Drowning in a Sea of Paperwork: Toward a More Patient-Centered Billing System in the United States

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Hospitals and physicians are working to improve the health care experience for patients. However, these improvement efforts frequently neglect a common source of patients' concerns: the medical billing system. Frustrations for patients abound, from the emergency department visit that prompts a seemingly never-ending and incomprehensible deluge of bills to the "This is not a bill" insurance statement that arrives 18 months after care is provided. This sea of paperwork costs time and money and creates confusion and frustration. We describe the problems with the current system and how providers, health plans, and policymakers may improve it.

Problems With the Current Billing System

Although expressly required to do so by law in only about half of states (1), health plans commonly issue explanations of benefits (EOBs) to detail the treatments being claimed by the health care provider, their cost, the amount covered by insurance, and the outstanding balance. Patients also receive a statement from the health care provider for any uncovered claims or outstanding balances. This system has several shortcomings.

First, the sheer number of bills and EOBs patients receive is overwhelming. In a recent study on medical debt, nearly all of the patients interviewed reported difficulty managing the volume of bills (2). A single medical encounter, such as an emergency department visit, can lead to a cascade of bills—for the emergency department physician, a consulting specialist, the laboratory, and radiology. In most cases, an EOB is also sent to an enrollee even if there is no outstanding balance.

Second, bills may arrive months after care is received, and distinguishing between new bills and repeat invoices for unpaid bills can be difficult. There are often discrepancies between the bill and the EOB, and receipt of the EOB may not coincide with arrival of the bill.

Third, the format of bills and EOBs causes additional confusion. Patients report that medical bills do not provide sufficient information to describe a claim, what has been paid, and what is still owed and to whom. In a recent health literacy study, interpreting an EOB was found to be one of the most difficult tasks (3).

Fourth, the system is costly. Despite the rapid movement toward electronic payments in other industries, health care billing remains largely paper-based. We estimate that the mailing and printing costs for just 1 single-page statement per claim exceed $1.7 billion for the 2.5 billion medical claims generated each year (4). The cost of creating and collecting bills contributes to the $361 billion in annual health care administrative costs (5). An additional cost is patient time, given that Americans spend more time than residents of any other industrialized country resolving disputes related to medical bills or health insurance (6).

Finally, the complexity of bills and EOBs and the lag time for their receipt prevent them from fulfilling their intended purpose as fraud detection and informational tools (7). The latter is particularly important given the growth of high-deductible health plans. Patients are increasingly expected to shop for health care services, yet they often cannot use EOBs or bills to effectively track their spending and understand the effect of their choices.

Toward a More Patient-Centered System

Simplification, consolidation, and real-time point-of-care cost information could help address these inefficiencies. First, bills and EOBs could be simplified for easier comprehension. Unlike other receipts, medical bills may use only abbreviations, codes, or scientific terms when listing the services rendered. In addition, bills and EOBs may list "chargemaster" prices, which often have no relationship to what the patient or health plan will pay. Such extraneous information should be eliminated.

Second, bills and EOBs could be consolidated and distributed in a timely manner. Patients should receive 1 bill per episode of care—a visit, a hospitalization, a surgery—across *all* providers. Some health systems have already moved to consolidated billing, and payment reform presents an important opportunity to accelerate this change. For example, all providers within an accountable care organization could be required to issue consolidated bills for care they provide, on a per-episode or monthly basis. Such consolidated billings and elimination of EOBs when there is no patient liability could decrease the volume of mailings.

Although simplification and consolidation will help, a more fundamental problem is the current system's post hoc nature. Instead of bills and EOBs being sent months later, a more patient-centered system would incorporate a real-time "checkout" model. Consistent with pharmacy and dental care, medical providers would give patients an estimated cost before and a final bill immediately after care is provided. This model could reduce the sticker shock of a bill that is received weeks after care. Making a checkout model the norm is also essential for effective price transparency because it will help patients know the effect of their health care

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decisions in a clear, tangible, and timely way and will help them pursue lower-cost care.

There will be challenges to implementing these strategies. The complex, state-specific interplay of regulatory and contractual requirements complicates change. Although progress has been made toward real-time claims adjudication, including administrative simplification provisions in the Patient Protection and Affordable Care Act (8), many roadblocks to a full checkout model remain, such as the challenging human factors affecting clinical flow. For example, claims may not be processed until the provider bills for payment and signs the encounter note, which may be days later.

However, there is reason for optimism. As patients become increasingly responsible for out-of-pocket payments, they will demand more transparent health care pricing and more convenient payment methods. Providers, health plans, advocates, and policymakers can contribute to these efforts. Providers can move toward consolidated billing. Health plans can simplify EOBs, reduce their frequency, and work with providers to automate the billing process and make real-time bills a reality. Advocates can ensure that billing system reform has a place in the broader conversation about health care reform. Policymakers can ease regulatory barriers for providers and payers to pursue innovative strategies and, if necessary, mandate change.

Conclusion

Health care reform efforts have largely focused on improving "front-end" clinical interactions while neglecting "back-end" billing systems. Redesign of the billing system would relieve a common frustration and is critical for a more patient-centered health care system.

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