

A LITTLE CONSIDERATION, IF YOU PLEASE?

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A few months ago I set pen to paper (figuratively speaking, of course), and addressed some concerns I have had with the current health benefits payer / payee system. I titled my ramblings “Who Owes Who What... and Why?” The issues I addressed struck a chord with many of my colleagues, and I am thankful for the positive feedback received.

I have since reviewed my work, and have come to realize that the issues I dealt with can be broken down into two subcategories: (1) consumer skin in the game, and (2) the added value of an assignment of benefits.

First, I am much chagrined regarding the lack of insured “skin in the game.” In other words, the fact that insureds have no incentive to seek out fair priced healthcare, and providers need not fear disgusting customers with unconscionable pricing, irks me. In any other industry, if consumers were charged varied prices for the same service, based solely on the source of funds, that vendor would be chased out of town. Not so in healthcare. I feel that the solution can be boiled down to two concepts: (1) Pricing Transparency, and (2) Consumer Awareness. I am presently working on a more fleshed out discussion of these ideas, and look forward to sharing my theories relating to these topics with you soon.

This article deals with the second issue which (as the title would suggest) relates to the legal concept of “consideration.” In my previous article, I briefly addressed consideration and reminded the reader that consideration (an exchange of valued services or goods) is one of three necessary contractual elements; (offer, acceptance, and exchange of consideration). In other words, without an exchange of consideration, there is no contract.

I.

Consideration is an interesting topic. Rarely do people clash over an offer, or acceptance of that offer. More often than not, controversies and conflicts arising from a failed contract arise due to the issue of consideration. Failure to provide goods or services “per the contract,” and failure to pay for goods and services, is a failure to provide consideration. Failure to deliver what was promised is failure to deliver adequate consideration per the terms of the agreement, and is by far the most common issue giving rise to a “breach of contract.”

Consideration literally is: “What I am giving to you, and what you are giving to me.”

Consideration has, surprisingly, come up twice in my recent ponderings. I thought of consideration once when I was digesting an especially heinous network agreement, and again when debating a healthcare provider’s excessive charges. In both circumstances, I found myself wondering: “What am I giving to you, and what are you giving to me?”

II.

When a provider enters into a network agreement with a benefit plan, what consideration does that provider receive; what benefit does that provider enjoy? Surely, if there were no PPO networks, patients would still visit healthcare providers and those providers would still receive compensation for their labors. Why, then, does a provider enter into a network agreement? What consideration, above and beyond monetary compensation for services (which the provider would receive with or without the network agreement) makes entering into a PPO arrangement worthwhile?

III.

Consider this... In response to the United States' "Great Depression" Congress passed during the first term of Franklin D. Roosevelt (1933 to 1937), a series of economic reforms, which came to be known as "The New Deal."

New Deal economists argued that cut-throat competition had hurt many businesses. The response was to develop the NIRA. At the epicenter of the NIRA was the National Recovery Administration (NRA). Businesses that joined the NRA program agreed to limit or eliminate certain practices. To mobilize political support for the NRA, they launched the "NRA Blue Eagle" publicity campaign to boost what was called "industrial self-government."

NRA members would post in shop windows, on sides of trucks, and in advertisements, images of the NRA Blue Eagle. Americans were "strongly urged" to do business only with member companies. As a result of this campaign, profitability was restored.

Just as those businesses valued their position as NRA members, and proudly posted the NRA Blue Eagle on their storefronts – thereby enjoying increased customer flow arising from incentives to visit NRA businesses – so too do I believe that healthcare providers today profit from being members of networks.

IV.

Anyone who owns a business will tell you that having customers directed through their door, instead of being aimed at the competition, is valuable. Indeed, in an era when businesses are spending in excess of three-million dollars for a 30 second advertisement during the 2010 Superbowl broadcast, marketing is certainly something that is valuable. A provider, who signs into a PPO network, receives what is, in reality, advertising space with participating benefit plans, delivered straight from the benefit plan to the patient.

V.

In addition to advertising space, providers that join networks also benefit from "prompt payment" deadlines. A provider that is not included in a network has no control over

how quickly they can expect payment to arrive, once they submit their claim for reimbursement. A network agreement, however, includes language which imposes a deadline upon the payer; such that providers know when they will receive payment.

Just as advertising is valuable, prompt payment is valuable as well. A basic economic concept called “Time Value of Money” (or “TVM”) addresses the fact that a dollar in hand is worth more than a dollar owed. TVM explains that when you have money, you can use that money to purchase things that are more valuable to you than the money itself, invest the money and earn interest, and avoid the costs of pursuit inherent with having to seek payment from debtors.

VI.

Both direct-to-consumer advertising and prompt payment guarantees are valuable forms of consideration received by the healthcare provider when he or she enters into a PPO network agreement.

VII.

The next question should be obvious to you: “What consideration is received by the benefit plan or insurance carrier (the “payer”), in exchange for the consideration discussed above?” Indeed, a contract is no more, (and should be no less), than a quid pro quo. This for that, tit for tat, is the name of the game. So, what value does a network agreement bring to the benefit plan?

VIII.

The first and most obvious answer is a discount. This form of consideration, however, fails to withstand scrutiny. To apply a discount, per the terms of the network agreement, a payer must pay without delay and is often restricted in its ability to audit the bill. As a result, providers often claim that payers must pay the bill (minus the discount), even if the payer believes certain charges appearing on the bill are not eligible for coverage under the terms of the Plan or Policy, or the amount exceeds the amount allowable under the terms of the Plan or Policy. In other words, the payer is required to pay an inflated rate, minus a small discount, leaving an amount due which exceeds the benefits available in accordance with the terms of the Plan or Policy. Consideration is by its definition something of value gained by a party to an agreement. Additional cost to the payer is therefore not consideration. If a payer is paying more because they enter into an agreement (the same payer would pay less if they merely processed claims in strict accordance with the terms of their Plan or Policy), then the discount does not represent something of value; there is no consideration.

IX.

The other form of consideration a payer supposedly receives is the provider’s promise not to balance bill the insured participants. Balance billing is a practice utilized by health

care providers when an insurance carrier or benefit plan pays less than the total charge amount. A provider will accept payment from the insurance carrier or benefit plan, and bill the patient for the balance. Unlike a discount off of inflated prices, which is clearly not consideration, this covenant against balance billing is clearly valuable. The real question, however, is “Who is it valuable to?”

It makes sense from a customer service perspective that an insurance carrier or plan administrator wants to avoid balance billing of their participants. The truth is, however, that when a person agrees to accept medical services from a health care provider, that person enters into an arrangement with the provider, whereby the patient will receive treatment (something of value) and the provider will receive monetary compensation (something valuable). This constitutes an offer (to provide services), acceptance (of that offer), and an exchange of consideration (services for payment). The patient and provider have dictated the terms of their own contract. The patient benefits from the service performed by the provider, and the patient is thus technically responsible for payment to the provider for said services. [Please note; I will not discuss the lack of bargaining power on the part of the patient, or the uneven balance of power in the aforementioned exchange. It is enough to say that, in most cases, the provider holds all of the cards. The impact of that fact is a discussion best reserved for another day.]

X.

Presently, a patient that is insured may take a provider’s bill which they incur (as a result of their having accepted a provider’s offer, and having received services and treatment from that provider), and said participant may submit it to their insurance carrier or benefit plan. Said insurance carrier or benefit plan will then issue payment to the insured, limited by the terms of the benefit plan or policy. Rarely does this happen.

More often, a patient will assign to the provider their right to submit a bill and seek payment from their insurance carrier or benefit plan. The provider then seeks payment from the insurance carrier or benefit plan instead of billing the participant, and having the patient seek payment from the payer. This is called an “assignment of benefits.”

In either case, the participant is only entitled to the benefits set forth by the terms of their Plan or Policy. Insurance carriers and benefit plans are not required to pay more than the eligible amount, regardless of who submits the excessive bill. If a patient accepts services from a provider which charges excessively, the patient – and not the insurance carrier or benefit plan – should be responsible for the charges in excess of the eligible benefit amount.

As the network is presently constituted, however, two providers charging different amounts for the same service are both paid their full charge amount by a single insurance carrier or benefit plan (minus a discount).

There is no incentive, on the part of the provider, to charge reasonable fees or develop innovative, cost saving procedures or adopt new efficiencies, as the insurance carriers and benefit plans fail to place a cap on eligible expenses.

XI.

Balance billing can be prevented by entering into a network agreement. Balance billing can also be prevented by revising provider practices such that their bills do not exceed fair amounts. Balance billing can be prevented by patients who negotiate with providers and ensure the charge amounts will not exceed eligible benefits available from their insurance carrier or benefit plan.

XII.

As with false discounts, so too do I believe the only entities that benefit from a rule against balance billing are the patients (who will not be held responsible for accepting services from overcharging providers), and the providers themselves, who are not required to develop more efficient practices in order to keep prices low and competitive.

XIII.

If insurance carriers and benefit plans allow providers to balance bill, educated patients will pushback against the providers. The fear, that patients will blame the benefit plan and insurance carrier for balance billing, is reasonable until said plan and carrier educate patients regarding payment practices and the prevalence of excessive charging by medical service providers.

If an insured individual's \$500 mountain bike is stolen, and said individual purchases a \$1,000 mountain bike to replace it, does that individual become enraged at his insurance carrier for only compensating him for the \$500 loss? If an insured is involved in a motor vehicle accident, and their \$25,000 sedan is totaled, does that insured become enraged when the carrier refuses to purchase a \$50,000 luxury sedan to replace the loss? Of course not! Why, then, is health insurance the only insurance that is expected to pay for unnecessary, excessive, luxuries for the sake of customer convenience and service provider inefficiencies?

If insurance carriers and benefit plans advise their participants as to why the eligible benefit amount is what it is, (show them data reflecting average wholesale pricing, provider expenses, what the provider most often charges, what the provider most often accepts, what other providers in the area charge, what other providers nationwide charge, what services and supplies were unnecessary or billed in error), and explain to the participant how and why a provider's charges exceed the allowable amount, the participant will come to realize that fault lies with the provider – not the payer.

The participants are responsible for resolving disputes with providers. Once participants have some "skin in the game" a free market will force providers to compete, and develop strategies to keep costs down while improving the quality of their wares.

XIV.

For these reasons, I put forward a theory that a benefit plan or insurance carrier which enters into a network agreement, in order to secure a discount and prevent balance billing, does in fact receive nothing of value! There is no consideration, and thus, no binding contract.

XV.

Consideration comes up once again when we examine how a healthcare service provider is compensated for treatment rendered to a plan participant.

We have already discussed that, as the system is currently constituted, a provider will provide treatment to a patient, and that patient will – in exchange for said services – assign their right to file a claim with the insurance carrier or benefit plan, to the provider. We have already identified this process as an “assignment of benefits”.

The insurance carrier or benefit plan will then forward payment directly to the provider. If the benefit plan administrator or insurance carrier determines that the amount charged exceeds the amount available, they will (sometimes) pay to the provider less than the billed amount.

Sometimes, the provider will accept said payment and consider the matter closed in full. More often, however, the provider will deposit the payment, and pursue the patient for the remainder. As discussed already, this is called “balance billing.”

In my mind, however, this is not only balance billing... It is theft! It is a prime example of “having your cake and eating it too.” The provider enjoys all of the benefits of billing the insurance carrier or benefit plan (deep pockets, timely payment), but also rests assured that – should the insurance carrier pay less than the billed amount – the provider can balance bill the patient as well!

XVI.

If you were a healthcare services provider, and you could treat one of two patients, both of whom have no insurance, and have the same personal assets, you would be indifferent as to whom you treat. If, however, one of the patients is insured, you would no doubt prefer to treat the insured individual. This scenario plays out in provider’s offices from coast to coast. Why is the insured patient a more attractive option? Both patients have agreed to the same charge amount, yet, every provider will agree that billing an insurance carrier is preferable to billing the patient. This is because insurance carriers have deep pockets, and prompt payment is almost guaranteed. While the insurance carrier has substantial financial resources, the patient may not have the financial means to satisfy his debt. While the insurance carrier hires individuals who are trained to read, process, and pay provider bills, the patient will no doubt be confused by the bill. While the insurance

carrier is required by network agreement and law to pay promptly, the patient is not so restrained and even enjoys statutory protections against certain collection activities.

Billing an insurance carrier has value above and beyond the money received.

XVII.

If health insurance were managed the same way as other insurance, a patient would be billed by their provider. The insured would then submit the bill to their insurance. The health plan or health insurance carrier would then issue to the insured a payment equal to the available benefits, in accordance with the terms of the benefit plan or policy. The insured would then be responsible for resolving their outstanding medical bill. This system would enrage providers, who must then pursue each patient and seek payment from said patients (who may, once the insurance money is in hand, decide they have more pressing needs than paying for services already rendered).

Alternatively, I propose that when a patient offers their right to obtain benefits from their insurance, that assignment of benefits is in and of itself consideration in full, exchanged for services and treatment. It is my theory that an assignment of benefits is thus not a form of access to consideration, and rather, is the consideration itself.

XVIII.

One might ask why a medical service provider would ever choose to accept an assignment of benefits in lieu of the right to bill a patient for 100%.

The reasons why assignment is still an attractive option are many, and have already been discussed.

First, there is the certainty of payment. Next, there is promptness of payment. If the provider bills the patient, the provider must pursue said patient for payment. This entails debt collection activities, unearned interest on unpaid bills, costs of pursuit, and extreme administrative costs inherent in the billing of many individual billable parties. Compare that to a scenario where the number of billable parties is reduced to a much smaller group of insurance carriers. These carriers are much more likely to pay than individual patients (eliminating debt collection costs). These insurers will pay promptly as well, meaning the funds will find their way into the provider's account quickly and efficiently. Finally, the carrier's pockets are no doubt deeper than the patient's, should a dispute arise or a substantial amount be due.

XIX.

There are those that feel billing the insurer directly via an assignment of benefits, and then balance billing the patient for the difference is no different than billing the patient for the full amount. This is because the patient will submit the bill to the insurer, just as the provider does in the assignment of benefits scenario, receive whatever the insurance

carrier deems is the fair market value for the services, and the patient will then be responsible for the difference. Regardless of who bills the insurance, and who the insurance sends the check to, the insurance pays what it pays, and the patient owes the balance.

The difference, however, boils down to reliability and ignorance.

Reliability: Providers know that many patients will take their insurance payment, and use it elsewhere – failing to pay their medical bills. Unlike participants, however, insurance carriers have deeper pockets and are more reliable. No insurance carrier will use the money to buy a new pickup truck!

Providers don't want to chase patients for payment.

Ignorance: If patients actually see the bill, they will compare prices, seeking to obtain medical services for the amount their insurance will pay them (or less) so that the patient will not be out of pocket any costs. Looking at automobile insurance as an example, an insured will accept payment of the fair market value for damages suffered to their car in an accident. That insured is then incentivized to find the least expensive mechanic to fix the damage, so that the insured will not have to pay anything additional out of pocket; and if the mechanic is frugal enough, the insured may even be able to pocket some excess benefits. Mechanics, in turn, see the way the wind is blowing – the insured has skin in the game, and is shopping around for the best price – and in turn develops new, more efficient ways to do business, so that prices can stay competitive in the free market.

Providers have no incentive to reduce costs by increasing efficiencies or keep prices competitively close to the actual cost paid by the provider.

Providers want to keep patients in the dark about their pricing.

Conclusion

Given the choice of an assignment of benefits or pursuing the patient, as payment in full for services rendered, most providers will no doubt select the former over the latter.

By educating plan participants, paying only fair amounts covered by the plan or policy, offering an assignment of benefits as consideration in full, and not fearing the balance billing bogey man, will benefit plans and insurance carriers force providers into a new age of transparency, and efficiency.

So long as the payer, for fear of balance billing, is willing to put up with unpredictable and unconscionable billing practices, and instead seek to soften the blow with increased premiums, an ignorant populace will continue to assume that said rising costs are solely an attempt by payers to maximize profits, legislators will pass insurance reforms, and providers will continue to operate in the dark.