WHO OWES WHO WHAT. . .AND WHY?

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Regarding the patient, provider, and benefit plan relationship – something has got to change.

Based upon my understanding of contract law, a contract consists of three things: Offer, Acceptance, and an Exchange of Consideration. In the context of a provider / patient relationship, the provider offers to treat the patient, and the patient accepts said offer. The treatment is in and of itself the consideration supplied by the healthcare provider. In exchange, the provider accepts monetary compensation as payment.

To be a valid exchange, in almost all other contexts, the parties must dicker the terms of the agreement, whereby they agree upon what the consideration shall consist of, and confirm that they do indeed approve of the exchange. In the realm of healthcare, however, the patient has no idea what the provider expects by way of consideration. In other words, the patient agrees to accept the provider's consideration (services), in exchange for an unknown sum of money. No other industry besides healthcare could legally enforce contracts such as this. Without doubt, in any other industry, any contract whose terms consist of: "I will provide the following services, and you will pay me whatever I ask for" would be held unconscionable. This should be especially true in a scenario where one party has all of the power and undue influence, over the other party. In healthcare, it is impossible for the patient to decline the offer. To decline the offer, in most healthcare circumstances, is unthinkable. As such, the provider holds all of the cards. There is no room for negotiation.

The issue is then compounded by the health insurance payer system. The reason open ended contracts such as the one described above could not survive in any other industry (besides healthcare), is because the consumer, upon seeing these terms, would refuse to accept them. These open ended agreements are allowed to thrive in the healthcare industry, however, because (1) as explained, the provider has all of the power (the consumer is powerless to say "no"), and (2) the consumer is not directly responsible for payment. Instead, the bill is directly forwarded by the provider to an insurance carrier or other third party payer. The patient never sees the bill. The patient may be advised of the matter post submission, and then only in the form of an explanation of benefits (EOB). The consumer is unlikely to examine the EOB, however, as it clearly states in bold letters "This is Not a Bill." The only time the consumer feels the effect of these open ended agreements is when their premiums rise, or if they are balance billed.

This leads into the next issue, which relates to how billing is accomplished. With every other form of insurance claims are processed in the same fashion. First, the insured suffers a loss. Next, the insured reports the loss to the insurer. Next, the insurer assesses the damages, and provides compensation to the insured, with said compensation equivalent to what the insurer feels is the fair market value for the loss, based upon industry accepted parameters. Finally, the insured either uses the compensation to

address the loss or not. How the insured uses the funds is of no concern to the insurance carrier.

As an example, consider a motor vehicle accident. The insured is struck at a busy intersection. The insured calls their automobile insurance carrier. The carrier has an examiner view the vehicle, and he then assesses the value of the loss. The value of the loss, and thus funds available, are based on standards set by the industry and the particular carrier. The insurance carrier sends a check to the insured for that amount, (minus a deductible if applicable). The insured may then: (1) choose to have the carrier's preferred mechanic repair the car, and pay said mechanic the amount advanced by the insurance carrier, (2) find another mechanic that will fix the car for less, with the insured then pocketing the difference, (3) choose not to repair the vehicle, and pocket the full amount paid by the insurer, or (4) select a mechanic that will charge more (but presumably do a better job). If the insured selects this fourth option, however, the insured – not the insurer – is responsible for paying the difference.

Obviously, these hypothetical scenarios change based upon particular contractual terms, laws, and other factors. The bottom line is, however, that the responsibility to "shop around" and act as an informed consumer falls squarely upon the shoulders of the insured. The risk of loss (or reward of gain) goes to the insured; the insurer pays what it pays, regardless of the insured's decision.

Not so in the realm of healthcare.

In the realm of healthcare, health insurance carriers are charged vastly different amounts for the same service by similar providers practicing within less than a mile from each other. These medical service providers even charge different entities different amounts for the same service. Moreover, the insurance carrier is expected to pay these varied charges in full, regardless of what the carrier believes is the actual, fair value of the loss.

In the automobile collision example, the insured remains the insured throughout the exchange. The insured has a contract with the insurer, whereby he or she is owed money from the insurer when he or she suffers a loss, in exchange for the payment of premiums. The insurance contract is solely between the insurer and the insured. The insured also has a contract with the mechanic. The mechanic repairs the insured's car, and the insured owes the mechanic payment for that service. The mechanic's service contract is solely between the mechanic and the insured. In that everyday example, there is absolutely no relationship between the insurer and the mechanic.

In the case of healthcare, however, the medical provider bills the insurer directly. The medical provider will even pursue a claim against the insurer if they feel they are under compensated. Yet, what consideration has the provider provided to the insurer? The medical service provider has not provided any service to the health insurer. The only consideration received by the insurer came in the form of premiums, paid by the insured – NOT the provider. The insurer therefore owes consideration to the insured – NOT the provider. Why, then, can the provider bill the insurer directly; and why, then, does the

provider have an enforceable expectation of payment from the insurer? The answer is an assignment of benefits.

The reason patients don't care how much their provider charges their insurance, and thus feel like they have no "skin in the game," is because unlike the other scenario described above (the automobile example), a healthcare service provider accepts an assignment of benefits from the insured rather than bill the insured. The insured never sees the bill.

In my mind, the provider, in exchange for providing services to the insured, has two options:

Option 1 – The medical service provider bills the insured for the value of the provider's services, just as the mechanic bills the insured for the value of his services, and the insured is responsible for payment. The insured submits the bill to their insurance carrier, and the insurer would compensate the insured for the fair market value of their loss.

Option 2 – The medical service provider may accept from the insured – as consideration in full for the medical services provided – an assignment of benefits. This assignment of benefits is literally an assignment of rights from the insured, passing onto the medical service provider the right to submit the cost of the medical services to the insurer. The provider would then only be entitled to what the insurer determines is the fair market value of the loss, exactly as the insured was only entitled to what the insurer determined was the fair market value of the loss.

One might ask why a medical service provider would ever choose to accept an assignment of benefits in lieu of the right to bill the patient. If the provider bills the patient, they charge for 100%. If the insurance only pays the patient a percentage of that billed amount, it doesn't affect the provider – the patient is still responsible for payment of the full billed amount. Alternatively, if the provider accepts an assignment of benefits as payment, by accepting an assignment of benefits the provider limits its right to only the fair market value as determined by the insurer.
The reasons why assignment is still an attractive option are many. 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 if a substantial amount is due.

There are those that feel billing the insurer directly via 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 a check to. In the end, whether the patient sends the bill to the carrier, or the provider sends the bill to the carrier, the patient is responsible for the difference.

For example, in my preferred scenario, the patient is billed for $10,000.00. The patient submits the $10,000.00 bill to his insurance. The insurer feels the fair market value is $7,000.00. The insurer issues a $7,000.00 check to the insured. The insured passes on the $7,000.00 to the provider, and owes $3,000.00 out of pocket to the provider as well.

The opposition argues this example is no different than the current procedure, whereby the provider bills the insurance directly – via assignment of benefits – for $10,000.00. The insurer feels the fair market value is $7,000.00. The insurer issues a $7,000.00 check to the provider. The insured is then balance billed for the difference, which is $3,000.00.

In the end, the insurance pays the same $7,000.00, and the insured is out of pocket for the same $3,000.00. While at first blush this may make sense, if you examine the details you will see these two procedures vary drastically.

Unlike the current process (the second example), my preferred process (the first example) places the onus on the insured to select a reasonably priced service provider. This is because in my scenario, the check is issued by the insurer to the insured. If the insurer feels the fair market value is $7,000.00, the insured is incentivized to find (or negotiate with) a provider such that the service will cost $7,000.00. If the insurer feels the fair market value of the service is $7,000.00, and the insured finds a provider willing to perform the service for $5,000.00, the insured keeps the difference. If nothing else, the insured knows upon visiting an over-priced service provider that they – the insured – will be responsible for the difference.

In the second example, which is reflective of the current process, the patient has no incentive to make an educated decision or be a discriminating consumer as it relates to selecting a medical service provider. As a result, providers have no incentive to reduce costs by increasing efficiencies or keep prices competitively close to the actual cost paid by the provider. Furthermore, when the patient is balance billed, they are surprised, both by the bill and the cost.

Also, as mentioned before, an assignment of benefits (and the right to bill an insurance carrier directly) has value besides monetary rewards. In my scenario (the first example), providers must decide whether it is worth billing 100% to the patient if it means sacrificing the benefits inherent in billing the insurance carrier directly. As the process is constituted right now (the second example), the provider enjoys the rewards inherent in billing the insurer directly (assignment of benefits) as well as retaining the right to bill the patient for the difference between the desired charge amount and the insurer's fair market price determination. In other words, providers are having their cake (billing the carrier

whose deep pockets and prompt payment add value) and eating it too (getting whatever the carrier won't pay from the patient).
In conclusion, I feel that the payer / payee system as it relates to health insurance requires a complete overhaul. The process must more closely emulate all other fields of insurance, whereby the insured is the payee and the insured is incentivized to be an educated consumer by having some skin in the game. Such a consumer driven process will result in providers developing innovative ways to cut costs, increase efficiencies, and compete for patients' business.

Insurers, meanwhile, will only be responsible to the insured (or the provider that accepts an assignment of benefits as consideration in lieu of their billed amount), and will only pay what they believe is the fair market value of the service. This, in turn, will result in lower premiums.

It will also result in insured individuals comparing insurer pay-outs, examining the processes applied by insurers in determining fair market values, and – once again – insured individuals will be incentivized to "shop around" and select insurance carriers that are most generous in their determination of what fair market values are while keeping costs low. In the end, insured individuals will have the ability to choose between insurers that charge lower premiums but offer lower pay-outs, and insurers that charge greater premiums but offer higher pay-outs.