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Surprise Billing: No Surprise In View Of Network Complexity

Simon F. Haeder, David L. Weimer, Dana B. Mukamel

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Bipartisanship is in the air in Washington, D.C. Well, at least on one issue that has frequently made the news over the past several years: surprise, or balance, billing. Driven by devastating stories in the popular press, a slew of proposals have been introduced in Congress over the past year. While diverse in their approaches, all of the proposals seek to increase consumer protections and shield patients from unexpected and often outsized bills. President Donald Trump has expressed his support for these efforts. Without a doubt, federal action on the issue is long overdue.

Yet, ultimate success seems far from certain, as jousting among competing stakeholders has replaced the usual partisan quarrels in D.C. Moreover, while surprise billing has unquestionably caused great individual harm, the current debate has largely missed two other important problems related to provider networks: inaccurate provider directories and inadequate provider networks. These problems are inherently complex, harder to turn into news stories, and defy simple solutions. Yet, they also affect a much larger number of Americans' financial and physical well-being than does surprise billing.

Surprise!

As generally defined, surprise billing refers to unanticipated bills hailing from circumstances in which consumers sought services at an in-network medical facility such as a hospital or ambulatory surgery center. However, during their treatment, they unknowingly received services from an out-of-network provider. Usually, the out-of-network provider sends a bill to the consumer's insurance company, which pays a certain amount for the services. The remainder, or balance, of the bill is then sent to the consumer. Stories about surprise billing have been reported with increasing regularity in the nation's media, and scholarly work has begun to shine a light on the issue. Importantly, these bills are not just a nuisance but often can amount to tens of thousands of dollars, sometimes financially crippling those who receive them.

Not all specialties are equally subject to this phenomenon. The usual culprits are specialists such as anesthesiologists, emergency department physicians, and radiologists. Indeed, for many of them rejecting network contracts has become a deliberate business strategy for maximizing reimbursement. Limited competition, combined with episodic but urgent and unplanned demand by patients, makes this strategy feasible for these specialists. Moreover, in addition to differences across specialties, there appears to be significant geographic differences in the prevalence of surprise billing. Several states, including California and New York, have taken action to limit consumers' exposure to surprise bills. And unquestionably, they have had some success, as a number of consumers have benefitted from the newly established state-level protections. However, states are legally limited by the restrictions of the Employee Retirement Income Security Act of 1974, leaving millions of Americans—whose employers self-insure—in harm's way, unless there is also federal intervention.

Current Proposals At The Federal Level

Judging by the increasing number of bill introductions and hearings, federal policy makers seem ready to address balance billing. Much has been written about the subject in blogs on this site (see, for example, here, here, here, and here). The subject is complex, and, unsurprisingly, proposals differ widely on important dimensions, such as the degree of consumer protections or to which medical entities or procedures they apply. At the most basic level, proposals have sought to provide more information to consumers when making choices

about seeking medical services. In fact, the federal government has already taken steps to increase price transparency for consumers. Earlier this year, the Centers for Medicare and Medicaid Services required that all hospitals make public their charged prices. Of course, prices often bear little resemblance to actual payments. To make things worse, billing codes are virtually impossible for consumers to decipher so that the ultimate effect of this type of increased transparency on surprise billing will likely be negligible.

Proposals currently introduced in Congress have taken a more aggressive stance. Virtually all of the proposals include hold-harmless provisions that protect consumers from balance billing. These proposals generally limit consumers' financial exposure to those out-of-pocket payments they would have been responsible for at an in-network provider for the same procedures. Of course, this leaves the question of payment settlement between the insurer and the provider. Vast differences in the proposals emerge with respect to payment settlement. Some proposals simply require insurers to pay providers in full. Others include mediation or arbitration components. Yet, others rely on benchmarks, such as a percentage of reimbursements for Medicare or commercial insurance products. Various combinations of these approaches also abound. Finally, other proposals have sought to expand the use of bundled payments for certain medical episodes that force facilities and individual providers to come to an agreement. Alternatively, providers could be required to enter into networks that match those of the facility in which they practice. This is referred to as network matching or in-network guarantee. Not surprisingly, with large sums at stake, stakeholders have been vocally defending their positions on the issue.

Thinking More Broadly

To date, the focus of the media and policy makers has largely been on surprise billing related to out-of-network charges; that is, circumstances created primarily when patients find themselves in urgent and unplanned situations requiring care, when they do not have the option of searching for a network provider. Yet, inherently similar situations can also arise from certain aspects of network design, specifically, two factors that can frustrate and overwhelm patients when they search for in-network providers.

First, consumers may face unexpected out-of-network charges because of their reliance on inaccurate provider directories. That is, consumers may seek care from what they think is an in-network provider based on the directory they received from their insurer, but later find out that the provider has either left the network or was never part of it to begin with. Provider directory accuracy may seem pedestrian, but it can be a major problem for consumers. And the problem is ubiquitous and significant. Our previous research found that network accuracy is rather dismal, both inside and outside Affordable Care Act Marketplaces, as "secret shoppers" were only able to schedule appointments in 29 percent of cases for plans sold outside of Covered California and 27 percent of cases sold on Covered California (see here). Of course, providing real-time, accurate information to consumers can be a Herculean feat. Nonetheless, the issue deserves more attention in the current debate about solutions to surprise billing. The recent bipartisan reform efforts presented by Senators Patty Murray (D-WA) and Lamar Alexander (R-TN) appear to be the first to pay any, albeit limited, attention to this issue, yet it has received remarkably little media coverage.

Second, current proposals addressing balance billing are solely focused on circumstances in which consumers are "surprised" by the out-of-network treatment and associated costs. Yet, there may be even more frequent circumstances where consumers are confronted with potentially inadequate networks that do not offer reasonable access to providers. Specifically, providers in the network may be too far away, may not have convenient service hours, may not offer timely appointments, may not offer services in the consumer's language, or may not be accessible via public transportation. This may force consumers to knowingly seek care, especially urgent care, outside of their network, understanding full well that they will face higher charges. As we show in our forthcoming paper, regulations on network adequacy differ vastly based on program, state, or product type, and are often inherently meaningless. To make things worse, standards are not empirically grounded, and compliance is rarely actively monitored by regulators. Ultimately, the standards often offer but a mirage of appropriate access.

The Path Forward

Surprise billing is getting prominent attention in the nation's media. It makes for good stories––outsized bills thrust upon sick and struggling patients often stuck between two uncaring bureaucracies. In today's polarized polity, seldom do Americans from both sides of the aisle agree that something is inherently wrong, as they do in this case. And no question, surprise billing has caused significant harm to consumers. Not surprisingly, policy makers from both parties are starting to jump on the bandwagon. Nonetheless, in view of the high stakes involved and the remarkable lobbying clout of insurers and providers, the outcome is far from certain.

The current solutions to surprise billing being discussed in Congress and in the media are all focused on the situations that arise when patients encounter providers in urgent and unplanned situations, such as a non-network specialist called in to consult during a complication for a patient in a network hospital. In these unplanned, urgent cases, patients have no opportunity to "search and shop" for an in-network specialist. Indeed, patients may not even be aware that out-of-network physicians participated in their care because they never had direct contact with them. All proposals being debated before Congress are designed to address this situation.

Yet, these proposals are not going to fix the surprise billing issues that arise from network design decisions. Indeed, one might argue that these high bills are not really "surprises," especially in the second case, described above, in which patients do not have an adequate supply of physicians within a reasonable distance and therefore make a choice to see a non-network provider. However, the financial implications of these choices are just as horrific and disastrous for individuals, and should be addressed as well. They may be arguably more detrimental because consumers may delay or defer care to avoid out-of-network charges. The solution, however, is likely to be through reform or regulation of network design rather than financial regulation of non-network providers. Crucially, improving the accuracy of provider directories, ensuring network adequacy, and improving network quality, all of which affect a larger number of Americans, defy easy solutions because of the inherent complexity, large resources required, and unclear trade-offs involved. And, of course, they lack the extensive attention of the media and policy makers that surprise billing has garnered.

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Provider networks are a tool to give greater control to the private insurers, to the detriment of patients (loss of provider choice, surprise bills, etc.). Networks are not particularly effective in controlling costs, as demonstrated by the fact that payments through private insurers are much higher than those of Medicare and Medicaid public insurers. Also networks further burden the health care system with yet more administrative waste - a uniquely American feature of health care financing.

In contrast, a well designed, single payer model of Medicare for All has, in essence, a single universal "network" of health care professionals and institutions. Besides, since cost sharing would be eliminated (as in HR 1384 - Jayapal), there would be no surprise bills because there are no bills at all. The entire system is prepaid through equitable taxes while remaining affordable for society through the economic tools of a single payer system (global budgeting, negotiated rates, separate budgeting of capital improvements, etc.).

Why do we want to keep tweaking our highly dysfunctional, wasteful, inequitable system that leaves so many uninsured and underinsured, when improving and expanding Medicare to cover everyone would fix our problems at a cost we could afford?

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7500 Old Georgetown Road, Suite 600

Bethesda, Maryland 20814

T 301 656 7401

F 301 654 2845

customerservice@healthaffairs.org

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