

Health Plans need to fix Inadequate Networks

By Michael Hicks, M.D., M.B.A. and Jaime Ronderos, M.D., both of Dallas

One of the most current and confusing topics in healthcare today involves the issue of “balance billing.” Balance billing is the relatively uncommon situation where a doctor who does not have a contract with a Health Insurance Plan sends the bill to the patient for payment of any balance unpaid by the Health Plan. This is the result of a Health Plan failing to provide a complete network of doctors for their patients. This is called an “Inadequate Network.”

When insured patients get hospitalized or have surgery, they are worried about their health, but usually feel secure in their health insurance plan protection. They pursue their treatments, they solve their health dilemmas and eventually they return home. It is only then that a small number of patients discover that their trust in their Health Insurance Plan was misplaced. The bills for their care are not fully paid. They discover the Plan had an incomplete or inadequate network. The resulting transfer of costs to the patient is not fair. These patients have chosen their PPO Health Insurance Plans specifically to avoid unexpected costs. The Health Plans should be required to pay all charges if they cannot provide complete networks for their insured patients.

When a patient first decides which health plan to choose they weigh the options and specifics of each plan carefully. When asking about out-of-network charges, patients are reassured with vague language that the doctor networks are large and that if necessary, out-of-network doctors will be paid “usual and customary” rates. That suggests that out-of-network doctors will be paid fairly for the work they do. What the Health Insurance Plans do not reveal is that their networks are often inadequate and their payments for out-of-network doctors are unilaterally set by the Plans themselves and are neither “usual” nor “customary”. They do not reveal that the “allowable charge” from which they base their payment is not an accurate measure of the true market rate for medical services. In fact, this “allowable charge” and the “usual and customary payment” are discounts taken by the Plan, without the consent of the out-of-network doctor. The doctor, who took care of the patient, deserves a fair payment but gets an unexpectedly small amount from the Health Insurance Plan; the patient is then billed for the balance. This is what leads to “balance billing.”

In many cases the Health Plan out-of-network payments are less than the payments to in-network doctors. Clearly, it serves the Health Plans to allow holes in their network coverage: this shifts

unexpected costs onto the patient and the Plans reap large profits. Where else to leave these holes but in hospitals where charges are large and hospital-based doctors are committed to care for everyone? These network holes are almost invisible to the patient and cause predictable out-of-network charges. These practices allow the Health Insurance Plans to transfer costs they should cover back to the patient. Amazingly the Health Plans then dare to blame the patient and the doctors for the Plan's own Inadequate Networks! When patients enroll in PPO Health Plans they expect to be financially protected. When patients go out-of-network they anticipate a modest increase in their out-of-pocket expenses, but they never anticipate that their Health Plans would only pay a fraction of the bill and leave them holding the bag.

In the late 1980's Health Insurance Plans introduced HMOs as the solution to health care, patients were subjected to stringent restrictions on access to specialists and treatments. The public was upset. The legislature had to act to protect the public from this "profit over patient" mentality, and drew up legislation protecting patient's rights and regulating the way HMOs operated in Texas. The Health Plans quickly scaled down the HMOs in Texas and devised the new, "better," PPO plans. These were supposed to satisfy the needs of the patient. However, these PPOs have turned into a new style of HMO: many treatments are rejected; networks are inadequate; and the Health Insurance Plans claim they are not responsible. Again the public is upset.

In Texas, the health insurance industry sells a defective PPO product. Texas has very few limits on PPOs. In any other industry, such a compelling public trust would command close scrutiny and regulation. The Texas Legislature needs to define the PPO, define the coverage they must provide and require that the Health Insurance Plans maintain complete networks or pay for charges patients incur in their Inadequate Networks.