Hello and welcome to the Rx Counter. Today we've got a third year student Paloma Kleiman presenting the article first kidney failure than a $540,842 bill for dialysis by Jenny Gold. Paul, the counters yours.

Thanks, Matt. So the topic for today's discussion is going to be based around surprise medical bills. This is an article from KH and Kaiser health news where they'll do a bill the month about the surprise medical bills this one in particular was quite egregious upwards of half a million dollars for dialysis.

Just discusses relatively healthy guys 50 years old pretty young.

just had to go in one day because he was feeling kind of crappy and ended up with kidney failure. So kidney failure is typically covered by what? Medicare, right? The thing is it takes a certain amount of time before you can actually qualify for the benefits. And even then it has to be a certain clinic. That's part of your plans network. Unfortunately for this fella, he was in Montana who all of the dialysis clinics are under one of two companies usually, which actually cover 70% of the dialysis market. His insurance plan did not have a contract with the dialysis care. So he was stuck with the bill of just over a half million dollars for 14 weeks of dialysis. So I guess my first question is, is that okay?

No, I think that opens up the question about health literacy. talks about the wife being a physician. So we're obviously not making, giving coverage for this and figuring it all out very clear to anybody. Because physician has a hard time figuring out that obviously a lay person is going to have a really hard time figuring out what they said was the arm. There are there were no networks.

It's been no providers in network within a certain amount of distance, right. What ended up being the case was they're looking under providers when there should have been looked on their facilities that Right, right. And they just make it so hard for them. Because if they would have looked under facilities, they would have found that there was a nonprofit organization that would have covered the war that was in network, and that would reduce costs. But if you're looking up online, and you just, you know, you're in that state of mind, you know, I need to figure this out now, and go down the ground to find providers only and then don't see any providers listed in the network. You start to like, start to worry Then really thinking about, you know, how can we make it easier for people just to figure out how to figure out there in network treatment plans? And so I mean, you can't just at the end of the day, we can't just be leaving people with $540,000 bill and say, See you later. Good luck. Because it's really just not an ethical. Right. So are you saying that there should be an easier way just to see these rules and then maybe just assign them? I know that I think this assign them a case manager, or was there a case manager just called and they could talk to, because this needs to be, you know, kind of like how what we do for Medicaid party, is we walk patients through how to sign up for their plan, what's the best plan for them? How do we get them, so they have, you know, co pays that are reasonable, not so we can just say all right, finding in network and if you can't, you're stuck with $500,000.

In another thing is it this is such an acute case, you don't really have a whole lot of time to look around, right? And especially if, like it said, 70% of all the dialysis clinics in the US are owned by two companies. Your insurance plan isn't with both of them, or even with one of them. But there's the closest one is to three hours away.
Right. So that brings up another question about social determinants of health. Luckily, in this situation, they could drive that time not many people. Some people don't have the opportunity to drive two hours away to get treatment is a $5,000 that goes on with that. So I mean, we need to consider all options here. And we can't just assume that people are going to be able to drive two hours and then afford it and then figure out if it was a network or not. I think social workers need to be assigned to these people right off the bat. And that needs to be squared away before they even start treatment. Not this happen.

Unknown Speaker 5:01
So even before they start dreaming, I would say that might be counterintuitive, but to say, to get appropriate timely care, what do you say to that?

Unknown Speaker 5:11
So what I mean, so they can find the end. Okay? Yeah, yes. So just pretty much. So they can start by finding the network and then facilitate the right moves from there on out, as they said, and this time we have 90 days before Medicare starts kicking in. So maybe they need to find obviously, you can't wait 90 days all the time. They can find maybe a cheaper alternative until that 90 days kicks in. Right. And I think we need to be assigning people to help the patients out with it, because we can't just leave it all on them because they have a lot going on in their lives and they just found out the right

Unknown Speaker 5:51
question. I think I read his article.

Unknown Speaker 5:55
Details. So you know, what the reason why he gets here care about his community of customers. This is because testimonials the one and all the network one

Unknown Speaker 6:06
cannot even host so much as they did like a Google search or whatever. Okay,

Unknown Speaker 6:11
you just admitted to the hospital and they started dialysis in the hospital. I think the hospital said all right, you're getting dialysis through this and it's just like somebody that the hospital had a contract with, but unfortunately, it's payer provider insurance company did not

Unknown Speaker 6:29
I'm kind of wondering why the hospital recommended that

Unknown Speaker 6:37
Tivo? How about to find out you know, we're facilities. Why do you recommend this is a kind of questionable so

Unknown Speaker 6:45
that was suddenly brought up an article on the way kind of a controversy with this is the way that the hospitals can make money off of this isn't that from the Medicare patient is only getting paid? 200 some bucks, Lord, they make up the depth efficiency and that payment from the commercial payers, or the commercial, the patient with commercial insurance,

Unknown Speaker 7:06
were under under or uninsured or uninsured. And so

Unknown Speaker 7:08
they say, Hey, I'm getting 200 bucks from this Medicare patient, this guy is going to corrupt. He said, This guy doesn't follow the Medicare for 90 days. Let's charge him 500,000. That's how they make up for the
$200 a bonus.

So that brings up the question, Where do we shift cost to do we shift more of it to CMS to give better Medicare billing? Do we shifted to the hospital where they do have to eat that cost? Or, I mean, obviously, we can't keep it in a patient because that's unmanageable. So

brings a question because I want to look at the billing. I think I have it pulled out right here. Because if you look at the billing, it's kind of like the font here. Yeah. $6,000 for haemodialysis treatment, and my words, I think that just means labor, cost of labor. Right? So, right administration, that labor costs $6,000. It's the that is on 111. Let's go down $6,000 again on 114 14 weeks

of it, so,

right. So $6,000 every three days, for 14 weeks. And Mike, like I said, we're trying that as labor.

And that's and that's not even covering drug costs which

are happening. 200 300 bucks, right?

And that's even funny too, because as you can see here, so calcium.

One of the one of the egregious ones is

vitamin B 12. Yeah, that's

right. Or you can already think about obviously, outpatient you can think about the tablet forms

are going to be under $10. But

obviously, we might need the

price a little bit.

has to be probably specially formulated. But still, I think we can all agree that there's a little bit much to be

in decades, they're regulated, those fields are regulated, can do shit. But also because all the providers are in network, you have more even distribution of this service fees, right? It is correct. So we don't have hospital be powder paid from this service and if you have your maker from other people, so more you will need distribution.
And I think we can all respect that the hospital needs to make money with the lights on employees, but do they need to be making that much money? Obviously not. So there is kind of a middle ground that needs to be needed and CMS can probably pay more than $235 a month. So we I agree, we can have CMS pay a little bit more. We can have the hospital lower their administration fees. And the thing is, is this an itemized bill. But I mean, if someone without a health background is told calcium cost $140 a month. Oh, man, that makes sense. Like I was we're just sending like calcium 140 bucks. Right? So I think that we need to like, really? How did you prove them that calcium was $140? In my opinion, I could if I just wrote out a bill to my patient and outpatient setting and said, to arrest at $500 somebody. But that's pretty much what this is just an itemized bill of a drug and a price and there's no algorithm to how we get to that price, but it's

there. So then the question is, like I said, Do we go back to standardization of cost do we make it so that because that's certainly some of the legislation that's coming across, there's a bunch of stuff federally and a lot of states have done stuff, where it looks at the media cost in the area because it's all geographically speaking, which I think is probably for the best because geographically speaking costs in some place like California versus somewhere and Iowa are very different, because it has to adjust for cost of living regardless, that's economics. But what it will do, what reimbursement will look at. It will look at local reimbursement rates for providers will local reimbursements for facilities, labs, you name it, and it'll take that or some other equation that I didn't unfortunately have time to look into and give that as the set reimbursement rate for certain insurance for the under insured for the uninsured. So people like so you're saying there's two different brackets. So if I fall on the chart, I'm going to be this shirt on?

Well, you're insured plan you the pays, the price is going to be still negotiate. But with new legislation, it's kind of kind of set a standard, where and the geographical area, you're going to hit this median. But there's also an adjudication process that sets up a board and independent board where the provider or the facility can kind of appeal it and say, well look at all these complications, and then the payer, or whatever will say, Okay, now where that final costs still lies. I'm still not entirely sure whether that cause that final bill will still come to the patient because currently as it stands at something called balance billing, where here's all the cost, and the insurance will paid 1520 30% whatever, and then the patient stuck with that 70% granted, sometimes The in the hospital can charge more for people that are uninsured or uninsured to make up losses from other care they provided. So I guess with that model, what are some obviously good, pretty bad things about it?

It's not it's not necessarily fair money is

because the health care expenses, there's so many variables so he can guarantee that the damage is visible for

right so still be hospitals in the struggle. I think that the future healthcare going to make those hospital providers have some reasonable profit margin, it goes in for hospital. Please, it had to be as appropriate.

We had to make them be able to make some profit, but not something that should be taking consideration. This bill right here in this whole article is considering fee for service, right? We are just billing for the service that we did. Once he leaves if you're sick, healthy, whatever, I don't care, I get my money. Whereas if we took into consideration value based and we need to make sure this guy is really becoming healthy and living with his complications, then reimbursement can be structured that way. But as I said, this was a 14 week treatment $500,000
send them out the door. I did this fee. I did the ServiceNow the other famous food and that's the end of the transaction which that should not

Unknown Speaker  15:00
So, going back to where it's at now, they also have this thing called DRG. where they'll look at administrative costs, they'll look at supply costs, and then have some sort of factor that though, multiplied by, in but that is specific to a diagnosis. And then there's other factors that you can put on top of that to better represent any complications that happen.

Unknown Speaker  15:37
That's also good idea. Because you literally put those houses in the writers

Unknown Speaker  15:44
accountable. You can just try to get this feeling to the patient. But you still wanted to cover their costs the coverage and also want to kind of reward them for medical home. Yeah, you better performance, you're going to get a better paid.

Unknown Speaker  16:05
And that's my ultimate value basis, like my job or my goal and value based healthcare is to make sure that the bills and the claims submitted to the payer is not as much as they typically have been in the past. Therefore, they don't have to pay as much. And they can compensate me with whatever they do have to pay a percentage of whatever, they didn't have to pay their own. So if we, I mean, we took that into consideration. We wouldn't want that patient why not want that claim to be $540,000 because insurance only paid 16,000 of it. And

Unknown Speaker  16:42
14? Well,

Unknown Speaker  16:44
not only that, but then could also incentivize

Unknown Speaker  16:47
more preventative care. Right. So which is your thought would be hard with this

Unknown Speaker  16:53
exactly, because he didn't have any symptoms. So this falls through the cracks, but still, it'll incentivize The system to keep people out of the hospital because the hospital is where so many people have so much money put into covering those bills covering that care,

Unknown Speaker  17:11
right. And people kept getting sicker, and people get sicker. And that's why when people are avoiding getting health care, because they know if they step foot in the hospital, things like this can happen. Imagine a value based structure, if we don't want that we don't want people to stay at home because they broke a bone. But I look up YouTube tutorials for broken bones and somebody, we don't want that. And unfortunately, our generation is falling under that because they think that they can self treat anything and everything. And there's web ND there's YouTube, there's those kind of online resources that people like I will read this one time, and then I'm good to go. We found out last weekend that even the good resources like Jama published the vaping

Unknown Speaker  17:59
music I think it was new elements in it that are like Annals of Internal Medicine

Unknown Speaker  18:05
regardless. And so if they read online and they don't know how to analyze medical literature and they see, oh, this is good for me, but I don't know what the statistics behind all of this means. I'm going to do that I'm going to start making or I'm gonna so my arm together because I just got cut off or something like that, because I've read this online. So I think that we need to, I mean, we need to want people to want to come to the health care providers, we want to
incentivize, you know, it's good for you to come and see your physician, your pharmacist, or any healthcare provider, because if you don't, bad things will happen. And not my bad things where I'm going to charge you $500,000 with bad news for you, I might get sick and die. This for all we know, maybe there was some leading causes or even signs of this as diseases or complications that we could have prevented 10 2030 years ago. He is a athletic trainer, like a personal trainer, but he's very much Dude, very athletic. Sometimes those people, they just look at their physique or say I'm doing this this lead. So maybe I'm just an overall healthy guy, but they don't know what's going on inside of their body, maybe. So I think that we need to, like persuade people that anything and everything is possible. We need you to come in annually, regardless of your healthcare, or whatever you

Unknown Speaker  19:23
need me to come. Let's just make sure everything is going up to bed. You know, the reason why people are not because of this. So then, if, because a big

Unknown Speaker  19:33
problem with a lot of these certain cases, is it and the reason they get this attention is because they are just they're surprised bills, right? Because you go in expecting care because you went into a facility that's in network, but the facility doesn't use a lab, a provider of service that is not a network. So then my question is next. Do we have some sort of thing for to make quoting an issue? Where we have somebody like, Hey, I think I broke a bone. Or if I, I mean, obviously not something that acute, but like, Oh, I want to have this elective treatment, right? What's my cloak and everything I've

Unknown Speaker  20:10
always thought about because I mean people if you come into a pharmacy and you get like an inhaler, and it's not the right one on the formulary, it's like, oh, your actor inhaler is going to be $240. They're going to question it before they pay for it,

Unknown Speaker  20:25
right? And

Unknown Speaker  20:26
then I'm going to be doing the work to contact the provider to get the right one. So their insurance does cover it. Is there any way we can translate that to

Unknown Speaker  20:35
extensive medical bills? The thing is, there are some hospitals that have done this because I was looking at some other articles kind of of this nature. And there I think it was somebody that came in for like a back surgery class be something I don't know something routine, and the hospital gave them a quote and then when he went into the procedure uncomplicated, no additional services needed. And it was like 50% more than what the quote actually was a real life example my dad works with MRIs and scanning patients and they're starting to transition more into trying to get the bill before they even go into the procedure. Good. Yeah. I appreciate that. I think I read the article in

Unknown Speaker  21:23
the in the also falling

Unknown Speaker  21:28
issue. Yeah, just

Unknown Speaker  21:33
tech gnosis service provider. I think that's actually the tech surgeries they want to want to monitor spinal nerves activity. This helps a third party to do their thing in

Unknown Speaker  21:49
harmony whatnot.

Unknown Speaker  21:55
Well, I think we can all agree this is certainly an issue um, but It's something that is hard for a group of us six of us p
threes that can do anything at this level so what is it that we can do we can advocate we can advocate ever

Unknown Speaker  22:15
same as

Unknown Speaker  22:17
we can with legislation advocacy

Unknown Speaker  22:20
and also educate the patient

Unknown Speaker  22:23
the patient come to my pharmacy she just feel it's huge amount of money she wanted to look

Unknown Speaker  22:32
at that can identify the reason she was a woman provide while the physician can do

Unknown Speaker  22:38
now even in her attending position, some some guy I think that it's not just

Unknown Speaker  22:46
the pathologies. There was a pathology work in the hospital.

Unknown Speaker  22:53
Thanks for

Unknown Speaker  22:56
so I told her that okay, this is what happened. I can Recommended. I think the education because sometimes people
freak it out I didn't know how to distress our shit happen. So we have to calm them down within know what happened
and tell them what options on their work and help it in

Unknown Speaker  23:20
education advocacy. That's, that's kind of the note I guess we're going to try to end on.

Unknown Speaker  23:27
Thanks, Paul, for bringing this to our attention. It's for everyone else for coming up to the counter. We'll see you next
time.

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