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Health Care's Third-Party Spending Trap

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Many doctors—myself included— will gladly substantially discount their fees in return for up-front payments from people who pay directly for their health care. Hospitals, ambulatory surgical centers, and urgent care clinics do the same. Why shouldn't they? They don't have to pay an army of staff to fill reams of forms and wait weeks to months to collect payment from an insurance company that sometimes is lower than what they get from their direct-pay patients.

Yet most of these same providers have much higher "list prices"—the official prices they list publicly—which are used to negotiate compensation contracts with health insurance companies and other third party payers.

Examples abound of outlandish differences between the publicly posted "list prices" of providers and health care facilities and the "discounted" prices these same providers offer to uninsured patients negotiating on an individualized, "special case" basis. I recently wrote of a patient of mine who saved $17,000 by negotiating to pay directly for his hernia operation rather than using his health insurance. In Oklahoma City, the Surgery Center of Oklahoma takes no Medicare, Medicaid, or private insurance, and provides a range of surgical services to the community for a small fraction of the prices offered by other doctors and facilities that use the conventional third party system. And they list their prices proudly on their website. This and other examples of providers who have opted out of the third party game have been recently documented at Reason.

Contrary to "conventional wisdom," health insurance—private or otherwise—does not make health care more affordable. The third party payment system is the principal force behind health care price inflation. This should come as no surprise.

Nobel-winning economist Milton Friedman, in his masterpiece "Free to Choose," wrote of four ways to spend money:

Category I—You spend your money on something for yourself. Here you are very careful, because it is your money, and the good or service you are buying is for you.

Category II—You spend your money on something for someone else. Here you have the same incentive as in Category I to economize, but since you are buying something for someone else, you are not quite as meticulous when it comes to the purchase meeting the needs or values of the recipient.

Category III—You spend someone else's money on something for yourself. Here you are not concerned about how much you spend, because it is not your money. But because you are spending on yourself, you make sure you are getting what you want.

Category IV—You spend someone else's money on something for yet another person or persons. (This is what we ask our legislative representatives to do every day.) Here you are the least incentivized to economize, or to buy something that meets the needs or values of the recipient.

Like the government does, third party payers operate under the dynamic outlined in Friedman's Category IV. This becomes most obvious when it comes to the government acting as third party payer, e.g., Medicare and Medicaid. And it doesn't just pertain to health care (think of $800 toilet seats for the defense department). When the government buys goods or services for other people with other peoples' money, special interest pleading, political concerns, and cronyism run the game. And "leakage" of money through "waste, fraud, and abuse" is a given.

But private insurance companies are also spending other peoples' money—the premiums paid into a risk pool—on medical services for other people. When they negotiate compensation schedules with providers and facilities, they don't have to bargain hard enough to reach the best price possible. They just have to reach a price that is good enough—one that allows them to charge premiums that compete well with rival insurance companies. They pass on the difference between what they could have negotiated and what they actually negotiated to their customers who pay the premiums.

Meanwhile, when the third party payer is perceived as picking up most of the tab, then health care consumers and health care providers engage in Category III spending. Neither have an incentive to take cost into consideration.

People who negotiate direct payment from providers get much better deals than the insurance companies get. In the example of my patient who saved $17,000, the hospital asked for $23,000 to use its facility for a simple outpatient surgery. He got a bid for just over $2,000 at another hospital, when he offered to pay directly as a "special case." But insurance companies regularly agree to pay the hospitals thousands more for their facility charge. This makes complete sense when viewing the payment mechanism through the lens of Friedman's spending categories.

When health care providers give discounts for direct payment they don't lose money in the process. Otherwise they wouldn't do it. And, in order to keep direct-pay patients from walking away, they need to keep their prices acceptable to the patients paying the bill. Just imagine the prices providers would offer if a much greater proportion of the population paid directly for health care. My patient would have saved more than $17,000, because all of the providers involved would be openly competing with other providers for direct-pay business. Just look at the fields of cosmetic surgery, Lasik eye surgery, and dentistry, as examples of how the absence—or minimal presence—of third party payers drive prices down and quality and service up.

This isn't to say we don't need health insurance. Health insurance that covers truly unforeseen, costly catastrophic occurrences makes sense for most people. As does life insurance, property and casualty insurance, and auto insurance. But health insurance that covers routine, predictable events isn't really insurance. It's prepaid health care. And it is driving up prices for everyone with everyone else's money.

Policymakers need to understand that the key to "affordable health care" is not to increase the role of health insurance in peoples' lives, but to diminish it. We need much less Category IV spending on health care, and much more of Category I.