The Daily Dish

Surprise Billing

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Eakinomics: Surprise Billing

A recurring topic in health policy is the notion of surprise billing — the unexpected cost of paying for a provider that is not in your insurance company's network. A quick Google search of surprise billing shows that there is a lot of federal and state legislative interest as well. How should one think about this?

Patients are likely to be hit with a surprise medical bill in three primary situations:

- Visits to the emergency room, where the patient typically has no choice of providers;
- Ancillary care services — think neonatologists, radiologists, anesthesiologists, pathologists, and assistant surgeons — that are received outside of the care provided by a patient's primary provider in the course of a procedure or test; and
- Ambulance services, where the patient has no say in who arrives to transport for emergency care.

Surprise bills are fairly common; 14 to 19 percent of emergency room visits and 9 percent of hospital stays produce a surprise bill. Surprise bills are often large; the typical emergency bill is over two and one-half times the charge from an in-network emergency room. A 2012 New York Department of Financial Services study found that the average out-of-network emergency bill was just over $7,000, and on average consumers paid for nearly $3,800 of that.

In sum, surprise billing is an unexpected event that requires significant financial resources. That's hardly a unique economic phenomenon, and the usual solution is … insurance! The unique aspect of this event, however, is that it takes place in the context of an insurance contract. What could be modified? There are really two pieces: the surprise and the bill. The former can be ameliorated by giving patients clear, up-front knowledge that they will be treated by an out-of-network provider and perhaps providing an estimate of the likely charge. That would reduce the surprise element of the phenomenon.

But that still leaves the bill. The current, unpopular approach to dealing with the bill is to have the patient pay it, which is the same as self-insurance. Conceptually, the next logical approach would be to purchase insurance against the risk of surprise bills. But who would sell such an insurance policy, given that patients have some control over seeing out-of-network providers for much of their care?Such a policy is a recipe for moral hazard, as the moment I have secondary insurance, I have no incentive to stick to network providers.

A third possibility is to socialize — i.e., spread — the costs of surprise bills through the regulatory state. For example, one could regulate that insurers must cover the costs billed by out-of-network provides. Unfortunately, that would undercut the insurers' incentives to form networks and control the costs of health care. That does not seem appealing. A more appealing approach would be to make the hospital or other care setting liable for any costs above and beyond the normal network charges. Because those facilities are typically involved in assigning providers, this solution has nice incentive effects, perhaps lowering the number of surprises. In addition, the facilities are better positioned to self-insure through capital reserves (or equity holders for profit-driven entities).

Regardless, the key fact is that the service has been provided, and after-the-fact there will be some spreading of the costs of the service. The costs can't just magically disappear.

Legislative solutions will likely be some combination of these strategies. There will be notification requirements to reduce surprises and caps on the amount patients have to pay (i.e., limited use of their self-insurance). There will be some division of the bill between insurers, hospitals/facilities, and providers, either by regulated formula or an after-the-fact negotiation (or perhaps arbitration). The key is to move away from a reliance on self-insurance for patients and more broadly spread the costs in the health care system.