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Hospitals, Insurers Balance at Risk as Congress Tackles Surprise Billing

By Shira Stein

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- Doctors and hospitals both gain from current relationship structure
- Doctors don't want to be hospital employees

Hospitals and the doctors who work in them are facing a battle with insurers over who will have to pay when lawmakers move to protect patients from unexpected high medical bills.

Any potential legislative solution to these surprise medical bills will likely mean doctors who aren't part of a hospital network will have to change those relationships, a Republican health-care lobbyist said. Those providers typically include anesthesiologists, radiologists, pathologists, and emergency doctors, the patient-care providers at the center of the surprise billing debate.

Those doctors tend not to be employees of the hospital system in which they work, and that's why a patient can sometimes get a separate bill for seeing an out-of-network provider. Doctors and hospitals both see advantages to this arrangement, including independence and sharing of liability for negligence.

People typically get two types of surprise bills: in an emergency situation when a patient goes out of network, and in a situation where a person goes out of network because they don't understand their insurance and benefits.

Lawmakers are working on solutions, but legislation is still in the drafting phase, which means few details are available. Sens. Bill Cassidy (R-La.) and Michael Bennet (D-Colo.) are teaming up with a group of lawmakers from both parties to hash out a bipartisan proposal that could be available sometime next month. Senate Health, Education, Labor, and Pensions Committee Chairman Lamar Alexander (R-Tenn.) has said unexpected high medical bills are a major contributor to the cost of health care.

Doctors are concerned that any legislation could effectively require them to become employees of hospitals. Some insurers have a different concern—that premiums could go up because "opaque" arbitration would predetermine the cost of certain services at higher levels than they are now.

A group of health insurers and other payers of medical claims, led by America's Health Insurance Plans and the American Benefits Council, sent a letter to congressional leaders March 18 with a list of requests to consider as they draft legislation to curb surprise billing. The suggestions include prohibiting doctors from sending unexpected bills to patients in cases of emergency or involuntary care. No doctors' groups have signed on to the letter.

Consultants from the Brookings Institution and the American Enterprise Institute told the HELP Committee it should put a stop to the practice of physicians billing for their services independently. That effectively would require hospitals to contract for a bundle of services with an insurer, including payments for anesthesiologists and other ER doctors.

States have different ways of handling the network structure. For example, Texas and California prohibit hospitals from directly employing physicians. The intent was to make sure physicians have the independence to advocate for patients when they see situations they don't feel are safe, Mary Dale Peterson, president-elect of the American Society of Anesthesiologists, said in an interview, but it could be leading to these surprise bills.

"There's a problem with the process, but that doesn't necessarily mean you throw out the process," Vidor Friedman, president of the American College of Emergency Physicians, said in an interview when asked if doctors should become hospital employees. If they did, it would be "completely changing the way health care is delivered in the United States," Friedman added.

Relationship Benefits

Being independent from a hospital system allows doctors to have more autonomy and ownership over their practices, Friedman said.

Having their own practice allows doctors to negotiate with insurers on their own, rather than having the hospital negotiate that price, William Thorwarth, CEO of the American College of Radiology, said in an interview. Independent practices also allow doctors to control their scope of services and build an equity position in their practice, he added.

Radiologists "would much rather be in network" because billing is more difficult when they are out-of-network, but they are "not willing to give up their ability to independently negotiate an appropriate fee schedule," Thorwarth said.

To require radiologists to sign a contract with a hospital would be "completely unacceptable," Thorwarth said, because it would hamstring them in a negotiating circumstance with hospitals and insurers.

Hospitals also benefit from not employing emergency doctors directly because it spreads out the liability for any bad health outcomes of a patient, Friedman said. If a doctor is employed by the hospital, the hospital bears all the liability, he added.

It is also easier for hospitals to handle their taxes and benefits if they don't have high-income employees on their payroll, Friedman said.

Solutions

Doctors are not keen on being required to become hospital employees, but they are on board with other solutions.

Ideally, hospitals and doctors who work in them contract with the same insurers so patients don't get caught in the middle, Peterson said. Insurers should have a responsibility to make sure hospital-based physicians are in the same networks as the hospitals where they work, she added.

"There is no reason for patients to be penalized for being out of network" in emergency care, Friedman said. The Affordable Care Act leveled the amount of coinsurance and copayments patients pay for in and out of network care, but it didn't level the deductible.

Friedman's group thinks Congress should correct this, that deductibles for out-of-network emergency or unanticipated care should not be higher than in-network care. But if lawmakers were to make that change, they would need to answer the question of who pays when emergency health incidents happen that can cost a lot of money.

Another potential solution would be to have insurers pay all the hospital bills from different providers and then bill the patient for their portion, Friedman said.

Surprise billing could also be prevented by an established mechanism of arbitration that establishes out-of-network prices based on a fair-market price database in a geographic area, Thorwarth said. That idea is being tested in a few states, including New York, but it may be a tough sell in Congress because insurers are against it. The AHIP letter said lawmakers should "avoid the use of complex, costly and opaque arbitration processes that can keep consumers in the middle and lead to higher premiums."

There has also been discussion about rate setting by the government, but that's an unlikely solution. It "would undermine the contracts that currently exist" and regulate the market, he said.

Other Concerns

Hospitals angling for the best position on surprise billing legislation are also trying to convince Congress to delay Medicaid payment cuts to hospitals that treat a high level of low-income patients who are unable to pay for their services. Those cuts are slated to take effect Nov. 1.

Medicaid payments to these hospitals were supposed to be reduced beginning in 2014, but Congress has delayed the cuts several times, and hospitals are hoping for another reprieve.

Analysts had predicted that Obamacare would decrease the amount of hospitals' uncompensated care because more low-income people would have insurance, but to date, that hasn't happened as quickly as expected.

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