'Surprise' Medical Bills

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"Surprise" medical bills are no longer a surprise for physicians; we are aware that we are often not being paid for what we do. The term "surprise medical bill" means that a patient who thinks he has "insurance" is surprised when he gets a bill from a physician for services rendered; a bill that his pre-paid medical plan has *refused* to pay.

People who think they have medical insurance probably do not have true medical insurance. What they have is pre-paid medical plans run by corporatists. Medical corporatists are those in charge of incorporated organizations that exercise control over persons and activities.

The persons they control are those employed by entities that contract with them to "provide" medical care for their employees, and the activity they now control is your medical care, and often, your physician. When an employee needs or wants medical care, the employee is a patient controlled by the medical corporatist, and the physician is either someone who has signed up to be part of "the network" of physicians agreeing to work for whatever the corporatist pays, or outside that network.

Commercial insurance may be through self-funded employers, who pay the bills, and are responsible for the risk of insuring their employees. They can do this through ERISA (Employment Retiree Income Security Act of 1974), in which case federal laws and the rules of the U.S. Department of Labor apply, not those of state departments of insurance. That means that when a physician or a patient is cheated by a self-funded employer, the only recourse is in federal court, which is very expensive and unlikely to be successful. Therefore, there are very few challenges to this pernicious system in federal court.

Self-funded employers use various "insurance companies" as plan administrators, whose only function is processing medical bills. These use a group of physicians whose remuneration is under their control, which they call a "network," to coerce physicians into lower and lower prices. Physicians join such networks because the burden of regulation and the different payment rates for independent physicians versus hospital "systems" make it difficult to stay in practice as an independent physician. Physicians who do submit to networks often find payments ("reimbursements") continually slashed to the point of financial insolvency. That has forced many physicians to sell their medical practices to hospitals and become hospital employees. This occurs because hospitals have clout and can negotiate much better prices for their employed physicians than can independent physicians. Hospitals also get revenue from employed physicians who are subtly or blatantly coerced to make sure that imaging studies, lab work, home-care nursing, and hospitalizations are done within the hospital's system.

Ever since large "insurers" have morphed into third-party plan administrators, they use their networks to coerce physicians into lower and lower prices. They have developed ways of discriminating against physicians outside their networks. For example, huge differences in deductibles and "copays" for out-of-network physicians have created a situation in which self-funded employers can often get away with paying almost nothing on patients' medical bills.

Physicians who refrain from submitting to the network trap are labeled as greedy "surprise" billers and vilified and targeted by the media and the huge third-party medical plan administrators. Patients have no clue what is really going on, or that their employer is responsible for the medical bill, because the bills and correspondence are all from the "Plan" administrator. The employer hides behind the façade of the administrator. Then, when patients are billed for the amounts owed, both "insurers" and patients become incensed, and now use the term "surprise" medical bill to demonize non-network physicians as "abusing" the patient—even when the physician has saved the patient's life or ability to chew or to walk.

Third-party administrators and America's self-funded employers have also banded together within lobbying groups such as America's Health Insurance Plans, American Benefits Council, ERISA Industry Committee (ERIC), and National Business Group on Health. All these entities are very much opposed to a single-payer system in the U.S. (e.g. "Medicare for All," which is another nightmare.) They know that a single-payer system will lead to big tax increases, will be very expensive, and may cut at least some of them out. The current Medicare and Obamacare system is already in bed with some of these plans. Although these corporatist entities oppose "single-payer," if it ever did come to pass, they would jump on the bandwagon to get anything they could drain into their own coffers. For example, "A Medicare Administrative Contractor (MAC) is a private health care insurer that has been awarded a geographic area or 'jurisdiction' to regionally manage the policies and medical claims for Medicare Part A and Part B Fee-For-Service beneficiaries."[1]

Third-party administrators prefer to run things themselves without government involvement. To achieve that goal, they plan to ban "surprise" billing. That will choke off any remaining independent physicians. Of course, "surprise" billing is a product of their own creation, because self-funded employers, in conjunction with their plan administrators, have simply refused to properly pay bills from out-of-network

physicians. Now, they paint those hard-working physicians as evil for directly billing employees whose medical bills the plan has contracted to pay, but has failed to pay. America's Health Insurance Plans, American Benefits Council, ERIC, and National Business Group on Health have signed on to aggressive letters to Congress, both House and Senate, and President Trump, urging them to ban "surprise" bills not only from physicians, but even from ambulances.

The wealth of these entities and their influence over your medical care is frightening. Anthem is now a member of the American Legislative Exchange Council (ALEC), which bills itself as a "conservative" group of state legislators and private-sector members. ALEC has drafted a statement on "Surprise Medical Billing." This calls for an end to the practice by forcing physicians to mandatory mediation. ALEC supposedly promotes the free market, but there is absolutely no remnant of the free market in mandatory mediation when the mediation is controlled by the plan administrators.[2]

There is the usual revolving door between government "service" and private enrichment. Several years ago, United Healthcare was heavily fined for using flawed physician fee data. Andy Slavitt, the immediate past administrator of the Center for Medicare and Medicaid Services came to CMS from the Optum division of United Healthcare. A previous CMS administrator, Marilyn Tavenner, left CMS to become CEO of America's Health Benefit Plans for a few years prior to her retirement. Both were appointed by Obama.

In the case of third-party administrators Aetna, Anthem, Centene, Cigna, Humana, Molina, United Healthcare, and Wellcare, their CEOs made from $11,300,000 to $25,300,000 in "total compensation" in 2017. That's just one year of "compensation." "Realized compensation" may be much more; for example, exercised stock options led to a take of $83 million for one CEO.[3]

These CEOs managed to enrich themselves without taking care of a single patient; no sudden call to do an operation lasting all night; no witnessing the horror of sickness, death of a child, stabbings, car crashes. No stress when moments count in saving a life: stanching bleeding, reversing diabetic ketoacidosis, putting a chest tube into a victim of violence; no screaming or crying in the emergency room; no exhaustion after a disaster or a terrorist attack sends terribly injured victims to the hospital, whose medical care cannot be delayed until after lunch, or until after 8 a.m.

Patients are taken care of by people who gave up their twenties to go to medical school; to go deeply into debt, in many cases, to pay for their education; and then to do from three to seven or even more years of residency and fellowship, working 80 hours a week, or sometimes even more, in order to learn how to save lives and to treat cancer, infections, stroke, heart attacks, pulmonary embolism, ectopic pregnancy, and so on and on. Physicians, unlike politicians, cannot say, "Mistakes were made…." Unlike the corporatist CEOs and other highly paid "healthcare" company executives, who are largely unknown, the physician is right there, on the front lines with the patient and the patient's family.

In a preview of reality, Ayn Rand wrote, in *Atlas Shrugged*, in 1957, "I observed that in all the discussions that preceded the enslavement of medicine, men discussed everything—except the desires of the doctors. Men considered only the 'welfare' of the patient, with no thought for those who were to provide it."[4]

When someone is in a car crash that fractures his facial bones, and lacerates his tissue, grinding dirt and grit into his torn flesh, who puts him back together? A physician, who may be on call at night for such emergencies, but who may not be within "the network" rounded up by the pre-paid medical plan.

In such a case, the physician may be up all night, putting the patient's face back together again. What is your son's face worth to you, I wonder? Because when the pre-paid medical plan refuses to pay the physician because he is not "in network" and you therefore get a bill from the physician for the difficult work he has done for your son, you vilify the very person who has done the most to help you!

The "surprise" is that after the "insurance company" has been paid to take care of your medical problems, insurance functionaries will decide whether to pay the physician who saved you, and often, they decide to "deny" payment. That is robbery.

Does anybody think that young people will continue to give up their youth, and to work exhausting hours doing very difficult work, in order to be physicians, when physicians are treated like trash? When politicians such as Barack Obama or Kamala Harris say you can keep your physician under their scheme, how can they be so certain? Has anybody asked the physicians?

Medical care requires people willing to sacrifice their young years putting in the time, effort, intellect and grit, in medical school, the clinic, and the hospital, daily witnessing trauma, sickness, suffering, and death, to learn how to save your life after you have been fractured in a car crash, or shot on a ballfield.

How Did We Get Here?

First, understand that nearly everything we know and can do in medical care we learned within the past 75 years; most of it did not exist until the 1960s or even later. There were no antibiotics available until the 1940s; no polio vaccine until 1955; no coronary bypass surgery until the very first in 1953; no organ transplant until the very first kidney transplant in 1954; no CT scan (computerized tomography) until the late 1960s. The list goes on and on.

In the late 1800s, workplace injuries, in steel mills and on railroads, were common and often disastrous, so protection from catastrophic losses was offered through unions.

In the early 1900s, various entities, including the American Medical Association (spurred by the fact that physicians were often stiffed on their bills, just as today), President Theodore Roosevelt, and the American Association of Labor Legislation (AAAL) unwisely sought to disrupt a free market

in medical care by developing legislation related to the payment of medical bills. The AALL drafted legislation, but it was opposed by physicians, causing the AMA to withdraw support. Unions opposed the legislation because they feared compulsory medical insurance would weaken their power to negotiate medical benefits for their union members. The private insurance industry also opposed the legislation.

Maybe all of them realized in some way that when the government is in charge of your medical care, the government is in charge of your life. Government has a monopoly on force. Medical care is not a proper function of government; nothing in our Constitution authorizes or allows the federal government to control citizens' medical care and in these United States of America, citizens are supposed to tell their "public servants" what to do; they are not supposed to tell us what to do.

In the early 20th century, hospitals existed, but since not that much could be done for sick or injured people back then, people went to hospitals only in dire circumstances. At that time, medical insurance was not common. An administrator at Baylor University Hospital conceived the idea of having Texas public school teachers pay a fee each month in exchange for regular medical checkups, and to pre-pay for future medical services; and so "Blue Cross" was born.[5,6]

President Franklin D. Roosevelt tasked Secretary of Labor Frances Perkins with designing the un-Constitutional Ponzi scheme we know as "Social Security." Both FDR and Perkins knew the scheme was un-Constitutional, but Perkins met Justice Harlan Fiske Stone at a party, and he slyly advised her to disguise "Social Security" as a tax. FDR wanted "health insurance" in the bill, but since it would not have passed with that portion, the health insurance portion was left out.

The Supreme Court, eight of whose members were appointed by FDR, declared "Social Security" Constitutional when it was challenged (*Helvering v. Davis*, 1937). Another glaring mistake of that Supreme Court was the *Korematsu* opinion, approving the rounding up of American citizens of Japanese ancestry.

In 1945 the U.S. population was approximately 140 million. Approximately 16 million men of working age served in the armed forces during World War II. There was a labor shortage due to the absence of 16 million working-age men. FDR imposed wage and price controls on April 8, 1943, with Executive Order 9328. So, employers who needed to hire people could not offer them more money in wages. Therefore, they got around the problem by offering employer-sponsored health insurance to employees. The next blunder was the Internal Revenue Service decision in 1943 that employer-based medical plans would be tax-free. (But if *you* buy a similar plan, it will not be tax-free!)

Next, the Wagner-Murray-Dingell Bill in 1943 faced intense opposition, as did President Harry Truman's plan, because they were recognized as Socialism, which is an enemy of Freedom. The same thing happened to President John F. Kennedy's plan, but after JFK was assassinated, President Lyndon Johnson managed to get Medicaid and Medicare passed on Jul 30, 1965, partly, it was thought, because of feelings that JFK should be honored by getting his scheme passed posthumously.

Under Medicare and Medicaid, working Americans are forced to pay the medical bills of strangers, often people wealthier than they are—even for trivial ailments for which nobody in the 1950s or 1960s would have consulted a physician.

Then President Richard Nixon expanded Medicare, and signed the "Health Maintenance Organization Act of 1973," which created more chaos, and gave HMOs incentives not to provide medical care since they lost money when "covered lives" demanded more.

Employer-sponsored pre-paid medical plans often contain cost-saving measures, such as narrow networks. The plan decides which physicians you can see if you want their services to be "covered."

"Health care" companies are now part of exchange-traded funds, and their purpose is to make money for stockholders, not to take care of you when you are sick or injured. Government interference in medical care and corruption have paved the way for this horrific scenario.

Real medical insurance would work like homeowners' or automobile insurance works. You would be protected from unforeseen, large losses. Homeowners' insurance does not pay for updating the kitchen, for a swimming pool, or for painting the bathroom. Auto insurance does not pay for new tires, oil changes, or tune-ups.

With real medical insurance, you do not want to have a loss; you certainly do not want to get cancer, or break a bone. Neither does your insurance company or your physician want that to happen. When you do break a bone, you want to get well; your physician wants to succeed in getting you back to the state of health you were in; and the insurance company will pay.

With pre-paid corporate plans, you are paying, directly or through your employer, using money that would otherwise have been paid to you. The employer and medical plan company want to keep as much of that money as possible, because they are beholden to shareholders, not to you. However, you have paid it, or had it paid on your behalf, so you want to use the plan as much as possible. Your physician is in the middle, between you and the pre-paid medical plan company, being kicked, bludgeoned, and stoned.

When your "health insurance" will not pay the bill for treating a serious condition, such as multiple fractures of the jaw, then that is a very important wake-up call to you that something is seriously wrong with what you are used to calling "health insurance." The corporatist company considers you a "covered life," and the way the company executives are able to rake in tens of millions for themselves is by getting your payments and then doing the least they can do for you, all the while advertising their "care" and vilifying the physicians who gave you back your ability to chew, or to walk.

Those pushing for legislation to abolish what they call

"surprise medical bills" haven't a clue about what is going on. What has Sen. Lamar Alexander ever done? He has been a "public official." What has Sen. Bernie Sanders ever done? He has been a "public official."

I write as someone who has received a horrendous surprise medical bill. My surprise medical bill has reached $86,229, or maybe I should say more than $320,000, paid in Social Security and Medicare taxes.

I was surprised as a 17-year-old orphan when I received my first tax-vulnerable paycheck and found that my earnings were robbed from me by the federal government at gunpoint to pay for everyone else's parents' medical care, under Medicare.

Since I do not want to be forced into Medicare myself, I will never be able to get a single cent of what has been robbed from me in Medicare and Social Security taxes and given to other people in Medicare and Social Security benefits. The provision that denies Social Security benefits to anyone who declines Medicare Part A was added to "Social Security" during President Bill Clinton's time in office, by unelected, unaccountable bureaucrats in the un-Constitutional administrative state, specifically the Social Security Administration, found in the "Program Operations Manual System" HI 00801.002. So, for me, this is Social Insecurity. Money was taken from me with a fraudulent promise, and I need it for my retirement, but under this illegal provision, I can not get any of it back. Congress could easily reverse this with a one-paragraph bill.

Medical care in this nation has been taken over by socialist government and medical corporatist parasites, and things are getting worse. Physicians are leaving the practice of medicine, and physicians have the highest rate of suicide of any profession, twice the rate of the general public. Meanwhile, our patients find themselves livestock on government and corporatist ranches.

Where Do We Go from Here?

What is needed here is a true free market in medical care, which once existed in America. This would free true insurance companies to sell any insurance product for which they envision a market; free every citizen to buy true medical insurance under the exact same tax treatment as companies buy it; and free every citizen to buy true medical insurance across state lines, so that no onerous state "mandates" would force people to buy coverage for things they won't, or even can't use, such as maternity for people who cannot get pregnant, or substance-abuse coverage for people who are not going to use drugs. Freedom would go a long way toward fixing the problem without using force against anyone.

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