US Congress wants to take the surprise out of medical bills

Congress aims to legislate against unexpected medical bills, which can be financially devastating for unsuspecting patients. Susan Jaffe reports.

Legislation to reduce health-care costs is gaining remarkable bipartisan support in a Congress nearly paralysed by political gridlock amid members' increasing calls for the impeachment of President Donald Trump. The unifying issue is surprise medical bills, which was cited in recent polls as Americans' top financial worry, ahead of paying for prescription drugs, housing, health insurance premiums, or food. Four of ten adults younger than 65 years who were surveyed said they had received a surprise medical bill in the past 12 months.

The problem afflicts even people with generous health insurance coverage, including members of Congress. Senator Bill Cassidy, a gastroenterologist and Louisiana Republican, received a US$3000 bill from the doctor who treated his daughter after she fell and was bleeding from her forehead, he recalled at a hearing on the proposed Lower Health Care Costs Act, which was held in the week beginning June 17 by the Senate Committee on Health, Education, Labor and Pensions.

The committee was scheduled to vote on the legislation in the week beginning June 24, and members were likely to approve it. The measure would prohibit health-care providers from billing patients for payment that was greater than the amount allowed by their insurance plans. It also contains provisions to ban tactics by pharmaceutical companies that delay access to cheaper drugs, and eliminates gag clauses in contracts between providers and insurers and other anti-competitive activities that increase medical costs. The House of Representatives is considering similar legislation, called the No Surprises Act.

At a House committee hearing on the legislation last month, California Democrat Katie Porter took a seat at the witness table to testify about her harrowing experience with a ruptured appendix. She was on her way to a campaign event last August when she had severe abdominal pain. Her campaign manager drove her to a hospital emergency room, where she was treated by a surgeon who did not participate in her employer's insurance plan. It was only after the insurance company learned that Porter had just been elected to Congress that it agreed not to charge her $3000 for the surgery.

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"There are thousands of Americans with fewer resources than me who are surprised with bills far more devastating than mine", she said at the hearing.

Michael Burgess, a Texas Republican and physician, recalled a high school teacher in his district who received a $110 000 hospital bill after spending 4 days in the hospital following a heart attack. The bill was more than twice his annual salary. Cathy McMorris Rodgers, a Washington state Republican, told the story of one of her constituents who also had a major heart attack and ended up in a hospital in the neighbouring state of Oregon. When she was discharged a month later, she owed the hospital $227 000 because the facility did not accept her insurance.

Provider networks

Health-care providers who do not participate in a patient's insurance plan are considered to be outside of the plan's provider network. Insurers negotiate special rates with providers who become part of the plan's network. But it is not unusual for a hospital that accepts a certain insurance plan to have anaesthesiologists, pathologists, radiologists, other medical staff, or even an entire emergency department who do not, unbeknown to patients and in an emergency or other situations, patients may not have the option to go to an in-network provider.

When researchers at the Kaiser Family Foundation analysed millions of 2017 medical claims for employees of large companies, they found that 18% of emergency hospital visits and 16% of in-network hospital admissions included at least one bill from an out-of-network provider. The proportion was much higher in Texas, New York, Florida, and New Jersey, where almost one in three hospital admissions resulted in out-of-network bills, according to their study released last week.

"People get health insurance precisely so they won't be surprised by health-care bills", said Senator Maggie Hassan, a New Hampshire Democrat at last week's hearing. "It is completely unacceptable that people do everything they are supposed to do to ensure their care is in their insurance network and then still end up with large, unexpected bills from an out-of-network provider."

But physicians and other medical personnel cannot be required to form

REUTERS/Jonathan Ernst

contracts with certain health insurers, said Charles Kahn, president and chief operating officer of the Federation of American Hospitals. This organisation represents more than 1000 investor-owned or managed community hospitals and health systems. "We still have, primarily across the country, a voluntary medical staff system", he said.

Both the Senate and House legislation would remove patients from the dispute and would require these patients to pay an out-of-network provider no more than the proportion that they would owe an in-network provider for the same services.

The balance of the out-of-network bill to be paid by the patient's insurer would be limited to the median payment for that procedure or that which service insurers have negotiated with other providers in the local area. The US Department of Health and Human Services would determine the geographical areas and calculate the median amount on the basis of information supplied by insurers. Health-care providers would accept the median payment as full payment and would be prohibited from billing patients for additional amounts.

So far, patient advocacy organisations and insurers have welcomed this approach, but provider groups are less enthusiastic.

Government price controls

Requiring insurers to pay out-of-network health-care providers the government-mandated median in-network rate "absolves plans of one of their most basic obligations—developing adequate networks of physicians to care for their premium-paying customers", according to a response from the American Medical Association. Insurers would have no incentive to form contracts with providers who are paid a higher amount, and these clinicians would probably eventually be removed from the provider networks of the insurance companies.

"If an insurance company is going to sell an insurance policy to an unsuspecting public, they should have adequate provider networks that include all of the appropriate specialties", said Barbara McAneny, a New Mexico oncologist and the American Medical Association's immediate past president. Some insurance plans already have such limited networks that even providers do not know whether they are in-network or out-of-network, she said.

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"In my practice, I try to be in-network with every health plan in the area but, for example, there was one plan that came to town and said, 'we want to pay you a fraction of [what government-run] Medicare pays', which was below my cost of doing business." She rejected the offer.

The American Hospital Association, which represents about 5000 hospitals and health systems, called the median in-network rate an "arbitrary, government-dictated reimbursement" that would weaken provider networks, particularly in rural areas, where there is a shortage of providers, and result in fewer provider choices for patients.

The median in-network payment limit sets a bad precedent, said Charles Kahn at the Federation of American Hospitals. "Before you know it, there's no need for networks because we've got rate controls that limit what we can be paid for the services we provide", he said."We prefer a market-oriented system that's based on negotiation and if it makes sense to be in-network, then it works, and if it doesn't make sense for us, we have the option not to be rather than have an external price imposed on us."

Instead of the government intervening in what physician and hospital groups say are private negotiations with insurers, the providers favour using an independent arbitrator to resolve disputes over payments to out-of-network providers. This approach has been used by New York State, to minimise surprise medical bills, but under a federal law, states cannot regulate insurance coverage provided directly by large employers (rather than under contract with a separate insurance company). These so-called self-funded plans insure about 100 million Americans. That prohibition explains why New Yorkers continue to experience a high percentage of surprise medical bills, according to the Kaiser Family Foundation researchers.

Insurers believe the median in-network rate is a good compromise, said Jeanette Thornton, a senior vice president at America's Health Insurance Plans, which is a trade association that represents insurance companies. This rate would apply in a low number of situations, such as emergencies in which patients are not able to choose their providers. "We think this benchmark should be reasonable and fair and based on what similar providers are making in contracts with plans."

The alternative, which is supported by provider organisations, would allow an arbitrator to decide how much an out-of-network provider should be paid. "We just don't think that gets at the root cause of surprise medical bills—these excessive costs that are really raising premiums for people and stressing out American families", Thornton said.

Any legislative fix will need President Trump's support before it can take effect. A White House spokesman declined to answer questions about how the president would like to work out the payment details. Yet in comments last month, Trump was unequivocal about the results he wants: "No one in America should be bankrupted unexpectedly by health-care costs that are absolutely out of control", he said."No family should be blindsided by outrageous medical bills."

Susan Jaffe