

## Editorial

# Laws on Surprise Medical Bills: Gateway to Single Payer

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According to the non-profit organization Consumers Union, “A surprise medical bill is any bill for which a health insurer paid less than a consumer expected.”<sup>1</sup> In the current environment, in which many people expect everything to be covered by insurance, that definition may apply to anyone who receives any bill from a hospital or physician—including bills for deductibles and co-pays. Although laws about surprise medical bills aim to restrict the amounts out-of-network physicians can charge, Consumers Union acknowledges that patients “can be surprised by bills from both in-network and out-of-network providers.”<sup>2</sup>

A 2015 *Consumer Reports* online survey of 2,200 U.S. residents with private health insurance found that one-third of all respondents reported receiving a surprise medical bill.<sup>3</sup>

In recent years, New York, Maryland, Texas, Colorado, New Jersey, Connecticut, and California have passed laws to address the issue of surprise medical bills.<sup>2</sup> Federal efforts are also underway to eliminate surprise medical bills. U.S. Sen. Bill Nelson (D-Fla.), a ranking member of the Senate Committee on Commerce, Science, and Transportation, has asked the Federal Trade Commission to investigate surprise medical bills for emergency room visits.<sup>4</sup>

In his letter to the FTC, dated Dec 1, 2016, Sen. Nelson says: “Section 5 of the Federal Trade Commission Act generally prohibits ‘unfair or deceptive acts or practices in or affecting commerce.’ I am concerned that these out-of-network surprise bills could be both unfair and deceptive.... I urge the FTC to investigate this issue to ensure that consumers are protected against surprise ‘out-of-network’ bills.... Furthermore, the commission should consider whether these ‘out-of-network’ charges should be banned altogether in cases of emergency treatment when a consumer has no other viable choice for treatment options.”<sup>5</sup>

In one of the Republican “replacements” for the Affordable Care Act (ACA), The “Healthcare Accessibility, Empowerment, and Liberty Act” (HAELA) proposed by Rep. Pete Sessions, Title V on “Increasing Price Transparency and Freedom of Practice,” section 501, “Ensuring Access to Emergency Services without Excessive Charges for Out-of-Network Services,” (a)(5) “Enforcement with Respect to Excess Charges,” reads: “A hospital, physician, or other entity that violates the requirements of subsection (j)(1) with respect to the furnishing of items and services is subject to a civil money penalty of not more than \$25,000 for each such violation.”<sup>6</sup>

## Patient Misperceptions

It is hard not to sympathize with a hard-working couple sitting on the couch in their modest home, staring at a

medical bill that is more than they earn in a year. But, there are also patients’ misperceptions contributing to their reactions of surprise.

Many patients believe that all physicians working at a hospital are employees of the hospital, and the hospital bills for and controls the fees charged by its physician employees. Some mistakenly believe that out-of-network means that a physician is not employed by the hospital. Sen. Bill Nelson is in this category, and in his letter to the FTC he says: “As recently detailed in *The New York Times*, consumers are increasingly facing situations in which they go to an emergency room at an ‘in-network’ medical facility of their health insurance provider but are then treated by a doctor who is not employed by the facility and, consequently, is considered an ‘out-of-network’ provider.”<sup>5</sup> Consumers Union acknowledges this misperception: “More than 60 percent of survey respondents mistakenly assumed that if they went to an in-network hospital, all the doctors at the hospital would also be in-network.”<sup>2</sup>

Many patients do not understand that hospitals and independent physicians provide separately billed services within the hospital inpatient setting. Some patients mistakenly believe that if they go to an in-network hospital, the hospital has an obligation to ensure that all care provided in their hospital is in-network, including care provided by independent, non-employed physicians. Consent for Treatment/Financial Agreement forms, which patients sign when they enter the hospital, often specifically advise: “I further understand that physicians may function as independent practitioners and I will receive a separate bill for their services.”

Many patients also do not understand the free-market nature of care provided by out-of-network physicians, and how they may be receiving higher quality personalized care albeit at a higher fee. If out-of-network billing (balance billing) is outlawed, patients will experience decreased access to personalized care, and no option of choosing higher quality care. The eight-minute, in-network patient encounter and rationed care will be the only kind available.

Moreover, many do not fully understand the concept of deductibles and co-pays. They believe that they paid for insurance and insurance should cover everything so that they do not incur any out-of-pocket costs. Consumers Union also acknowledges this problem: “Another cause of surprise bills: patients pay cost-sharing for a procedure and then discover later that they owe the whole bill because they haven’t met their deductible.”<sup>2</sup> This problem is further exacerbated by insurers that typically either will not count any out-of-network cost toward the patient’s deductible, or set the out-of-network deductible at twice the deductible

amount that would apply for using in-network physicians.

Patients who receive surgery or other procedures at a hospital are also often surprised to receive a bill from physicians they never met—anesthesiologists, radiologists, and pathologists.

### **Hospitals Seek More Power and Control over Staff Physicians**

Hospitals are constantly positioning themselves to achieve more power and control over physicians on their medical staff, while at the same time, solo physicians and physicians in small groups are being driven into hospital employment due to the oppressive and costly burdens imposed on them by the Affordable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act (MACRA). Both hospitals and insurance companies have engaged in a merger frenzy, largely in reaction to “ObamaCare,” in which large Accountable Care Organizations were encouraged. It’s hoped that the Trump Administration and Republican-controlled Congress will repeal this oppressive, tyrannical Act.

Hospitals that provide outpatient care in a hospital-owned clinic are often paid two to three times what an independent physician is paid for providing the same service in a private outpatient setting. Hospitals seek to preserve their outrageous “chargemaster” rates (undiscounted list prices for all procedures and services offered by a specific hospital) for inpatient care as well. Hospitals use their highly inflated chargemaster rates in bargaining with insurance companies for better rates. The uninsured, self-insured, and patients with high-deductible plans bear the burden of these high costs. A hospital in which all staff physicians are either employed by the hospital or contracted with all plans in which the hospital participates, can also serve as bargaining chips for hospitals negotiating rates with insurance companies. If out-of-network billing at market rates is outlawed, all physicians working at hospitals will be in-network, and hospitals will achieve their goal of increased bargaining power and control. Hospitals will implement strict cost-containment protocols to patients’ detriment.

### **Outlawing Market-Rate Out-of-Network Billing Results in Insurance Company Profit Windfalls**

Insurance companies favor government price controls on physician services. Out-of-network billing, however, represents a necessary “check and balance” on insurance companies, and if out-of-network billing is eliminated, insurance companies will attain total control over physician fees.

An unconstitutional law recently passed in California as Assembly Bill No. 72 allows insurance companies to dictate payments, which out-of-network physicians must accept. In effect, all physicians in California will become de-facto in-network physicians. Against their wills, physicians will essentially be forced to contract with insurance companies. Shortly after the law was passed, AAPS sued to protect patients and physicians and to stop implementation of this law.<sup>7</sup>

AAPS argues that the California law:

- Violates the U.S. Constitution’s 14th and 5th Amendment due-process clauses, and those of the California Constitution, by preventing physicians from pursuing their rights in court.
- Violates the U.S. Constitution’s 5th Amendment “takings” clause—proscribing that private property shall not be taken without just compensation—by depriving out-of-network physicians of their services’ market value.
- Violates the equal-protection clauses of both the federal and state constitutions by having a disparate impact on minority patients, who will suffer a sharp decline in care access as out-of-network physicians are forced to withdraw services from predominantly minority communities.

If insurance companies are allowed to set fees for out-of-network physicians, all physicians will suffer. The only leverage in-network physicians now have is that if they do not like the terms of the insurance contract or if they believe fees are set too low, they can refuse to sign contracts with the insurer and become out-of-network physicians. Once that leverage is eliminated, insurers will be free to reduce fees paid to all physicians and achieve windfall profits.

Out-of-network bills should be paid by insurance companies in most cases, and patients almost never end up paying the full out-of-network bill. Many insurance plans have a maximum out-of-pocket cost provision, which should serve as a stop-loss measure for patients incurring large bills. Unfortunately, some insurance companies have eliminated the out-of-pocket maximums for out-of-network services so as to maximize their profits. Insurance companies should pay or negotiate out-of-network bills in good faith, rather than urging legislatures to eliminate this freedom in medicine.

### **Gateway to Single Payer**

If the California out-of-network coverage bill is allowed to stand, other states will likely pursue similar laws, paving the road to a single-payer system. The government will control insurance companies, and the insurance companies will control and set fees for all physicians. This socialist initiative is similar to Medicare, the socialized single-payer program for the elderly and disabled, with government-controlled prices.

Private insurance companies process Medicare claims and set local medical review policies, and government sets the fees physicians in the Medicare program (both “participating” and “non-participating”) must accept.

Meanwhile, insurance companies are about to fall into the same government trap that they willfully stepped into when they supported ACA. “ObamaCare,” they thought, would force people to buy their insurance products, and insurance companies would profit. The reality was that more sick people with costly conditions signed up for their plans, and not enough healthy people signed up, leaving insurers to suffer big financial losses. Many left the Act’s federal “marketplace” as a result.

Likewise, insurers, focused on prospective windfall profits

if all physicians are forced to become in-network physicians, may fail to realize that government likely will severely restrict their ability to raise health insurance premiums in the future.

## Conclusion

Surprise medical bill laws, and especially laws that outlaw out-of-network billing at market rates, represent the gateway to single-payer medical services delivery in the U.S. These laws trample physicians' due-process rights and the right to allow the market, not government, to determine appropriate fees. These laws further advance socialism in medicine to the detriment of patients and physicians alike. Socialism in medicine always results in shortages, rationing, and decreased access to timely care. Socialism also strongly discourages personalized care and innovation.

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# AAPS PRINCIPLES OF MEDICAL POLICY

**Medical care is a professional service, not a right.** Rights (as to life, liberty, and property) may be defended by force, if necessary. Professional services are subject to economic laws, such as supply and demand, and are not properly procured by force.

**Physicians are professionals.** Professionals are agents of their patients or clients, not of corporations, government, insurers, or other entities. Professionals act according to their own best judgment, not government "guidelines," which soon become mandates. Physicians' decisions and procedures cannot be dictated by overseers without destroying their professionalism.

**Third-party payment introduces conflicts of interest.** Physicians are best paid directly by the recipients of their services. The insurer's contract should be only with subscribers, not with physicians. Patients should pay their physician a mutually agreed-upon fee; the insurer should reimburse the subscriber according to the terms of the contract.

**Government regulations reduce access to care.** Barriers to market entry, and regulations that impose costs and burdens on the provision of care need to be greatly reduced. Examples include insurance mandates, certificate of need, translation requirements, CLIA regulation of physician office laboratories, HIPAA requirements, FDA restrictions on freedom of speech and physicians' judgment, etc.

**Honest, publicly accessible pricing and accounting ("transparency") is essential to controlling costs and optimizing access.** Government and other third-party payment or price-

fixing obscures the true value of a service, which can only be determined by a buyer's willingness to pay. The resulting misallocation of resources creates both waste and unavailability of services.

**Confidentiality is essential to good medical care.** Trust is the foundation of the patient-physician relationship. Patient confidences should be preserved; information should be released only upon patient informed consent, with rare exceptions determined by law and related to credible immediate threats to the safety or health of others.

**Physicians should be treated fairly in licensure, peer review, and other proceedings.** Physicians should not fear loss of their livelihood or burdensome legal expenses because of baseless accusations, competitors' malice, hospitals' attempts to silence dissent, or refusal to violate their consciences. They should be accorded both procedural and substantive due process. They do not lose the basic rights enjoyed by Americans simply because of their vocation.

**Medical insurance should be voluntary.** While everyone has the responsibility to pay for goods and services he uses, insurance is not the only or best way to finance medical care. It greatly increases costs and expenditures. The right to decline to buy a product is the ultimate and necessary protection against low quality, overpriced offerings by monopolistic providers.

**Coverage is not care.** Health plans deny payment and ration care. Their promises are often broken. The only reliable protection against serious shortages and deterioration of quality is the right of patients to use their own money to buy the care of their choice.