
Why New York Should Simplify Medical Bills and Improve Health Care Price Look-Up Tools

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Prepared by:

Jake McDonald
Client Services Counsel
Medicare Rights Center

The Medicare Rights Center is a New York-based, national advocacy organization that works to ensure access to affordable health care for older adults and people with disabilities. With 30 years of experience working with beneficiaries, families, and professionals, Medicare Rights possesses specialized knowledge about the barriers people with Medicare face in accessing affordable health care, as well as policies and reforms that would make it easier for these individuals to get the care they need.

Based on its experience working with thousands of Medicare beneficiaries in New York and across the country, Medicare Rights supports Health Care For All New York's (HCFANY's) goals of simplifying medical bills and involving New York beneficiaries as the state develops and implements its all-payer database. While state action will not, in all cases, affect Medicare beneficiaries directly, lessons from policy decisions in the Medicare realm can inform best practices used by New York to regulate its commercial insurance industry.

The need for medical bill simplification in New York

When medical bills fail to itemize and explain—in plain language—the services that were provided to a patient and the information that was submitted to a patient's health insurance, patients can become confused and frustrated, and may incorrectly make payments on bills that should be paid for by their insurance.ⁱ New York's medical bills are not standardized, and different providers may send bills on different timeframes with different information and different payment options. In general, medical bills frequently lack key information.ⁱⁱ

For example, a typical hospital inpatient bill for one of Medicare Rights' clients will include only a few individual line items, even when the patient received numerous additional services while they were an inpatient. The same client might also receive a completely itemized bill for tests done in a lab, without knowing why and if all the tests were actually performed. In both cases, it is not always clear what right an individual has to dispute the bill or question its contents. Exacerbating confusion is the fact that Medicare Rights' clients often receive bills with due dates set just a few weeks away—even for amounts in the tens of thousands of dollars. In short, clients often cannot tell from their bills whether a claim was submitted to their health insurance, what service the bill is for, whether that amount is appropriate, and if there are any alternative payment options (e.g. paying on an installment plan, online, etc.). Further, some clients receive bills that contain outright incorrect information, and they do not know their means for redressing errors.

When faced with unexplained bills, especially those that are unaffordable, many beneficiaries delay action out of anxiety or a lack of information about their options. Often, individuals call Medicare Rights' helpline only after their bill has been sold to a collection agency and begun accruing interest.

In the Medicare program, one population that is particularly vulnerable to billing errors and confusion are those whose low incomes qualify them for the Qualified Medicare Beneficiary (QMB) program, a Medicare Savings Program (MSP). Under federal law, it is illegal for providers to bill people with QMB any cost-sharing for Medicare-covered services. Despite this protection, Medicare Rights regularly sees that people with QMB have been billed by their providers and, often, these individuals attempt to pay the bills. This means that people who are struggling to pay necessities like their rent or mortgage may go into collections or on a payment plan for bills that they should not even owe.

As Medicare Rights sees in its client advocacy, beneficiaries often do not realize that the bills they are receiving are the same ones their Medicare Summary Notice (MSN), which is essentially an Explanation of Benefits (EOB) for Medicare beneficiaries, tells them they are not responsible for paying. If bills were clearer, it would be easier for beneficiaries to compare their bills to their MSNs/EOBs, and mistakes like these might be avoided.

The need for consumer participation in the development of New York's all-payer database and related tools

Policymakers often expect patients to make health care decisions by rationally weighing costs and potential health benefits before receiving a service. Unfortunately, patients are largely unable to do this for numerous reasons, foremost among them being the difficulty in finding accurate, user-friendly information about costs.ⁱⁱⁱ Patients often have no idea how much a health service will cost them or how costs vary depending on provider.^{iv} Confusion owing to a lack of information may arise before, during, and even after a service is received.^v

For people with Medicare, numerous variables can affect the cost of a service, such as the geographic area and type of facility in which the service is performed, the cost of supplies,

and special types of billing arrangements (e.g., different charges for the same services depending on whether the patient was admitted to a hospital at the time). Due to the complexity of these variables, Medicare expects providers to educate patients about the costs of different services. For example, Medicare providers can contact Medicare Advantage plans with which they contract or their local Medicare Administrative Contractor to look up Medicare-approved amounts for the services they are providing.

Recently, the Centers for Medicare & Medicaid Services (CMS) also made available the Procedure Price Lookup.^{vi} This tool enables beneficiaries to compare average beneficiary cost-sharing for services performed in different types of facilities. Unfortunately, even with these tools the real cost of services is still largely hidden from patients and, as a result, they often are uncertain of how much they will owe for care. A consequence of this uncertainty is that patients do not necessarily shop around for the best value health care—though policy decisions are often based on the idea that they do. In addition, most existing tools do not incorporate quality information, so patients—when they price shop at all—are basing care decisions on price alone, or have to use a secondary tool to compare quality ratings.

Regardless of whether an individual has Medicare, employer insurance, Marketplace coverage, or another type of coverage, it is difficult for them to meaningfully act as health care consumers, a role that policymakers increasingly want them to perform. New York’s all-payer database is a great step forward in providing better information to consumers. Yet it is vital that such a database include a consumer pricing look-up tool that is designed and maintained based on input from the patients who are expected to use it.^{vii} Specifically, New York must seek out and incorporate feedback from the public on the creation of consumer-facing tools that allow patients to fully use the all-payer database to compare the price and quality of services offered by different medical providers.^{viii}

States like Colorado, Maine, and New Hampshire have created public portals through which users can search an all-payer database for information on a health care service and find enough pricing information to make an informed decision about where to receive the service.^{ix} These tools provide significant transparency: if you know the service you need, you can get an estimate of what it would cost based on the type of coverage you have and the provider you visit. While New York has a variety of tools available to consumers, they all lack the specificity, ease of use, and information about both pricing and quality information that would help ensure that New Yorkers are in the best position to truly shop around for their health care.

It is also worth noting that while consumer tools like those described above at their best help patients make educated decisions about getting their care, they are missing one key piece of information: they do not tell an individual when their health coverage will refuse to cover a service. Yet this understanding is vital for helping patients make educated decisions, since the cost of uncovered care can be immense. To partially address this, Medicare requires providers to give their patients an Advance Beneficiary Notice (ABN) in limited situations where the provider believes Medicare will not cover the service. ABNs help providers and patients understand costs and coverage before a service is performed.

When used appropriately, ABNs help ensure that providers and patients are communicating about the cost of a service and liability for that cost while the patient still has time to seek alternative care. While ABNs are not a foolproof method for ensuring that patients know the costs they may be responsible for before receiving a service, they do provide another tool for the state to consider. Specifically, all New York patients—not just those with Medicare—would benefit from having a system for identifying when care will not be covered, what the service will cost, and who will be liable for it.

References

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- ^{ix} As examples, consider the following: New Hampshire’s NH HealthCost: <https://nhhealthcost.nh.gov/>; Maine’s CompareMaine: <https://www.comparemaine.org/>; and Colorado’s Shop for Care: <https://www.civhc.org/shop-for-care/>.