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Jeffrey Singer: The Man Who Was Treated for $17,000 Less

Bypassing his third-party payer, my patient avoided a high hospital 'list price.'

JEFFREY A. SINGER

Every so often I have an extraordinary and surprising experience with a patient—the kind that makes us both say, "Wow, we've learned something from this." One such moment occurred recently.

A gentleman in his early 60s came in with a rather routine hernia in his lower abdomen, one that is easily repaired with a simple outpatient surgical procedure. We scheduled the surgery at a nearby hospital.

My patient is self-employed and owns a low-cost "indemnity" type of health insurance policy. It has no provider-network requirements or preferred-hospital requirements. The patient can go anywhere. The policy pays up to a fixed amount for doctor and hospital bills based upon the diagnosis. This affordable health-insurance policy made a lot of sense to this man, based on his health and financial situation.

When the man arrived at the hospital for surgery, the admitting clerk reviewed the terms of his policy and estimated the amount of his bill that would be paid by insurance. She asked him to pay his estimated portion in advance. (More hospitals are doing that now because too often patients don't pay their portions of the bills after insurance has paid.)

The insurance policy, the clerk said, would pay up to $2,500 for the surgeon—more than enough—and up to $2,500 for the hospital's charges for the operating room, nursing, recovery room, etc. The estimated hospital charge was $23,000. She asked him to pay roughly $20,000 upfront to cover the estimated balance.

My patient was stunned. I received a call from the admitting clerk informing me that he wanted to cancel the surgery, and explaining why. After speaking to the man alone and learning the nature of his insurance policy, I realized I was not bound by any "preferred provider" contractual arrangements and knew we had a solution.

I explained that just because he had health insurance didn't mean he had to use it in every situation. After all, when people have a minor fender-bender, they often settle it privately rather than file an insurance claim. Because of the nature of this man's policy, he could do the same thing for his medical procedure. However, had I been bound by a preferred-provider contract or by Medicare, I wouldn't have been able to enlighten him.

Hospitals and other providers make their "list" prices as high as possible when negotiating contracts with health plans and Medicare regulators. No one is ever expected to pay the list price. Anybody who has seen an "Explanation of Benefits" statement from a health plan will note a very high charge from the provider, and an "adjusted charge" based upon the contracted fee schedule, which usually leaves the patient with little or nothing in out-of-pocket expenses. The only people routinely faced with list prices are those few people who have insurance like my patient's—that doesn't include a pre-negotiated fee schedule with contracted providers—or those who have no insurance.

Most people are unaware that if they don't use insurance, they can negotiate upfront cash prices with hospitals and providers substantially below the "list" price. Doctors are happy to do this. We get paid promptly, without paying office staff to wade through the insurance-payment morass.

So we canceled the surgery and started the scheduling process all over again, this time classifying my patient as a "self-pay" (or uninsured) patient. I quoted him a reasonable upfront cash price, as did the anesthesiologist. We contacted a different hospital and they quoted him a reasonable upfront cash price for the

outpatient surgical/nursing services. He underwent his operation the very next day, with a total bill of just a little over $3,000, including doctor and hospital fees. He ended up saving $17,000 by not using insurance

This process taught us a few things. First, most people these days don't have health "insurance." They have prepaid health plans. They pay premiums to take advantage of a pre-negotiated fee schedule arranged for and administered by a third party. My patient, on the other hand, had insurance.

Second, even with the markdown for upfront "cash-pay" patients, none of the providers was losing money on my patient. Otherwise they wouldn't have agreed to the prices. With the third-party payer taken out of the picture, we got a better idea of the market prices for the services. It is the third-party payment system that interferes with true price competition, so "market clearing prices" can't develop.

Take the examples of Lasik eye surgery or cosmetic surgery. These services are not covered by insurance. Providers compete on the basis of quality, outcomes and price. And prices have continually dropped as quality and services have improved—unlike the rest of health care.

When my patient returned for his post-op visit we discussed the experience. It was clear to both of us that the only way to make health care more affordable is to diminish the role of third-party payers. Let consumers and providers interact through market forces to drive down prices and drive up quality, like we do when we buy groceries, clothing, cars, computers, etc. Drop the focus on prepaid health plans and return to the days of *real* health insurance—that covers major, unforeseen events, leaving the everyday expenses to the consumer—just like auto and homeowners' insurance.

Sadly, we are heading in the exact opposite direction. ObamaCare expands the role of the third party and practically eliminates the role—and the say—of the patient in the delivery of health care. Will they ever learn?

Dr. Singer practices general surgery in Phoenix, Ariz., and is an adjunct scholar at the Cato Institute.