

Not the Last Word: Surprise Medical Bills are Hardly Charitable

Joseph Bernstein MD

The term “surprise medical bill” [20] refers to the unexpected charges from a provider who does not participate in a patient’s health insurance plan (a so-called out-of-network provider). These charges are often higher than “in-network” fees, and therefore, come as a most unpleasant surprise to the patient.

According to a February 2020 study conducted by The Peterson Center on Healthcare and Kaiser Family

Foundation [18], 67% of Americans are worried about surprise medical bills and 78% support passage of federal legislation to protect patients from them. It is no surprise, then, that politicians of both parties have come together to voice disapproval of the practice.

I hope that this disapproval will surmount the resistance of special interests, and legislation will be passed. In particular, three rules are needed in the new law, because there are at least three types of surprise medical bills.

The first type covers emergency services, and the abuses here can be huge. For instance, National Public Radio [19] reported that a patient received a surprise medical bill of USD 41,212 from Carolinas Medical Center for an emergency appendectomy, more than triple the price suggested by Healthcare Bluebook.

A second type of surprise medical bill comes for a provider chosen on an elective basis, for nonemergent medical care. The “surprise” nature of the bill lies in how much the provider charged, and how much of the bill is the recipient’s responsibility.

The third kind of surprise medical bill comes from providers the patient did not hire directly, but who offered services associated with elective care that was sought. For instance, a patient receiving a joint replacement from an in-

network surgeon might also receive bills from out-of-network anesthesiologists, radiologists, pathologists, medical consultants and surgical assistants. These bills are particularly vexing at the receiving end, because the patient might not have realized that there would be separate charges for subsidiary services; that is, the patient might not have anticipated the bill at all, let alone one from an out-of-network provider.

Fixing emergency surprise medical bills is the most realistic. A fair law would dictate that in an emergency, a patient is responsible only for in-network fees. Any balance above that would be the responsibility of the health insurance company, and would be factored into the price of insurance policies. I think this is likely to add only a small amount to the overall cost of an insurance policy. Making payment balances the responsibility of the health insurance company does not mean that insurers should pay unreasonable charges. If the charges are excessive, the health insurance company can fight them. But there is no doubt that a health insurance company is better suited to that battle than is a patient.

Fixing the second type of surprise medical bills needs a different approach, because these bills really should not come as a surprise. If the care given does not address an emergency, patients should be provided with informed financial consent and proceed accordingly.

The law here should mandate that if the patient received a full description of the anticipated charges and how much they would be expected to pay, the patient

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is indeed responsible. Conversely, if full financial disclosure was not given, the patient should only be obliged to pay only in-network prices (with no supplement from the health insurance company). This creates a necessary incentive to providers to be fully transparent about their prices—a worthwhile aim, independent of the surprise medical bill issue.

(As an aside, I would have benefitted from mandated price transparency myself. Last year, I bit my lip and developed a mucocele. I went to a local oral surgeon to have it excised. When the bill came, I was surprised to find that I was responsible for USD 450. But that's on me: I failed to ask about costs in advance. I had not been this chagrined about a surprise bill since the time many years ago, when, in a foolish attempt to impress my date, I ordered at a fancy sushi restaurant in Manhattan without consulting the menu. A mucocele excision would have been cheaper.)

The third category of surprise bills seems hardest to remedy. On the one hand, the bill is for elective services, so maybe patients should be on the hook. Yet, because patients are not in a good position to inquire (they don't know the provider, for one thing), the situation may be closer to that of emergency services.

I propose that surprises of the third type would be substantially minimized by the following rule: If the care was given at a not-for-profit hospital, the hospital should have to pay the provider all amounts above what the patient would owe for in-network services.

Making the hospital responsible for the balance gives the hospital three choices:

- Insist that all staff physicians agree to "in-network" fees as condition of appointment (and perhaps lose some members of the staff);
- decline to participate in some plans that staff members find

objectionable (and perhaps see some patients go elsewhere); or

- simply pay the bill.

All three options have costs, but currently hospitals are not internalizing them. Rather, they are foisting these costs on unsuspecting patients. Indeed, this might be part of the hospital's business plan. Consider a hospital that needs emergency coverage. One solution would be to pay a fair stipend for this coverage. Another more expedient solution is to appoint physicians who refuse to participate in any health insurance plan. Such physicians might be eager to work at this hospital, even without a stipend, for they can surprise-bill a large number of captive patients.

Aiding and abetting surprise medical bills hardly sounds like charitable behavior—yet nonprofit hospitals get their tax-exempt status because they claim to act charitably.

In the past, nonprofit hospitals could earn their charity bona fides by providing free care to those who could not afford to pay. These days, however, very little free care is given to anybody—people in need are covered by the Affordable Care Act. That being so, nonprofit hospitals are starting to look like for-profit entities: Revenues in the billions, executive salaries in the millions (Table 1). These days, nonprofit hospitals need to find a timely charitable mission—or give up their tax-exempt status.

Sparing patients from surprise medical bills is a charitable mission that all not-for-profit hospitals should not only endorse but enforce.

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Authors of the paper, "Surprise Medical Bills: How to Protect Patients and Make Care More Affordable" [14]

Dr. Bernstein is correct that surprise medical bills are a problem. A 2019 study found that for one large insurer, 39% of visits to the emergency department (ED), and 37% of admissions at in-network hospitals resulted in an out-of-network bill [21]. At the same time, many hospitals have solved the problem of surprise medical bills, and physicians in most specialties never send surprise bills [3]. What explains these patterns? How should we go about fixing this problem?

In earlier work [3], we identified four scenarios that result in surprise medical bills:

1. Emergency Care 1: Patient receives care at an ED in an in-network hospital, but one or more treating physicians (including on-call specialists) are out-of-network.
2. Emergency Care 2: Patient is treated at an out-of-network facility in an emergency.

Table 1. Compensation paid [7] to the President/CEO at five leading American Hospitals [22].

Rank	Institution	Compensation (in USD)
1.	Mayo Clinic	3,160,764
2.	Massachusetts General Hospital	4,723,847
3.	Johns Hopkins Hospital	2,765,436
4.	Cleveland Clinic	7,628,936
5.	New York-Presbyterian Hospital	7,407,452

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3. Routine Hospital Care: Patient visits an in-network hospital but is treated by a physician who is out-of-network.
4. Transport by Ambulance: Patient is transported to a hospital by an out-of-network ambulance or air ambulance.

In all of these scenarios, patients have little or no control over who treats them, limited ability to go elsewhere to avoid a surprise bill, and only a small likelihood of being treated at the same place more than once. This combination makes it profitable for physicians in certain specialties (emergency medicine, anesthesiology, radiology, pathology) and certain businesses (air ambulances) to be out-of-network providers. The financial effects are not limited to the patients who receive the surprise bills, since providers will choose to be in-network only if the amount they receive from insurers is worth more to them than the right to engage in balance-billing by remaining out-of-network. The cost of including these providers in the network increases the insurance premiums for everyone.

Dr. Bernstein offers some helpful suggestions for addressing surprise medical bills, but he goes astray by tying one of his reforms to hospital nonprofit status and the impressive salaries earned by CEOs at some nonprofit hospitals. Neither of these factors drive the phenomenon of surprise bills or affect their amount.

Taking Dr. Bernstein's three proposals in order, we agree with his idea for handling the surprise bills generated by emergency medical services. But if those services are provided at an in-network hospital, we believe they would be better handled by his third proposal. We also have no objection to Dr. Bernstein's second proposal, which requires out-of-network providers in nonemergency settings to fully disclose their own bills in advance. In fairness, Dr. Bernstein's second scenario has received less

attention—partly because it is different from the other scenarios, and partly because it is not responsible for many surprise medical bills.

Dr. Bernstein's third proposal requires nonprofit hospitals to foot the bill for any reasonable billed charges that exceed an insurer's in-network payment for care delivered by physicians within the hospital. As Dr. Bernstein outlines, this proposal is likely to trigger various adjustments. Many hospitals will require all affiliated physicians to align their in-network status with the hospital ("all for one, and one for all"). Stipends will probably have to be paid to ensure certain specialists continue to remain on staff—similar to the financial arrangements many hospitals have developed to ensure physicians in certain specialties are available to provide on-call coverage for the ED [3]. Once the fates of the hospital and medical staff are tied together some insurance contracts that were acceptable to the hospital will be unacceptable to the medical staff and vice-versa. So, if a critical mass of physicians prefer to be out-of-network given the terms the insurer is offering, it does not matter if the hospital is happy with the proposed contract. Similarly, if the hospital is unhappy with a proposed contract, it does not matter if physicians are thrilled with the terms.

The advantage of an "all for one, and one for all" approach is it forces those closest to the situation to arrive at true market prices for the services in question in advance, rather than requiring courts or government regulators to try to do so after the fact. Our preferred reform—that hospitals would only be allowed to send a single bill for all services provided—would have similar effects [14].

The main issue with Dr. Bernstein's fix to the problem of surprise medical bills is that it does not apply to the 25% of community hospitals in the US that are for-profit institutions [4]. Although

we agree with Dr. Bernstein that many nonprofit hospitals do not earn their tax exemption, it is not at all obvious why the application of the proposed reform should turn on a hospital's institutional status [15]. Dr. Bernstein's concern with the high salaries earned by CEOs at some nonprofit hospitals is also a red herring; the reforms that he proposes would be equally desirable even if the CEOs of the hospitals in Table 1 of his article were paid USD 1 a year.

We close by noting that surprise bills are not a problem in most markets. When you take your car to an auto body shop, there is bundled, all-in pricing. The person who fixes the dents doesn't send you an inflated, separate bill from those for the rest of the repairs—and then balance-bill you when your insurance refuses to pay it in full. It doesn't speak well of our healthcare system that body shops can figure all this out on their own, but we may end up needing federal legislation to force hospitals and doctors to do the right thing.

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I applaud Dr Bernstein for his timely article on surprise medical billing—a pernicious and ugly problem that, as he notes, the vast majority of Americans want addressed. Nearly 40% of insured, nonelderly adults have been hit with these bills, and nearly 60% support legislation to end the practice even after hearing arguments that it could lead to doctors and hospitals being paid less [18].

Dr. Bernstein proposes a number of good solutions in his column. The fight, of course, regarding every effective solution is over the money. Not only is there the painful cost to individual patients

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from surprise bills, they cost all insured patients plenty in higher premiums. One study from New Jersey, for instance, found that just one insurer could have saved USD 497 million in 2013 by paying out of network claims at a 150% of Medicare rate rather than the billed charges. [5]. Many providers and the private equity firms that own many large physician staffing companies are loath to give up this extra reimbursement. As bipartisan support for a benchmark-based surprise billing solution moved forward in Congress last year, these groups pushed arbitration as an alternative to fix the problem [13]—a solution that had already been shown to raise prices when used in New York state [6]. An arbitration-based solution will, I believe, at best, generally maintain the status-quo, and, at worst, lead to excessively high charges [17] for out-of-network care that would, I fear, cause most providers to drop out of insurance networks. By fixing the financial gut-punch that patients usually experience when shocked with surprise medical bills, and by guaranteeing out-of-network insurance payments far above in-network rates, arbitration will prompt most doctors to leave insurance networks as soon as they can. It would, in fact, generally be foolish to remain as an in-network physician.

I believe these types of arbitration-based solutions (like those backed by the American Academy of Orthopaedic Surgeons [AAOS] [16]), would catastrophically raise insurance rates for all Americans. Like many employers, insurers, and consumer groups [9], I support a solution based on benchmarking out-of-network fees to a multiple of Medicare as the best answer. One advantage of a properly structured plan would be that it could also address the problem of narrow networks—a phenomenon that occurs when insurers unduly limit network size. The ideal out-of-network rate could be

determined by the Congressional Budget Office or other impartial analytics firms and would be set low enough to remove any incentive for talented medical professionals to abandon insurance networks while remaining high enough to make it relatively expensive for insurers to leave popular medical providers out of their networks. Through this system, the best physicians and hospitals would be most accessible to the most patients at a reasonable cost.

Whether it is providing unproven stem-cell treatments or employing physician-owned distributorships, I have watched as doctors repeatedly turned strategies that were originally scorned as purely money-making schemes into customary, routine aspects of medical care. We cannot allow this to occur again with surprise billing. The AAOS claims to represent both patients and the profession [2]. This is one of those inevitable instances where patient and physician interests do not intersect, and therefore, all of us, including the AAOS, other professional societies, and individual surgeons must choose whose interests come first. By siding with patients and keeping their healthcare costs within reason, we will be on the right side of history on surprise billing.

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While Dr. Bernstein nobly seeks to spare patients from surprise medical bills, it seems a bit too easy to simply punt the financial responsibility for these bills to hospitals and insurers. Perhaps it is worth

questioning why out-of-network clinicians are entitled to full charges in the first place—after all, aren't they responsible for surprise medical bills?

Let's take the normal way doctors get paid by insurance companies. In general, physicians who are "in-network" are those who have contracted with an insurance company. That is, they have given up their ability to charge whatever they want in exchange for the ability to see more patients from that insurer's network. And since few patients have the means to front out-of-network bills, a patient's ability to choose an in-network provider is why doctors—particularly those performing elective surgery—stay in-network [1]. (If a patient chooses to have elective surgery with an out-of-network surgeon, we should not consider the bill that patient receives to be a surprise).

However, patients don't always have a choice. In elective surgery, patients can choose the facility and the surgeon. But they can rarely choose other involved clinicians like assistants or anesthesiologists, who may bill separately. As a result, these clinicians have no incentive to go in-network and can thus charge patients whatever they want, and the patient cannot choose an alternative provider.

The result, unsurprisingly, is that care from providers who patients can't choose comes with higher charges, and is more likely to result in a surprise bill. We have found that approximately 1 in 5 patients undergoing elective surgery with an in-network surgeon at an in-network facility received an out-of-network bill, averaging over USD 2000 more than insurance would typically pay [8]. These came most frequently from surgical assistants (charging USD 3600 more than insurance would pay) and anesthesiologists (charging USD 1200 more than insurance would pay). Among patients undergoing orthopaedic surgery, similarly egregious charges came from neurologists (charging over USD 18,000 for

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neuromonitoring during spinal operations) and non-physician providers such as durable medical equipment (accounting for surprise bills in 13-22% of knee operations) [12]. What right do these providers have to charge patients whatever they want, and to expect someone to pay in full?

So, before endorsing Dr. Bernstein's solution of making hospitals and insurers pick up the tab, let's also take pause: Allowing doctors to charge whatever they please come at the expense of rising costs for hospitals, insurers, and patients [8, 11]. In fact, his fix would make it even easier to stay out-of-network, because a juicy automatic payment from a hospital or insurer is much more attractive than hounding individual patients for a balance bill [10].

Therefore, rather than adding an incentive for doctors to stay out-of-network, we should be focused on how to protect patients. As Dr. Bernstein says, patients should never receive a surprise bill in the first place. But "who picks up the tab?". Dr. Bernstein chooses hospitals and insurers—and it's worth noting that they often do so. But to ignore the role of physicians entirely, as Dr. Bernstein proposes, would let the fox guard the proverbial henhouse.

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