How Outrageous Pricing & Egregious Profits Are Destroying Our Health Care

BITTER PILL

Analysis of Steven Brill's *Time* Magazine Article

by Arthur H. Gale, MD

The most important takeaway message from this landmark article is the detailed account of the outrageous pricing practices of hospitals and the important role played by their secretive chargemaster.

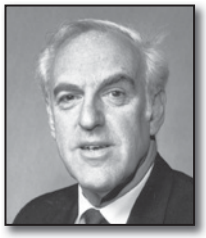
In the March 4, 2013, issue of *Time* magazine a 24,000 word article (the longest ever published in *Time's* existence) author-journalist Steven Brill identifies a major source, likely the most important, of high health care costs.

By "following the money" Brill concludes that hospitals and their arbitrary internal price list for their products and services - known as the chargemaster - are the main culprits. Surprisingly, the hero of the article turns out to be the much maligned Medicare, the only organization that has the power to stand up to the hospitals' outrageous pricing system.

Brill cites many examples of sky-high hospital charges and compares them to what Medicare pays. For example, one hospital charged a non-Medicare patient $199.50 for a troponin blood test. For a Medicare patient the charge was $13.94. Another hospital charged a patient $157.61 for a CBC. For a Medicare patient the charge was $11.02.

"Hospital finance people argue vehemently …they lose as much as 10% on the average Medicare patient. But even if the Medicare price should be, say, 10% higher, it's a long way from $11.02 plus10% to $157.61." The author quotes Jonathan Blum, deputy administrator of the Centers for Medicare and Medicaid Services: "I was driving through central Florida, and it seemed like every billboard I saw advertised some hospital with these big shiny buildings. So when you tell me that they are losing money on Medicare patients and shifting money costs from Medicare to other patients, my reaction is that central Florida is overflowing with Medicare patients and those hospitals are expanding and advertising for Medicare patients. So you can't tell me they are losing money when they serve Medicare patients."

Chargemaster prices are completely arbitrary. They have no connection to the real cost of providing a service or product. They differ from hospital to hospital. Hospital administrators don't want



Arthur H. Gale, MD, MSMA member since 1976, is a *Missouri Medicine* Contributing Editor. He practices Internal Medicine in St. Louis.
Contact: agalemd@aol.com

to talk about them. They say they are meaningless because insurance companies routinely get discounts. But they are not meaningless.

"Insurers will try to negotiate prices that are 30 to 50% above Medicare rates rather than discounts off the sky-high chargemaster rates. But insurers are increasingly losing leverage because hospitals are consolidating by buying doctors' practices and even rival hospitals. Getting a 50% or even a 60% discount off the chargemaster price of an item that costs $13 and lists for $199.50 is still no bargain." The fact is the insurer needs the hospital more than the hospital needs the insurer.

Brill says: "That so few consumers seem to be aware of the chargemaster demonstrates how well the health care industry has steered the debate from why bills are so high to who should pay them."

The ultimate defense of the hospitals, especially the non-profits, when challenged about their exorbitant charges, is their charity care. An ad by the American Hospital Association in a popular Congressional tip sheet urged Congress not to cut hospital payments because it would jeopardize the $39.3 billion in care for the poor that hospitals now provide. But that $39.3 billion figure is calculated on the basis of the chargemaster price. Based on what Medicare actually pays for this care, charity care costs the hospitals less than $3 billion. That's less than one-half of one percent of U.S. hospitals' annual revenue. Worse yet hospitals egregiously even include bad debt in their charity care!

Brill asks rhetorically what the wealthy 'non-profit' hospitals do with all their profits. His answer is that they add more buildings and add more beds despite the fact that the U.S. has more hospital beds than it can fill. They also use their profits to buy more equipment, hire more people, buy more physicians practices, buy rival hospitals, and of course raise their executive salaries.

The author cites data that show that inpatient care at hospitals is only marginally profitable. DRGs or fixed payments for various diseases have been successful in controlling hospital profits. On the other hand outpatient care is "wildly profitable," a veritable gold mine. Outpatient services include such items as clinical laboratories, radiology imaging, especially CT scans, same-day surgery, and cancer chemotherapy.

To illustrate his point, Brill cites the case of a patient who received an $87,000 bill for an outpatient procedure for the insertion of a spinal stimulator at facility owned by Mercy Health. By following the money closely he found that Medtronic sells the stimulator to the hospital for about $19,000. Because Mercy Health, where the procedure was performed, is part of a chain of hospitals it probably paid 5% to 15% less than that. The hospital sold the stimulator to the patient making a $30,000 profit, "a margin of more than 150%." The patient was never told the price of his stimulator or the cost of the procedure beforehand. He assumed that the $45,000 that his union insurance provided would cover just about any outpatient procedure. He never expected that his bill would be almost twice the covered amount. Eventually, by hiring a private medical billing specialist, the patient was able to get a reduction of his bill and ended up paying $10,000 out of pocket. That' a hefty sum for an average working man.

The author then launches into a withering critique of Mercy Health, a chain of 31 hospitals, with headquarters in St. Louis. The most recent IRS filing shows that the chain had $4.28 billion in revenue. Its executive vice president, Myra Aubuchon made $3.7 million, its president and CEO Lynn Britton made $1,900,000. In all, seven executives were paid more than $1,000,000 annually. Mercy is owned by a religious organization called Sisters of Mercy. Its stated mission is to carry out a healing ministry. Its charity care, according to its auditors, Ernst and Young, was worth 3.2% of its revenue. However the auditors caution that this figure is based on charges not actual costs. In other words, the charitable figure is based on the chargemaster. Since the actual costs are about one tenth of the chargemaster, charity care at Mercy amounts to about three-tenths of one percent of its revenue. For this insignificant amount of charity care Mercy and other non-profit hospitals get generous tax breaks.

Brill contrasts the fore-mentioned scenario with Medicare. He describes the case of an 88-year old man who collapsed from a heart attack. He survived two weeks in the intensive care unit of the Virtua Marlton hospital in Philadelphia. The patient then spent three weeks in a convalescent center. Virtua Marlton is part of a four-hospital chain. 2010 Federal filings showed that the CEO of this chain made over $3 million and two other executives received annual salaries of $1.4 million and $1.7 million respectively. The hospital had an operating profit of $91 million.

The patient received a bill totaling $268,227 from the two health care facilities. According to Brill, "Medicare made quick work of this bill paying just $43,320. The patient paid nothing." In similar cases throughout the country Brill states that Medicare has saved the taxpayer billions of dollars. He notes that "the convalescence home does not have to accept Medicare patients and their discounted rates. But it does accept them and encourages doctors to refer them."

Because of his research on how hospitals calculate charges Brill believes that 'Obama Care' won't work because

it won't lower costs. The players are all the same. Hospitals will continue to ratchet up prices as will private insurers, big drug companies, and device manufacturers .

Brill concludes "that the real issue isn't whether we have a single payer or multiple payers. It's whether whoever pays has a fair chance in a fair market. We don't have to scrap our system and aren't likely to. Put simply, the bills tell us that this is not about interfering in a free market. It's about facing the reality that our largest consumer product by far - one-fifth of our economy - does not operate in a free market." Brill implies that if private insurers could somehow acquire the bargaining power of Medicare we would have a truly free market in health care.

Brill has a number of suggestions for changing the system like taxing hospitals and outlawing the chargemaster. But because of the hospitals' enormous political clout both locally and nationally he realizes that most of his proposals are unrealistic at the present time.

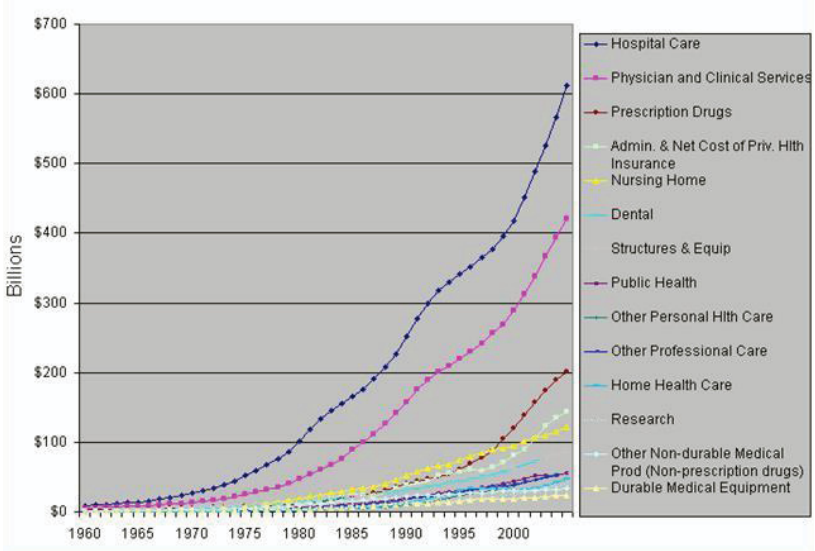
One of Brill's proposals that will resonate with doctors is reforming the tort liability system: "Finally, we should embarrass Democrats into stopping their fight against medical malpractice reform…Trial lawyers who make their bread and butter from civil suits have been the Democrat's biggest financial backers for decades. Republicans are right when they say tort reform is overdue." He also recognizes that Medicare underpays physicians. He proposes that Medicare patients who are financially able should be assessed an extra fee to increase physician reimbursement. For a lay person, Brill is uncommonly sensitive to the current plight of physicians.

In conclusion Brill states: "Over the past few decades, we've enriched the labs, drug companies, medical device makers, hospital administrators and purveyors of CT scans, MRIs, canes and wheelchairs. Meanwhile, we've squeezed the doctors who don't own their own clinics, don't work as drug or device consultants, or don't otherwise game a system that is so gameable. And of course, we've squeezed everyone outside the system who gets stuck with the bills." The one flaw in Brill's article, in my opinion, is that he leaves off this list insurance companies whose astronomical profits rival those of the hospitals.

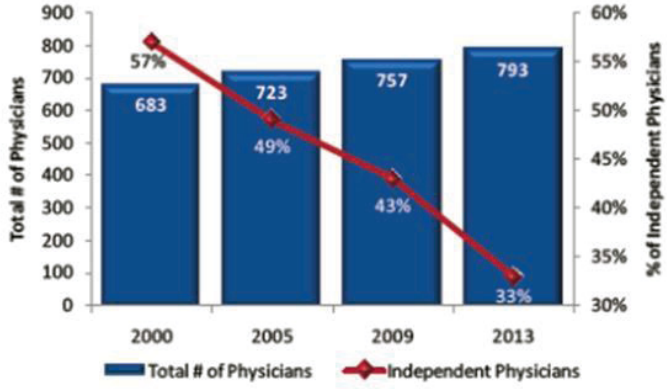
In my view, the most important takeaway message from this landmark article is the detailed account of the outrageous pricing practices of hospitals and the important role played by their secretive chargemaster. Because of the political power wielded by hospitals, this expose' of hospital charges will perhaps produce little or no substantive change. Its most enduring effect may be that the image of the hospital as a benign efficient community institution has been permanently tarnished. MM

1 Picture = 1,000 Words

Hospitals: Main Driver of Soaring Health Care Costs & Employed Physician Status



Total Physicians vs. Independent Physicians Projected Change, 2000 - 2012 (000s)



Source: Medical Group Management Association (MGMA), 2011