COVID-19, BALANCE BILLING, OUT-OF-NETWORK CLAIMS, AND CONFUSING CHARGES – AN UGLY COMBINATION

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The COVID-19 crisis has sparked a discussion on an old, but repeatedly important and troublesome issue: balance billing and/or overbilling. During the early days of the COVID-19 crisis, news outlets were quick to report examples of health insurance coverage confusion, network issues, and billing issues, all related to a variety of COVID-19 claims.

In April, the federal government chose to tackle this concern by placing prohibitions on how providers could bill COVID-19 patients who received services from providers receiving funds under the Public Health and Social Services Emergency Relief Fund.

This attempt to control balance billing and excessive charging practices led to media confusion, with numerous media outlets reporting that the federal government had banned all balance billing and/or all surprise billing, which was not the case.


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The confusion on this basic attempt to stymie out of control billing, during a health crisis, highlights to need to discuss, yet again, the ever-pressing problem of balance billing, cost, network controls, and why excessive balance billing continues to happen.

Practically speaking, when a member receives a balance-bill, the employer itself, the sponsored health plan, and the payer all go into "panic mode," which is understandable.

It is no secret that hospital chargemasters are essentially arbitrary. Leaving aside the fact that many plans have engaged a patient advocacy solution to assist with balance-billing, many health plans, TPAs, brokers, and patients want to know: Who's to blame, and why is balance-billing allowed to happen? What is really going on when a provider balance-bills a patient? What can be done to avoid it?

WHO'S TO BLAME?

It's easy and intuitive to blame medical providers for overbilling. The bill has the hospital's name on it, and the bill is designed to compensate the hospital for use of its operating room, staff, and other resources. But blaming the provider is like blaming a person for taking advantage of a large loophole. It's a dog-eat-dog world out there, and most of us take advantage of loopholes.

Nothing illegal, hopefully, but if something is within our legal rights and it saves or makes us money, most people can reasonably be expected to operate within the parameters of that advantageous loophole.

Instead, perhaps we should scrutinize the legal regulatory authority. For years there have been certain legislative proposals in the works, both on the federal and state levels, that would effectively limit provider billing to a more reasonable amount, or at the very least provide a system of checks and balances.

As it stands, though, alarmingly few laws like this exist today, and those that do tend to favor providers far more than any fairness they offer to health plans or patients. The reason? Everyone is stuck in the past.

The old system, where insurers have unlimitedly deep pockets, is not at all the case with self-funding, yet that still seems to be the mentality that legislatures and medical providers are using. Until there is a meaningful legislative change to add some sort of limitation on, or even a reasonable formula that must be followed by, provider billing, there won't be any change to the paradigm where any price goes.

WHAT IS REALLY GOING ON?

Over years of dealing with overbilling and the problems it creates, it has become clear to many in the industry that hospitals do not really expect to get paid their gross charges. Hospitals do not collect, nor do they intend to collect on balance-bills. It seems that the collections threats are scare tactics used to gain higher payments from health plans, as many plans will do whatever it takes to protect the patient. With some plans, that tactic works well; other plans call a hospital's bluff.

Think of it this way: when I walk into my local bike shop and ask for a tune-up, they quote me $179. Does it actually cost them the full $179 to provide the service? Probably not. *Could* they charge less? Sure. But the market bears it, and, more importantly, there's no law prohibiting the shop from charging that fee.

Many suggest comparisons to other markets are inappropriate, since there's a third-party payor (i.e. insurance) involved – but that does not fundamentally change the dynamic except to remove the relevance of the "the market bears it" factor.

The medical services industry is not a "free market" since in most cases, expecting patients to actually shop around is extremely unrealistic; without the market-bearing aspect, we are left with only the reasoning of "there is no law against it." For payors, that is not a good enough justification for such inflated, arbitrary billing.

WHAT CAN BE DONE ABOUT IT?

How about patient advocacy? With respect to plans that systematically allow non-network claims at any amount less than full billed charges, most have adopted some form of patient advocacy or defense, to attempt to minimize the noise

and impact of balance-billing, protect patients, and still ultimately save money on claims. That is what reference-based pricing vendors typically aim to accomplish and most do a pretty good job.

But, no matter the vendor, there are still some providers who simply will not go away without a big fight. The prevailing reference-based pricing mentality seems to be that no network is the best network, and for some plans that works very well.

It depends on the employee population, employer's risk tolerance, geographical location, and provider population density (and potentially other factors), and a health plan's friendly neighborhood RBP vendor or broker are in the best positions to advise on that aspect – but at the end of the day, small, regional networks have tended to be a key to successful reference-based pricing for many health plans.

DIRECT CONTRACTS & NARROW NETWORKS

"Narrow networks" constitute a middle ground between a direct contract with a provider and a traditional PPO model; although some large national networks now offer certain "narrow network" options, a health plan or TPA can create a de facto narrow network by simply contracting with a small curated group of providers.

By picking and choosing providers, the payor is able to limit the size of the network (making the steerage created more valuable to each individual provider) and ensure that providers make certain concessions in exchange for the increased steerage.

"Custom" narrow networks can exponentially increase steerage for the chosen providers, but keep in mind that to many providers, the decision of whether to contract, or what rate to offer, depends on the volume of steerage – and volume is measured in number of lives, not in percent of lives.

In other words, a health plan that contracts with two local physicians will in theory give each provider 50% of its total steerage, which is a very attractive percentage – but when the hospital asks how many lives make up that 50%, if the answer is 25 lives, the conversation is going to become much more difficult.

If, however, the answer is 2,500 lives, you may have another story. That is one reason that TPAs often negotiate direct contracts across an entire block of business – however, that may leave the hurdle of having all groups potentially opted-in to the contract, possibly without wanting to be.

WHAT DOES THE FUTURE HOLD?

A couple of years ago, we at The Phia Group conducted a survey. One of the questions was "How do you view reference-based pricing?" The results were as follows:

- 76% of responders said, "Catalyst for change (part of a greater solution that will be a long term answer)."
- 14% of responders said "Stop-gap (a band aid that won't resolve excessive healthcare costs long term)."
- 6% of responders said "Harmful (once enough people get balance billed, we'll look bad and it will become prohibited by law)."
- 4% of responders said, "The whole shebang (the way to permanently solve healthcare price gouging)."

State surprise billing legislation definitely seems to be a step in the right direction toward curbing provider billing (although some states have shifted a higher burden onto the health plan rather than truly limiting billing). It is difficult to tell whether the rise of reference-based pricing has been a catalyst for that change, or simply the self-funded industry realizing, fifteen years ago, what legislatures have only just begun to realize in the last few years. ■