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BLINDSIDED BY MEDICAL BILLS

In an escalating doctor-insurer feud, vulnerable patients seeking care at in-network hospitals often are stuck with surprise costs

By Jenny Deam

Michael Ciaglo

Ava Pettit, 8, hugs the family dog, Zoe, at home in Webster. About a year ago, Zoe bit Ava in the face while jumping for a treat. Ava's parents rushed her to a hospital in their insurance network, but surprise medical bills soon resulted.

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Samia Schmella, with son Neil, recently had outpatient gall bladder surgery. Despite careful planning, Schmella was almost left with a $4,000 surprise bill.

Jason Pettit sat at his daughter's hospital bedside awash in fear. His only solace was knowing he had good insurance and was in the right place.

It had happened so fast, a moment of play turned to blood and panic. Just before lunch, 7-year-old Ava was on the floor with the family's German shepherd. Pettit held out a pizza roll, but the dog lunged just as his daughter popped it in her mouth. Two holes opened in the little girl's face and she started to scream.

Pettit doesn't remember the five-minute drive from his house in Webster to Clear Lake Regional Medical Center or the sprint through the emergency room doors. He wasn't wearing a shirt or shoes, and his chest was turning red from where he pressed Ava's torn face against his body.

He fished out his Aetna card.

"I'm at a hospital that is in my network. Everyone who's in this building should be in my network," he thought.

Then the bills from out-of-network doctors began to roll in.

Pettit had tumbled into a multimillion-dollar business practice called balance billing. The system allows doctors outside a patient's coverage network to set higher rates and then shift the "balance" not paid by insurers onto patients.

It happens most in emergency care, where vulnerable patients have no way of knowing in advance who will treat them. Just because the hospital is in-network does not mean the doctor will be, too.

Emerging evidence suggests it may be no accident.

In Texas, 48 percent of overall claims from emergency room physicians were

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Ava Pettit was taken for emergency care at Clear Lake Regional Medical Center, an in-network hospital, but it turned out all of her providers were out of network.

outside the networks of the state's three largest insurers, Blue Cross and Blue Shield of Texas, Aetna and UnitedHealthcare, according to internal claims data compiled by the Texas Association of Health Plans, the state's insurance trade association.

That compares with less than 10 percent in virtually every other specialty, with many like obstetrics-gynecology as low as 3 percent, the insurance data shows.

Insurers argue it is not, as some doctors suggest, that emergency room patients don't understand their insurance deductibles or mistakenly show up at an out-of-network hospital during a crisis. In fact, TAHP data shows that in an overwhelming 89 percent of Texas emergency room claims, the hospital or other facility was in-network.

So patients can go to the right hospital but get socked once inside the door.

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"It's a system totally rigged against patients. They can't win," said Stacey Pogue, a health policy analyst for the Austin-based Center for Public Policy Priorities who has been studying the

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Stew and Samia Schmella get twins Laney and Neil ready for bed. The Schmellas were braced for a fight over a bill from an out-of-network surgeon, but luckily most of the cost was written off.

problem for a decade.

In Texas, the average out-of-network bill for an emergency room visit may be double or triple the average in-network rate, insurance data shows.

Talk of blame instantly touches off a vigorous round of finger-pointing: Hospitals say it is out of their control. Insurers contend doctors refuse reimbursement offers. Doctors argue insurers offer rates so low they are forced to be out-of-network.

But a 2016 Bank of America/Merrill Lynch insider's investor analysis of Envision Healthcare, which owns one of the nation's largest suppliers of emergency physicians to hospitals, suggests a more intentional scenario.

"By consistently going out of network, a provider is able to gain better pricing and a better margin," the report, obtained by the Chronicle, stated in its business analysis.

"Isn't this why we have insurance? As the patient we have the smallest voice, the least amount of resources. Why are we the ones left footing the bill?"

—Jason Pettit

Such strategy doesn't work in other medical specialties because the network status of those providers is usually known by patients, and insurers can steer to in-network doctors, the report said.

In emergency settings, it concluded, patients "can't choose which doctor sees them."

Dr. Jeffrey Bettinger, a reimbursement specialist for the American College of Emergency Physicians, a professional organization headquartered in Texas, disputed the notion that fellow emergency

room doctors remain out-of-network to boost profits.

"I don't think it's ever a business a strategy," he said.

Still, the issue was further explored in a Yale University study where researchers analyzed 9 million insurance claims between 2011 and 2015 and found the rate of out-of-network emergency physician billing in 16 hospitals skyrocketed once Envision and its emergency staffing firm, EmCare, took over a hospital's emergency room management.

"It literally looked like a light switch was turned on," said Zack Cooper, an assistant professor of health policy and economics at Yale and co-author of the study released in July. He said in a recent interview that the rate of out-of-network billing went "virtually from zero to nearly 100 percent within a year when EmCare got a contract."

He cautioned that not all of the nation's emergency physicians are out-of-network, and those who are don't necessarily use it as a way to intentionally boost profits. But the pattern is striking, he said, when focused on EmCare. The study's findings indicate "a deliberate strategy to increase revenue since out-of-network payment rates are significantly higher than in-network rates."

Envision dismissed the Yale study as flawed.

"The authors make grossly inaccurate conclusions based on a significantly narrow sample size," the company said in an email.

"We agree that there is a problem with our current health care reimbursement system. Patients are caught in the middle," the statement said, adding that the problem is made worse as insurers narrow networks and introduce high-deductible plans.

Envision announced in February that it had begun moving its doctors into existing networks. So far, the company said Friday, 40 percent are now in-network with an additional 35 percent coming next year.

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The emergency physician who examined Ava Pettit said the girl would need cosmetic surgery and summoned an on-call surgeon. Ava was whisked to an upstairs room to wait, and someone came in to draw blood for tests. Then someone else came to talk about anesthesia. In the blur, it was hard to keep track.

"We had no control over who they sent into our room," remembered Ava's mother, Amber Pettit.

The surgery was successful, and Ava went home the next day.

The Pettits had picked Clear Lake Regional because the hospital was covered under their Aetna plan. "It didn't occur to me it could be any different," Jason Pettit said. But in the end, they were four-for-four on out-of-network doctors:

- Gardentown Emergency Physicians, an EmCare physician group, billed $1,311. Because the emergency room doctor was out of network, Aetna paid none of it.
- Dr. Marion Rundell, a pathologist who ran the blood tests, billed $73.75. He was also out of network, and the insurer again paid nothing.
- Dr. Kimberly Carpin, the cosmetic surgeon, billed the family $1,400 and was out of network. Aetna paid $499, leaving a balance of $900.
- Guardian Anesthesia, also out of network, billed $1,760. Aetna paid $346, leaving $1,413 to the Pettits.

The hospital was covered, and the family had to pay the remainder of their deductible. Each of the other bills they

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Stew Schmella says, "The doctors may have a valid complaint, but they are making their problem my problem."

fought against for weeks. Eventually, the anesthesiology group wrote off the bill. But the Pettits were still on the hook for a total of $2,285.81 from the others.

Carpin said she takes care of all emergency patients but often has no idea of their insurance status.

"I try to get in network with as many companies I can," she said in an interview.

The Houston plastic and reconstructive surgeon said she understands the Pettits' frustration with out-of-network doctors at in-network hospitals.

"You think it's a package deal, but it's not," she said. "That's the reality of medicine."

The other doctors did not respond to calls and emails asking for comment. Aetna also did not comment.

HCA Gulf Coast Division, parent company of the hospital, said in an emailed statement it was "sensitive to bills that patients may receive from affiliated or contracted physicians, and we encourage those physicians to participate in the same insurance networks as we do."

The Pettits live frugally but without much financial cushion. They had no choice but to enter into a series of payment plans with the doctors for fear the bills would be turned over to collection.

"Isn't this why we have insurance?" asked Jason Pettit, who at the time was paying roughly $450 each month out of his paychecks for the Aetna policy. "As the patient we have the smallest voice, the least amount of resources. Why are we the ones left footing the bill?"

The full burden of balance billing that Texans shoulder each year is unknown. The closest estimate comes from a decade-old Texas Department of Insurance survey that found even people with the broadest type of coverage were on the hook for $44 million per year.

The average surprise doctor bill is typically less than $1,000, although some can be significantly higher - enough to strap a tight budget but not enough to trigger a protracted fight or lawsuit, health experts said.

So tens of thousands of patients each year grumble yet pay.

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At the heart of the problem is an increasingly bitter feud between doctors and insurers over reimbursement rates.

Emergency medicine doctors and their lobbyists complain they are being painted as greedy when the blame really lies with an inflexible insurance industry, unwilling to give up some of its billions in profits and sky-high CEO salaries to pay providers what they are worth.

"This is one of the ways for the insurance companies to save money by paying us less," said Dr. Diana Fite, a 37-year veteran of Houston-area emergency medicine.

Other doctors argue they balance bill only as a last resort to come closer to recouping actual costs.

"What choice do we have?" asked Dr. Arlo Weltge, a Houston emergency medicine physician.

Doctors vent that they hold little or no power when up against the more powerful insurance industry that sets the rules with take-it-or-leave-it offers. They want to be in-network, the say, but sometimes insurers won't even take their calls.

The Texas Medical Association's biennial survey of doctors across all specialties showed that 35 percent of doctors who attempted to join a network in 2016 got no response from the insurer. That compares to 29 percent in 2014 and 26 percent in 2010, the medical group said.

Not true, insurers counter.

"We absolutely will take their call," said David Milich, CEO of UnitedHealthcare of Texas. "They may not think the reimbursement payment we offer is appropriate, but there are two sides to any negotiation."

Aetna's market president for Texas, Mike Nelson, said his company, too, will "actively work with providers on contracts that are reasonable to both parties." He added, though, "there are some providers who choose to stay out of all networks to take advantage of (nonparticipating) billing rules."

The typical negotiation dance is that doctors join an insurer's network - even at a rate they may not like - in exchange for the insurance company pointing patients to their in-network practices.

Such quid pro quo breaks down in emergency rooms.

Emergency physicians don't need insurers to drive volume because there already is a steady supply of patients. Some health policy experts allege this creates a perverse incentive to remain out of network and bill at higher rates.

"It's guaranteed business, like being the only bottled water vendor in Death Valley," said Mark Hall, director of Health Law and Policy Program at Wake Forest University and senior fellow at the Brookings Institution.

Emergency room doctors acknowledge theirs is a unique situation, but they see a financial liability - not a boon.

They point to the 1986 federal Emergency Medical Treatment and Labor Act that requires doctors to assess and stabilize all comers to the emergency room regardless of the patient's insurance status or ability to pay. Doctors call it an unfunded mandate to perform lifesaving medicine.

"People talk about surprise medical bills. Well, we have surprise patients," Houston emergency room physician Dr. Cedric Dark said. "Unlike other physicians, no one schedules an appointment with us and we don't get to check insurance status before you get to see a doctor. We treat them all."

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In recent years, a new business model has exploded as hospital administrators, wrestling with the logistics and expense of around-the-clock skilled emergency physicians, began outsourcing emergency care to independent physician groups and staffing firms, said Travis Singleton, senior vice president of Merritt Hawkins, one of the nation's largest physician staffing firms and health care consultants.

By Texas law, in most circumstances, hospitals cannot directly employ doctors.

While smaller, local physician emergency physician groups help fill the void, two national giants now dominate: EmCare and TeamHealth.

EmCare, headquartered in Dallas, is part of Envision, which has 23,000 employed or affiliated physicians or health care providers in 45 states, including some in the Houston area. In this year's third quarter, the net revenue for physician service was $1.68 billion, a 7.6 percent increase from the same time last year, according to Envision's most recent earnings report.

"Arizona, California, Florida, New Jersey and Texas accounted for approximately 64 percent of our physician services net revenue," Envision said in its 2016 Securities and Exchange year-end filing. It is not always clear what groups are affiliated or owned by EmCare because often they use different names, as in the Pettits' case.

TeamHealth is no longer publicly traded so its financial information is unavailable but the SEC filing for 2015 indicated it was comparable in size to EmCare.

Still, as outsourcing solved one problem it may have created another.

When an emergency physician works as an independent contractor for a company far away he or she might be less connected to the hospital's culture and way of doing things, including falling under its insurance plan, Singleton said.

The 2016 investor's analysis of Envision explained that emergency room physicians are generally immune to "large-scale pressure" to join networks and that "going out of network is one of the few things that a provider can do to get the managed care company (insurer) to raise its price."

Envision did not comment on the report except to say it is now outdated.

"There might be some ER physician groups staying out of network as strategy, but I have not seen it personally," said Clayton Stewart, lobbyist for the Texas Medical Association. "Typically physicians want to be in-network."

Michelle Kimball, president and CEO of Physicians for Fair Coverage, a national lobbying group that represents emergency physicians, radiologists and anesthesiologists in 43 states including Texas, said her group's members are willing to be in the same networks as hospitals but want the freedom to

negotiate separately.

"Doctors don't want to be controlled by the hospitals," she said.

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"The doctors may have a valid complaint, but they are making their problem my problem," said Stew Schmella, a Houston attorney who potentially was on the receiving end of a surprise bill.

While such bills are most often associated with emergency care, it does happen elsewhere in hospitals. The common thread appears to be when patients are unaware in advance who will treat them or have no way of knowing a doctor's network status. Other instances include radiology, anesthesiology, pathology, neonatology and the use of assistant surgeons or other medical support.

In February, Schmella's wife, Samia, was scheduled for outpatient gall bladder surgery. The couple thought they were being so careful, checking to make sure everyone who was part of her treatment team was covered by their Blue Cross and Blue Shield of Texas plan. They set up a payment plan at Memorial Hermann Southwest Hospital for out-of-pocket costs.

A few weeks after the surgery, the Schemllas got an estimate of benefits, or EOB, from Blue Cross and Blue Shield that showed an out-of-network surgical assistant submitted a claim. The insurer indicated it would pay $70.06 of the $4,492 claim, potentially leaving the couple responsible for the balance.

A notification from American Surgical Professionals confirmed the claim. The letter said a bill from Fort Bend SA Services would be forthcoming and they could owe what the insurer did not pay. It explained that surgical assistants are sometimes called in as "medically necessary" for procedures.

That struck the Schmellas as odd because it was a routine procedure with no complications.

"Did my wife meet him? Who knows?" asked Schmella. "She was under anesthesia."

Health care watchers call this "drive-by doctoring" where an additional doctor or assistant is present during treatment or asked for a consultation and is then able to bill for services, often out-of-network.

In Texas, 43 percent of the overall claims from assistant surgeons to the state's three major insurers were out-of-network, claims data show. That is second only to emergency physicians.

Schmella braced for a fight, infuriated by the charge. Then he got a bill for $21, which he quickly paid.

David Richardson, chief financial officer of Houston-based American Surgical Professionals, said the remainder of the bill was just written off.

In a statement, Richardson acknowledged his company is out-of-network in most places it operates.

"We have had discussions with insurance companies about going in-network that have been met with negative outcomes," he said.

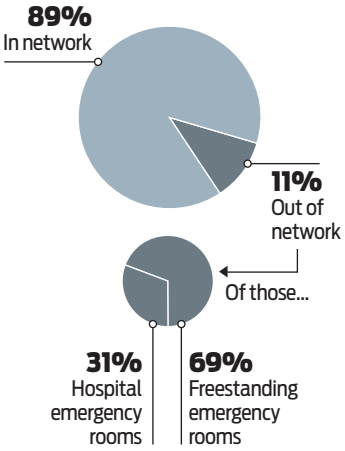
American Surgical, Richardson said, encourages hospitals to inform patients of the possibility in advance of surgery.

Memorial Herman Health System said in a statement that it is "actively working" to make sure surgical assistants' insurance aligns with the hospital's. Hospital-based physicians, including emergency-room doctors, are already contractually required to be in-network, though "medical providers may choose to terminate their agreements with insurance companies at

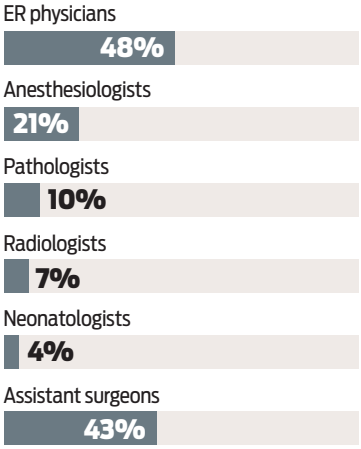
Emergency room claims

Patients overwhelmingly go to the emergency room at hospitals and facilities that are in-network, but once inside they face out-of-network doctors.

Percent of 2015 ER claims that turn out to be ...



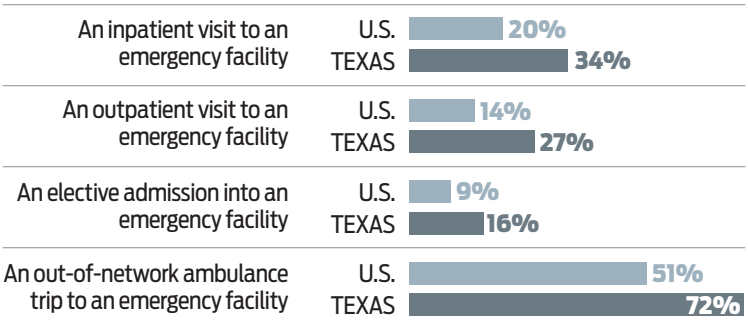
Out-of-network claims commonly come from these types of providers



Source: Texas Association of Health Plans

Chances of getting a surprise bill

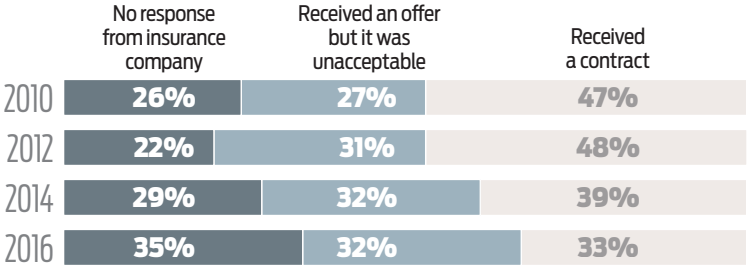
The chances of your getting a surprise bill for out-of-network medical expenses after a visit to the emergency room are significantly greater for Texas residents.



Source: Texas Association of Health Plans

When doctors try to join your network

According to a survey of doctors, more than 1 in 3 get no reply from an insurance organization. Another third receive an offer that seems too low. And the problem is getting worse.



5,800 doctors surveyed via email

Source: Texas Medical Association

Houston Chronicle

any time," the statement said.

The entire episode disgusted Schmella.

"It just shows how arbitrary this all is," he said.

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Three times in the past eight years, Texas lawmakers have attempted to tackle balance billing through a mediation process.

On May 23, Gov. Greg Abbott signed the latest version, Senate Bill 507, to widespread acclaim as a triumph for consumers.

The original 2009 law establishing mediation has been expanded and tweaked, now with more specialties and facilities, including freestanding emergency centers, and the threshold for disputed bills dropped to $500 from $1,000. The law also now requires better notification so patients know mediation is possible.

The catch is, about three-quarters of the state's insured are ineligible.

Mediation in Texas is available to only a sliver of patients, mostly those enrolled in fully funded broad-based plans where the insurance company handles all aspects of coverage.

The roughly 75 percent of insured Texans who cannot use the system include people with federally regulated self-funded plans where large employers take on the risk and pay claims, as well as Medicare and Medicaid recipients and those with health maintenance organization plans. However, people with HMOs or government plans are generally already protected from balance billing.

Mediation limits are also an issue in other states where lawmakers have attempted to tackle balance billing. But in a handful they have done something Texas appears unwilling to do: remove patients from the middle.

States as politically diverse as Florida, New York and California have established systems where patients at an in-network hospital receive an in-network charge from the doctor treating them, even if the doctor is outside their plan.

"Other states have been able to do this, why can't Texas?" asked Pogue, of the Center for Public Policy Priorities, who sees an easy fix.

She said the fundamental flaw in Texas' mediation process is it still puts the burden on patients. They have to know it exists and then navigate the process.

The problem may be that not everyone appears to want patients out of the fray.

"At times, the only way for a physician to get fair payment is to get the consumer involved," said Weltge, one of the Houston emergency physicians. Patient anger can sometimes influence the company to reconsider its payment to doctors, he said.

The Texas Medical Association concurs.

"The second the system takes the patients out of the mediation process is the moment that removes any incentive for the insurance companies to provide adequate networks," TMA lobbyist Stewart said.

In the Schmellas' case, a notation in the letter they got from the out-of-network surgical assistant group read: "Most of the time a simple call from you as a member of the insurance carrier can help us get our claim and reduce the amount you are responsible for."

"Patients are being used as leverage," said Chuck Bell, program director for Consumers Union, a national consumer advocacy group. "It's just disappointing."

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Dee Dee McCollin can't believe balance billing is allowed.

In March 2016, after injuring her eye, she called her cousin at 3 a.m. to help her go online and make sure she picked a hospital within her Molina Healthcare plan. She had lived in England for many years and just returned to Houston. She was unsure how the U.S. system worked.

When the two women arrived at in-network Cypress Fairbanks Medical Center, she showed her insurance card.

"I was very careful with the words I used. I said, 'Does that cover me to be treated today?' " she remembered. She was told it did.

The emergency room doctor diagnosed a scratched cornea and sent her home with a prescription for pain medicine. The entire hospital visit lasted about half an hour.

Two weeks later, a $350 bill came from the hospital. It was her out-of-pocket share of the $1,555 hospital claim. She set up a $50-per-month payment plan. Then a second bill arrived, this one from EmCare.

The emergency physician was out-of-network, and Molina indicated it would pay $120 of the $1,374 claim. That left her to pay $1,253.95 plus another $33.49 surcharge because her treatment was after 10 p.m.

Confused, McCollin called the hospital and said she had already set up a payment plan for her costs.

No, she was told: "That was just for you to be in the building." The emergency physician billed separately and since he was out-of-network she was responsible.

HCA Gulf Coast Division, which also now owns Cypress Fairbanks, did not address McCollin's experience directly but said in a statement it encourages contracted doctors to join the same network as the hospital.

Eighteen months later, she remains locked in battle. If she loses, she vowed to pay as slowly as possible and do so each month with a bag of dimes.

"I don't have any qualms about paying what I owe. I pay my bills," she said of her co-pay. "But what I don't understand is the other bill. I don't understand doctors saying they don't make enough money so they have to make me pay. If I don't make enough money I don't blame someone else."