Annals of Surgery: Publish Ahead Print

DOI: 10.1097/SLA.0000000000004152

Surprise Billing in Surgical Care Episodes – Overview, Ethical Concerns, and Policy Solutions in Light of COVID-19

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Disclosure: The senior author (ACO) has received research funding from the Blue Cross Blue Shield Affordability Cures Research Consortiumunrelated to the submitted work.

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Mini Abstract

The unparalleled nature and magnitude of COVID-19 has heightened the urgency of resolving the issue of surprise and balance billing. In the present article, we leverage the four-box model to create a framework for addressing the ethical tension inherent to care episodes that entail surprise billing. We also contextualize surprise billing with the ongoing COVID-19 pandemic, highlight the consumer protections in recent federal legislation, and provide an overview of policy solutions.

Although used interchangeably, balance billing and surprise billing represent*distinct scenarios*. Balance billing implies that a patient is billed *directly* by a provider for the difference between what the provider billed and what the insurer reimbursed. These circumstances often occur in emergencies and involve out-of-network (OON) providersbecause in-network providers are contractually prohibited from sending enrollees a balance bill. Surprise billing on the other hand, refers to situations where patients receive services from providers who they assumed were contracted yet were actually OON. Thus, they are "surprised" when they discover a bill for unpaid services and with it a full, direct responsibility for payment.[1]As demonstrated in a recent analysis by Dekhne et al, surprise billing often arises when patients receive services from multiple providers in a single episode of care, assuming that all providers are contracted even though only the facility or primary surgeonwas in-network.[2]

It is worth noting that surprise bills are very large because they are relatively unconstrained by market forces (i.e. insurer negotiating leverage). By definition, these encounters are also beyond a patient's ability to circumvent and, unsurprisingly, have garnered considerable public attention in recent years.[3,4] According to a Kaiser poll, up to two-thirds of Americans express concern about an inability to afford unexpected medical expenses, and 78% support enactment of federal legislation protecting against surprise medical bills.[5]

The ongoing COVID-19 pandemic has intensified public concern about surprise billing due to hospital triage protocols and staffing shortages that increase exposure to OON facilities and providers.[6]Two pieces of federal legislation were recently enacted to ensure consumer protection in the midst of the crisis. The Families First Coronavirus Response Act (FFCRA) mandates that all payers (Commercial and federal) jettison cost-sharing related to COVID-19 testing.[6] The Coronavirus Aid, Relief and Economic Security (CARES) act includeda $100

billion appropriation for providers and hospitals that was conditional on their agreement *not* to a) bill patients above in-network rates, and b) bill uninsured patients for COVID-19 related care.[6]

Disconcertingly, surgeons have been increasingly implicated in encounters with*surprise* and *balance* billing.[7,8] Approximately 20.5% of in-network acute surgical care episodes also contain an OON component with a mean balance bill of $2,011.[8]Understandably, patients wanthigh-quality care at an affordable cost, while surgeons desire a fair compensation commensurate with expertise and level of service rendered. However, as the ensuing vignettes underscore, there are several scenarios (elective and emergency) that generate a surprise bill wherein an informed choice by a surgical patient *was not the case.* This is salient because the practice of medicine is based on the need to care for patients and is predicated on trust. With this in mind, surprise billing greatly undermines the patient-physician relationship.[9]

Although there is no reason to believe that surgeons purposefully aim to financially harm patients, we must also acknowledge an ethical tension borne from the differing expectations with respect tohealthcare financing.Consider the scenario of a 30 year-old male who presents to the emergency room with acute appendicitis and undergoes a laparoscopic appendectomy. Following recuperation, he learns that the surgeon was OONdue to a COVID-19 related staff shortage[10]and is left with a large bill for professional fees.The four box model, developed byJonsen et al, is a useful framework for analyzing clinical ethical dilemmas; and entails the following dimensions: medical indications, patient preferences, quality of life and contextual features.[11]They are based on the four core bioethics principles: beneficence, non-maleficence, respect for autonomy, and justice. Using this model, the medical indications for treating acute appendicitis center on the surgeon acting under the ethical principles of beneficence and non-maleficence. Therefore he/she performs a laparoscopic appendectomy as part of their fiduciary duty. The patient makes an

autonomous decision to undergo the operation. Thus, the two main boxes of medical indications and patient preference are in agreement posing no conflict. However, the contextual features which center on the principle of justice create a dilemma by introducing a financial element to the shared decision-making. A patient, particularly in an emergency setting, should not have to factor in the financial burden of surprise billing for OON services. Additionally, the surgeon should be free to provide the necessary care with knowledge of appropriate compensation. Addressing surprise billing at the policy level preserves the doctor-patient relationship and allows both the surgeon and patient to focus on appropriate care in an emergency setting.

In a second scenario, a 50 year old female sees a surgeon for consultation regarding localized breast cancer. She is scheduled for lumpectomy and afterward, receives a surprise bill for the OON anesthesiologist. The patient was aware that the surgeon was in network and the surgery had been approved but she was not informed that the anesthesiology group was OON. Analysis using the four box model demonstrates that medical indication for surgical excision of the breast mass is aligned with the patient's preference.[11]Unlike the first scenario, this is not anemergencyprocedure,and there ismore time prior to the actual surgery for the patient and surgeon toconsider the contextual features of this case, particularly financing. Here the question arises, what is the responsibility of the hospital, surgeon's office and payer to notify the patient in advance of out of network providers? An informed patient can potentially make changes on where and by whom she receives care in an elective setting rather than receiving a surprise bill after the fact. However, this can create a conflict for the surgeon and surgical team who want to provide care for the patient and yet, rely on appropriate compensation which may be lost if the patient transfers care. Though this case differs from the first scenario that was presented primarily based on acuity, the conclusion remains that preservation of the patient-surgeon

relationship by providing just and financially-affordable care is most important. By developing policy solutions to surprise billing practices, these ethical conflicts can be mitigated so surgeons can practice with beneficence, nonmaleficence and respect for patient autonomy.

While strong consensus exists, at the federal level, for legislative action to deter surprise medical bills, there is less agreement on *the most viable*mechanism to do so. Subsequently, a broad range of proposals have been generated to address the market failure that underpins surprise billing. In parallel,several states have also enacted laws, through their respective Departments of Insurance, to protect citizens.[1,5,12] We present a brief overview ofpotential policy solutions and where relevant, highlight accompanying trade-offs.

Benchmark payments – California passed Assembly Bill 72 in 2016 which set the upper limit of payments for uncontracted providers.[12]OON providers are paid the higher of 125% of Medicare or the Average Contracted Rate (ACR) (i.e. prevailing in-network rate) determined by the state insurance regulators.[12]This approach is controversial given the anticipated decrease in physician revenue and the broader issue of what is an appropriate payment level.[13,14] Furthermore, benchmarking doesn'taccount for other critical factors that would otherwise be captured in a payment negotiation such as surgeon experience and case complexity.[14]

Arbitration – In 2015, the state of New York passed legislation that allowed a 3rd party arbitrator to settle surprise bills. Using local market data, a *fair rate* is determined for the services provided. A priori, patients and physicians agree to whatever price is determined by the arbitrator. This process is intensive and has high administrative overhead from the vantage of the state, as it requires a third party to investigate every disputed surprise bill.[14] Many physician groups support this means of settlement given it provides opportunity for greater reimbursements than mandated benchmarks (nearing 80th percentile of billed charges).[13,15]

BundlePayments– Under these arrangements, health services are reimbursed by episode of care, including both facility and professional fees in single lump sums.[16] Hospitals and physicians then parse the payment based on their negotiated split. Bundles have been touted in their ability to reduce post-acute care spending[16]; however, an overlooked benefit is elimination of surprise billing. By definition, in a bundle, both the provider and facility are reimbursed together, so neither party can be uncontracted. Testing is currently underway by both public and commercial payers. Trade-offs of pursuing a bundle strategy are a) it would require a complete overhaul of existing payer-provider contracts b) they are administratively complex to execute i.e. aggregating and adjudicating claims.

There are threecritical elements of any effective policy solution for surprise billing: 1) comprehensive protections (i.e. across inpatient and ambulatory care settings) of patients' economic welfare, 2)restoration ofOON professional fees as close as possible to a fair, market-based level and 3) a credible means of audit and enforcement.[17] During the COVID-19 pandemic where in-network physician availability is more sporadic and patients have less choice over provider, widespread policy changes are needed to protect patients from additional economic insult. The surgical community should remain forceful advocates for state and federal efforts to promote price transparency and comprehensive protections against surprise billing. The unparallelednature and magnitude of COVID-19 has heightened the salience and urgency of resolving this issue.

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