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FOR YOUR INFORMATION
The Idaho Statesman
Boise, Idaho
Tuesday July 31, 2018
by Audrey Dutton

What having a baby says about fractured US health care system

Reporter recounts what it cost to have a baby in the US

I'd written about health care for seven years. Worked on the business side of a clinic for two years. Was raised by a nurse. So I thought I had a pretty good understanding of health care in the U.S.

Then I got pregnant.

Navigating the system for nine months was a refresher course in how convoluted, secretive and occasionally magical American health care can be.

The Treasure Valley is fortunate to have health systems that consistently earn good or great scores from Medicare and other organizations, and we have excellent doctors and nurses. (My obstetrician, Bryan Hodges, once made headlines for a photo showing his compassion in the delivery room, which doesn't surprise me at all.)

We're also fortunate that several nonprofit health insurers still sell plans on our state's Obamacare exchange — giving consumers a choice and keeping prices competitive.

But none of that changes the fact that being a patient in our current system is like playing a cruel game where the most you can expect from a win is to walk out healthy with a giant bill.

My husband and I won the game, going home with a healthy baby and total charges, before insurance, of $41,046.

THAT BRAN MUFFIN COST HOW MUCH?

It's been three months, and the bills have finally stopped rolling in.

The pre-insurance rate for my healthy pregnancy and uneventful delivery was the price of a new Mercedes Benz. That's in Boise, one of the cheapest places in the U.S. for medical care.

The cost of the main event and subsequent hospital stay was $22,210 — not counting a $4,386 bill for an epidural, which was worth every penny. I have no idea how much of that was for the nursing care in my delivery, how much was for the hospital bed, and how much of it was for the food I ordered in the days after.

Neither the bills from St. Luke's nor the paperwork from my insurance company, Blue Cross of Idaho, gave me any clues. St. Luke's says it sends a detailed bill to insurance companies, so they can provide that information to the patient. But on my paperwork, Blue Cross reported paying for "obstetrical services" — not the specific service, like "ultrasound" or "gestational diabetes test."

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A NOTE ON TRANSPARENCY

About those "obstetrical services" ...

An explanation of benefits, or EOB, is a document your insurance company sends you after your claim has been processed, telling you what your health care provider submitted in your claim, their price, the insurance discount and what you owe. It's probably the most important piece of paper you have if you want to fight an insurance claim or clear up a billing error.

I'd been insured by Aetna for 10 years before switching to Blue Cross. Aetna's EOBs offer a lot of detail, including the crucial "CPT code" that specifies exactly what service you were billed you for. (If you take nothing else away from this column, please remember this: Always request the CPT code that was submitted on your claim. Google it. Does the description of what that CPT code stands for match the service you actually got? If not, you and your insurer might have been overcharged.)

I'm not sure why, but Blue Cross offers no detail. Its EOBs are vague. One of mine just said "shots."

When health care costs are skyrocketing, transparency is vital. If an insurance company wants to avoid overpaying for incorrectly billed services, its members need to know what procedures/CPT codes their hospital or doctor submitted with their claim. And patients need that information to make sure *they* aren't paying for something they shouldn't. I shouldn't have had to ask Blue Cross customer service for the CPT code for each of nine "obstetrical services" listed on one EOB — especially when those identically described services ranged in price from $5 to $508.

But the hospital isn't totally blameless here, either. My bills from St. Luke's didn't have detailed breakdowns of what went into my hospital charges. I'm not sure I'd have gotten much more information from other hospitals. The lack of transparency is an industry-wide problem.

"Our experience is most patients don't want all the details listed because it can be confusing," St. Luke's told me in a statement. "Approximately less than 5 percent of our patients will ever ask for a detailed bill. If the patient would like to have one, they can call St. Luke's any time and we are happy to provide those details upon request."

BACK TO THAT BILL

Whatever St. Luke's billed for any service is not what we paid. It's not even what the health insurance company paid. That was just the amount that St. Luke's decided to bill — its retail price.

Blue Cross of Idaho regularly negotiates discounts off that retail price with providers like St. Luke's. These events are tense power struggles between Idaho's largest health care businesses.

Whatever happened in the last negotiations, it set up a discount that lowered my bill from $22,210 to $8,383 for my daughter's birth.

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If I didn't have health insurance, St. Luke's would have sent me a $22,210 bill. It would have been up to me to 1) know that hospitals sometimes give uninsured people a discount, or even write off the bill if they're poor, and 2) try to cut a deal with them.

And in Idaho, health care consumers are going in without all the information. None of these prices are made public.

The issue isn't just my bill from St. Luke's, or just my EOB from Blue Cross. It's that our system is a patchwork of businesses that operate separately and sometimes in opposition to each other. Decisions about prices are made in secret. The people providing the services don't know what things cost or what a patient will actually have to pay. And customers often are left confused and overwhelmed.

SORRY, BLUE CROSS, IF YOU WERE LEFT HOLDING THE BAG

One of my first moves in playing this health-care game was to get an insurance plan with the lowest possible out-of-pocket maximum. I knew our bills would hit the OOP max the second I went into labor, so I didn't even bother looking at deductibles.

My husband's Blue Cross of Idaho plan through work had a $4,000 family OOP max; the Statesman's best option was in the $10,000 range. His plan's premiums were a lot higher than the Statesman's, but we'd save thousands if we got the more expensive insurance with the lower cap on costs.

We switched over in January, almost halfway through my pregnancy.

What I didn't realize going into this was that pregnancy and baby-having can be a special kind of thing in health care. In my case, the payment was bundled. Instead of charging me copays every time I went in for an office visit, my doctor's practice charged a lump sum of $3,880 when the baby arrived.

Does that mean Blue Cross, the insurance company I ended with, essentially picked up all my office visit costs from 2017? That could be hundreds of dollars.

While that's another example of how convoluted our insurance-centric system can be, I found the simplicity on my end refreshing. We only got one bill from the obstetrician. I didn't have to worry about how many times I went in for checkups; it was all going into the same pot at the end.

CANADIANS ARE HORRIFIED

Of course, I wouldn't be playing this game if I lived in another country.

When I posted my total charges on Twitter, the rest of the world was quick to remind me of that.

"The only thing we had to pay was a few hundred dollars because we requested private rooms," said one Canadian.

Even now, I'm still dealing with insurance claims from January.

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Those "obstetrical services" I talked about earlier? Turns out some of them were for preventive care, like prenatal blood tests, which should have been fully covered under my plan. After countless emails and phone calls with Blue Cross, the only explanation I've gotten is that the tests, given to every pregnant woman, weren't covered because of the diagnosis my doctor submitted on those claims.

What was the diagnosis? "Normal pregnancy."

"If you have questions," a Blue Cross representative told me, "please contact the provider's office to discuss. If the provider agrees a different diagnosis or procedure should have been billed, the provider can submit a corrected claim."

This week, my appeal was supposed to go before a committee at Blue Cross. But it didn't, because my doctor's office didn't send them records they'd requested. The Blue Cross representative assigned to my case asked me to call the doctor's office and see what I could do to get her the records. When I did, the doctor's office said there was no record request in my file; they never got it.

Who is served by a system this fractured?

MY TAKEAWAY, AS A PATIENT

The system is slightly better than it used to be due to some changes in the Affordable Care Act. (The law made breast pumps and some prenatal care free for patients — fully covered by insurance.)

But it's still broken.

A health care system that every person will someday be forced to use shouldn't be so hard to navigate, so opaque and so power-imbalanced that the sane option is to give up. To shrug off that blood test you shouldn't have been billed for. To get so overwhelmed by the mountain of incomprehensible paperwork that you don't check for errors. To ignore the $20,000 bill you can never pay.

And the ACA didn't make a dent in the cost of having children.

We gladly would have forked over all our money for our daughter's healthy birth. But why should we? It's short-sighted and wrong that a mountain of bills, taking months or years to pay off, greets Idaho families when they bring home their babies.

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