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EDITORIAL

Beyond Balance Billing

Imagine the following scenario which, regrettably, is all too common. You are admitted to the hospital for an elective procedure and something goes awry. A super sub-specialist is called in to help and while you did all of your due diligence to have a procedure in a hospital in your network, you subsequently receive an unanticipated bill from the sub-specialist for thousands of dollars. You *thought* you were covered; after all, you made an extra effort to confirm that your physician was in the network. What you failed to do was to ask your physician a question that most patients would never think of: "if something goes wrong, are the specialists whom you may call on to help covered by my current plan?" I think that most folks – even those with a health care background – would never consider such a question and, as a result, are at risk of facing a situation that I call "beyond balance billing."

Let's first put this in context, as it relates to the policies of organizations like the Centers for Medicare and Medicaid Services (CMS), and then juxtapose the tactical reality of the behavior inside a "narrow network."

In March 2015, CMS published five "statements" that define their strategic vision for the future of all quality reporting programs.[1] Put together, these vision statements articulate a future state where quality measurement and public reporting play a critical role in healthcare quality improvement: "….CMS quality reporting programs are guided by input from patients, caregivers, and healthcare professionals…feedback and data drives rapid cycle quality improvement…public reporting provides meaningful transparent, and actionable information…quality reporting programs rely on an aligned measure portfolio…quality reporting in value-based purchasing program policies are aligned." These laudable policy statements are the key components of the CMS physician-specific quality apparatus for the near term. Nowhere does it say, "Be careful, you could be balance-billed by practitioners outside of your network."

Opposite CMS are the private payers, such as Aetna, Cigna, and Anthem. They are responding to the pressures of the Affordable Care Act by creating so-called "narrow networks," those that limit patients' choice of hospitals and physicians to roughly 50% of those covered within a specific area.[2] These networks are established using traditional and non-traditional insurance tools. For example, traditionally speaking, networks are established to help drive patients to "higher quality providers" who deliver services with a good outcome at a competitive price. This nicely connects to those five aforementioned CMS strategies, whereby everyone is transparent regarding his total charge and outcome with a particular procedure or test. This represents the ideal scenario.

Non-traditional network construction might borrow some of those same attributes, but also be more focused on reducing professional fees and reducing costs *across the board*. Ideally, narrow networks should also deliver high value (good outcome at a very low price), but in practice, narrow networks have come under criticism because patients do not understand the choices available to them; frequently they are surprised when hospitals and doctors do not appear in the network in their particular marketplace. Clearly, there is plenty of blame to go around here as it relates to both traditional and non-traditional narrow network design and construction.

However, "beyond balance billing" is a real syndrome. In a recent *Modern Healthcare* story,[3] even physicians who are admitted to a hospital may not recognize the extent to which they are liable for balance billing by non-participating specialists who may not be in the narrow network, whatever its fundamental design. As patients, physicians may be able to have such charges reversed or diminished, but the average, well-meaning patient with good private insurance, albeit in a narrow network, may have no idea as to which specific providers are covered. It is unrealistic to expect the average patient to ask, "Who is my anesthesiologist? Who is the pathologist who will review my biopsy? What if the pathologist consults with a colleague in an institution outside of the insurance company's network?"

This is another example of the consequences of our fractured non-system. With good intentions, CMS and the private payors want networks that will deliver high quality, low cost care that all consumers would appreciate. In practice, because hospitals and doctors are largely separate entities, we are faced with the conundrum of balance billing from persons most patients will never meet face to face. No wonder our patients are frustrated with the care we deliver and public policy makers want reform!

What recourse do we really have in this very complex situation? I believe, from a policy perspective, we ought to commit to the following:

- Let's ban balance billing altogether and prohibit providers from billing patients for more than the agreed upon co-payment or deductible.[2]

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- Let's make the bills that patients receive easier to discern and drop arcane language that only an actuary would appreciate.

- In addition, let us mandate that insurance companies "shelter" plan members[2] from balance billing in at least certain specific clinical situations and let's provide a public list of said emergency situations that everyone can agree to.

- Let's implement a dispute resolution process akin to the one that already exists in the state of New York to keep these kinds of matters out of the courts and make the findings of the dispute resolution apparatus completely transparent and publicly available online.

- Finally, let's be frank about both traditional and non-traditional narrow network design and construction by giving our patients all the information they need to make an informed purchase decision.

We cannot hold patients responsible, *a priori*, for every potential financial contingency relative to their care, either in a planned or emergent situation. We can provide transparency about our clinical services and certainly more information about what specific providers actually do on a day to day basis. Narrow networks, in my view, are a good idea. Let's make them agile for the future by promoting unprecedented levels of transparency and public accountability.

David B. Nash, MD, MBA
Dean
Jefferson College of Population Health
David.Nash@jefferson.edu

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