Surprise medical bills increase costs for everyone, not just for the people who get them

2 October 2020, by Erin Duffy, Erin Trish, Loren Adler

Surprise billing raises insurance costs

About 12% of insurance companies' medical care spending goes to health care providers in six categories known for surprising billing. Patients rarely get to choose the provider, and the costs are often high.

Type of provider	Share of total insurer spending
Emergency medicine	1.5%
Radiology	2.3%
Anesthesiology	2.4%
Pathology	2.4%
Emergency outpatient facility	3.1%
Emergency ground ambulance	0.3%
Total	12%

Credit: The Conversation, CC-BY-ND Source: E. Duffy, et al., American Journal of Managed Care, 2020

Surprise medical billing is one of the most urgent topics in health care.

Too often after a hospital procedure or visit to an emergency room patients get hit with unexpected bills from out-of-network doctors they had no role in choosing. These include assistant surgeons, emergency room doctors and anesthesiologists.

Most research and media coverage focuses on how burdensome these bills are for the patients who receive them. As health economists and policy analysts, we think there is a broader impact of surprise billing that deserves to share the spotlight.

Evidence from our recent study suggests that everyone with commercial health insurance is paying higher premiums today because lawmakers allow the practice of surprise billing to persist. Fixing surprise billing won't just help the patients being billed; it offers the potential to lower health insurance premiums for everyone.

No choice, no competition

Patients can typically choose their doctors before they get treated. For example, they might pick a primary care doctor or the hospital and surgeon for a planned procedure based on reputation and whether those providers are in their insurance network. Picking a doctor who is in their insurance provider's network typically comes with lower costs for the patient.

When the system works well, a patient ends up with a provider they like at a price negotiated by their insurer.

But patients don't always have the opportunity to make this informed choice. In an emergency, a patient accepts the ambulance that arrives on the scene and the physicians who treat them in the emergency room. For elective procedures, even though the patient chooses the hospital and lead surgeon, they do not choose the radiologists, pathologists and anesthesiologists who are integral to their care.

About one in five commercially insured patients treated at an in-network emergency room is seen by an out-of-network physician. In about one in 10 elective procedures at an in-network hospital with an in-network surgeon, the anesthesiologist, assistant surgeon or similar physician is out-of-network.

This is not the way a market typically works. In a functioning market, consumers can choose service providers based on quality and price.

At its core, market failure arises because this system allows the subset of hospital-based physicians whom patients don't choose to negotiate with insurance companies independent of the

hospital at which they practice. Therefore, ambulance companies, emergency facilities and hospital-based physicians can still receive a substantial volume of patients whether they are in- or out-of-network. They are assured a steady stream of patients, in part, by the nature of their work. They don't need to join networks to get patients. And, as out-of-network providers, they can set their own prices.

If the insurer pays less than their full charges, the out-of-network provider can send the patient a surprise bill for the balance.

Using Medicare as a benchmark shows the markup

With this out-of-network option to submit surprise bills, these unique providers have a valuable alternative to joining networks. This gives them bargaining leverage when they negotiate with insurers, allowing them to negotiate higher prices than they otherwise could have.

As a result, these providers are out-of-network more often, set higher charges and have higher in-network prices than other types of providers who rely on being in-network to generate patient volume.

To gage just how much higher prices are, researchers often use Medicare as a benchmark for comparison. Medicare does not negotiate with providers. It instead sets prices administratively in an attempt to reflect efficient costs.

The numbers are telling.

Radiologists, or those who view MRIs, CT scans and other diagnostic images, get paid roughly twice as much by commercial insurers as Medicare pays, on average, for in-network services.

Emergency room physicians receive in-network payments that are triple the Medicare reimbursement.

Anesthesiologists and pathologists receive in-network payments three and a half times the Medicare reimbursement.

The average payments for other specialties have an upper bound of around 150% of Medicare.

This suggests that the ability to submit surprise bills generates a substantial markup in negotiated prices paid by commercial insurers.

In addition to high in-network prices, we have observed in our research that insurance plans pay out-of-network providers full charges one-quarter of the time. This prevents patients from getting surprise bills, but it is costly for insurers.

It's not just the patients getting these services who bear the inflated costs. Everyone enrolled in commercial insurance plans also pays. When insurers or employers pay providers high prices, those costs are passed on to enrollees through higher premiums.

A lot of insurer spending goes to services for which surprise billing is common

This might not be so important if these unique providers accounted for only a very small share of health care spending. But we found that is not the case.

In our recent study, we found that about 12% of insurers' spending on medical care goes to providers who commonly issue surprise bills: anesthesiologists, radiologists, pathologists, emergency medicine physicians, emergency facilities and emergency ground ambulance services.

Eliminating the ability to submit surprise bills for these unique providers would reduce their ability to collect large out-of-network payments. This would bring their leverage in price negotiations with insurers in line with those of other specialties in which patients are able to choose their providers. In turn, less insurer spending would result in lower premiums.

Two possible fixes

We looked at two potential federal policy approaches to address how surprise billing might affect insurance premiums. In both approaches, we

assume that surprise billing is banned, but the details of out-of-network payments are handled differently.

In the first approach, instead of charging what they wish, out-of-network providers would receive the average amount that insurers currently pay to similar in-network providers in the local area. This approach could reduce average payments for services where surprise billing is common by about 15%, according to the Congressional Budget Office .

A second approach would cap charges from out-of-network emergency facilities and lead hospital-based doctors to negotiate how much they get paid with the hospital. The hospital would negotiate payment with the insurer for this combined service.

Without the option to treat patients who did not choose them on an out-of-network basis, bargaining leverage for these unique providers should fall in line with specialties that cannot submit surprise bills. The precise impacts are difficult to predict, but we assume that prices shift to about half again the cost of Medicare—the high end of what these other specialties are paid.

This means savings for the health care consumer and the health care system in general, not just the people unfortunate enough to get a surprise bill.

We estimate that premiums would drop by US$67 per member-year—or 1.6% – under the first scenario. Under the second scenario, premiums would drop $212 per member-year, or 5.1%.

Applied to the U.S. commercially insured population – about 177 million people – we estimate that these reductions would save $12 billion and $38 billion, respectively.

Our research suggests that a federal policy eliminating surprise medical bills would reduce premiums for everyone with commercial insurance, in addition to sparing individual patients from these burdensome bills.

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