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Arbitration Not the Answer to Fix Surprise Medical Billing

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Surprise medical billing — when patients are unexpectedly charged exorbitant prices from providers who do not accept the patient's insurance — is squarely on the radar of policymakers inside the beltway. However, a popular proposed solution is likely to do more harm than good.

Surprise bills from out-of-network providers can be eye-popping. Whether it is a $109,000 bill for a heart attack patient rushed to a nearby out-of-network hospital or a urine test that cost $18,000, everyone has heard a story about surprise medical bills — and most people wonder why the legal system can't figure out a way to protect patients from them.

Surprise medical bills are not random. Instead, they reflect clear strategic (if not outright abusive) behavior by certain types of providers. Evidence shows thatphysicians who are least likely to be chosen by patients, like anesthesiologists and emergency department ("ED") doctors, often set their list prices in a way that maximizes their ability to engage in "balance billing." Indeed, some ED staffing companies have deliberately decided to be out-of-network for all patients that walk through the door — again maximizing their ability to balance bill — but leave patients owing massive amounts.

What can we do to fix this problem? Policymakers have a variety of tools at their disposal, from explicit price capping to more market-oriented contract reforms. However, mandatory arbitration seems to be attracting a lot of attention from policymakers, particularly since it was implemented in New York in 2015. The arbitrator can consider a wide array of information (including proposals from both the provider and insurer), and then settle on a "fair" price.

At first glance, this approach probably sounds appealing. Arbitration seems like a fairly light touch policy that sets up a way for stakeholders to adjudicate their issue with minimal government intervention.

Policymakers should not be fooled. Arbitration is neither "light touch" nor a solution to the true problem at hand. Instead of solving the fundamental issue, it kicks the can down the road to an arbitrator who faces the same challenges of any rate setter.

Common sense suggests that arbitrators are likely to develop simple rules of thumb to resolve disputes over surprise medical bills (New York's law includes a benchmark). Stated differently, arbitration is just rate-setting in another guise — and the arbitrator faces the same challenges of any rate setter. Even the most knowledgeable rate setter would find it difficult to come up with a "missing price" that closely approximates the true market price. And, whether rates are set too high or too low, rate setting can introduce large market distortions and unintended consequences.

Arbitration alleviates none of these tradeoffs and instead largely serves to make the process less transparent. If the arbitrator choses a bad rule of thumb (as some argue the New York law does), the incentives to become an out-of-network provider could even be increased.

Rather than pursue arbitration, policymakers should encourage market actors to determine appropriate prices for themselves. Consider a typical example: the patient goes to an in-network hospital, but the doctor in the ED is out-of-network. Rather than try to deal with the resulting surprise medical bills with arbitration, policymakers should require all services provided in an ED must be bundled together in a single hospital bill. This approach forces the hospital to negotiate with the ED physicians for a market price — which will then be reflected in the hospital's bill (and payment).

A similar approach can be taken in cases where patients schedule in-network procedures, only to find out an ancillary provider, like an anesthesiologist, was out of network. Again, policymakers should force hospitals to take responsibility for who will be staffing their facility, and ensure that patients are not surprised by a bill when they have chosen to go to an in-network facility.

Finally, it is important to emphasize that most hospitals have eliminated the problem of surprise medical bills. For example, at the median hospital, only about 1% of visits to the ED have any out-of-network bills. Meanwhile, at a small number of hospitals nearly everyone who comes to the ED receives such a bill. A relatively small number of hospitals have allowed these bad-apple providers to get away with sending surprise medical bills — and we should make those hospitals fix the problem they have created.

No one has ever gotten a surprise bill from the guy at the auto body shop that installed the bumper. All-in pricing prevails in markets where consumers choose their providers and are able to shun those who misbehave. Policymakers should build on that insight. Forcing hospitals to solve the problem of surprise medical bills will work — and will minimize the chances of unintended consequences.

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