through a network of hospitals, doctors and other healthcare providers. Typically, the HMO will not pay for care that is provided by out-of-network providers.
In-network Provider		Hospitals, pharmacies and doctors who have contracted with the health plan. These hospitals and doctors agree to the plan's rules and fee schedules and agree not to charge or "balance bill" patients for amounts beyond the agreed upon fee.
Network Adequacy		A health plan provider network's ability to deliver adequate care to patients. This involves delivering the right care to a patient at the right time, without having to travel unreasonably far to access providers in their network.
Out-of-network Provider	OON	Doctors, pharmacies, hospitals, and other healthcare providers who have not contracted with a given health plan are "out-of-network." This means that the insurance company has not negotiated rates with them, and may limit coverage of services by these providers. Using out-of-network providers often results in higher out-of-pocket costs for patients.

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Preferred Provider Organization	PPO	A type of health plan that provides healthcare coverage through a network of providers. Typically the PPO requires you to pay higher costs if you seek care from out-of-network providers.
Private Health Insurance		Health insurance offered by a private entity instead of the state or federal government.
Provider Directory		A directory of in-network providers, generally provided by an insurer, to help enrollees find in-network care.
Qualified Health Plan		Health plans that are sold in the marketplace under the Affordable Care Act (ACA).
Self-funded Plan (also self-insured plan)		A plan where the employer or union assumes the financial risk for providing healthcare benefits to enrollees. These plans are regulated by the U.S. Department of Labor and are typically associated with large employers.
Surprise Medical Bill	SMB	Any medical bill for which a health insurer paid less than the patient expected. Surprise bills can come from in-network or out-of-network providers.