TIME

The Hidden Cost of 'Surprise' Medical Bills

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You only think you're covered

When Luke Postell was born three weeks before his due date, he couldn't breathe. He was immediately whisked into the hospital's neonatal intensive-care unit, where he spent the first week and a half of his life in a tangle of blinking machines, pumps and tubes. On the 11th day, he went home, happy and healthy. "That's the most important thing in the world," his father Danny says of his bright-eyed now 18-month-old. "To have him home with us, I'd pay anything in the world."

But he didn't think he'd have to.

Danny and his wife Linda, who teaches fourth grade at a public school in Canton, Ga., got their health insurance through the state's Blue Cross Blue Shield plan. Because Danny had torn his Achilles tendon earlier that summer playing basketball, the family had already blown through their $5,000 deductible. Linda's doctor and their local hospital were both listed as in-network providers, so the Postells didn't expect they'd have to pay any more out of pocket for Luke's birth.

But then a stream of mysterious bills started rolling in. Why hadn't anyone told them there'd be a $1,746 fee for an initial neonatal visit? What is the $240-per-day charge for Luke's "supervision of care"? Wasn't this all–$4,279 in the end–supposed to be covered by insurance?

Danny, who knew something about medical billing from his work as a pharmacist, quickly discovered the cause. While the local hospital was considered an in-network provider, the neonatal intensive-care unit at that same facility was not. Once Luke was whisked across that invisible line, wham: everything was out of network. "You'd think someone at some point would have told us that," Danny says.

The Postells have plenty of company. An estimated 1 in 3 American adults with private health insurance falls victim every two years to what are known, aptly, as "surprise medical bills," according to a 2015 survey by Consumer Reports. Such bills arise when an in-network medical facility contracts with out-of-network medical staff, including emergency-room doctors, anesthesiologists, surgical assistants or lab technicians. Depending on the service, average out-of-network charges can be up to 14 times more than what the government would pay for a Medicare patient, according to a study by America's Health Insurance Plans, a trade group.

"Sometimes it's just a few hundred dollars if the person reading a lab report was out of network," says Julie Silas, a senior attorney at Consumers Union, a division of Consumer Reports. "But it can easily be tens of thousands of dollars if someone's spent days in an in-network hospital and not known that the attending physician was out of network."

Between Luke's birth and Danny's surgery, which also occurred at an in-network facility but involved out-of-network care, the Postells felt blindsided. While Blue Cross Blue Shield ended up reducing the initial $4,279 bill for Luke's care to a more manageable $2,469 and capping the family's total out-of-network payments at $12,000, the Postells were still asked to pay $7,000 more than they had budgeted. A year and a half later, they're still chipping away at it.

"Has this been difficult for us? Yes. But will we survive? We better," Danny says. Then his voice sharpens. "But I can't stop thinking, What if this happened to the sweet lunchroom lady? Or one of the bus drivers at school? It's just not right."

President Obama's signature legislation, the Affordable Care Act, goes part of the way toward fixing this problem, but it leaves two gaping loopholes. The first has to do with how much people can be asked to pay out of pocket. The ACA caps that amount at $6,850 for individuals and $13,700 for families. But those caps apply only to in-network care. If patients go to an out-of-network hospital or, like the Postells, inadvertently receive out-of-network care at an in-network facility, the amount they pay doesn't count toward that annual cap.

The second loophole has to do with emergency-room visits. The ACA requires insurance companies to bill patients in a medical emergency as if they are in network, even if they end up at an out-of-network hospital. So if a patient usually pays a 20% co-pay at an in-network facility and a 60% co-pay at an out-of-network one, insurers must abide by the in-network co-pay.

That's a huge step in the right direction. But it doesn't solve the problem of surprise billing. Even in an emergency, doctors and other medical staff who are not in a patient's network can charge separately for their services. "The out-of-network doctor can still bill the patient the difference between what the insurer pays and what the doctor charges," Silas explains. In other words, if you break your arm and go to the nearest emergency room, your insurance company bills as if you went to an in-network hospital. But any of the out-of-network doctors or medical staff at that hospital can still send you an invoice. Surprise!

In most states, hospitals are not legally required to tell patients if the medical staff with whom they contract are in network, and patients themselves often don't know which specialists will be involved in their care, says Beth Stephens, a health-access-program director at Georgia Watch, a nonprofit advocacy group. As a result, she explains, even the savviest and best-informed patients can be ambushed by surprise bills.

In some cases, that happens when a hospital maintains an exclusive contract with an out-of-network specialist group. In Texas, for example, 20% of hospitals that the top three insurance companies considered in network had no in-network emergency-room doctors on staff, according to a 2014 study by the Texas nonprofit Center for Public Policy Priorities. One of the three biggest insurance companies in the state had no in-network emergency-room doctors at more than half its in-network hospitals. "They get you in a trap," says Dana Pass, whose husband's bladder-cancer screening was performed at an in-network hospital that contracted with an out-of-network anesthesiologist group. "There's nothing we could have done except not have the procedure." The Passes ended up paying $664 for the anesthesiologist's services–a bill they fought for a year until it was eventually refunded.

In other cases, patients have received surprise medical bills after they've gone to an in-network hospital and seen an in-network doctor but unintentionally received a type of medical device or drug that their insurance company does not cover. "In some cases, not even the doctor knows if something is covered by insurance," says Cindi Gatton, a private patient advocate in Georgia.

Last summer, when Elaine Hightower, a graphic designer in Atlanta, found out she had to have two surgeries, one on each thumb, for arthritis, she chose an in-network surgeon and facility and then called her insurance company to make sure the procedure was covered. Since Hightower had already reached her in-network deductible of $3,500, she didn't expect to have to pay more. It wasn't until months later, when she was whacked with a $6,300 out-of-network bill, that she discovered that the anesthesiologist on duty the day of her procedure was out of network and that the bioengineered implant that her doctor had used in the procedure was not covered by her insurance.

Unfortunately, by the time that bill arrived, Hightower had already had the same procedure performed on her other thumb, using the same surgeon, anesthesiologist and implant. She's now bracing for another $6,300 hit. If you include her $568 monthly premium, her in-network deductible, plus the $12,600 in surprise bills, Hightower expects to pay $22,916 for her health care last year alone. That's close to half her after-tax take-home pay. "It's just totally unaffordable," she says.

For many Americans, health care is the single biggest annual expense. Last year alone, the average family of four covered by a typical employer-sponsored health plan spent $10,473 in premiums and other out-of-pocket costs, according to the nonpartisan research organization the Milliman Medical Index. That's almost 20% of the median American family's annual income of $53,000. (Employers spend an average of $14,198 more per family.) While there are no good national studies showing how much Americans pay in surprise bills every year, a recent Consumer Reports survey found that 41% of families in Georgia alone had received one, and industry experts say the problem is getting worse. As hospitals and physicians' groups band together to negotiate higher reimbursement rates, insurance companies respond by narrowing their network coverage to reduce costs.

Efforts to fix the problem through legislation have been halting, largely because the issue pits three powerful players in the health care industry–hospitals, physicians' groups and insurance companies–against one another. Those groups all know that any new law shielding patients from surprise bills would require one of them to eat those costs instead. Steven Stack, the president of the American Medical Association, which represents physicians, puts the onus on insurance companies to include more hospital-based physicians in their networks. Tom Nickels, an executive vice president of the American Hospital Association, takes a similar tack, arguing that it's insurance companies' responsibility to tell patients which providers are covered. In recent years, patient groups have sued Anthem and rival Blue Shield of California on the grounds that the companies were not transparent about which providers were in network.

Insurance companies, for their part, feel besieged. With the cost of health care ticking up by an average of 6% a year for services and nearly 14% for pharmaceuticals, insurers feel they have no choice but to negotiate reimbursement rates with doctors to keep premiums and deductibles as low as possible. Not all oblige. "Providers that choose not to participate in a network plan have a variety of reasons, the main one being that they want to charge higher rates for their services," explained Clare Krusing, who represents

America's Health Insurance Plans. "When you have a pricing structure like that, patients are being asked to write a blank check."

At least 10 states have attempted to tackle the problem of surprise billing, although most stop short of prohibiting it outright. In California and Florida, for example, providers are no longer allowed to issue surprise bills in medical emergencies. In New York, which has one of the most comprehensive laws, providers and insurance companies must now submit to arbitration to determine who pays and how much. On the national level, Representative Lloyd Doggett of Texas has introduced a bill that would require hospitals to inform patients about out-of-network staff and provide them with an estimate of how much a procedure will cost. Obama's 2017 budget includes many of those same provisions. Despite bipartisan support, neither has much of a chance of passing this gridlocked Congress.

Danny and Linda Postell, who have become accidental activists in the fight against surprise billing, don't have a specific solution in mind. To them, it's a moral issue. "We're going to be able to pay our bill eventually," Danny says. "But there are lots of people out there who would see a $12,000 bill and be out of luck."

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