The Adverse Effect of Surprise Out of Network Bills on Consumers and on the Health Care Market

Statement at the Pennsylvania Insurance Department Hearing on Balance Billing

by

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1 Introduction

Commissioner Miller and colleagues, thank you for inviting me to speak to you today. My name is Martin Gaynor. I am the E.J. Barone Professor of Economics and Health Policy at the Heinz College at Carnegie Mellon University in Pittsburgh, where I have been for 20 years. I have been doing research and teaching on the economics of health care and on markets and competition for over 30 years. Much of my work focuses specifically on the economics of health care markets. In addition, I was recently on leave from Carnegie Mellon serving as the Director of the Bureau of Economics at the U.S. Federal Trade Commission in Washington, D.C. There I was in charge of all economic analysis at the FTC, including both competition and consumer protection matters. Health care was a major focus at the FTC while I was there, and continues to be a major focus. As a consequence, I am very familiar with consumer protection and competition issues in health care.

2 Surprise Out of Network Billing

2.1 The Phenomenon

I want to focus on the issue of surprise out-of-network billing. This happens when consumers go to a hospital that is in their health insurance plan's network, and then subsequently receive a large unexpected bill for uncovered out-of-network services from a physician who provided services at the in-network hospital.[1] This can happen, for example, when a patient goes to an in-network hospital for emergency care and is treated by an out-of-network physician in the emergency room, or when a patient receives surgery at an in-network hospital, performed by an in-network surgeon, but the anesthesiologist is not in the plan's network. Since the physician is not in the plan's network, the patient has to pay the entire bill, which can run into hundreds or thousands of dollars. Patients are not informed in advance that they will be treated by an

[1] This happens because hospitals and physicians are separate, independent firms that have separate contracts with insurers. Therefore a hospital may be in a consumer's insurance plan network, but a physician may not.

out-of-network physician nor told how much it will cost, and do not have the opportunity to choose whether to give their consent.

2.2 How Prevalent is Surprise Out-of-Network Billing?

While there have been some well publicized instances of surprise out-of-network bills, and I assume that more will come to light at this hearing, there is not a great deal of systematic evidence on the extent of this problem. However, we do have some good evidence on the extent of this problem from the state of Texas, and from a survey conducted by Consumer Reports.

The Center for Public Policy Priorities published a report in 2014 on the extent of out-of-network billing by physicians at in-network hospitals.[2] They examined what percentage of physician fees (percent of dollars) were billed out-of-network at in-network hospitals for emergency room treatment, anesthesiology, radiology, and neonatology. They report information for the three largest insurers in Texas: Blue Cross Blue Shield, Humana, and United Healthcare. This information was became available after the Texas Department of Insurance adopted a reporting requirement in 2013.

They found that for United Healthcare 68% of all emergency room physician bills were for out of network physicians at in network hospitals. For Humana the number was 42%, and for Blue Cross Blue Shield 41%. Further, 45% of United's in-network hospitals had no in-network emergency room physicians. That number was 56% for Humana and 21% for Blue Cross Blue Shield. We don't know how many of these out-of-network bills at in-network hospitals were surprise bills to consumers, but it seems likely that many, if not all, of them were.

For anesthesiology, 25% of bills at in-network hospitals were billed out-of-network for United, 23% for Humana, and 7% for Blue Cross. 14% of United in-network hospitals had no in-network anesthesiologist; 38% for Humana, and 1% for Blue Cross Blue Shield. The numbers are somewhat lower for radiology, pathology and neonatology. For full details see the report.

In March 2015, the Consumer Reports National Research Center conducted a national survey of to assess consumers' experiences with health insurance. One of the questions was about surprise medical bills. 14% of respondents said that they were charged at an out-of-network rate when they thought the provider was in-network; 63% said they were charged an amount higher than they expected; and 23% said they received a bill from a doctor they did not expect to get a bill from. Consumer Reports also asked questions about consumers' information about network providers. 14% of respondents said that they had been surprised to find out that a provider they thought was in-network was out-of-network. 64% reported that they assume that doctors at an in-network hospital are also in-network.

The evidence from the Texas data and the Consumer Reports survey document that this appears to be a substantial problem.

[2] Pogue, S. and M. Randall. (2014). "Surprise Medical Bills Take Advantage of Texans: Little-Known Practice Creates a 'Second Emergency' for ER Patients". Center for Public Policy Priorities, http://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf.

3 What Contributes to Out-of-Network Billing?

The overwhelming majority of private health insurance plans in the United States have provider networks. These networks typically include many, but not all, providers in an area. So most individuals with private health insurance in the US are enrolled in a plan with a provider network. It should be understood that this means that the majority of individuals with private health insurance coverage face the prospect of very high out of pocket bills if they utilize an out of network provider.

There are two important financial impacts on consumers of utilizing an out-of-network provider. First, either the cost of the care isn't covered at all, or in some cases, the consumer bears a higher share of the cost than for an in-network provider. Second, since the provider is not in the network, this means that the provider's fees have not been negotiated to a lower level by the consumer's insurance company. Therefore, if a consumer sees an out of network provider not only must they pay a large share, possibly all, of the costs, but they will pay for care at a higher rate, possibly substantially higher.[3]

Plans which have more limited provider networks have been growing in popularity in recent years. These plans, which include so called "narrow network" plans or tiered networks, typically are offered at lower premiums due to the more limited networks.[4] While to my knowledge there are no data on the size or growth of these plans offered through employers, there is information on narrow network type plans offered through the ACA insurance exchanges. The University of Pennsylvania's Leonard Davis Institute measured physician participation in Silver Plans on ACA exchanges as a means of assessing the broadness of provider networks. They found that, overall, 41% of networks included 25% or fewer of local physicians.[5] McKinsey and Company have gathered information on hospital inclusion in exchange plan networks, as opposed to physicians.[6] They find that 45% of all networks offered in the exchanges are narrow, ultra-narrow or tiered (with regard to hospitals).[7]

Clearly many consumers enrolling in exchange plans are in narrow networks. Unfortunately there are no similar data for employer sponsored plans, but it seems likely that narrow network plans are growing in popularity there as well as in the exchanges.

I want to be clear that I am not opposed to narrow networks. Narrow networks have real benefits for consumers in driving down costs, and may help improve quality. However, with narrow networks more providers are out-of-network.

The key takeaway is that more consumers are potentially subject to surprise out-of-network bills as enrollment in narrow network plans grows.

[3]Some providers' out-of-network fees are set at charges, which are their list prices. The rates that insurers negotiate with insurers can be half or less of charges.

[4]Bauman, N., Bello, J., Coe, E. and J. Lamb. (2015) "Hospital Networks: Evolution of the Configurations on the 2015 Exchanges." McKinsey Center for US Health System Reform, http://healthcare.mckinsey.com/2015-hospital-networks.

[5]Polsky, D. and J. Weiner. (2015) "The Skinny on Narrow Networks in Health Insurance Marketplace Plans." Data Brief, Leonard Davis Institute, University of Pennsylvania, http://ldi.upenn.edu/brief/skinny-narrow-networks-health-insurance-marketplace-plans.

[6]Bauman et al., op. cit.

[7]McKinsey classifies networks with 70% or less of local hospitals as narrow, and networks with 30% or less as ultra-narrow.

In addition, certain provisions in the Affordable Care Act (ACA) may also have influenced the prevalence of out-of-network billing for emergency room physician services. The ACA requires that health insurers not limit their enrollees' access to emergency services, whether they are from in-network or out-of-network providers. Enrollees' cost-sharing for emergency services obtained from an out-of-network provider can be no more than for services obtained from an in-network provider, but out-of-network providers are allowed to balance bill consumers.[8] As a consequence, out-of-network emergency room doctors don't have to agree to insurers' in-network rates in order to treat in-network patients, and can balance bill. This may have played a role in the prevalence of out-of-network billing by emergency room physicians.[9]

4 The Problem with Surprise Out-of-Network Billing

Surprise out-of-network bills are a serious problem. First, surprise out-of-network bills are unfair to consumers. Surprising consumers with bills they were not told about and had no reason to expect is clearly unfair. It also meets the FTC's definition of unfairness. The FTC defines unfair practices as those that "cause[] or [are] likely to cause substantial injury to consumers which is not reasonably avoidable by consumers themselves and not outweighed by countervailing benefits to consumers or to competition."[10] Surprise out-of-network bills cause substantial injury to consumers – they are large bills that consumers have to pay out of their own pockets. They are not reasonably avoidable – consumers are not told or warned, but are surprised, so there is no way they could have avoided these bills. They do not provide countervailing benefits to consumers or competition. There is no claim that the out-of-network physicians providing the service provide superior care to in network physicians. Even if that were so, there is no justification for keeping consumers ignorant about the fact – consumer ignorance in this matter has no countervailing benefits.

Second, surprise out-of-network bills harm the functioning of health care markets. In order for markets to work the terms of sale must be clear to all parties in advance and those terms must be honored. This is such a basic part of our everyday lives that it may not seem obvious. Consider, however, what would happen if supermarkets did not post prices for milk, but only revealed the price once you were at the checkout counter, or even worse, if you didn't even know what the milk cost until you received a bill months later. Not surprisingly, markets wouldn't work very well if that is how pricing was done.

That's what can happen to health care markets if surprise out-of-network billing is allowed to continue. Surprise out-of-network bills punish, rather than reward, consumers who are trying to be responsible and keep their bills down by going to providers in their plan's network. If consumers fear that they may face large unexpected bills despite their best efforts to be responsible shoppers, they may avoid or delay obtaining needed care.

As consumers react to the prospect of surprise out-of-network bills, plans with narrower or tiered networks and more cost sharing (which put consumers at greater exposure to the risk of surprise out-of-network bills) will become unpopular. Competition in health care markets

[8] See http://www.regulations.gov/#!documentDetail;D=HHS-OS-2010-0014-0001.

[9] It does not, however, explain out-of-network billing by doctors in other specialties.

[10] https://www.ftc.gov/about-ftc/what-we-do/enforcement-authority

depends on providers competing to be included in health plans' networks. If there is little reward to providers for being in-network, or little penalty for being out-of-network (or for engaging in surprise out-of-network billing), then providers will have little reason to compete to be in insurers' networks. In addition, if networks become very broad, or simply include all providers, there is little incentive for providers to compete by offering lower prices or better quality care. This can lead to higher prices, higher health care costs, and higher premiums, making health care less affordable and more of a burden for everyone. As a consequence, surprise out of network bills have the potential to cause real harm to the functioning of health care markets.

5 Summary and Conclusions

Health care plays a vital role in the lives of Pennsylvanians. It is a very large part of our economy, and it has a large impact on our finances and the quality of our lives. We have a market based health care system, so the health care system only works as well as the markets upon which it is based. Surprise out of network bills undermine the functioning of health care markets. They are unfair to consumers and violate a fundamental requirement of market exchange: that consumers and producers must understand and agree to the terms of sale prior to a transaction, and those terms must be honored afterward.

This is a harmful practice and should not be allowed to continue. Intervention in markets is a serious business, and there is the potential for unforeseen and undesired consequences that work against the intention of a policy, so any possible actions should be weighed very carefully. However, as a basic condition, consumers must know what they are purchasing and what it will cost. Therefore I have the following recommendations.

- At a bare minimum, consumers must be told in advance, clearly and in a way they can understand, whether they will be treated by an out-of-network provider and how much it will cost them if this occurs.
- Ban balance billing by out-of-network providers if consumers are not in a position to choose. This could be if they are receiving emergency care, or if there are no in-network providers (e.g., all anesthesiologists are out-of-network). If a consumer goes to an in-network hospital and they are unable to choose between in- or out-of-network physicians, either because it's an emergencey situation or because there are no in-network providers from which to choose, they should not have to pay more out-of-pocket for the physician services they receive than they would if the physician was in-network.
- A stronger and more comprehensive alternative to those outlined above would be to make all services provided at an in-network hospital subject to in-network rates and rules. Physicians who provide services at an in-network hospital could only bill at in-network rates and patients would face the same out-of-pocket expenses no matter who the physician was. This would cover all services provided by out-of-network doctors (or other providers) through an in-network hospital, not just emergency care or situations where there are no in-network doctors. It has the attractive feature of eliminating surprise out-of-network bills entirely, although potential market impacts should be analyzed carefully before deciding on such a policy.

- Information should be gathered about the provision of in- and out-of-network services and billing and that information should be analyzed and made publicly available.