

NCN in 2009

A Hard Look at Healthcare

AUGUST 2009

2009

Holding Providers Accountable for Out-of-Network Billed Charges

JANUARY

America's Health Insurance Plans (AHIP) released findings this month from a study regarding exorbitant charges on out-of-network physician bills.¹ It confirms what many know—physician charges are all over the board, from appropriate to entirely outrageous. While physicians are culpable, they are not the only ones perpetuating the problem. Payers can take some responsibility for rewarding this behavior.

FEBRUARY

MARCH

The healthcare system in the United States is broken—that is not news. With healthcare at 18% of GDP and growing, the issues are complex, vast and have far-reaching repercussions. For starters, the system rewards volume, not better health. Provider contracts with insurance companies, and the supposed steerage that accompanies them, are so prevalent that networks have lost their value.

APRIL

MAY

The national discussion seems singularly focused on providing universal coverage, so healthcare charges are getting lost in the debate, and it's charges that need a common sense cure. Conventional wisdom about healthcare reform must be challenged and changed; it's not all about access. The proponents of healthcare reform promise the world—controlling costs without restricting access or giving individuals more responsibility for paying for care.² In fact, the current rate of growth is unsustainable for much longer. Irrational provider charges and the insurance companies' response to them are not the entire issue, but they are exacerbating the problem.

JUNE

JULY

AUGUST

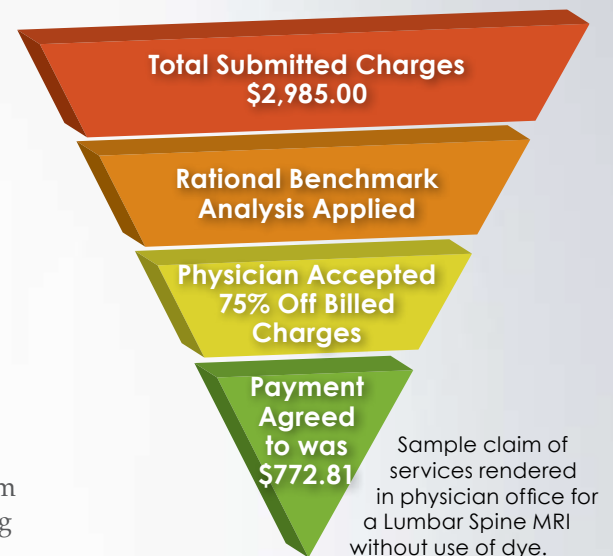
SEPTEMBER

OCTOBER

NOVEMBER

DECEMBER

How Claims Repricing Is Applied



The system rewards volume

We have a healthcare system where providers can and do generate demand. In areas where there is a surplus of doctors, particularly specialists, they order more tests and treatments per capita, and they keep their practices busy. But health of the population is not better.³ When services are performed out-of-network, insurance companies often pay providers a percentage of billed charges. For example, if a provider thinks that \$200 is appropriate compensation for their service, they may charge \$1000 estimating that an 80% discount could be applied by the insurance company when figuring reimbursement. If physicians are given incentive to charge as much as they can, why wouldn't most do so? The idea that taking a percent of the billed

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Claim a Better Way™

1 America's Health Insurance Plans (AHIP), "The Value of Provider Networks and the Role of Out-of-Network Charges in Rising Health Care Costs: A Survey of Charges Billed by Out-of-Network Physicians," August 2009 <http://www.ahipresearch.org/PDFs/ValueSurvey/AllStatesReport.pdf>

2 A 'Common Sense' American Health Reform Plan, By Uwe E. Reinhardt, New York Times, August 17, 2009 <http://economix.blogs.nytimes.com/2009/07/31/a-common-sense-american-health-reform-plan/>

3 The Atlantic Online, "How American Healthcare Killed My Father," by David Goldhill, September 2009 <http://www.theatlantic.com/doc/200909/health-care>

charge is appropriate is a fallacy. What about the provider who charges appropriately, and is only paid a percentage? He gets cheated. At this point, a percent off of a billed charge is arbitrary, irrelevant and meaningless.

Even the use of usual and customary (U&C) data is flawed because those rate tables are created by collecting data on what physicians charge, not for what they actually accept. As long as payers are rewarding providers for this behavior, they will continue to perpetuate outrageous charges. Ideally, a cost-based methodology would be used to determine appropriate payment, but unfortunately actual cost data is not available for physician bills. There is a rational alternative.

Fair profit to the provider

Let's ask ourselves not what a doctor is charging but, what is a doctor accepting? This may be one indication as to where appropriate charges lie: the provider is probably accepting payment he thinks is rational. By paying providers based on an average of what is commonly accepted, within an appropriate variance, we can bring some common sense to the system. This is not a perfect solution, but it is a start toward a rational one.

What about the patient and possible balance billing?

Insurance companies are concerned about their members receiving a bill to pay the difference between billed charges and reimbursement. With appropriate practices and good communication to all parties, insurance companies can help hold the provider and the patient accountable. Patients shouldn't have to pay a balance bill if the charges are billed and paid appropriately. Insurance companies could proactively communicate with providers about their methodology for appropriate payment, and show transparently how that payment is calculated. All parties should feel as if they've been treated fairly.

Naturally, doctors and insurers all want to serve patients well, but current irrational economic incentives create distortions.⁴ Arbitrary charges and payments don't make sense, and they perpetuate the problem.



About NCN—NCN is the national leader in cost management for out-of-network claims. We use cost-based data and transparent reporting to maximize savings on healthcare claims. At NCN we claim a better way for payers, providers and patients.

⁴ The Atlantic Online, "How American Healthcare Killed My Father," by David Goldhill, September 2009
<http://www.theatlantic.com/doc/200909/health-care>



Contact us today at:
 1-800-499-9708 x199 or e-mail kbattaglia@ncnelink.com
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