Surprise Billing 101: A Case Based Discussion

Committee on Legislation and Advocacy (COLA) &
David Welsh MD, MBA

Close your eyes and imagine an elephant…

Everyone imagines the elephant from a different viewpoint

We can view Surprise Billing from 3 different viewpoints as well:

- Providers
- Insurers
- Patients

A case of Surprise Billing from the patient's perspective

Dr. J, a retired surgeon, had treated patients In Network and Out of Network (OON). When she needed testing and intervention for her personal health, she was determined to avoid the OON problem. Thus, she chose a hospital and radiology department that was in Network.

In spite of her due diligence, she received a large OON bill with a harsh phone call. Unknown to Dr. J, the radiologist covering her case was not within her network. The insurer would not help. The hospital declined to help. Her radiology colleagues could not help.

A brief history of Surprise Billing

- Originally called “Tiering”
- Recently gained media attention
    - Driven by new data on the scope of the issue
- ⅓ of insured, non-elderly adults struggling with medical bills cited OON providers were a contributing factor.
- 7 in 10 people with unaffordable medical bills did not know that their provider was OON at the time that they received care.
- At least 6 states currently have policies that protect consumers from Surprise Billing.
    - New York’s policy is highly cited and well regarded.

Policies Under Consideration

Billing regulation: requires insurers and providers to charge for services as if the patient is in-network, with a few possible addendums

- Forces Medicare rates
- Bases rate on what insurers pay other providers for services
- Involves an arbitration process

Policy Lobbying

For the most part:

- Physicians and physician groups are pushing for arbitration
- Insurers and bureaucrats are pushing for a “take it or leave it” approach
    - Insurers make deals with hospitals and if you want to work for or have privileges at that hospital you must accept their payment scheduling

The AMA's stance

- Limit patient responsibility
- Avoid rate setting
- Ensure out-of-network care within 30 days
- Avoid payment disputes from the start with robust independent dispute resolution (IDR)
- Allow patients to choose elective out-of-network care
- Strengthen network adequacy
- Ensure insurer transparency

Where do we find common ground between the various stakeholders?

The patient should not have to foot the bill.

Where is the schism between stakeholders?

How should the price be set?

Please split into small groups of 3-4 people

A case from the provider's perspective

Dr. Johnson is a radiologist who works from her home in San Diego, CA who is currently on call for a hospital in Orlando, FL. Mr. Jones has had a tumultuous year. Recently discharged from the hospital after a MI, he is involved in a car accident and is feeling drowsy with an increasingly worsening headache. The astute emergency physician orders an emergent CT scan which is sent off to Dr. Johnson who notes that Mr. Jones has an epidural hematoma and is rushed off to surgery. A few weeks later, Mr. Jones is then less than pleased to find out that Dr. Johnson's readings are not covered by his insurance because she is out of his network. He calls Dr. Johnson's group, disgusted at the price of his bill.

Discussion points

- Is this surprise billing? Why?
- Is Dr. Johnson at fault for not being within network?
- Is Dr. Johnson powerless?
- Is it in the provider's best interest to charge Mr. Jones or an insurer?
- Would the provider benefit from:
  - A forced Medicare rate?
  - Arbitration?
  - Receiving a payment based on what insurer's pay other providers

A case from the insurer’s perspective

Ms. Green is having a rough day at work. As the CEO of a multi-state health insurance company, she just found out that there was a Mr. Jones who recently utilized a significant amount of OON services. The reason the case is on her desk is because she has been trying to set rates with the radiology group that Mr. Jones unintentionally used. She wants to use this as a perfectly good example of why the group should accept their rates. Since she does not have a contract with negotiated rates for service, she is unable to clear the amount requested from Dr. Johnson.

Discussion points

- Is this surprise billing? Why?
- Is this the insurer's fault? Why or why not?
- Is it in the insurer's best interest to cover Mr. Jones' costs?
- How can the insurer ensure that their patient is not stuck with the bill while also maintaining their network?
- Would the insurer benefit from:
  - A forced Medicare rate?
  - Arbitration?
  - Basing their payment on what they pay other providers

Time’s up!

Points from the provider’s perspective

Points from the insurer’s perspective

General Overview

Contact your representative and senator!

Major medical professional associations have agreed that we need to:

- Limit patient responsibility
- Avoid rate setting
- Ensure out-of-network care within 30 days
- Avoid payment disputes from the start with robust independent dispute resolution (IDR)
- Allow patients to choose elective out-of-network care
- Strengthen network adequacy
- Ensure insurer transparency

Congresslookup.com

Latest bill (S. 1531) introduced has 26 bipartisan cosponsors

tinyurl.com/SB1531

Questions?

David Welsh MD, MBA
djwelsh_1980@yahoo.com