

Are You in My Network? Contesting Iatrogenic Financial Burden

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After 4 years of medical school and 2 years of residency, I have become increasingly comfortable with my ability to medically manage patients. However, a recent patient encounter uncovered an area of my education that has been neglected. One humbling night on call on the labor and delivery floor, I was interviewing a soon-to-be mother when she asked, “Are you in my network?” I had no idea how to answer her question and felt lost as to how to find the information she requested.

This question likely stems from the unfortunate rise in surprise medical bills patients face after receiving care. A 2016 *New England Journal of Medicine* article by Dr Zach Cooper, popularized further by the lay press, describes just how many patients fall behind on medical bills (1). Patients are often surprised by out-of-network bills, which can amount to thousands of dollars. Surprise medical bills are defined as bills generated by out-of-network providers despite obtaining care at an in-network emergency department or hospital. Dr James Grant described surprise medical bills eloquently by outlining the various specialty physician bills a patient may generate from a single visit including but not limited to surgeons, radiologists, pathologists, and anesthesiologists (2). Even if the initial emergency room physician is in-network, hospitals and insurance providers fail to guarantee that the subsequent providers are in-network as well. In many regions of the United States, as Dr Cooper’s study demonstrates, these specialists are commonly out-of-network, leaving patients burdened by exorbitant fees. The numbers are astounding in that 22% of emergency department visits nationally involve out-of-network physicians.¹ In Texas, a study of the 3 largest insurance providers found up to 50% of emergency departments did not even have any in-network emergency physicians (3).

The question I faced that night made perfect sense. Although the patient had been covered by her insurance plan for prenatal care, she could not be sure about the anesthesiology, radiology, and pathology services that she may receive during her child birthing hospitalization. Unfortunately, the simple protective concepts of health insurance

have become lost in a quagmire of stakeholders that comprise the fragmented US health-care system. The confusion leaves patients perplexed as to how their medical bills will be paid. Physicians seem equally confused as their billing departments are often subcontracted to outside servicers leaving few physicians with the adequate knowledge to counsel patients on the financial implications of their decisions.

It is no secret that physicians are inadequately educated about health-care economics; in fact, various studies have demonstrated that physicians are consistently unaware of the costs their patients face (4–6). Furthermore, when specifically questioned about the costs of the care they provide, physicians have been found to underestimate costs (7,8). Sadly, medical bills are responsible for the majority of bankruptcies in the United States—a fact often left out of standard medical school curriculum. Therefore, a large opportunity exists for physicians to take hold of this issue by leading reform efforts to clarify the medical billing culture and advocating for the financial security of our patients.

Perhaps those most well aware of the medical consequences of financial misfortune are health-care providers in the developing world. On May 17, 2001, then Secretary-General of the United Nations, Kofi Annan, said to the World Health Assembly, “the biggest enemy of health in the developing world is poverty.” More recently, Partners In Health has fundraised under the slogan “#PovertyMakesYouSick.” But perhaps the wisest quote comes from one of the forefathers of medicine, Rudolf Virchow, when he proclaimed, “Physicians are the natural attorneys of the poor.” And so, regardless of practicing in developing countries or in the United States, we

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are charged not only with securing our patient's physical health but also obligated to protect their financial health.

A recent article by Rosenbaum and colleagues articulated this conundrum perfectly with the following scenario: "Helping a patient become well enough to climb the stairs to his apartment is meaningless if our care leaves him unable to afford that apartment. Protecting our patients from financial ruin is fundamental to doing no harm (9)." Unfortunately, the manner in which medical bills are issued often leads patients to this very path of financial ruin. A 2015 study found families often turning to high-interest short-term loans in attempts to cover medical debt (10). In more extreme, but still not uncommon scenarios, patients sacrifice their homes in order to pay their medical bills. In fact, multiple studies have found about 20% to 30% of families faced with foreclosure cite medical costs as the principal reason (11).

Solutions to improve medical billing have been proposed at multiple levels. Studies have urged hospitals to unify their bills into a single package inclusive of all fees (10). Others have urged regulators to mandate insurance companies to broaden their networks so that they are inclusive of all professional fees. Perhaps the most comprehensive solution would be the single payer system proposed by many politicians but also physicians, including Dr James Burdick in his book "Talking About Single Payer: Health Care Equality for America." Regardless of the proposed solution, something must be done for the sake of our patients.

At present, many patients are suffering from iatrogenic financial struggles, while at the same time physicians are predominantly unaware of the repercussions of the bills their services generate. No one seems to be taking responsibility for burdening patients with exorbitant medical bills. Billing servicers, hospitals, insurance companies, and physicians all play some role in generating surprise bills for patients, yet all of these stakeholders have been slow in acting to change this status quo.

This creates a profound opportunity for physicians to take charge. As patient advocates, we are constantly looking out for the best interest of our patients, and as such advocates, we should be motivated to lead reform in this area. We should admit our responsibility for medical bills, educate ourselves about the billing process, and engage other stakeholders in conversations about reforming a confusing system for everyone. Certainly, a new mother's experience at the hospital could be greatly improved if the anesthesiologist offering her an epidural knew whether or not the procedure would be covered by her insurance. Someday I hope that the confusing insurance system would be simplified such that the patient-physician relationship can be restored with neither one of us worrying about networks.


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