

The Healthy Person's Guide To A Medical Bill



By Chuck Dinerstein, MD, MBA — May 12, 2017



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Medical bills are difficult to understand that makes pricing transparency an impossible dream. Here is a common sense guide to understanding these bills, especially for the uninitiated or those that see them only occasionally. It's hopefully a Rosetta Stone, but some aspects of pricing will remain mystical.

Charges: The Imaginary Numbers Of Health Care - this is the amount that your doctor or hospital is charging. It is an imaginary number (for the mathematically inclined like the square root of -1) but is frequently presented as a specific number like \$300.75, suggesting that there was a significant degree of mathematical precision involved in its determination.

Don't believe it.

Physicians learn to set prices by talking to their peers or are given these charges by their senior partners or companies that employ them. Hospitals are no better; charges are mythical numbers, paid only by foolish people without any form of insurance, which includes the service provided as well as any other expense that can be factored in.

Allowable Costs: What They Are Likely To Get - This is the first of the real numbers you will encounter on a bill. Or at least somewhat real. These are charges that have been contracted, on your behalf, by third parties, e.g. insurance companies or the government - the "payers" [1].

Two big third-parties structure physician and hospital fees, Medicare and the AMA. The AMA does so through its [Relative Value Update Committee](#) [2], which determines the value of medical services (called RVUs) based on physician work (52%), their practice expenses (44%) and malpractice expenses (4%). For example, a moderately complex office visit has an RVU of 4.64. This number is multiplied by a dollar amount to determine the allowable cost. All payers use these

RVUs but Medicare is by, and away the biggest payer and their dollar multiplier is the industry standard - currently \$35.8013 for 2017.

So to come up with a real number, that office visit has an allowable charge, per Medicare, of \$166.22. Other payers use a percentage of that multiplier, for example, [Medicaid pays \\$30 in New York](#) ^[3] for that care - a multiplier of \$6.4655; a private insurer may pay 110-120% of Medicare's multiplier

Deductibles: Now It's Real Money - This is the first number describing what you owe. Every payer has some baseline expenses that come out of pocket, which means your pocket. Until you have paid this amount for your healthcare bills, the insurance is not making any payments. For example, [Medicare's deductibles](#) ^[4] include the first \$183 for physician care during the year.

Deductibles impact the cost of your insurance in health care just like they do house and car insurance - you can choose a lower deductible in return for paying a higher premium, but unless someone else is paying the cost or you have high-cost pre-existing conditions you probably shouldn't. Many low-cost plans feature high deductibles in the range of \$5,000 annually, which is why the complaint about health care reform is that it isn't helping the poor. They have guaranteed access, sure, but can't afford the deductible plus \$5,000.

So here is how to create your own 'value proposition' for these schemes; **if you are healthy** you will not need a doctor, so you won't pay the deductible, only the insurance, making a high deductible fine, because you will probably only need it in a catastrophic event. You will blow through it on day one of a hospital stay. **If you are chronically ill**, your total cost is the deductible and the insurance premiums but you are going to be better off. For most of us, our health puts us between these poles. The insurance companies have a great deal of data on their costs and calculate the breakeven point for their insurance plans and use information about patients (age, do you smoke? Past history) to set premiums and deductibles accordingly. Now that isn't really the case, there is a ceiling on how much difference they can charge based on the risks they are undertaking. The data are less relevant because the government is controlling what they can charge. But the government needs insurance companies to stay in business or no one has coverage. It is a bit of a rigged game and, like Vegas, the odds are with the house, not you.

Co-Payments: Now It's Real Money, Right Now - this is your payment at the time of a service irrespective of what the insurance company pays or whether you have paid your deductible. Health economists believe that you will use more and more health services after meeting your deductibles because services are 'free.' We all know people who have rushed to get something done in a calendar year. Companies know this too, that is why you see a lot of end-of-year advertisements for things like new glasses, before you lose your annual allowance. In order to get people to use health services more carefully (frugally?), to 'have skin in the game' you may have to pay a co-payments, a set amount for each service, typically more for specialists than general care.

Co-payments help bridge the gap between what the physician wants and what the insurance company pays. The insurance company figures your co-payment into their calculations so that they pay less, you pay a bit more to have 'skin in the game' and not over-use health care and the physician feels that their fee is more in line with their expectations.

Insurance payment: Real Money For The Doctor - When a doctor "participates" in an insurance plan they 'accept' allowable charges as full payment by contract. This payment goes directly to the physician as the amount of money that the insurance company is actually 'paying' for the service. When doctors do not participate or accept their allowable charges, payment is instead sent to the patient. Medicare works this way. As a physician, I was not happy with that idea because often the patient thought it was a gift for them and kept it. Losing a few payments to "I thought the money was for me" makes you want to participate with insurance companies.

Your Payment: It's Not Over Yet - In the best case scenario, this is the total of your deductible and co-payment. But that is not real life. If you insist you want a certain physicians but that physician does not 'participate' and sets their fees, you are looking at another remaining balance. In the jargon this is "balanced billing."

It happens more than you think. The presence of non-participating providers in a participating hospital is a frequent problem. In an emergency, you may have to use facilities and physicians outside your network. They are not subject to contracted fees and charges, you remember **charges** at the very top - well, that imaginary number is now your real one.

That's not the only case. Sometimes you have faithfully found a hospital and physician within the network, but while hospitalized you have care from other doctors (usually consultants, assistants or anesthesiologists) who are not part of the network, and then they send you bills for much larger amounts. These new "surprise bills" you did your best to avoid are such a large problem that [New York](#) ^[5] and other states now have laws controlling this behavior.

NOTE:

[1] This is a misnomer. It is true that insurance companies and the government send out payment checks, but the premiums and taxes you pay are the sources. You are still the ultimate payer.

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[4] <https://www.medicare.gov/your-medicare-costs/part-b-costs/part-b-costs.html>

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