

# The True Cost of Healthcare

A View of Healthcare Costs from the Inside

From the Website: [www.truecostofhealthcare.org](http://www.truecostofhealthcare.org)

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  - i. Far fewer people are hospitalized now than in the past.
  - ii. The bureaucracy we endure doesn't help.

# INTRODUCTION: HIDDEN COST

When I began my medical career more than a decade ago, people were already very concerned about the skyrocketing cost of healthcare. However, as much as everyone knew medical costs were high, no one in my profession seemed to know why. None of my colleagues could answer even simple questions about what, specifically, was costing so much. This seemed to be a real problem: how could we begin to control these costs, if even the people in the field didn't know what they were?

Why didn't we know? To start with, unlike any other business in America, almost all of the financial transactions in healthcare are hidden from the providers as well as the patients. We order tests, procedures and medications to manage our patients, but very few doctors, or other healthcare providers, have any idea how much any of those things cost. Patients only rarely pay directly for these services and payment for any service varies substantially from different payers. Hospitals have separate billing departments that are far removed from anyone ordering or performing tests or procedures. No one directly involved with patient care has any notion of the charge or reimbursement for their service. Even most private doctor's offices contract billing companies, who just send them a check each month from the total amount collected, leaving them no notion of the actual charge or reimbursement for an individual service they provided.

This is a big problem -any cost that is hidden or confusing is easy to inflate. Because of that (and because I hate not knowing what's going on) I began gathering information on how much my patients were charged for their medical care. It was not easy. As an example, to find out how much someone would have to pay for a medication I would often have to phone the pharmacist and provide all of the information regarding the patient, drug, dose, directions and number of pills before even the pharmacist knew the price. I've also spent years collecting information from individual insurance companies regarding reimbursement rates, phoned radiology departments, laboratories, billing departments and even had patients bring me their bills. When anyone has to put this much effort over so many years into finding something out, you have to ask how much trouble someone has taken to hide it.

Like everything, the information is out there. It's just buried so deep that it's very hard to find. The purpose of this website (book) is to dig it up and lay out as much of the information about medical costs as possible. With this information, I'll try to explain how and why most of the costs are hidden and suggest ways in which you can avoid being overcharged.

Different chapters deal with the cost of different aspects of healthcare: medications, office visits, hospitalizations, tests, procedures and insurance. Sometimes exact costs are elusive because of the many factors that go into the cost of, for example, an MRI or an X-Ray or an office visit, where only advice is sold. In these cases, I'll give the typical formulas for billing and insurance reimbursement as an indication of value.

I promise that each section on each type of medical cost will have a lot of information that seems bizarre. It seems bizarre because it is. Remember that when people talk about the "US healthcare system," they often like to point to it being a "free market system." What's bizarre is that nothing I'm going to describe looks very much like a market at all. As I said, no one appears to know what anything costs--not the people buying (the patient), not the people selling (the doctors and hospitals). The cost of a product is a central feature to any market system. If no one knows what these costs are, how can this "market" be "free"?

# MEDICATIONS: WHAT YOUR PHARMACIST WON'T TELL YOU

If there's any cost that should be easy to understand, it's the cost of medications. Pharmacies buy prescription drugs in bulk from pharmaceutical corporations the same way they buy aspirin, and then sell them for a profit. But somehow this simple transaction is wrapped in so many layers of confusion that almost no one understands what's really happening. So let's start by trying to figure this out.

Anytime you go to a store (say, a grocery store) you expect to see all of the products being sold with their prices plainly displayed. When you go to the checkout, that's the price you expect to be charged. You also expect to be able to check the price of the same or a comparable product in competing stores so you can shop around. That's how the free market works.

Imagine what it would be like if a grocery store never displayed the price of anything. And the price you're charged might be totally different from the price the next customer is charged for the same product. In fact, suppose you couldn't even pick your own groceries. A grocery list would be handed to you by a food expert and you'd be billed based on your particular "grocery plan". Eggs might cost you \$5, the next person \$10 and some poor guy who doesn't have a grocery plan would have to pay \$50 for the same carton. Don't even think about shopping around. Your grocery plan follows you everywhere and determines the price you pay and, since you're only allowed to buy what's on the list, you can't even price compare similar items (like brown eggs vs. white eggs). The only way to save money would be to go without groceries. Do you think this would make food cheaper or easier to get? Well, what's described above is pretty close to how prescription medications are sold in the U.S. Why?

## IN THE BEGINNING

A lot of very useful medications have been developed since 1980 so, as recently as a decade ago, the vast majority of these were brand name only and rather expensive. A typical medication for high blood pressure or high cholesterol would cost \$4-\$5 per pill. For medicines taken daily (or worse 2-3 times per day) this could add up very quickly. This is especially true for a person taking 5 or 6 medicines daily for a number of chronic diseases. Drugs started to become a significant portion of people's medical costs, so insurance companies stepped in and offered plans that would cover a number of these medications (with many restrictions). Under these plans, the patient might only be responsible for a \$10-\$20 monthly copay instead of the regular \$100- \$150 monthly cost per medicine.

## TIMES HAVE CHANGED.

Now a lot of patents have expired, and many of the medicines that are commonly prescribed by doctors are generic and very cheap. Medications that used to cost pharmacies \$400 for 100 pills (and then were sold to you for a profit) now cost pharmacies anywhere from \$1-\$10 per 100 pills. That's right: many medicines got more than 100 times cheaper. What they sell them for, though, is their business.

Most pharmacies realized that it wasn't in their interest to tell anyone that drug prices were dropping. With everyone used to using insurance to buy their medication, the pharmacies could just continue to charge the same copay, and make a substantial profit without ever having to bill the insurance company. In the meantime, the insurance companies were happy because people still bought prescription drug

coverage for these medications, believing that they were saving money when, in fact, they weren't. It cost the insurance company nothing. Everyone won (except the customer).

The copays are still based entirely on the insurance plan so the same medicine in the same pharmacy might cost \$5, \$10 or \$25 for a months' supply. What's more, people might pay several hundred dollars a year to get prescription drug coverage on their insurance, even though that coverage increases the cost of many medications and cost the insurance company nothing. It's like buying a book of coupons that say "one for the price of two" at your local grocery store. You can see why they didn't want to tell you about it.

## SOMEBODY HAD TO FIGURE IT OUT, RIGHT?

A few years ago Wal-Mart received a lot of publicity about their policy of selling generic prescription medications to people without insurance. For \$4, an uninsured person could get a one month supply of a generic medication. \$10 bought 3 months of the same medication. This looked like another Wal-Mart attempt to undercut the competition. But the thing that almost no one reported was that ANY pharmacy could sell most of their generic medications for the same price as Wal-Mart and still make a profit. The real story was that no one else did what Wal-Mart was doing. Wal-Mart wasn't doing this for charity, or because they had special purchasing power. These generic medications are inexpensive and Wal-Mart could gain a lot of publicity, and still make a profit selling them.

Costco does the same thing in a slightly different way. They buy medications from pharmaceutical companies and then sell them for slightly more than what they pay. In other words, Costco buys and sells prescription medications in the same way they buy and sell everything else in their stores. And this is somehow revolutionary? That alone should tell you how absurd the medical field is, and why prices are so hard to control. (Note: I'm not just giving Costco free advertising. I mention them because, so far, they've given the closest thing to the actual price of these medications and that's what I'm trying to find).

Many of Costco's prices are given in the table at the starting on page 5. I haven't been able to cover everything. Each price on the list took a phone call from me or my receptionist, asking the pharmacist about one medication at a time, and just changing the dose of the same medications changes the price - and not in any way you could predict. And of course the price can vary over time because generic suppliers will change their formularies and force the pharmacies to go elsewhere.

The list is for some of the most commonly prescribed medicines by primary care doctors. For example: A person can have high blood pressure, diabetes, high cholesterol, congestive heart failure, and coronary artery disease and be treated effectively with lisinopril, carvedilol, simvastatin, furosemide, metformin and glipizide all for a total of only \$172 per YEAR! (See table on next page). Throw in aspirin for about \$5 per year and it's still a total of less than 50 cents per day for everything. If it's a male who also has an enlarged prostate, his terazosin would cost only \$27 per year and if taking all of those medications every day depresses him, he can get Prozac (Fluoxetine) for \$21 per year. But, if the same patient uses his insurance and has even a \$5 monthly copay for each medication the same list would cost about twice as much. (If that doesn't strike you as ironic, nothing will.) I should emphasize here that these are highly effective medications used to treat many of the most common causes of death and disability in this country.

For medications taken daily for chronic conditions the list gives the price for a 100 pills and a FULL YEAR'S supply. For other medications the price of 30 and 100 pills is given

<b>Costco's Prices for Generic Medications as of October, 2013 Medication and Dose</b>	<b>Price for 100 Pills (Without Insurance)</b>	<b>Price for a Year (365 Pills Unless Otherwise Stated)</b>
<b>Blood Pressure Medications</b>		
Amlodipine 5 Mg	\$12.86	\$25.49
Amlodipine 10 Mg	\$10.44	\$26.49
Atenolol 25 Mg	\$6.90	\$14.78
Atenolol 50 Mg	\$8.22	\$16.80
Atenolol 100 Mg	\$9.93	\$23.56
Benazepril Hcl 5 Mg	\$10.83	\$32.95
Benazepril Hcl 10 Mg	\$10.83	\$32.95
Benazepril Hcl 20 Mg	\$10.83	\$32.95
Benazepril Hcl 40 Mg	\$10.83	\$32.95
Bisoprolol 5 Mg	\$27.92	\$88.27
Bisoprolol 10 Mg	\$27.92	\$88.27
Carvedilol 3.125 Mg	\$7.18	(730 Pills) \$32.95
Carvedilol 6.25 Mg	\$7.18	(730 Pills) \$32.95
Carvedilol 12.5 Mg	\$7.18	(730 Pills) \$32.95
Carvedilol 25 Mg	\$7.18	(730 Pills) \$32.95
Clonidine Hcl 0.1 Mg	\$10.83	(730 Pills) \$63.44
Clonidine Hcl 0.2 Mg	\$10.83	(730 Pills) \$63.44
Clonidine Hcl 0.3 Mg	\$8.62	(730 Pills) \$37.19
Diltiazem 24hr Er 180 Mg	\$42.42	\$140.95
Diltiazem 24hr Er 240 Mg	\$51.02	\$167.21
Enalapril 10 Mg	\$10.83	\$32.95
Enalapril 20 Mg	\$10.83	\$32.95
Enalapril-Hetz 5-12.5 Mg	\$10.83	\$32.95
Furosemide 20 Mg	\$9.23	\$15.38
Furosemide 40 Mg	\$7.71	\$13.87



<b>Costco's Prices for Generic Medications as of October, 2013 Medication and Dose</b>	<b>Price for 100 Pills (Without Insurance)</b>	<b>Price for a Year (365 Pills Unless Otherwise Stated)</b>
Furosemide 80 Mg	\$10.83	\$32.95
Hydrochlorothiazide 12.5 Mg	\$10.83	\$32.95
Hydrochlorothiazide 25 Mg	\$7.32	\$10.50
Irbesartan 75 Mg	\$11.48	\$31.84
Irbesartan 150 Mg	\$15.15	\$44.66
Isosorbide Mn Er 30 Mg	\$22.86	\$75.75
Isosorbide Mn Er 60 Mg	\$24.47	\$100.28
Lisinopril 10 Mg	\$9.53	\$20.33
Lisinopril 20 Mg	\$9.53	\$20.84
Lisinopril 40 Mg	\$11.95	\$32.85
Losartan 50 Mg	\$15.70	\$40.32
Losartan 100 Mg	\$25.28	\$70.81
Losartan-Hctz 50-12.5 Mg	\$25.70	\$68.89
Losartan-Hctz 100-25 Mg	\$29.80	\$90.09
Metoprolol Tartrate 25 Mg	\$7.18	(730 Pills) \$32.95
Metoprolol Tartrate 100 Mg	\$7.18	(730 Pills) \$32.95
Propranolol 20 Mg	\$7.18	(730 Pills) \$32.95
Propranolol 40 Mg	\$7.11	(730 Pills) \$27.50
Propranolol 80 Mg	\$6.99	(730 Pills) \$30.53
Ramipril 5 Mg Capsule	\$19.95	\$49.11
Ramipril 10 Mg	\$28.31	\$79.99
Spirolactone 25 Mg	\$10.83	\$32.95
Terazosin 1 Mg	\$10.83	\$32.95
Terazosin 2 Mg	\$9.13	\$25.08

<b>Costco's Prices for Generic Medications as of October, 2013 Medication and Dose</b>	<b>Price for 100 Pills (Without Insurance)</b>	<b>Price for a Year (365 Pills Unless Otherwise Stated)</b>
Terazosin 5 Mg	\$9.13	\$25.08
Triamterene-Hctz 37.5-25 Mg	\$10.83	\$32.95
Verapamil Er 180 Mg	\$35.27	\$100.69
Verapamil Er 240 Mg	\$34.77	\$111.59
<b>Cholesterol Medications</b>		
Atorvastatin 10 Mg	\$35.07	\$104.93
Atorvastatin 20 Mg	\$40.12	\$130.47
Atorvastatin 40 Mg	\$48.80	\$151.77
Atorvastatin 80 Mg	\$53.14	\$156.11
Gemfibrozil 600 Mg	\$21.85	(730 Pills) \$131.72
Lovastatin 10 Mg	\$10.83	\$32.95
Lovastatin 20 Mg	\$10.83	\$32.95
Lovastatin 40 Mg	\$19.42	\$53.75
Simvastatin 10 Mg	\$10.83	\$32.95
Simvastatin 20 Mg	\$10.83	\$32.95
Simvastatin 40 Mg	\$10.83	\$32.95
Simvastatin 80 Mg	\$17.00	\$46.68
<b>Other Cardiovascular Medications</b>		
Digoxin 125 Mcg	\$10.83	\$32.95
Digoxin 250 Mcg	\$10.83	\$32.95
Clopidogrel 75 Mg	\$34.13	\$77.82

<b>Costco's Prices for Generic Medications as of October, 2013 Medication and Dose</b>	<b>Price For 100 Pills (Without Insurance)</b>	<b>Price For A Year (365 Pills Unless Otherwise Stated)</b>
<b>Diabetes Medications</b>		
Glimepiride 2 Mg	\$10.83	(730 Pills) \$63.44
Glimepiride 4 Mg	\$10.83	(730 Pills) \$63.44
Glipizide 5 Mg Tablet	\$9.23	(730 Pills) \$36.08
Glipizide 10 Mg Tablet	\$7.18	(730 Pills) \$32.95
Glyburide 2.5 Mg	\$10.83	(730 Pills) \$63.44
Glyburide 5 Mg	\$10.83	(730 Pills) \$63.44
Metformin Hcl 500 Mg	\$7.21	(730 Pills) \$25.78
Metformin Hcl 850 Mg	\$7.18	(730 Pills) \$32.95
Metformin Hcl 1000 Mg	\$6.99	(730 Pills) \$30.02
Pioglitazone Hcl 15 Mg	\$28.04	\$65.38
Pioglitazone Hcl 30 Mg	\$25.03	\$71.07
Pioglitazone Hcl 45 Mg	\$41.93	\$110.89
<b>Other Endocrine Medications</b>		
Alendronate Sodium 70 Mg (Taken Weekly)	(12 Pills) \$15.89	(52 Pills) \$49.20
Allopurinol 100 Mg	\$9.63	\$23.16
Allopurinol 300 Mg	\$10.83	\$32.95
Armour Thyroid 15 Mg	\$16.29	\$49.40
Armour Thyroid 30 Mg	\$19.40	\$60.49
Armour Thyroid 60 Mg	\$20.53	\$64.24
Armour Thyroid 90 Mg	\$29.01	\$94.63
Armour Thyroid 120 Mg	\$34.16	\$112.60
Dexamethasone 4 Mg	\$25.48	N/A
Estradiol 0.5 Mg	\$10.83	\$32.95
Estradiol 1 Mg	\$10.83	\$32.95
Estradiol 2 Mg	\$10.83	\$32.95

<b>Costco's Prices for Generic Medications as of October, 2013 Medication and Dose</b>	<b>Price For 100 Pills (Without Insurance)</b>	<b>Price For A Year (365 Pills Unless Otherwise Stated)</b>
Levothyroxine 25 Mcg	\$34.77	\$93.12
Levothyroxine 50 Mcg	\$38.70	\$98.18
Levothyroxine 100 Mcg	\$41.63	\$119.67
Levothyroxine 200 Mcg	\$55.36	\$173.67
Medroxyprogesterone 10 Mg	\$16.80	N/A
Prednisone 10 Mg	\$29.81	N/A
Prednisone 50 Mg	\$33.96	N/A
<b>Prostate Medications</b>		
Finasteride 5 Mg	\$21.24	\$69.39
Tamsulosin Hcl 0.4 Mg	\$28.69	\$75.35
Terazosin 1 Mg	\$10.83	\$32.95
Terazosin 2 Mg	\$9.13	\$25.08
Terazosin 5 Mg	\$9.13	\$25.08
<b>Anti-Anxiety and Sedatives</b>		
Alprazolam 0.25 Mg	\$10.59	N/A
Alprazolam 0.5 Mg	\$9.73	N/A
Alprazolam 1 Mg	\$9.02	N/A
Alprazolam 0.25 Mg	\$10.59	N/A
Buspirone Hcl 10 Mg	\$13.87	(730 Pills) \$69.09
Buspirone Hcl 15 Mg	\$24.55	(730 Pills) \$123.30
Clonazepam 0.5 Mg	\$11.95	N/A
Clonazepam 1 Mg	\$11.45	N/A
Clonazepam 2 Mg	\$17.22	N/A
Diazepam 5 Mg	\$11.04	N/A

<b>Costco's Prices for Generic Medications as of October, 2013 Medication and Dose</b>	<b>Price For 100 Pills (Without Insurance)</b>	<b>Price For A Year (365 Pills Unless Otherwise Stated)</b>
Diazepam 10 Mg	\$11.04	N/A
Lorazepam 0.5 Mg	\$11.25	N/A
Lorazepam 1 Mg	\$11.75	N/A
Lorazepam 2 Mg	\$18.22	N/A
Zolpidem Tartrate 5 Mg	\$14.78	N/A
<b>Anti-Depressants</b>		
Amitriptyline Hcl 25 Mg	\$9.23	\$19.22
Amitriptyline Hcl 75 Mg	\$9.73	\$22.86
Bupropion Sr 150 Mg	\$44.65	(730 Pills) \$282.60
Bupropion Hcl Xl 300 Mg	\$76.33	\$251.30
Citalopram Hbr 10 Mg	\$7.11	\$15.79
Citalopram Hbr 20 Mg	\$8.52	\$18.41
Escitalopram 10 Mg	\$12.66	\$38.30
Escitalopram 20 Mg	\$17.50	\$53.95
Lorazepam 0.5 Mg	\$11.25	N/A
Lorazepam 1 Mg	\$11.75	N/A
Lorazepam 2 Mg	\$18.22	N/A
Zolpidem Tartrate 5 Mg	\$14.78	N/A
Zolpidem Tartrate 10 Mg	\$15.13	N/A
Fluoxetine Hcl 20 Mg	\$9.23	\$20.33
Imipramine Hcl 25 Mg	\$14.38	\$42.24
Imipramine Hcl 50 Mg	\$16.39	\$47.99
Paroxetine Hcl 10 Mg	\$9.99	\$32.95
Paroxetine Hcl 20 Mg	\$9.99	\$32.95
Sertraline Hcl 50 Mg	\$23.94	\$54.67
Sertraline Hcl 100 Mg	\$21.60	\$45.35

<b>Costco's Prices for Generic Medications as of October, 2013 Medication and Dose</b>	<b>Price For 100 Pills (Without Insurance)</b>	<b>Price For A Year (365 Pills Unless Otherwise Stated)</b>
<b>Anti-Depressants Continued</b>		
Trazodone 50 Mg	\$10.83	\$32.95
Trazodone 100 Mg	\$10.83	\$32.95
Venlafaxine Er 37.5 Mg	\$29.21	\$78.83
Venlafaxine Er 75 Mg	\$29.21	\$78.83
Venlafaxine Er 150 Mg	\$29.21	\$78.83
<b>Anti-Epileptic/Manic</b>		
Carbamazepine 200 Mg	\$7.18	(730 Pills) \$32.95
Divalproex Sod Dr 125 Mg	\$20.31	\$51
Lamotrigine 25 Mg	\$18.31	(730 Pills) \$133.65
Levetiracetam 500 Mg	\$43.36	\$126.88
Lithium Carbonate 300 Mg	\$6.99	(1000 Pills) \$28.61
Oxcarbazepine 600 Mg	\$41.33	\$140.56
Phenytoin Sod Ext 100 Mg	\$15.89	(1000 Pills) \$119.06
Topiramate 100 Mg	\$26.75	(730 Pills) \$136.24
Topiramate 200 Mg	\$33.80	(730 Pills) \$195.84
<b>Anti-Psychotics</b>		
Haloperidol 1 Mg	\$10.83	\$32.95
Olanzapine 5 Mg	\$29.25	\$90
Olanzapine 5 Mg	\$41.13	\$129.86
Quetiapine Fumarate 100	\$33.25	\$107.55
<b>Other Psychiatric Medications</b>		
Benzotropine Mes 2 Mg	\$27.18	\$87.75
Hydroxyzine Hcl 25 Mg	\$13.87	\$14.88
Hydroxyzine Hcl 50 Mg	\$13.47	\$19.93

<b>Costco's Prices for Generic Medications as of October, 2013 Medication and Dose</b>	<b>Price For 100 Pills (Without Insurance)</b>	<b>Price For A Year (365 Pills Unless Otherwise Stated)</b>
<b>Anti-Parkinson's Medications</b>		
Carbidopa-Levodopa 10-100	\$25.48	(1000 Pills) \$203.56
Carbidopa-Levodopa 25-100	\$30.53	(1000 Pills) \$207.29
Carbidopa-Levodopa 25-250	\$35.78	(1000 Pills) \$291.79
Pramipexole 0.25 Mg	\$12.86	\$39.61
<b>Anti-Alzheimer's Medications</b>		
Donepezil Hcl 5 Mg	\$23.47	\$63.74
Donepezil Hcl 10 Mg	\$30.34	\$79.55
<b>Antibiotics</b>	<b>Price for 30 Pills (Without Insurance)</b>	<b>Price for 100 Pills</b>
Acyclovir 400 Mg	\$11.14	\$24.57
Acyclovir 800 Mg	\$18.92	\$48.8
Amoxicillin 250 Mg	\$5.90	\$10.83
Amoxicillin 500 Mg	\$5.90	\$10.83
Azithromycin 250 Mg	(6 Pills) \$8.82	(18 Pills) \$17.71
Cefuroxime Axetil 250 Mg	\$25.76	\$56.38
Cefuroxime Axetil 500 Mg	\$25.13	\$54.65
Cephalexin 500 Mg	\$5.90	\$10.83
Ciprofloxacin Hcl 250 Mg	\$7.51	\$20.53
Ciprofloxacin Hcl 500 Mg	\$10.84	\$24.27
Clindamycin Hcl 150 Mg	\$11.45	\$22.55
Clindamycin Hcl 300 Mg	\$25.87	
Dicloxacillin 250 Mg	\$16.50	\$39.92
Ketoconazole 200 Mg	\$18.82	\$41.73

<b>Costco's Prices for Generic Medications as of October, 2013 Medication and Dose</b>	<b>Price For 30 Pills (Without Insurance)</b>	<b>Price For 100 Pills</b>
<b>Antibiotics Continued</b>		
Levofloxacin 500 Mg		\$60.65
Metronidazole 250 Mg	\$19.73	\$50.92
Metronidazole 500 Mg	\$33.56	\$91.00
Minocycline 50 Mg	\$18.13	\$37.21
Minocycline 100 Mg		\$64.28
Penicillin Vk 500 Mg	\$8.92	\$21.85
Sulfamethoxazole-Tmp Ds	\$6.70	\$11.35
Terbinafine Hcl 250 Mg	\$18.72	\$41.25
<b>Nsaids</b>		
Indomethacin 50 Mg	\$9.02	\$17.50
Meloxicam 15 Mg	\$6.30	\$7.51
Sulfasalazine 500 Mg	\$15.49	\$35.07
<b>Muscle Relaxers</b>		
Baclofen 20 Mg	\$10.74	\$20.13
Cyclobenzaprine 10 Mg	\$5.79	\$7.61
Chlorzoxazone 500 Mg	\$14.88	\$35.17
<b>Migraine</b>		
Sumatriptan Succ 100 Mg	(9 Pills) \$21.74	(27 Pills) \$51.73
<b>Narcotic Pain Relievers</b>		
Hydrocodon-Acetaminophn 5-325	\$16.50	\$34.57
Hydrocodon-Acetaminophn 7.5-325	\$20.33	\$46.38
Hydrocodon-Acetaminophn 10-325	\$16.50	\$34.87
Hydrocodone-Ibuprofen 7.5-200	\$18.82	\$48.50



<b>Medication and Dose</b>	<b>Price For 30 Pills (Without Insurance)</b>	<b>Price For 100 Pills</b>
<b>Other Pain Relievers</b>		
Gabapentin 100 Mg	\$8.02	\$12.86
Gabapentin 300 Mg	\$8.52	\$15.38
Gabapentin 600 Mg	\$15.02	\$33.96
<b>Gastrointestinal Agents</b>		
Dicyclomine 10 Mg	\$6.99	\$6.99
Metoclopramide 10 Mg	\$5.90	\$7.18
Omeprazole Dr 20 Mg	\$9.83	\$22.60
Ondansetron Hcl 4 Mg	\$15.68	\$31.15
Ondansetron Hcl 8 Mg	\$29.31	\$71.20
Pantoprazole 40 Mg	\$11.75	\$22.86
<b>Cough</b>		
Benzonatate 100 Mg	\$7.11	\$13.37
<b>Miscellaneous Medications</b>		
Anagrelide Hcl 0.5 Mg	\$22.31	\$49.75
Anastrozole 1 Mg	\$15.89	\$33.00
Bicalutamide 50 Mg	\$33.35	\$87.66
Hydroxychloroquine 200 Mg	\$13.16	\$27.50
Methotrexate 2.5 Mg	\$96.36	\$282.88
Pentoxifylline Er 400 Mg	\$11.55	\$25.88
Tamoxifen 20 Mg	\$13.97	\$35.88
Warfarin Sodium 1 Mg	\$5.90	\$10.83
Warfarin Sodium 2 Mg	\$5.90	\$10.83
Warfarin Sodium 5 Mg	\$5.90	\$10.83

## MEDICATIONS: THE BAD NEWS

The cost of medications isn't always inflated at the pharmacy. Although the medications discussed in the last section can be used to treat at least eighty percent of the medical problems I encounter each day, there are still many diseases for which no inexpensive treatments exist. If a pharmaceutical company still has a patent on a medicine, it can (and will) charge whatever it wants. And the pharmaceutical companies will often find ways to stagger the patents so one takes over when another expires (for example, they might patent the drug right away, and the delivery system later). Then, when a medication first loses its patent the price only drops slightly because, for the first six months to a year, one company gets exclusives right to the GENERIC version, and they can charge almost as much as the name-brand version.

Also, certain medications are just expensive to produce. There are no inexpensive medications for asthma and insulin has no generic version. (The cheapest brand of insulin cost the pharmacy about \$60 per vial but, for some reason, hospitals are able to purchase it for about \$16 per vial!?!). And if the disease is rare, or there are a number of alternative medications, then each medication is essentially a "niche market" and so most generic suppliers don't see a profit in providing them. Paradoxically, increased demand tends to drive the price of generic medications down not up.

### A FEW WORDS ABOUT FREE SAMPLES:

You've heard that nothing in life is free. Pharmaceutical companies would not provide free samples if they didn't know that it brought them more money in the long run. Of course, this ends up costing you more (either directly or through your insurance premiums). The purpose of free samples is to make it far too easy for physicians to pass them out rather than considering inexpensive alternatives that will do EXACTLY the same thing. And remember that most doctors have no idea what most medications cost, so they don't think to consider cost when prescribing. Does this mean they are giving you the best possible medication for your condition independent of cost? Not necessarily. The newest drug will often be the most expensive, but it's not necessarily better. It might not even be as good (more on this later). It's just that it's too convenient to hand you a box of pills from a shelf overflowing with free samples and if there is no consideration of cost, convenience wins. Physicians have really busy days.

So far the medications discussed can be classified into two broad categories: Those that are easily affordable to almost anyone and those for which the price is high (\$100-\$200 per month for each medication) but not so prohibitively high that a single medication would overwhelm the average individual. Now we'll discuss the medications that are priced well beyond these.

### YOUR MONEY OR YOUR LIFE

A few years ago, a patient of mine who had recently been diagnosed with brain cancer, told me about a medication he was prescribed that was so expensive that he had to call several pharmacies before he could find one that would supply it. The medication is called Temodar. It cost \$1400 for five pills and he needed to take 15 pills per course for a total of 13 courses. It actually cured his disease but, unfortunately, he died a couple of years later as a result of the side effects of his treatment.

It's understandable why pharmacies would be reluctant to carry a medication like Temodar. A single course cost \$4200 and, if for whatever reason, the insurance denied payment, it would be a serious

financial blow. This is especially true for small independent pharmacies that could not easily cover such a loss. Temodar is not unique in its price though.

Below is a list of relatively new and extremely high priced medications along with their price and indication. It should be noted that many of these medications are used to treat previously untreatable diseases such as advanced cancer, HIV, severe rheumatoid arthritis or to prevent the rejection of a transplanted organ. Some of these medicines have extended the lives of people for years. It should also be noted that most of them don't actually cure any of the diseases for which they are indicated. Also, it doesn't help that the patents on many of these medications have been extended (artificially) for decades.

In most cases, these medications are used along with other medications as well as surgery or radiation therapy that add substantially to the cost being given here. Also adding to the cost is the fact that many of these medications need to be given intravenously at an office or infusion center. Multiple courses of these medications would be taken for months to years (if not indefinitely) making the eventual cost completely unaffordable to almost anyone. This list is by no means exhaustive. It's simply a small sample of the dozens of medications that can easily cost tens of thousands of dollars per year. For some medications the exact dose (and therefore cost) varies for different diseases or different sized patients so a price range is given for the total.

1) Trastuzumab (Herceptin)

Used for certain types of breast cancer often in addition to surgery, radiation therapy and other chemotherapy agents

Price: \$600 per 100mg. dose to be given weekly for one year

Total cost of drug alone: about **\$32,000** (in addition to the cost of infusion as well as the other necessary therapies)

2) Rituximab (Rituxan)

Used for lymphomas, chronic leukemia and severe rheumatoid arthritis

Price: \$3,300 per 500mg dose. 6 x 500mg. to 1,000mg. infusions required (average)

Total cost of drug alone: about **\$28,000-\$38,000**.

3) Imatinib (Gleevec)

Used primarily for chronic leukemia

Price: \$5,800 for 30x 400mg pills to be given daily indefinitely

Total cost of drug alone: About **\$70,000** per year.

4) Erlotinib (Tarceva)

Used for advanced (terminal) lung and pancreatic cancers

Price: \$4,238 for 30 x 100mg. pills (for pancreatic cancer) \$4,736 for 30 x 150mg pills (for lung cancer)

Total cost for three month supply of drug (which is optimistic) **\$12,700** for pancreatic and **\$14,200** for lung cancer.

5) Cetuximab (Erbix)

Used for head, neck and colorectal cancers (along with other chemotherapies and radiation)

Price: \$550 per 100mg. Dose of 600-800mg. followed by 400-500mg weekly doses until it stops working

Total cost of drug alone: **\$25,000-\$32,000** for about 3 months (again, this is optimistic)

6) Voriconazole (Vfend)

Used for invasive fungal infections

Price: \$4,135 for 120 x 200mg pills. Dose: Two pills twice daily for 3 months (for cure).

Total cost of drug alone: **\$12,400**.

7) Maraviroc (Selzentry)

Used for HIV

Price: \$1,050 for 60x 300mg pills to be given twice daily indefinitely.

Total cost of drug alone: **\$12,600** per year.

8) Atripla (a combination of 3 anti HIV drugs)

Used for HIV

Price: \$1,752 for 30 pills to be taken daily indefinitely.

Total cost of drug alone: **\$21,000** per year.

9) Atazanavir (Reyataz)

Used for HIV

Price: \$1,067 for 60 x 200mg. pills. Dose: Two pills daily indefinitely.

Total cost of drug alone: **\$12,800** per year.

10) Etanercept (enbrel)

Used for severe rheumatoid and psoriatic arthritis.

Price: \$475 for 50mg. to be injected weekly until remission.

Total cost of drug alone: **\$25,000** per year.

11) Adalimumab (Humera)

Used for severe Rheumatoid arthritis, psoriatic arthritis and Crohn's disease

Price: \$2,015 for 40mg. to be used every other week until remission.

Total cost of drug alone: **\$56,000** per year.

The majority of the medications in this truly unaffordable category are for conditions that are either rare or unusually severe cases of a more common disease. (There are specialists who will use some of these medicines as first line treatment which is probably very inappropriate.) A notable exception is HIV which is somewhat common and almost always fatal if untreated. This is because any uninsured patient who contracts HIV will automatically qualify for Medicaid so the taxpayer gets the bill. In virtually all cases the patient needing any of the above medications will die very soon without them (in some cases they won't live long with them either). The pharmaceutical companies know that this is a "your money or your life" situation and price their products accordingly.

Getting an insurance company to pay for an expensive brand named medicine (or anything else) is no easy feat. You would think, then, that they might be motivated to expose the deceptions in the industry. That would reduce their costs. But they won't and here is why: It is never to your advantage to have a third party pay for anything that you could easily afford yourself. Insurance companies know this. But they make a lot of money by getting you to believe that they will pay for medications that, in reality, cost them nothing. They know that by keeping people in the dark about how inexpensive generic medications are and, at the same time, allowing the price of brand name medications to remain unaffordable, people will be frightened enough to buy expensive plans that cover ALL medications. Now you know that the majority of medications they cover cost them nothing, but that is a detail they would rather not discuss.

Insurance is necessary to cover any cost that people would have too much trouble covering themselves. Medical costs are among the most common reasons for bankruptcy in this country which underscores the need for health insurance. Knowing exactly how much insurance you actually need could save you thousands of dollars and that would decrease the insurance company's profit by just as much. So the more confusing they make the system, the more they profit.

## **What You Can Do**

- (1) Never be afraid to ask your doctor how much anything he prescribes you costs. He probably won't know but he can find out and, if enough people ask, he (or she) is likely to consider it more with each future prescription.
- (2) Beware of free samples. These medications are VERY expensive. If you ever have to pay cash for one, it will cost you far more to buy one month's supply than a whole year's worth of another medication. Even the copay is likely to be many times the price of a generic alternative.
- (3) Whenever you see a pharmaceutical representative at a doctor's office you should consider two things: They are there to take time that the doctor could be spending with patients and their sole purpose is to drive up medical cost. Doctors have plenty of ways to learn about new medications. The attractive blonde from the pharmaceutical company is not there to teach, she's there to sell and you're the one who's going to pay.
- (4) Remember, you are no more obligated to use your insurance to buy your medications than to drive everywhere just because you own a car. It's a free country; walk if you like, and pay cash anytime you like. The pharmacies may not like this but it's your money.

## OFFICE BILLING

One of the main problems I've been talking about is that it's hard to identify medical costs. If the patient doesn't know what something costs—if the doctor doesn't even know what something costs—how can you possibly hope to ever control the cost? A lot of players have some responsibility in both the high cost, and the mysteries in the cost of healthcare. But in the last section, it was pretty clear that front and center in the whole crazy system were the insurance companies. And it was pretty clear why: they move most of the money in the system, and if they end up keeping a lot of it, how would anyone else notice. So, we saw how they could do this with prescription medications because neither patients nor doctors know what a pill cost. But, at least from the doctor's perspective, they wouldn't be able to pull this off with the cost of a doctor's visit, right? After all, the doctor would obviously know what he was getting paid for his own services, right?

Wrong!

I have a solo practice. A lot of practices contract with billing companies, who deal with insurance companies for them and send them a single monthly check. They don't really know what they're being paid for a given service or why. But my wife does my billing with the help of my receptionist, so I can tell you from experience that the reimbursement process for a doctor's services is about as complicated, and ridiculous, as any other part of healthcare.

The hardest part of starting a medical practice is learning how to deal effectively with the insurance companies. Compared to them, medicine is easy. Over the years, with the help of my wife and receptionist, I've learned how to play many of their games in order to get paid for what I do. The task of playing these games, though, often takes much of my day and causes many headaches. I'll share some insights with you here.

You don't have to work in a private medical practice for long before one fact becomes painfully obvious: The insurance companies don't want to pay you! Why would they? The longer they hold on to any dollar they owe you the more they profit. They're masters at delaying and denying payment for any reason real or imagined.

When you start a solo practice, you're almost guaranteed to work several months for free. Your patients are paying premiums to the insurance companies, but the insurance companies aren't paying you to see them. This is because one of the first steps in beginning a practice is to get credentialed by the insurance companies. Until you do, you don't get paid. You need to fill out a separate application for each insurance company, and then follow up with multiple phone calls. If they lose the application, or just don't like the way you answer one of the questions (which will happen several times!) you need to fill it out again. They won't tell you your application was denied—you just won't hear from them. You can't apply for insurance credentialing until after you start your practice because each application will ask you detailed questions about your practice. And, no, you won't get "back pay" when the credentialing finally comes through. As far as the insurance companies are concerned, you weren't a doctor until then.

It doesn't end there. You can start asking for reimbursement, but insurance companies have managed to develop an almost perfect system of "profit through incompetence". If you make a mistake, they don't pay. If THEY make a mistake, they don't pay. So my receptionist usually spends hours on the phone to insurance companies tracking payments or following up on denials: Start with a voice menu, be put on hold, transferred, put on hold again, cut off, repeat. On a (very) good day she'll finally get the right person

and be told “after re-examination, it appears that you’ve done everything correctly and the check should be arriving soon” click, buzz...

They don’t just deny payment. They will lose all record that a bill was sent. This means that you hear nothing and, since most insurance companies have a time limit for how long it takes you to bill for a service, if you don’t follow up regularly on every bill for every patient to each different insurance company until the payment is received, the money could be lost forever. Even if you do everything correctly and they acknowledge it, they may take weeks to send you your payment.

How does this affect you? Well, start with my receptionist. Her job is (ideally) to work with the patients I’m not seeing (the ones waiting for me, or calling on the phone), while I’m working with the patient I am seeing. She enjoys that part, and so do my patients. The problem is that she can’t help the patients when she’s playing games with the insurance company, and that takes much of her time. The other problem is, it turns what could be a rewarding job: helping to keep people healthy, into a demoralizing job: playing head games with insurance companies.

I don’t pay her enough. I say this because I know that it wouldn’t be possible for ANYONE to pay her enough for what she has to go through each week. And it isn’t just about getting reimbursed. There are the hours spent authorizing tests, visits to specialists or expensive medications that a patient might need. If the authorization isn’t done properly, the insurance won’t pay and the patient gets stuck with the entire bill for whatever procedure or test I ordered (which, as you will see later, is an amount far greater than what the insurance would have paid). They’ve even sent MY payment to the patient more than once. That’s right: they’ve paid patients to see me (or so they told me)! When, after several phone calls, I finally found out what they had done, they told me that all I had to do was bill the patient for what they paid. Oddly none of the patients remember getting a check.

With all of these headaches, it’s no wonder that most private medical practices contract billing services to handle the insurance companies for them. They simply give the service a summary of the patients they saw along with the diagnosis and encounter codes, and the service takes care of all of the billing and gives the doctor a check each month based on what was collected. We have middlemen dealing with the middlemen. Considering how confusing the payment process is, I can’t imagine how a doctor using a billing service could possibly know THAT he was paid for seeing a patient let alone how much. And this plays back into the system. You’re coming to me for medical care, and neither of us knows how much it’s costing you or how much I’m getting paid. The insurance company decides both, but doesn’t want us to know.

Some doctors are tempted to forgo all insurance and simply take cash. I’ll happily see any uninsured patient for any problem that I can solve in my office. I usually charge them less than most insurance providers pay because I get the money right away instead of having to go through the insurance nightmare. But I can’t expect my patients to pay insurance premiums and then also pay me or go without insurance because:

- (1) If I don’t accept a patient’s insurance, then the insurance companies won’t allow me to authorize diagnostic tests, procedures or appointments with specialists. This would greatly diminish my ability to help the people who are already paying extra just to see me.

(2) I would be adding to the medical costs of people who are already paying too much for medical care. This is especially true if they got hospitalized; they'd really be in trouble. In effect, I'd be punishing the victim.

This issue became especially clear to me shortly after my son was born. My wife gets our hospital insurance from her employer (she's a nurse). We checked with the hospital, and did everything they told us to do, months in advance of my son's delivery. Both the hospital and our insurance told us that everything would be covered. We even had the anesthesiologist on call in case my wife needed him (she did). Everything went well.

The surprise came six weeks later when we received a bill from the anesthesiology group for \$798. We had been told for months that everything would be covered. What's more our insurance did pay them \$722 for their service, so what happened?

### BALANCED BILLING:

When a doctor or other medical provider bills an insurance company, they usually bill for an amount that is well above the expected payment. The reason for this is that different insurance companies reimburse at a different rate for any given service. If a provider bills above what all of them will pay then he'll get the maximum that each of them will pay and not short change himself. This works well if you only deal with insurance companies since they will only pay you according to their set fee schedule. What happened to us was that the anesthesiology group at the hospital didn't have a contract with our insurance (I had heard that they didn't contract with any insurance company at the time but I don't know this for sure). This meant that they were not held to any fee schedule and, therefore, could bill whatever they wanted and collect it ALL.

So here's what happened to a doctor and a nurse who'd already done all their homework:

(1) At no time prior to or during the delivery did anyone tell us that this group wasn't contracted with our insurance. They told us everything was covered. In what other business would it be legal to bill a client for an amount that wasn't disclosed until they were billed? And this AFTER being told that we weren't going to be billed?!

(2) Our insurance paid them for their service in spite of not having a contract with them. If it wasn't enough, why weren't we told ahead of time how much their bill was likely to be? We registered at the hospital two months in advance and anesthesiology was informed at the time and, apparently this wasn't a new policy for them.

(3) Few people have a choice whether to use an anesthesiologist when they are hospitalized. Since this was the only anesthesiology group available to this hospital this was a clear case of extortion.

We had no way of challenging the anesthesiologist (what they did was legal, believe it or not) so my wife called our insurance. As I said before, my wife does my billing so she has spent years getting insurance companies to pay us what they owe. She knew exactly who to call and what to say so, in a few weeks, they coughed up the balance (they HAD promised us that everything was covered). I couldn't help but think at the time: If WE could get caught off guard by such a scheme, what chance does anyone else have with the medical system? It was also one of the very few cases I can remember where the insurance company was the eventual victim, but if my wife hadn't known exactly how to play the game, it would have been us.



This brings me to the subject of how much an office visit should cost.

Most doctors perform a narrow range of activities. This simplifies our lives in two ways: We stick to doing what we know and it's easier to bill for what we do. Knowing exactly what the insurance companies will and won't pay for helps to decrease the number of headaches they cause. As I said before, it's to our advantage to bill for an amount that exceeds what we expect from any payer. This guarantees that we get the maximum amount each payer is willing to pay. Since most insurance companies reimburse office visits in a narrow pay range (unlike hospitalizations, covered next) billing for 20-30% above the expected amount is usually enough to cover outliers. Some medical practices bill far more than this but, with insurance companies, it doesn't matter. They pay whatever they want as long as your bill meets or exceeds what they're willing to pay. I should emphasize here that I have never been involved in the negotiation of any of these rates. I send each insurance company a bill and they send me a check for whatever they want (or not); nothing more.

The problem arises when either the patient doesn't have insurance or the insurance is denied for some reason. When this happens, the patient is on the hook for the full amount billed regardless of how much this is above the expected insurance reimbursement. This overcharges uninsured people, but also anyone else who goes for a test or procedure that wasn't properly authorized or simply uses an insurance company that wants to play games (they all do). Put another way, if your doctor doesn't fill out his paper work properly, you could be on the hook for everything.

That said, the reimbursement rates for office visits can be broken down as follows:

The pay is different for a new versus an established patient since I have to take time to get to know the new ones. I also rate the level of complexity of a patient based on the number of diagnosis and amount of time spent with a patient. The exact diagnosis usually doesn't matter much for payment other than the fact that some insurance companies won't pay for certain diagnosis so we should avoid making them. If a procedure is done then that is added to the cost of the visit. A physical exam might pay very well for some insurance plans and nothing from others. This is why I've learned to check with a patient's plan, often before seeing him, to see what's covered. Phone calls and authorizations pay nothing. (And checking what's covered pays nothing).

Here are some sample rates:

**Initial visit:**

Low complexity: **\$100-\$130**

Moderate complexity: **\$165-\$200**

High complexity: **\$200-\$240**

**Follow up:**

Low complexity: **\$60-\$90**

Moderate complexity: **\$100-\$130**

High complexity: **\$150-\$175**

If I do a procedure, it will be added to the cost. For example: a joint injection will pay \$60-\$90, abscess drainage \$100-\$130, a female pelvic exam \$30-\$100 and a physical exam, if it pays at all might bring in \$100-\$180. When I see a patient in the Hospital, I get \$110-\$170 on the day they get admitted (when I make all of the initial decisions about their treatment), \$60-\$80 on follow up visits and \$60-\$90 the day that I send them home.

HMOs have a very different approach to payment. When an HMO patient chooses me as their doctor, I get a monthly stipend of \$10-\$35 to have them as my patient. I get paid whether I see them or not (when I do see them I collect a copay of \$10-\$40). I do, on occasion, get paid by them for a specific service but I never know for what in advance since the rules change frequently and without warning or explanation. Each month I get a check along with a list of the patients who chose me as their doctor (or had me chosen for them). If there is a formula for how much I get paid for each HMO patient I have no idea what it is. I just know that every month I get a check and a list, even if I'm on vacation. I will probably continue to receive this check for months after I've retired and/or died.

From what I've just described, it's plain to see that, even in the narrow field of private practice, there is a range not just in what, but how we get paid. To simplify our lives, we just send a bill to all the insurance companies for an amount that exceeds the amounts listed above and take what they give us. We learn, over the years, to bill for things that we know will pay and not mention things that won't. The main problem with our approach to billing is that it punishes willing customers by substantially overcharging them if they try to pay for our services themselves. At the same time, we reward the insurance companies, who will do anything not to pay us. In what universe does that make sense?

# HOSPITAL BILLING

Spending time in the hospital is very expensive. Rather than giving you an itemized list of everything that might go into a hospital stay, I'll talk about something that should be almost as good: bills from a hospital, complete with final reimbursement amounts. That should give us a pretty good idea of the value of hospital services, since insurance companies have access to all the costs and specialize in being able to offer the minimum amount any institution is likely to accept.

What I'll show are copies of two actual hospital bills to patients. I'll use them to take you through some of the typical aspects of hospital billing and insurance reimbursement. And, as you've probably guessed, it's going to look a little strange.

PLEASE WRITE YOUR PATIENT ACCOUNT NUMBER ON YOUR CHECK  
TO ENSURE YOUR PAYMENT IS PROPERLY CREDITED TO YOUR ACCOUNT.

SUMMARY OF PATIENT SERVICES		INSURANCE INFORMATION	
Description	Billed to Insurance	PRIMARY Insurance Name	MVP HEALTH CARE
COR CARE POST CCU	5.00	Name of Insured	[REDACTED]
PHARMACY GENERAL	379.50	SECONDARY NONE	
M/S SUPPLY GENERAL	78.47	QUESTIONS	
M/S SUPPLY STERILE SUPPLY	327.20	Thank you for choosing [REDACTED] for your health care needs. For questions about your account, contact the Business Office at [REDACTED] Monday through Friday - 8:30 AM to 4:30 PM Financial Assistance: To determine if you qualify or for more information, please contact us at [REDACTED]	
LABORATORY GENERAL	58.32	ACCOUNT SUMMARY	
LABORATORY CHEMISTRY	1467.00	Statement Date	07/31/10 - 09/30/10
LAB HEMATOLOGY	585.00	(Date) of Service	07/31/10 - 08/02/10
LAB BACTERIOLOGY/MICROBIO	401.00	Account Number	V00479485
LAB UROLOGY	187.00	Billed Charges to Date	\$21,275.49
RADIOLOGY DIAG GENERAL	415.00	Insurance Payments Received	\$-2,052.95
CAT SCAN HEAD	2502.00	Insurance Adjustments Applied	\$-19,172.54
CAT SCAN BODY	2884.00	Patient Payments Received	\$0.00
PHYSICAL THERAPY GENERAL	83.00	<b>This is your Balance</b>	<b>\$50.00</b>
PHYSICAL THERAPY EVALUATE	300.00		
EMERGENCY ROOM GENERAL	4421.00		
DRUG SPEC ID DETAIL CODING	224.00		
EKG/ECG GENERAL	396.00		
TREAT/OBS RM OBSERVATION	6762.00		
ADJUSTMENT MISCPO	0.00		
ADJUSTMENT MISCPO	-18930.54		
ADJUSTMENT MISCPO	-242.00		
PAYMENT MISCPO: NEEDS APPROPR MODIFIER	-2052.95		
TOTAL DUE:	\$50.00		

**Figure 1: Hospital Bill**

The first bill is for a patient who spent two days in the hospital, and has private insurance (a Medicare advantage program). Let's see how the numbers add up. In the bottom right corner is the Account Summary. From the first line, you can see that the total bill came to \$21,275.49, or about \$10,000/day for two days. (The services leading to that cost are on the left: a couple of \$2,500 CAT scans, a \$4,400 ER charge, etc.) On the next line is the amount the insurance company paid: \$2,052.95—just less than 10% of the total due! Ouch! Doesn't that leave the patient on the hook for the remaining \$19,222.54 (still about \$10,000/day, which would be a little hard on most of us)? No, because the next line is the insurance Adjustment, which is the amount that the insurance company miraculously convinces the hospital to forgive. In the end, the hospital charges twenty-one thousand dollars, the insurance company pays two thousand dollars, the patient pays fifty dollars (that's right, just \$50) and the rest just goes away.

Now let's look at the second bill.

► SUMMARY OF PATIENT SERVICES		► INSURANCE INFORMATION	
Description	Billed to Insurance	PRIMARY Insurance Name	MEDICARE PART A & B
COR CARE GENERAL	7600.00	Name of Insured	[REDACTED]
COR CARE POST CCU	9120.00		
PHARMACY GENERAL	477.68		
PHARMACY IV SOLUTIONS	184.00		
M/S SUPPLY GENERAL	81.45		
M/S SUPPLY STERILE SUPPLY	463.20		
LABORATORY GENERAL	72.00		
LABORATORY CHEMISTRY	3142.17		
LAB HEMATOLOGY	468.00		
LAB BACTERIOLOGY/MICROBIO	157.33		
LAB UROLOGY	104.00		
RADIOLOGY DIAG GENERAL	785.00		
RADIOLOGY DIAG CHEST XRAY	433.00		
PHYSICAL THERAPY GENERAL	946.71		
PHYSICAL THERAPY EVALUATE	282.00		
EMERGENCY ROOM GENERAL	2661.68		
CARDIOLOGY ECHOCARDIOLOGY	2650.00		
DRUG SPEC ID DETAIL CODING	205.81		
EKG/ECG GENERAL	734.00		
ADJ MEDICARE AB; BAR ADJ	-23508.07		
PMT MEDICARE AB; BAR RCP	-6161.76		
<b>TOTAL DUE:</b>	<b>\$1100.00</b>		

► QUESTIONS	
Thank you for choosing [REDACTED] for your health care needs. For questions about your account, contact the Business Office at [REDACTED] Monday through Friday - 8:30 AM to 4:30 PM	
Financial Assistance: To determine if you qualify or for more information, please contact us at [REDACTED]	

► ACCOUNT SUMMARY	
Statement Date	07/14/10
Date(s) of Service	06/06/10 - 06/09/10
Account Number	[REDACTED]
Billed Charges to Date	\$30769.83
Insurance Payments Received	\$-6161.76
Insurance Adjustments Applied	\$-23508.07
Patient Payments Received	\$0.00
<b>This is your Balance</b>	<b>\$1100.00</b>

**Figure 2: Hospital Bill**

This bill is for a patient who spent three days in the hospital, and has only Medicare. Again, a long scary list of services is on the left, some costing almost ten thousand dollars each. Again, an Account Summary, with a bill coming to about ten thousand dollars a day, then a tiny insurance payment (this time six thousand dollars, or a little over 20% of the total), apparently leaving the patient on the hook for tens of thousands of dollars.

But again the magical insurance Adjustment comes in, and the hospital decides to forgive most of the bill. So, what's behind all of this charity?

## How Hospitals Craft Their Bills

The method of reimbursement for a hospitalization differs substantially for different insurance companies. It's not just that the rate is different for each service, but that different payers will reimburse different services. Medicare, for example, bases their reimbursement rate solely on the patient's diagnoses. A diagnosis of pneumonia will get a fixed Medicare payment regardless of how long the patient stays in the hospital, what tests are ordered or what treatment is given. Other payers might pay by the day, or for each individual service. But the hospitals do all their bills the same way, no matter who the payer is. So the best way for them to get paid is to put anything that might be reimbursed by any payer on every bill.

An insurance company will happily ignore the things it doesn't intend to pay, but will never add anything the hospital leaves out. It will also happily pay less than the hospital asks, but certainly will never pay more. In other words, there is no penalty for billing too much for a service, but if the hospital doesn't bill enough, it short changes itself. The only potential penalty would be for billing for a service not provided or a diagnosis not justified.

Now let's look at what all this means. When a business sends a bill, to you or to another business, you pretty much expect the bill to show the value of what they provided, and therefore what they expect to be paid. But an insurance company pays the hospital based on pre negotiated rates, no matter what the bill asks for. The hospital can turn away all patients with that insurance, of course but, for each insurance company, that would mean turning away a lot of patients—the insurance companies are now very big.

So because the hospitals know that they'll only ever get less than what they bill, the process of hospital billing has stopped being a normal business transaction, and turned into something more like a kid daydreaming about his Christmas list. But it works, (well, not really), as long as it's just a game between the hospital and the insurance company.

## HERE IS WHERE IT GOES TOTALLY WRONG.

Hospitals see no problem in sending bills to insurance companies for five to ten times the amount that they actually expect, because they are simply playing the game that the insurance companies fashioned. But remember, they only produce one kind of bill, and it's designed to send to someone who holds all the cards (an insurance company), and so can just refuse to pay anything they didn't already agree to pay. That's their game. But what happens when you have to play the game with the hospital alone (if you don't have insurance, or if your insurance doesn't cover that stay for some reason). Then you're on the hook for the ENTIRE amount. Most hospitals have a policy that allows people to negotiate for a lower amount, but most people don't know this. And don't expect the hospital to tell you about it, let alone help out. So even if you can remember to negotiate while you're convalescing from a long hospital stay, good luck trying to get the deal the insurance company gets.

For the average person, this is no small matter. In the first case, a two day hospitalization that the insurance company got for \$2,100 (after the insurance adjustment), would cost an uninsured person over \$21,000. The adjusted charge (\$2,100) would be a pretty nasty kick in the finances for most families, but they could bounce back. The unadjusted charge, which is what you'll get if you don't have insurance, is an almost certain trip to bankruptcy.

And you'd better believe the hospitals will go after you for every penny. Here's a copy of a letter one of my patients brought me.



As you look at this letter, remember: This 8 cent debt was SOLD to a collection agency, and they used a 44 cent stamp to send it.

This problem of excessive mark-up doesn't just apply to people who are hospitalized. Hospitals charge the same amount for a service regardless of whether or not the patient is in the hospital. Anyone getting routine tests or a diagnostic workup from a hospital is likely to be charged five to ten times what an insurance company would pay for it (five to ten times what the service is really worth). So people are completely dependent on their health insurance for even small medical costs. In what other industry would you do this? Would you use your car insurance to buy windshield wiper fluid or replace a burned-out headlight? Would you use your homeowners insurance to replace a screen? In medicine, people are routinely billed several hundred dollars for trivial tests that shouldn't cost more than a car headlight, just because they don't have insurance, or the insurance company denied coverage for that test.

This isn't just a problem for patients. Just because the hospitals are playing the game doesn't mean they're winning. Some aren't even even breaking even. Many small community hospitals are currently in deep financial trouble. There are probably a number of reasons for this but much of it probably has to do with the fact that small hospitals don't do well when they're playing a game designed to pit large hospitals against large insurance companies.

Rather than trying to collect a fair amount for each affordable service directly from patients, hospitals go through the insurance companies for even the most mundane fees. In order to do this, each hospital needs a large staff of billers, who spend thousands of hours each year chasing after the money that's owed them. That's administrative cost, which they need to cover out of insurance payments. And, since each patient only brings in a small profit, each denial puts them in a financial hole. Their answer: lean harder on the patients who owe them money.

How many ways is this system broken? As I said at the very beginning, one of the biggest problems with medical costs is that the real costs are so well hidden in all these games that almost no one even knows what they are, let alone what to do with them. This applies to doctors as much as patients. We saw how patients can easily be confused into buying drugs for far more than they cost, just because they have insurance. Doctors are run around just as much by the absurd system of insurance reimbursement. Now, we find that even the biggest players; the hospitals, are playing the same crazy games by the same crazy rules.

But now it begins to really hurt the patients. It's frightening enough to have to stay in the hospital because of a serious illness. Then add the worry of a potentially crushing debt, simply because a mistake was made in billing or charting, or because your insurance company just wants to play games. Hospitals often try to justify placing this burden on patients to make up for the financial problems the insurance companies give them. (The insurance companies blame the hospitals, of course). In other words, they both make the case that they're bullies because they're being bullied. The irony of this is remarkable. How can hospitals complain about not being paid after doing so much in so many ways to discourage direct payment. Again, in what universe does this make any sense?

## Hospital Financial Analysis

Hospitalizations are very expensive. Anyone who has ever had even a short stay in a hospital knows how enormous hospital bills can be. Next to the price of a house or a car, the cost of a hospitalization for any reason might appear to be one of the highest costs many people are ever likely to face. What's interesting is that people usually have a good understanding of the costs of these other products (houses, cars, etc...). But people typically have very little understanding of the actual cost of a hospitalization or any idea of how much hospitals are really paid. This is because hospitals are normally reimbursed by insurance companies that have secret prearranged deals with most of these hospitals so insurance companies usually only pay a fraction of what they're billed.

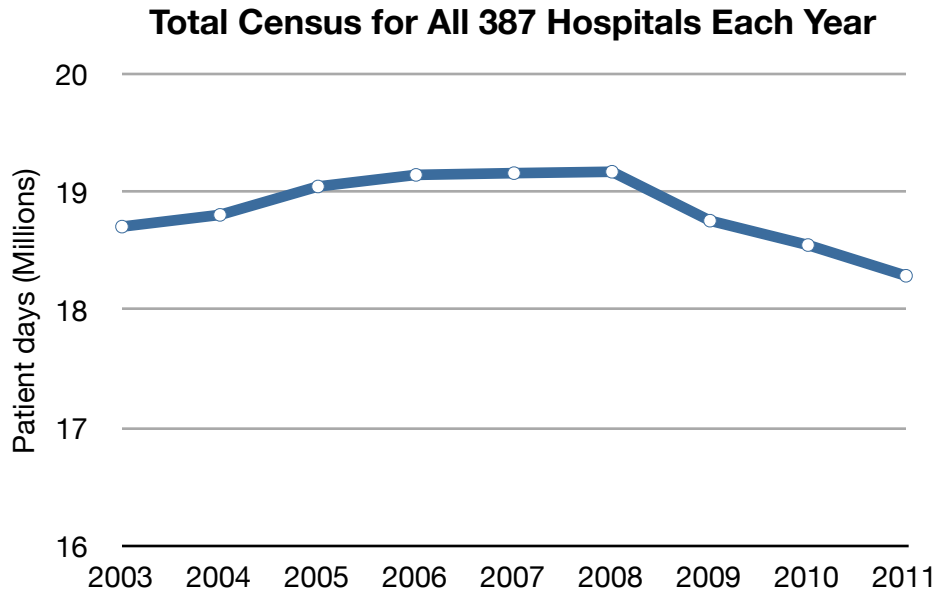
We may, however, have finally found a way to bring some transparency to the process of hospital finance. We recently discovered a very large data base that contains the complete financial records for all California hospitals going back to 2002. It's called The Office of Statewide Health Planning and Development (OSHPD) and it posts annual financial reports that are provided by every hospital in California each year.

In an attempt to untangle the mysteries of hospital finance we decided to use these financial records to determine exactly how much money in health care actually went to all hospitals. To answer this question we analyzed the financial records of 387 California hospitals over a nine year period of time (2003-2011). We extracted the census and financial data from these reports and organized this data in order to show how each individual hospital performed over this period and then made a composite table to show how all hospitals performed each year as an aggregate. Our goal was to discover how many people are being hospitalized each year, how much money is actually going to hospitals in California, at what rate is that amount increasing and to shed some light on how the process of hospital finance actually works.

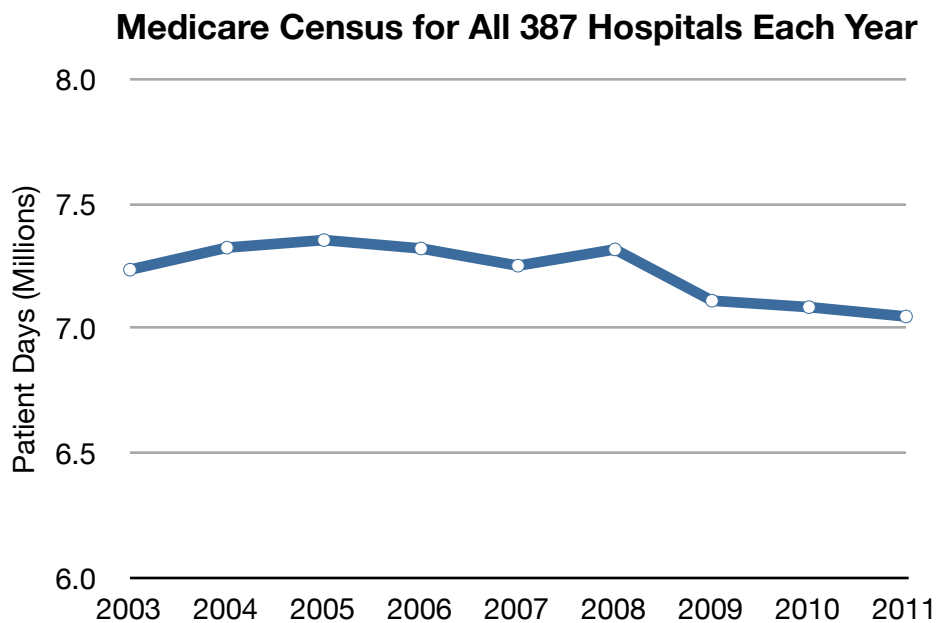
This study included financial reports from nearly every hospital in California from major university hospitals to small community hospitals, public hospitals, private for profit and non profit hospitals and even some rehabilitation facilities. The study also included 23 Kaiser hospitals that were used for census data only. Kaiser doesn't charge its patients extra for hospitalizations so their hospitals have no financial data to provide. All financial data was taken from the 364 remaining non-Kaiser hospitals in the study.

I think you'll find much of what we uncovered is rather interesting and is contrary to what most people would expect. To begin with, we'll talk about how many people are being hospitalized:





**Figure 1**



**Figure 2**

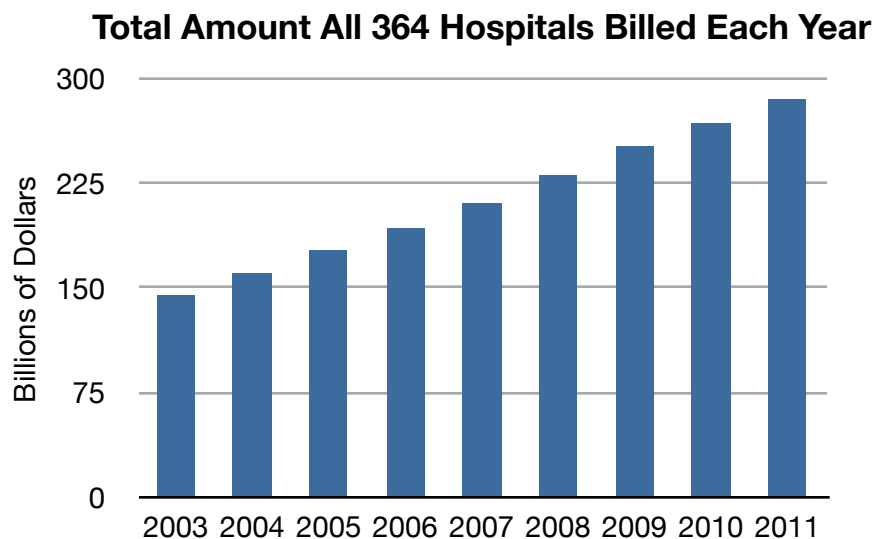
Figures 1 and 2 show the total census for all 387 hospitals combined for each of the nine years of the study (Figure 1) as well as the census for Medicare patients only (Figure 2). Hospital census is measured in patient days meaning the number of patients admitted to the hospital each year times the number of days each patient stayed in the hospital. For example, if a hospital admits

10,000 patients in a year and each patient stays in that hospital an average of four days that's 40,000 patient days for that hospital.

As you can see from Figure 1, the total census for all hospitals was just over 18.7 million patient days in 2003. This number increased slightly to just over 19 million by 2008 then dropped rather sharply (about 5 % total) to just over 18 million by 2011. This corresponds with a drop in the average occupancy rate for these hospitals. In 2003 hospitals had an average of 62% of their beds full each day but by 2011 it was just under 58% meaning that nearly one in two hospital beds were empty any given day in 2011.

These graphs are interesting because, even though the population in California had increased by about 2 million people (about 6%) during the time of the study and aged about two years (median) there were fewer people in California hospitals in 2011 than in 2003. This probably isn't because so many people lost their insurance in the recession of 2008 either. The number of Medicare patients who were admitted during this period dropped as well (Figure 2). Medicare only insures the disabled and people over 65 so no one loses their Medicare because of a recession.

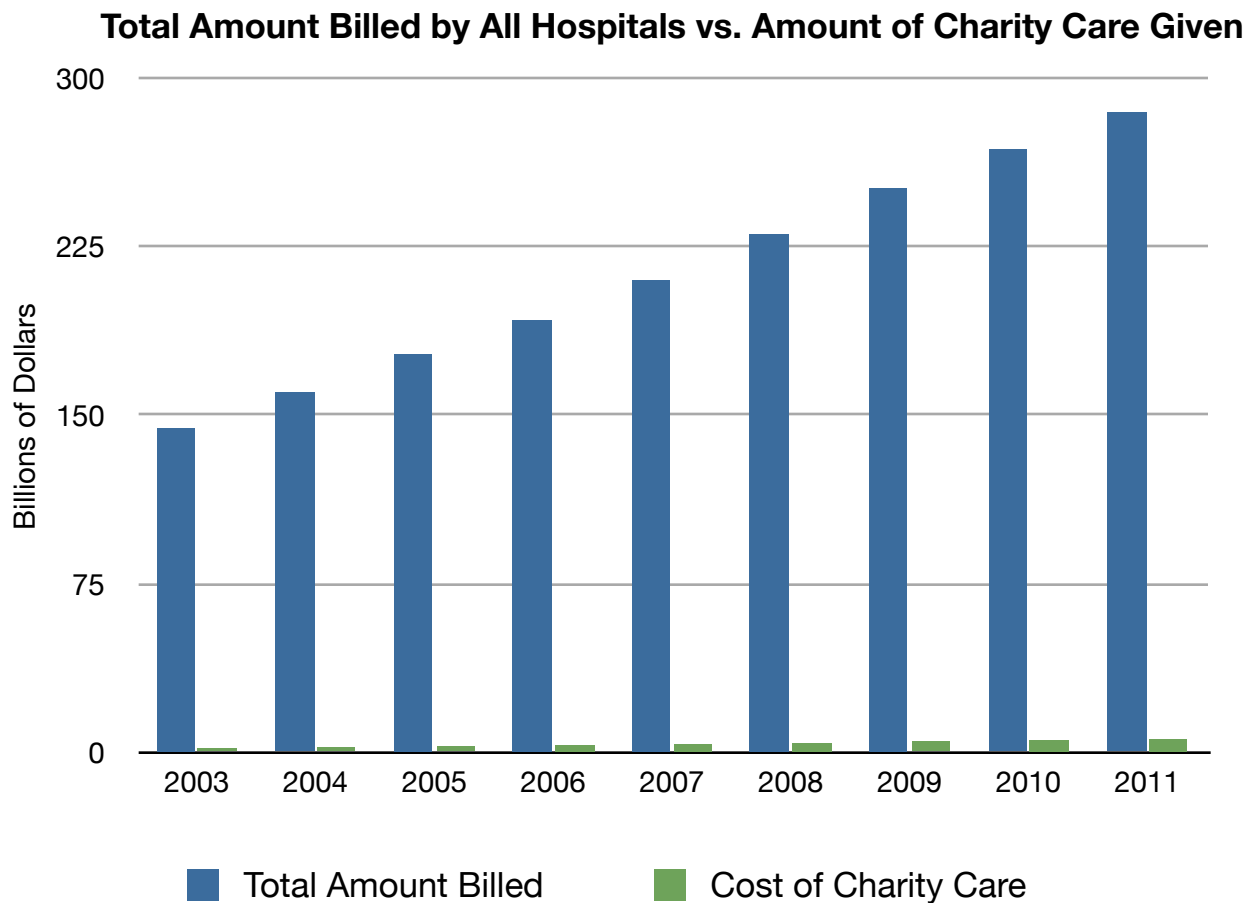
The fact that fewer people in all California hospitals in 2011 than in 2003 is also interesting because it seems to conflict with the story that healthcare costs are skyrocketing. If fewer people are in the hospital why are hospitals getting so much money? while you're pondering that question, we'll move to an analysis of hospital billing since this study is really about money and not hospital census.



**Figure 3**

Figure 3 shows the total amount all hospitals in this study billed for all of the services they provided. That includes hospitalizations, surgeries, ER visits, X-rays, blood tests... everything. In

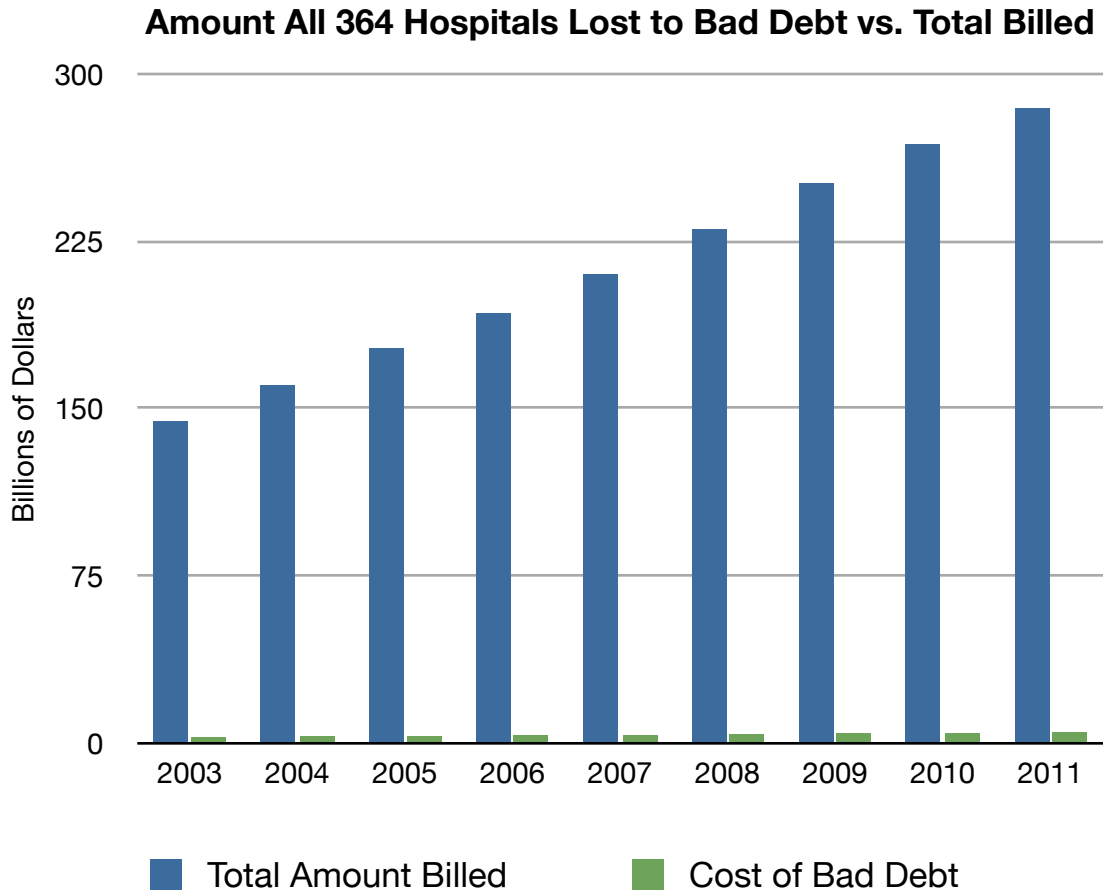
2003 the total amount all 364 non Kaiser hospitals billed (remember Kaiser doesn't charge their patients extra for these services) was a little more than \$146 billion. That amount rose steadily to about \$289 billion by 2011 which is just about double what all hospitals in the study billed in 2003. OK, that's a lot of money but, if you know anything about hospital finance, you would know hospitals never get anything close to what they bill. They usually receive only a small fraction. In order to understand this process better let's take a close look at what hospitals don't get. We'll start by itemizing all the free care they give.



**Figure 4**

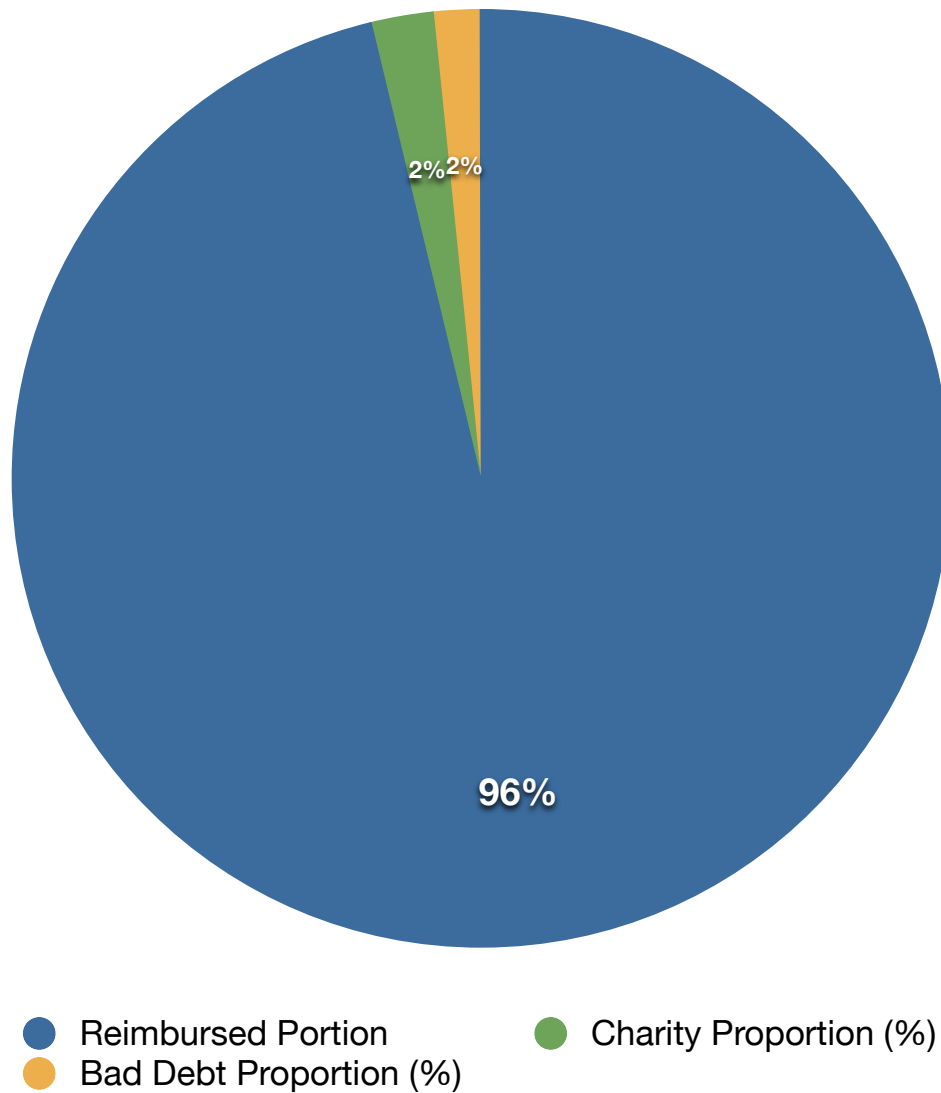
Figure 4 shows the total amount of charity care all 364 hospitals provided each year when compared to total amount they billed. In 2003 all of the hospitals in the study forgave a total of about \$1.9 billion of billed charges for charity care or about 1 1/3 percent of what they actually billed. That amount rose somewhat to a total of just over 2 percent by 2011 or just over 2 pennies for every dollar billed. From these figures it would be hard to argue that charity care was breaking most hospitals. To be fair, there were a few hospitals that forgave nearly eight percent

of what they billed for charity in certain years but, most hospitals didn't, and many of the largest hospitals never forgave much more than one percent of what they billed as charity.



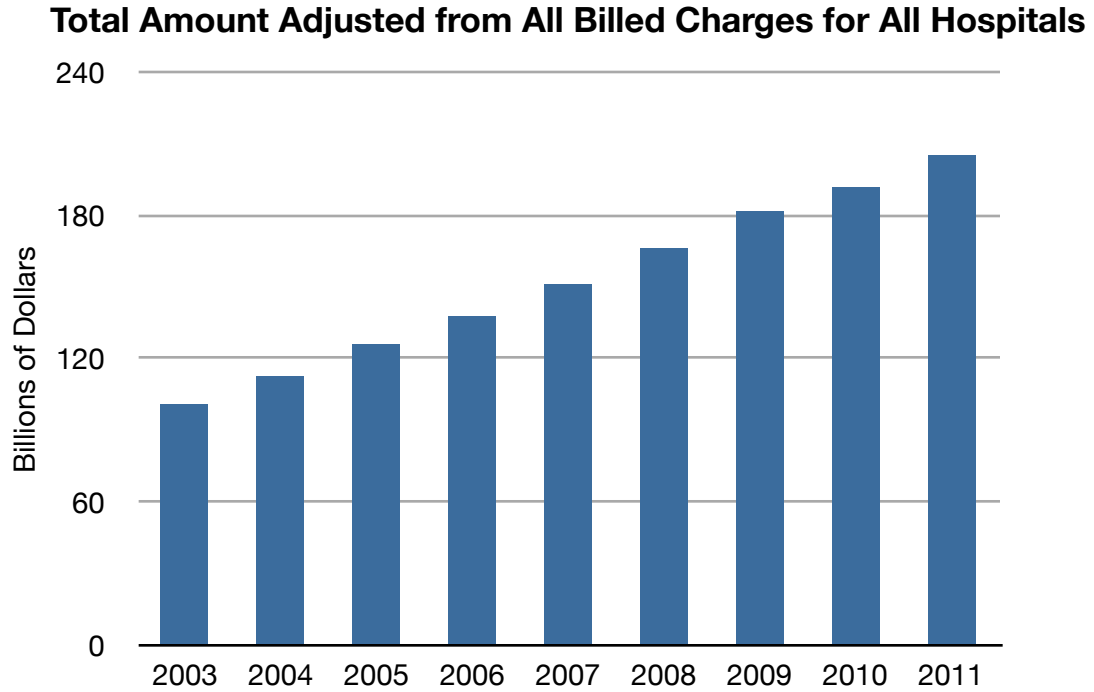
**Figure 5**

Figure 5 shows how much money all 364 hospitals lost to bad debt. We've all heard the stories of the uninsured showing up at the ER, getting medical treatment then disappearing without paying a thing, right? Well, how much of a problem is this for hospitals? According to the financial reports, and remember these reports are filled out by people the hospitals *themselves* employ, all 364 hospitals lost a combined total of about \$2.6 billion in bad debt or about 1.8 percent of what they billed in 2003. That percentage dropped slightly by 2011 to 1.65 percent of what they billed. Again in fairness, there were hospitals that lost over ten percent of their revenue to bad debt some years but, these were very few which is why it's important to have a composite study like this rather than relying on anecdotes.

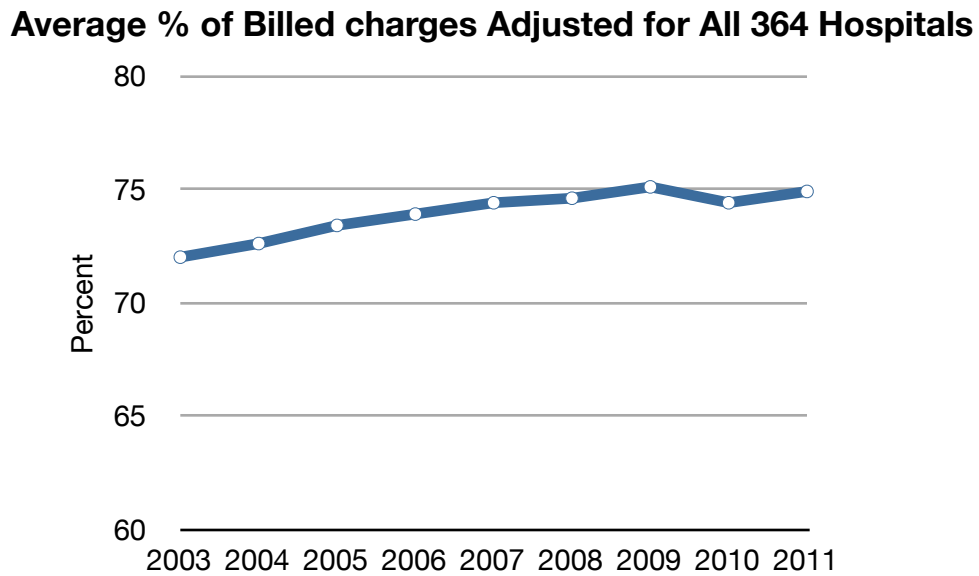


**Figure 6**

So, after subtracting the bills that went unreimbursed because of charity and bad debt, hospitals were still able to collect on slightly more than 96% of the bills they issued each year of this study (Figure 6). How much did they collect? Again, if you know anything about hospital finance you would know that hospital bills are almost never paid in full. Most of the time only a small fraction of what's billed is paid by any payer. The rest of the bill is discounted (*i.e.* completely ignored) by the payer in a process called a contractual adjustment. For a clear explanation of exactly how the adjustment process works, refer to the section on Hospital Billing.



**Figure 7**



**Figure 8**

Figures 7 and 8 show the total amount adjusted as well as the average percent adjusted from all billed charges that were *paid* each year of this study. In 2003 about 72 percent of the charges in the *paid* bills was adjusted out resulting in about \$102 billion in discounts that Medicare, MediCal and private insurance companies gave themselves. That amount and percentage rose

steadily each year so by 2011 about 75 percent of all paid charges were discounted for a total of more than \$208 billion! Put another way, in 2011 hospitals in California billed an average of four times what they expected to be paid by all payers.

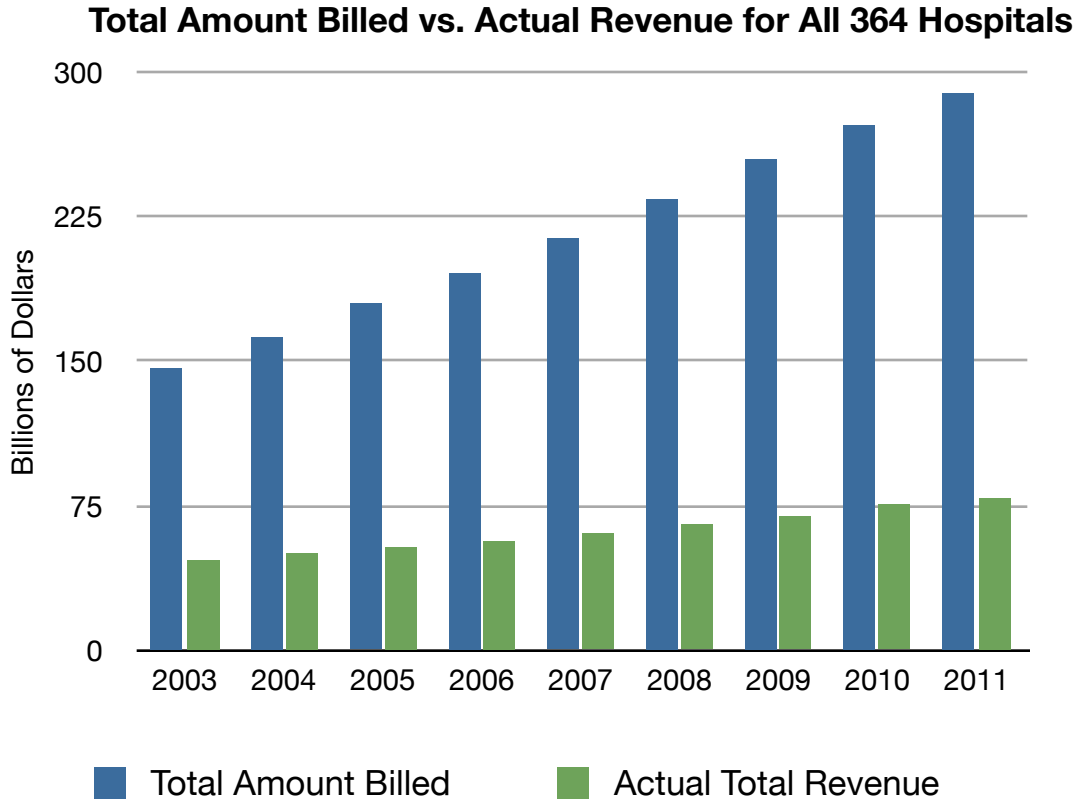
Does this seem a little strange? Well, it's a little like this joke: A guy walks into an auto dealer and sees the car he wants to buy. But when he looks at sticker price, he says, "\$80,000 for this car?! It's a Honda Civic!" The dealer says, "Don't sweat it, I'll let you have it for \$20,000." The guy says, "Done. But why put four times the real price on the sticker?" The dealer says, "Hey, that way you get to tell people you're driving an \$80,000 car." "Oh," the guy says, "but what do you get out of it?" Here, the dealer gets close and whispers: "yesterday, another guy came in, and he needed the car so badly we got him to shell out the full 80K."

OK... that doesn't sound very funny. Let's put it a different way: The dealer (asking \$80,000 for a \$20,000 car) is the hospital. He'll claim he gave you \$80,000 worth of care. The buyer is the insurance company. They'll also claim you got \$80,000 care (for your premiums) even though they both knew it would only cost \$20,000. And since it's medical care, not a car, you'll never know how much they inflated the price.

And here's where it's really not funny. The poor guy who really paid \$80,000 because he needed the car so badly: that's the guy who doesn't have insurance, but ended up in the hospital because he was having a heart attack. He'll pay, out of his own pocket, 4 dollars for every dollar of care he gets, all so the hospitals and the insurance companies can pretend medical care is way more expensive than it actually is. If you're uninsured, you'll be lucky if you can talk most hospitals into a 20-30 percent discount (if you even know enough to try).

It doesn't end there either. Because reimbursement rates differ substantially for different insurance policies, even for the same procedure in the same hospital, many people who *have* insurance can be caught in this trap. For example, people often pay considerably more for medical services if they have high deductible policies or HSA accounts. Since most people aren't told up front how much a medical service will cost them, they won't know what kind of deal their insurance got for them (or if their insurance got them any deal at all) until they get their bill.

What's more, the amount adjusted from each bill can vary widely for the same payer in different hospitals. Some hospitals had only 40-50 percent average adjustments meaning they billed an average of only about twice what they expected to be paid. Others hospitals had as much as 85 percent average adjustments some years, meaning they billed an average of six times what they really expected in payments! Try to think of how many ways a system like this can be used to abuse you.



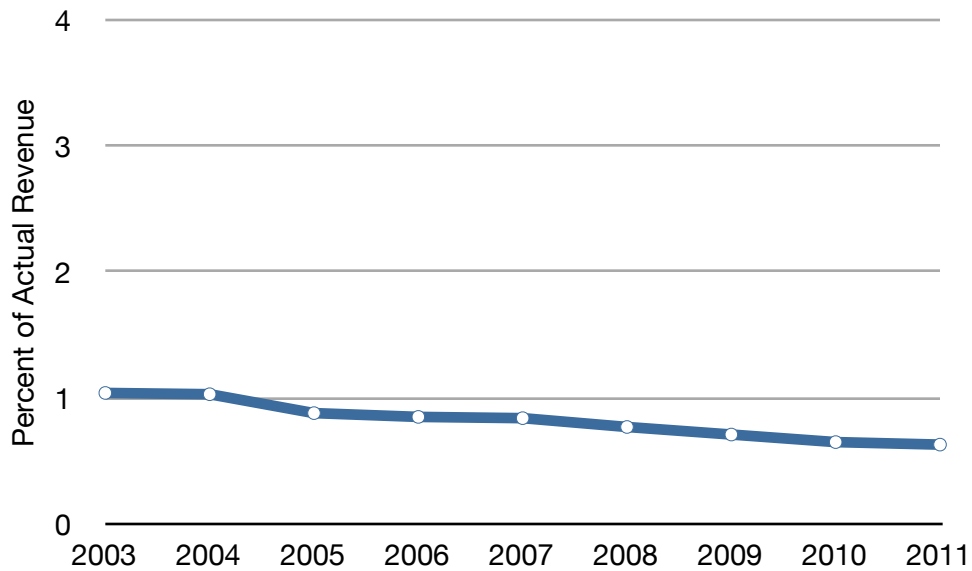
**Figure 9**

So, after all of the deductions from adjustments and free care provided, how much money did all of the hospitals in the study actually receive each year? Figure 9 shows the total revenue all 364 hospitals received for all of the medical services they provided each year as well as the total amount they billed (for comparison). In 2003 the total amount all hospitals in the study were actually paid was just over \$47 billion or just under 1/3 of what they billed. By 2011 that amount rose to about \$79 billion or just over 1/4 of what they billed. (In addition to what they receive from billing, some hospitals also get a fixed amount each year from insurance companies called a capitation. The Federal government will also pay a bonus to some hospitals for taking care of a disproportionate amount of poor or indigent patients. These were added to our figures for total revenue.)

That's still a lot of money but it should be noted that the rise in actual hospital revenue was not quite as steep as the rise in billed charges. Though hospitals billed for about twice as much money in 2011 as they did in 2003 they only received 68 percent more money in 2011 as they did in 2003. That averages to about a 6.8 percent annual increase in hospital revenue each year which is far less than the double digit increase in health care costs insurance executives keep telling us about.



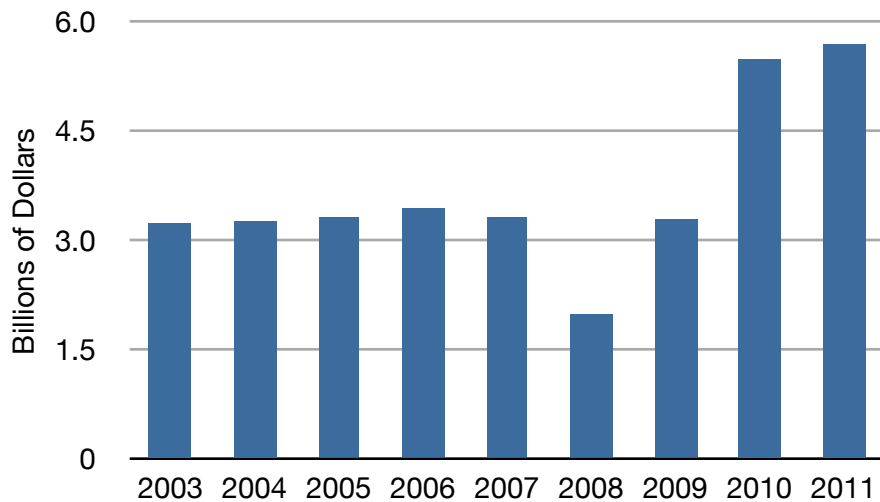
### Percent of Actual Revenue All 364 Hospitals Paid in Malpractice Premiums



**Figure 10**

Figure 10 shows the percent of their actual revenue all 364 hospitals paid in malpractice premiums each year. In 2003 all hospitals in the study paid a combined total of just under \$488 million in malpractice premiums. That’s just over one percent of their actual revenue! By 2011 hospitals were only paying 0.62 percent of their revenue in malpractice premiums. That’s right; medical malpractice only costs California hospitals a fraction of a percent of what they make each year. If we really did shoot all lawyers it would barely affect health care costs in California at all!

### Total Combined Profit for All 364 Hospitals Each Year

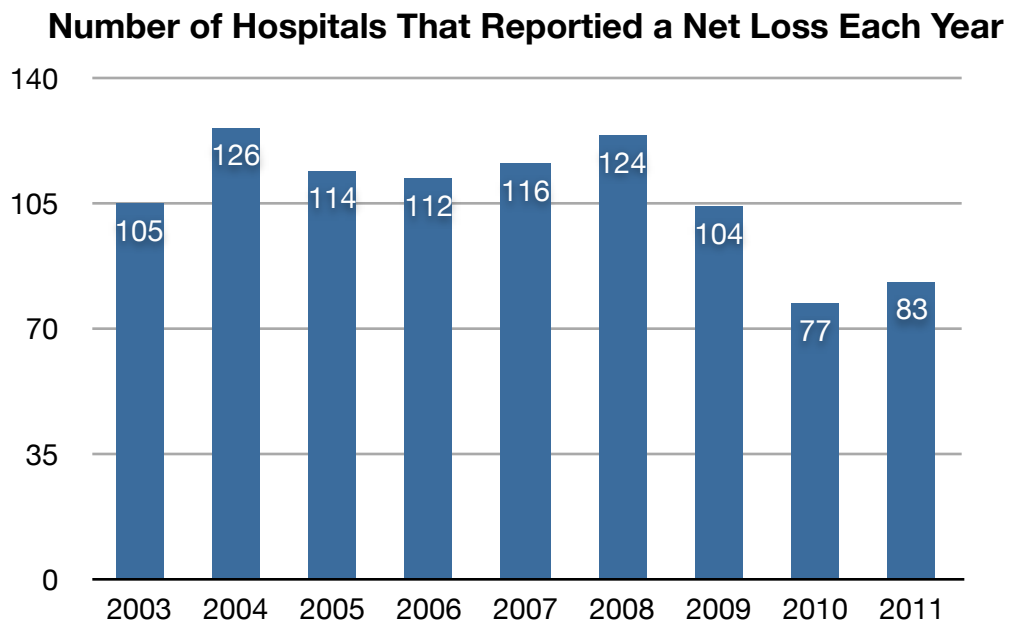


## Figure 11

So, if hospital only receives a fraction of what they bill, does that mean they barely get enough money to keep the lights on? Well, not exactly. Figure 11 shows the total amount all 364 hospitals made each year in net profit. In 2003 it was about \$3.26 billion or an average of just under \$9 million per hospital. By 2011 that amount rose to \$5.8 billion or an average of nearly \$16 million per hospital.

These profits are interesting for a number of reasons. First, the majority of the hospitals in this study are non profit. This means they don't have to pay any taxes on the \$16 million average profit they weren't supposed to make. Second, it's obvious from these profits that California hospitals have little reason to ever expect to receive any more than a small fraction of what they bill. That they do sometimes receive a substantial fraction of what they bill, and it's usually from the uninsured who are often the most vulnerable financially, makes this system all the more ludicrous.

Clearly, even though hospitals collect an average of only 27 cents for every dollar they bill, there's more than enough money to go around. One problem is that the money is *not* going around. Though some hospitals are making profits of hundreds of millions of dollars a year, many are barely able to stay afloat. As figure 12 shows (below) an average of just over 100 hospitals had a net loss each year of the study and there were a total of 91 hospitals that recorded a net loss overall (*i.e.* total of profits plus losses for all years was negative). In fact, there were eleven hospitals in this study that lost money *each and every year of the study* (and yet are still open for some reason).



## Figure 12

### Conclusions

Our goal for this study was to provide some transparency to the finances of California hospitals. We know of no other database for hospital financial records outside of California that is as extensive as the OSHPD which is why we focused entirely on that State. Even so, California is by far the most populated State in the United States. Fully one in eight people in the U.S. live in California and since the majority of hospitals in California were represented in this study, we feel that much of this data can be generalized to represent what's happening in hospitals nationally.

There were a number of interesting findings presented here. First, the number of people being hospitalized each year appears to be declining. This is occurring in spite of the fact that the overall population in California is growing (it increased by about 2 million people between 2003 and 2011) and aging (the median age in California increased about 2 years during that period). As a doctor, these results didn't surprise me so much since I wrote an essay about two years ago itemizing the reasons fewer people were being hospitalized each year. In short, medicine has become far more efficient and the criteria for hospitalizing someone has become far more strict in the last two decades. This has resulted in fewer reasons to hospitalize people as well as shorter stays for those who are hospitalized.

It's difficult to say whether hospitals will continue to admit fewer patients each year given our aging and growing population. The fact that most hospitals are nearly half empty most days implies there are probably too many hospitals in California already but, for some reason, the hospitals in this study actually increased their number of beds.

This study also helped to define the extent to which hospitals routinely over bill for their services. This over billing has been a problem for many years and, as we demonstrated, appears to be growing. It might not be such a problem if the discounts given were more evenly distributed but they're not. Reimbursement rates vary widely for different insurance plans for the same service, even in the same hospital. Since there appears to be no reason for hospitals to get more revenue than they already are getting, given their profit, why are hospitals billing so much?

The amount of free care hospitals provide is hardly an excuse for these excessive bills. Even the hospitals that provided the most charity or took the largest bad debt losses didn't lose more than about 15% of what they billed for free care (and that was rare). How does that justify an average 400% mark up in billing? The cost of medical malpractice in California also doesn't seem to be a factor. None of the hospitals in the study ever spent more than three percent of their revenue on medical malpractice and most spent less than one percent each year on this.

Hospital over billing leads to a lot of confusion about the cost of the services in health care and can often place an unfair financial burden on the people who need them. This doesn't just harm the uninsured either. This system has led to some very unfair practices by both hospitals and

insurance companies even for those who have insurance. As some recent news articles show, even doctors and financial executives have been caught off guard by the games insurance companies and hospitals play. A recent LA Times article shows how insurance companies have found ways to punish people with high deductible policies by getting them to pay hospitals more than even the uninsured pay.

Over billing isn't just a problem because of the uneven and unfair reimbursement rates either. It also leads to a grossly inflated perception of health care costs. The billing charges by hospitals are what we're usually shown when insurance companies are trying to justify their outrageous premiums even though they're supposed to have no basis in reality.

When analyzing hospital profits there were a number of interesting findings as well. First, the total profit for all hospitals was quite substantial (nearly \$34 billion over nine years) but about 90% of this net profit was brought in by roughly 1/4th of California's hospitals. The Top 90 most profitable hospitals in California made nearly \$30.5 billion in aggregate profit while the bottom 91 hospitals took a net total loss of about \$3 billion. So even though the total profits for all hospitals was quite large the individual profits were often modest and sometimes non-existent for the majority of California hospitals.

Finally, one of the most unexpected, and rather bizarre findings of our study was the fact that many of the most profitable hospitals in California were public (charity) hospitals. Of the 96 hospitals that brought in more than \$100 million in profit over the nine years, ten were County Hospitals. Again, these results are from the hospitals' own financial records and we can only comment on the information they've provided us. The hospitals include:

- 1) Los Angeles County Medical Center which earned \$1.061 billion in *profit*. This was the fourth highest overall profit for the State of California!
- 2) Alameda County Medical Center (aka "Highland Hospital") which earned \$776 million in profit, which was the sixth highest in California.
- 3) Olive View/UCLA which earned \$606 million ranking it fourteenth in the State.
- 4) Arrowhead Regional Medical Center earned \$567 Million (ranked seventeenth)
- 5) Harbor/UCLA earned \$444 million (ranked 24rd).
- 6) Riverside County Regional Medical Center earned \$387 million (ranked 33rd).
- 7) Contra Costa Regional Medical Center earned \$210 million (ranked 49th)
- 8) Ranch Los Amigos earned \$192 million (ranked 56th)
- 9) Ventura County Medical Center earned \$132 million and
- 10) Kern Medical Center earned \$115 million in profits

These profits appear to be largely the result of money the State and Federal government give the public hospitals. This money was meant to cover the losses charity hospitals inevitably face but, in recent years, it has probably been too much. We might argue that no hospital should really be making much of a profit. After all, even if the financial balance for a hospital is zero at the end of

the year everyone at the hospital still gets paid. As long as a hospital makes just enough money to adequately treat patients and pay all of its bills, why should it need to make a profit?

That said, I think everyone will agree that county hospitals *above all* should not be making huge profits. This is *especially* true when the profits are entirely at the expense of the taxpayer. Even though public hospitals will inevitably need at least some assistance from the State, the amount of assistance clearly needs to be re-examined.

It would be impossible to address in one analysis every potential issue that might be brought up by a study this vast in scope. The few issues we chose to focus on here were intended to make one point completely clear: Health care in the U.S. is broken. And nowhere is it more broken than in the ways in which we finance our hospitals. Hospital finance in the U.S. is a system which allows both insurance companies and hospitals to randomly and arbitrarily victimize unsuspecting people on a daily basis. It's a system that puts millions of people one disease away from financial ruin even if they *have* insurance and it's a system filled with so many complex and convoluted rules, as well as arbitrary traps, that even doctors can't avoid falling victim to them at times.

As long as so many hospitals and insurance companies can continue to amass huge fortunes through obscuring real prices and confusing people there will be a tremendous resistance by them to any type of change. They'll use fear, confusion and intimidation any chance they can to fight any kind of reform. Our best weapon against these abuses is knowledge, which is why we conducted this study. If we know and understand exactly what their games are we can call them out for their deceptions. Then, when we demand real reform to the actual problems that plague our current health care industry we won't be thrown off track by lies and obfuscations.

## DIAGNOSTIC TESTS

Not too long ago, a patient of mine called my office because she was worried that she might have a urinary tract infection. She had recently lost her job and her health insurance, but she wanted to be sure about the infection because she didn't want to take antibiotics unnecessarily. I called the lab at the local hospital and asked how much they charged for a urine analysis. They told me that it was 92 dollars! I couldn't believe it. 92 dollars for a test that requires a plastic cup, a 25 cent dipstick and 2 minutes of a technician's time! I called around to other local labs and the cheapest price I was quoted was 32 dollars. This was better than the first price but, compared to the four to five dollars they would get from most insurance companies, it was obscene.

This brings me to the subject of diagnostic tests and how much they should really cost. Most blood and urine tests are done with simple chemicals that cost anywhere from a few pennies to a couple of dollars. This means that it cost little more than that to run most of these tests. Add the lab time, and most tests still cost anywhere from pennies to a few dollars (labs are pretty efficient at running tests). There are a few expensive tests, such as genetic tests, but these are not frequently used in a routine screening or diagnostic work up. The cost of radiology tests can be broken down in a similar fashion. There is the original cost of the X-ray machine, CT scanner or MRI which are usually bought and paid for by the hospital or diagnostic center. In addition, there are the costs of maintaining the machinery (which is usually a fixed annual fee), paying the staff, preparing certain patients for the tests and the radiologist's fee for reading the X-ray.

The insurance companies know all of these costs and try to reimburse the minimum amount that the institution running the test is likely to accept. Routine blood work, for example, only gets paid a few dollars but a CT scan or MRI will bring in a few hundred dollars. A PET scan (which is relatively new technology) might cost a few thousand dollars but, as with everything else in technology, the price of this test is dropping.

How much will they bill you if you try to pay for any of these tests yourself? Well, as you know by now, all tests, procedures, office visits and hospitalizations are billed for an amount that exceeds what they expect from any insurance company (often by a lot) in order to get the maximum amount possible from all of them. This means that anyone who doesn't have insurance, or for whom the insurance is denied, has to pay five, ten or even twenty times what any insurance company would likely pay.

This not only makes people 100% dependent on their insurance for even the most trivial medical cost but also means they will have to pay an enormous penalty any time anyone makes a mistake ordering or authorizing a test if coverage is denied. In addition, this policy results in millions of people being excluded from healthcare, not because they can't afford it, but because they are not allowed to afford it. Most people could afford most of these services were they not priced at ten or more times their actual value.

Below is a list of commonly ordered medical tests along with a brief explanation of the test, typical billing charges and the reimbursement from Medicare and a sample PPO insurance company (the sample fee schedule is on pages 35-36). I obtained the billing charges by calling several different hospitals in the San Francisco Bay Area. Private labs and imaging centers that are not affiliated with hospitals charge less than hospitals, but some still charge well above what most insurance companies are likely to pay (they are getting much better though). It's pretty clear, even from this short list of tests and procedures, that that the

institutions providing them do not want you to pay for them yourself. The question is, why? Why would any organization go so far out of their way to discourage direct payment? This is especially strange when you consider what a nightmare it is to deal with insurance companies.

Also, consider how much the insurance companies have to pay for these tests. If that's all you had to pay, how hard would that be? How do the prices of these tests compare to the price of a tank of gasoline, a bag of groceries or a tune up for your car? Even the most expensive tests listed wouldn't cost you as much as a transmission overhaul so, why do we have to pay so much to have our insurance cover them?

### **Blood Tests:**

**Comprehensive metabolic panel:** A blood test that assesses liver and kidney function as well as electrolytes.

Hospital charge: \$179

Private insurance: \$15

Medicare: \$15

**Lipid Panel:** A blood test that checks total cholesterol and breaks it down to good and bad components.

Hospital charge: \$68

Private insurance: \$19

Medicare: \$19

**Complete Blood Count:** A blood test that checks your hemoglobin, hematocrit, white blood counts.

Hospital charge: \$51

Private insurance: \$11

Medicare: \$11

**Urine Analysis:** Looks for blood, signs of infection or protein in your urine.

Hospital charge: \$92

Private insurance: \$5

Medicare: \$4

**Hemoglobin A1C:** A single blood test that checks your average blood sugar for the last 3 months.

Hospital charge: \$61

Private insurance: \$14

Medicare: \$13

Thyroid Stimulating Hormone: A blood test that evaluates your thyroid function.

Hospital charge: \$108

Private insurance: \$24

Medicare: \$23

Prothrombin Time: A blood test to check Coumadin level and your blood's ability to clot.

Hospital charge: \$36

Private insurance: \$6

Medicare: \$6

PSA: A blood test that helps to check for prostate cancer.

Hospital charge: \$117

Private insurance: \$26

Medicare: \$22

HIV: Tests for HIV (obviously).

Hospital charge: \$92

Private insurance: \$20

Medicare: \$19

### **Cardiology:**

EKG: A screening test for abnormal heart rhythms and other signs of heart disease.

Hospital charge: \$367

Private insurance: \$26

Medicare: \$26

Echocardiogram: An ultrasound of the heart to look at valves and assess function.

Hospital charge: \$4,361

Private insurance: \$317

Medicare: \$291



Exercise Stress Test: This test is good for evaluating chest pain to see if your heart is the cause.

Hospital charge: \$1,182

Private insurance: \$123

Medicare: \$123

**Radiology: (Price includes fee for Radiologist)**

Chest X-Ray: To check for lung disease and some forms of heart disease.

Hospital charge: \$375

Private insurance: \$42

Medicare: \$41

Mammogram: Screening test for breast cancer.

Hospital charge: \$336

Private insurance: \$191

Medicare: \$146

Ultrasound of the Abdomen: Can assess Kidneys, Liver, Gall Bladder and other organs.

Hospital charge: \$1,440

Private insurance: \$184

Medicare: \$181

Ultrasound of the Pelvis: Images the Uterus and Ovaries.

Hospital charge: \$1,106

Private insurance: \$170

Medicare: \$169

CT of Head: Often used to look for lesions in the Brain.

Hospital charge: \$2,621

Private insurance: \$344

Medicare: \$269

CT of Chest with IV Contrast: Can accurately evaluate disease in the chest or lungs.

Hospital charge: \$5,295

Private insurance: \$431

Medicare: \$426

CT of Abdomen with IV Contrast: Accurately images the abdomen for tumors or other disease.

Hospital charge: \$5,680

Private insurance: \$463

Medicare: \$458

CT of Pelvis with IV Contrast: Often done at the same time as the abdominal CT.

Hospital charge: \$5,03

Private insurance: \$408

Medicare: \$403

MRI of the Brain: A more accurate way to image the brain than a CT scan but it's more expensive and can't be done as quickly or easily.

Hospital charge: \$3,422

Private insurance: \$578

Medicare: \$654

MRI of the Cervical Spine: Accurately images the neck.

Hospital charge: \$3,041

Private insurance: \$584

Medicare: \$587

MRI of the Thoracic Spine: Accurately images the upper back.

Hospital charge: \$3,422

Private insurance: \$584

Medicare: \$596

MRI of the Lumbar Spine: Accurately images the lower back.

Hospital charge: \$3,535

Private insurance: \$577

Medicare: \$588

**Procedures:** (Usually these procedures are done in an office not a hospital. The amount billed varies substantially for different medical groups but ranges from \$1,000 to \$8,000 for each).

Colonoscopy with Biopsy: If a lesion is found on screening colonoscopy a biopsy is needed.

Private insurance: \$603

Medicare: \$555

Upper endoscopy with Biopsy: Evaluates problems in the esophagus and stomach, again through a fiber optic tube.

Private insurance: \$447

Medicare: \$410



REPRESENTATIVE SAMPLE FEE SCHEDULE

JANUARY 2011

Code	Description	Rate	Code	Description	Rate
97001	PHYSICAL THERAPY EVALUATION	\$87.60	90991	CRITICAL CARE, EAM, FIRST 30-74 MIN	\$113.34
97010	APPLY MODALITY, 1 OR MORE AREAS/HOT/COLD PACK	\$6.75	90995	PREVENTIVE CHECKUP, NEW, 18-39 YRS	\$136.08
97012	APPLY MODALITY, 1 OR MORE AREAS TRACTION, MECH	\$18.50	90996	PREVENTIVE CHECKUP, NEW, 40-64 YRS	\$156.90
97014	APPLY MODALITY, 1 OR MORE AREAS, ELECT STIM	\$18.45	90991	PREVENTIVE CHECKUP, EST, INFANT	\$98.90
97032	APPLY MODALITY, ELEC STIMULATION, EA 15 MIN	\$21.89	90992	PREVENTIVE CHECKUP, EST, 1-4 YRS	\$109.18
97035	APPLY MODALITY, ULTRASOUND, EA 15 MIN	\$14.18	90993	PREVENTIVE CHECKUP, EST, 5-11 YRS	\$108.69
97110	TX PROC, 1+ AREAS, TX EXERCISE, EA 15 MINUTES	\$36.61	90995	PREVENTIVE CHECKUP, EST, 18-39 YRS	\$118.81
97137	TX PROC, 1+ AREAS, BURN/SCALDS, EA 15 MIN	\$38.50	90996	PREVENTIVE CHECKUP, EST, 40-64 YRS	\$129.75
97140	MANUAL THERAPY, 1+ REGIONS, EACH 15 MINUTES	\$34.47	99468	NEONATE CRT CARE, INITIAL	\$1,014.50
97530	THERAPEUTIC ACTIVITIES, DIRECT PT, EA 15 MIN	\$40.64	99469	NEONATE CRT CARE, SUBSQ	\$450.46
98940	CMT, SPINAL, 1-2 REGIONS	\$30.75	99472	PED CRITICAL CARE, SUBSQ	\$446.00
98941	CMT, SPINAL, 3-4 REGIONS	\$41.83	99479	IC LOW INF 1500-2500 G SUBSQ	\$145.15
98942	CMT, SPINAL, 5 REGIONS	\$53.74	99480	IC INF PRW 2501-5000 G SUBSQ	\$134.10
98943	CMT, EXTRASPINAL, ON OR MORE REGIONS	\$76.75	A4353	INTRIMITTENT URINARY CATHETER	\$7.94
99202	OFFICE/OUTPATIENT VISIT, NEW, EXPANDED PROB	\$88.29	30202	SCREEN MAMMOGRAM, DIGITAL	\$191.31
99203	OFFICE/OUTPATIENT VISIT, NEW, DETAILED	\$125.86	30283	ELEC STIM OTHER THAN WOUND	\$15.02
99204	OFFICE/OUTPATIENT VISIT, NEW, MOD COMPLEX	\$190.06	30296	ALPHA 1-PROTEINASE, PER 500 MG, INJ	\$3.79
99205	OFFICE/OUTPATIENT VISIT, NEW, HIGH COMPLEX	\$235.31	30296	CETIRIZINE SODIUM, PER 250 MG, INJ	\$0.99
99211	OFFICE/OUTPATIENT VISIT, EST, MINIMAL	\$25.77	30278	DAPTOMYCIN INJECTION	\$0.46
99212	OFFICE/OUTPATIENT VISIT, EST, PROB PROB	\$12.34	11561	IMMUNE GLOBULIN, IV, 500 MG, INJECT	\$37.60
99213	OFFICE/OUTPATIENT VISIT, EST, EXP PROB	\$84.87	11562	IMMUNE GLOBULIN, IV, 5 GM, INJECT	\$7.20
99214	OFFICE/OUTPATIENT VISIT, EST, DETAILED	\$125.25	11566	IMMUNE GLOBULIN, POWDER	\$31.29
99215	OFFICE/OUTPATIENT VISIT, EST, HIGH COMPLEX	\$167.18	11568	INJ IC OCTODAM IV NONLYO 500MG	\$36.04
99227	INITIAL HOSPITAL CARE, MOD COMPLEX	\$150.81	11569	INJ IC GAMBAGIAR IV NONLYO 500 MG	\$38.52
99229	INITIAL HOSPITAL CARE, HIGH COMPLEX	\$221.82	11745	INFLIXIMAB INJECTION	\$60.59
99231	SUBSEQUENT HOSPITAL CARE, LOW COMPLEX	\$44.19	12073	INJECTION NATALIZUMAB 1 MG	\$10.21
99232	SUBSEQUENT HOSPITAL CARE, MOD COMPLEX	\$79.89	30469	PALONOSETRON HCL	\$18.87
99233	SUBSEQUENT HOSPITAL CARE, HIGH COMPLEX	\$114.52	30505	INJECTION PEGFILGRASTIM 6 MG	\$2,543.78
99238	HOSPITAL DISCHARGE DAY MONI, <30 MINUTES	\$81.07	30487	ZOLECONIC ACID	\$222.80
99239	HOSPITAL DISCHARGE DAY MONI, >30 MINUTES	\$118.52	37187	INJ VONWILLBRND FCT COMPLEX HUMAN 32	\$0.89
99242	OFFICE CONSULTATION, EXP PROB	\$104.86	37189	FACTOR VIII RECOMBINANT	\$1.10
99243	OFFICE CONSULTATION, LOW COMPLEX	\$142.81	39035	BEVACIZUMAB INJECTION	\$69.62
99244	OFFICE CONSULTATION, MOD COMPLEX	\$209.51	39045	CARBOPLATIN, 50 MG	\$3.54
99245	OFFICE CONSULTATION, HIGH COMPLEX	\$254.82	39055	CETUXIMAB INJECTION	\$49.24
99253	INITIAL INPATIENT CONSULT, LOW COMPLEX	\$126.34	39201	GENOCITABINE HCL, 200 MG	\$151.76
99254	INITIAL INPATIENT CONSULT, MOD COMPLEX	\$183.17	39203	INJECTION OXALIPLATIN 0.5 MG	\$9.19
99255	INITIAL INPATIENT CONSULT, HIGH COMPLEX	\$220.28	39285	PACITAXEL, 30 MG	\$7.29
99282	EMERGENCY DEPT VISIT, LOW COMPLEX	\$44.99	39310	REUXIMAB CANCER TREATMENT 100MG	\$294.63
99283	EMERGENCY DEPT VISIT, EXP PROB	\$68.13	39355	TRASTUZUMAB	\$69.36
99284	EMERGENCY DEPT VISIT, DETAILED	\$127.30	39967	LOCM 3000G/3399MG/ML, EDCING PER ML	\$0.17
99285	EMERGENCY DEPT VISIT, HIGH COMPLEX	\$186.40			

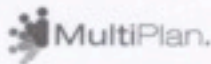
This fee schedule was sent to me by Multiplan. They are a PPO insurance and this schedule was used for my example rates for private insurance.

The Medicare rates were obtained from their website:

[https://www5.palmettogba.com/ecx\\_improvev2/](https://www5.palmettogba.com/ecx_improvev2/)

Which gives the reimbursement rate for each service for each region in the US.

As I've said many times in this report, all of these rates vary substantially from plan to plan in order to confuse everyone but this was as close as I could ever come to real information so here it is.



REPRESENTATIVE SAMPLE FEE SCHEDULE

JANUARY 2011

Code	Description	Rate	Code	Description	Rate
00100	ANESTHESIA SALIVARY GLANDS WITH BIOPSY	\$47,000	01001	DRUG SCREEN, QUANTITATIVE, SINGLE CLASS	\$32.6
11100	BIOPSY, SKIN/SUBCUTANEOUS MIMIMIAN, SINGLE	\$133.34	11001	URINALYSIS, AUTOMATED W/MICROSCOPY	\$4.4
12001	SAMPLE REPAIR, HEADLINE/OTRUNK/EXTREM, 2.5CM	\$222.22	20006	ASSAY, VITAMIN D (CALCIUM) [DIOX]	\$42.0
17150	DESTROY FLAT WART/MOLLUSCUM, UP TO 14	\$144.44	42542	ASSAY, COLUMN CHROMATOGRAPHY, QUAN, SINGLE	\$25.9
20612	ARTHROCENTESIS MAJOR JOINT/BURSA	\$99.99	42607	ASSAY, VITAMIN B-12	\$21.8
22554	ARTHRODESIS W/MIN DISKECTOMY, BELOW C2 SPINE	\$1,427.51	42728	ASSAY, FERRETIN	\$19.3
22832	ARTHRODESIS, POSTERIOR, LUMBAR	\$1,795.05	43036	DIYCOULATED HEMOGLOBIN ASSAY	\$13.8
22842	POSTERIOR INSTRUMENTATION, 3-6 VERT SEGMENTS	\$952.95	43098	MOLECULAR DIAGNOSTICS, W/AMPLIFICATION, EACH	\$23.8
22845	ANTERIOR INSTRUMENTATION, 2-3 VERT SEGMENTS	\$811.83	43094	MOLECULE MUTATION SCAN BY SEQUENCE	\$23.8
22851	APPLY SPINAL PROSTHETIC DEVICE	\$494.09	43095	ASSAY, OPiateS	\$27.8
22847	ARTHROPLASTY KNEE, TOTAL REPLACEMENT	\$1,775.95	43675	ASSAY, PPARATHERMOM	\$18.8
29881	KNEE ARTHROSCOPY/MENISCECTOMY, MEDIAL OR LAL	\$755.76	44153	ASSAY, PSA, TOTAL	\$26.1
29888	ARTHROSCOPIC AIDED REPAIR ANT CHUC LIGAMENT	\$1,147.90	44403	ASSAY, BLOOD TESTOSTERONE	\$26.8
30520	SEPTOPLASTY/SUBMUCOSUS RESECTION	\$768.74	44436	ASSAY, FREE THYROXINE	\$9.7
30535	CARP, ARTERIAL, SINGLE ARTERIAL GRAFT	\$2,169.04	44439	ASSAY, FREE THYROXINE	\$12.8
36418	COLLECT VENOUS BLOOD, VENIPUNCTURE	\$3.03	44443	ASSAY, THYROID STIMULATING HORMONE	\$23.8
36681	INSERT TUNNE, CNTR, CYANOPORT, 5 YRS	\$1,602.19	44480	ASSAY, TOTAL THYROTHYONINE (T1-3)	\$20.1
43238	UPPER GI ENDOSCOPY/EGOROSCOPY	\$448.81	44481	ASSAY, FREE THYROTHYONINE (FT-3)	\$24.0
43844	LAP GASTROSTOMY/GASTR BYPASS/ROUNTY	\$1,890.37	44702	CHEMURIC GONADOTROPIN TEST	\$21.4
43770	LAP, PLACE GASTR ADJUST BAND	\$1,270.38	44925	BLOOD COUNT, COMP, CBC W/UTO DIFF WBC	\$11.0
44970	LAPAROSCOPY, APPENDECTOMY	\$685.23	45003	ALLERGEN SPECIFIC IGE, QUANTITATIVE	\$7.4
45378	COLONOSCOPY, DIAGNOSTIC	\$503.89	45141	C-REACTIVE PROTEIN, HIGH SENSITIVITY	\$18.4
45380	COLONOSCOPY, BIOPSY	\$602.96	45703	HIV-1/2-R, SINGLE ASSAY	\$39.4
45385	COLONOSCOPY, REMOVE LESION W/SNARE	\$674.47	49708	URINE BACTERIA CULTURE, BY COUNT	\$11.4
47562	LAPAROSCOPY, W/HOLECYSTECTOMY	\$625.27	47491	INFECT ANTIGEN, NUCLEIC CHLAMYDIA TRACH, AMPL	\$49.8
47563	LAPAROSCOPY, W/HOLECYSTECTOMY W/HOLANGIOGRP	\$831.82	47591	INFECT ANTIGEN, NUCLEIC, NEISSERIA GON, AMPL	\$49.8
48150	TOTAL HYSTERECTOMY	\$1,135.79	47621	INFECT ANTIGEN, NUCLEIC, PAPILLOMAVIRUS, AMPL	\$49.8
48653	HYSTEROSCOPY, W/ENDOMETRIAL ABLATION	\$2,429.83	47890	INFECT ANTIGEN, IMMUNO, STREP, GROUP A	\$13.20
49460	ROUTINE OBSTETRIC CARE, VAGINAL DELIVERY	\$2,118.52	49312	CYTOPATH CELL ENHANCE (NO CERVIWAG)	\$131.22
49510	ROUTINE OBSTETRIC CARE, CESARIAN DELIVERY	\$2,395.98	49342	CYTOPATH, CERVIKAL/VAGINAL, MANUAL, SCREEN	\$28.8
49211	INLET CT, SPINE LUMBAR/SACRAL, EPIDURAL/INJECTION	\$461.79	49375	CYTOPATH, CERVIKAL, INFLUEN, AUTO, REPOD	\$37.8
49330	LUMBAR DISK SURGUS RYDE COMPREHENSIVE	\$1,092.27	49185	FLOW CYTOM: TRY TC ONE Y, EA ADD MARKS	\$71.8
49347	REMOVE LAMINA/COMPRESS LUMBAR SPINE, 1-3/0	\$1,228.47	49199	FLOW CYTOM: TRY INTRAP, 16% MARKERS	\$127.28
49375	REMOVE CERVICAL DISK, SINGLE	\$1,531.87	49237	TISSUE CULTURE, BONE MARROW	\$179.12
49463	INJECT TRANSFORAMIN EPIDURAL, LUMBAR, SINGLE	\$378.82	49305	TISSUE EXAM BY PATHOLOGIST, LEVEL IV	\$182.8
49594	REMOVE CATARACT, INSERT LENS, EXTRACAPSULAR	\$883.19	49312	SPECIAL STAINS, GROUP I	\$145.9
70496	CT SCAN, MAXILLOFACIAL, W/O CONTRAST	\$344.29	49373	SPECIAL STAINS, GROUP II	\$128.3
70551	MRI OF BRAIN, STEM, W/O CONTRAST	\$577.84	49342	IMMUNOCYTOCHEMISTRY, EACH	\$137.9
70553	MRI OF BRAIN, STEM, W/O FOLL BY W/ CONTRAST	\$900.09	49361	MORPHOMETRIC ANALY TURM RHC QUANTSEM	\$201.54
71020	X-RAY, CHEST, TWO VIEWS, FRONTAL/LATERAL	\$41.54	49367	MORPHOMETRIC ANALY HYBRID EA, CMPT	\$350.04
71290	CT SCAN, THORAX, W/ CONTRAST	\$430.63	49366	MORPHOMETRIC ANALY HYBRID EA, MNL	\$296.90
72100	X-RAY EXAM LOWER SPINE, 2-3 VIEWS	\$65.03	49074	IMMUNIZATION ADMIN, 1 VACCINE	\$30.77
72141	MRI, CERVICAL SPINE, W/O CONTRAST	\$584.37	49048	H PAPILOMA VACC 3 DOSE IM	\$140.87
72146	MRI, THORACIC SPINE, W/O CONTRAST	\$584.37	49049	PNEUM VAC, POLYVALENT, INTRAMUSC, UNDER 5 YRS	\$87.73
72148	MRI, LUMBAR SPINE, W/O CONTRAST	\$672.48	49078	CHECKIN FOX IMMUNIZATION	\$41.22
72156	MRI, CERVICAL SPINE, W/O FOLL BY W/ CONTRAST	\$914.48	49080	PSYCHIATRIC DIAGNOSTIC INTERVIEW EXAM	\$183.13
72158	MRI, LUMBAR SPINE, W/O FOLL BY W/ CONTRAST	\$907.47	49085	PSYCHOTHER, INDIV, INSIGHT, 20-30MIN W/EM	\$85.0
72182	CT SCAN OF PELVIS, W/O CONTRAST	\$336.04	49086	PSYCHOTHER, INDIV, INSIGHT, 45-60 MN	\$98.81
72183	CT SCAN OF PELVIS, W/ CONTRAST	\$487.29	49087	PSYCHOTHER, INDIV, INSIGHT, 45-60 MN W/EM	\$118.28
72194	CT SCANS OF PELVIS, W/O FOLL BY W/ CONTRAST	\$528.03	49088	PSYCHOTHER, INDIV, INSIGHT, 75-80 MN	\$142.11
72221	MRI, UPPER EXTREMITY JOINT, W/O CONTRAST	\$575.29	49087	PSYCHOTHER, FAMIL, (CONJOINT) W/PT PRESENT	\$121.28
73721	MRI, LOWER EXTREMITY JOINT, W/O CONTRAST	\$570.78	49082	PSYCHIATRIC MEDICATION MANAGEMENT	\$70.90
74150	CT SCAN, ABDOMEN, W/O CONTRAST	\$339.92	49094	COMPREHENSIVE EYE EXAM, NEW PATIENT	\$174.88
74180	CT SCAN, ABDOMEN, W/ CONTRAST	\$483.45	49012	INTERMEDIATE EYE EXAM, ESTABLISHED PATIENT	\$165.10
74170	ULTRASOUND, ABDOMEN, B-SCAN/REAL TIME, COMPL	\$184.11	49090	PLACE INTRACORONARY STENT, FIRST VESSEL	\$666.02
75825	ULTRASOUND OB 31-4 WK SINGLE FETUS	\$194.82	49300	ELECTROCARDIOGRAM (ROUTINE) ECG, COMPLETE	\$25.56
75811	ULTRASOUND OB DETAIL ECG, SINGLE FETUS	\$253.29	49310	ELECTROCARDIOGRAM (ROUTINE) ECG, REPORT ONLY	\$20.77
76830	ULTRASOUND, TRANSVAGINAL	\$170.29	49315	CARDIOVASCULAR STRAUS TEST, COMPLETE	\$122.55
76896	ULTRASOUND, PELVIS, COMPLETE	\$170.30	49326	ECG MONITOR/24 HRS, REAL TIME, COMPUTER REPORT	\$59.21
77094	MRI, BOTH BREASTS	\$880.74	49371	PT DEMAND ECG RECORING, MONITORING/ANALYSIS	\$300.25
77080	DXA BONE DENSITY, AXIAL	\$132.63	49308	TTE W/DOPPLER, COMPLETE	\$216.70
77361	RADIOTHERAPY PLAN, INTENSITY MODULATED	\$2,860.50	49307	ECG, TRANSTHORACIC, HEART, COMPLETE	\$200.12
77334	RADIATION TREATMENT AIDS, COMPLEX	\$203.40	49335	DOPPLER COLOR FLOW VELOCITY MAPPING	\$49.72
77418	RADIATION THERAPY DEL, INTENSITY MODULATED	\$246.29	49390	EXTRACRANIAL ARTERIES STUDY, DUPLEX, COMPLETE	\$254.51
77427	RADIATION TREATMENT MANAGEMENT, 5 TREATMENTS	\$208.95	49504	ALLERGY SKIN TESTS, PERCUTANEOUS	\$8.82
80046	M/BAIOLIC PANEL, BASIC	\$12.03	49516	ANTIGEN THERAPY SERVICES, SINGLE ANTIGEN	\$18.99
80050	GENEAL HEALTH PANEL	\$58.19	49610	POLYSOMNOGRAPHY, 4+ ADDITIONAL PARAMETRS	\$959.40
80053	M/BAIOLIC PANEL, COMPREHENSIVE	\$15.02	49611	POLYSOMNOGRAPHY, 4+ ADD PARAMETRS, W/CAP	\$1,036.37
80058	CRISTIC PANEL	\$43.88	49603	NERVE CONDUCTION TEST SA NERVE MOTOR W/ WAVE	\$91.36
80061	LRSD PANEL	\$19.04	49604	NERVE CONDUCTION TEST, SA NERVE, SENSORY	\$71.31
80074	HEPATITIS PANEL, ACUTE	\$67.68	49632	THERIOPHYSDIAG INJ, SCIM	\$30.77
80076	HEPATITIS FUNCTION PANEL	\$11.60	49613	CHEMO, W/ INFUSION, 1 HR	\$205.24

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MultiPlan, Inc. confidential and proprietary information

# HEALTH INSURANCE: MORE TRICKS OF THE TRADE

I recently saw a patient who I thought needed a CT scan of his head. In the last section (see diagnostic tests) I showed that head CTs go for \$300-\$350 if you're an insurance company. This patient has insurance so it shouldn't have been a problem. My receptionist called his insurance to get the proper authorization and I even spoke with them myself to make sure it went through; it did. The next day, the patient called my office to say that he couldn't get the test because he couldn't afford it. The radiology department wanted \$500 up front and then said that they would bill him for the remaining \$700. That's \$1,200! He has insurance, they approved the procedure, and still, he has to pay \$1,200.

My receptionist called around to ask how much the private imaging companies would charge a patient without insurance for a head CT. She was quoted \$690 by Nor-Cal imaging (a perfectly good imaging company that takes very good X-rays) but if the patient paid cash up front so they didn't have to bill him, it was \$414. This for a test that would cost him \$1,200 if he used his insurance. What a deal! It's not the first time I've heard a story like that and it's getting more and more common.

Another patient of mine had routine blood work done before an appointment. I ordered a lipid panel, a metabolic panel, a blood count and a thyroid test. If you check the reimbursement rates given in the last section, this should have been about \$75 worth of tests. A local lab even offers these same tests to cash patients for \$95 without a doctor's order.

**SPECIAL BASIC HEALTH PRG**  
CMP, LIPID, TSH, CRP, UA \$95  
A1c DIABETES TEST W/PRG \$24

**DISCOUNT BLOOD TESTING & LAB SERVICES**  
*For The Uninsured / Self Pay / High Deductible Person(s)*

Please see the following information regarding **FIRST CHOICE LABS WEST COAST MEDICAL LABORATORY PROGRAM**. This program is very popular with those individuals who:

1. Are uninsured - have been dropped due to a pre-existing condition.
2. Have insurance - policies that do not cover laboratory tests.
3. Have deductibles - that are much too high to pay.

Many families who cannot afford health insurance have used **FIRST CHOICE LABS WEST COAST** and have detected many serious health issues. We can save them time and money guaranteed.

If you have patients in need of Laboratory services they simply need to:

1. Contact us direct at toll free 1-855-735-7357.
2. We will take the patients basic information and tests requirements.
3. Payment is made to **FIRST CHOICE LABS WEST COAST**.
4. **FIRST CHOICE LABS WEST COAST** regulations are based to a convenient LabCorp location.
5. Results are mailed to patient and faxed to physician upon their request.

If we can answer any additional questions, please do not hesitate to call.

Best regards,  
*Mia Galoney*  
Vice Administrator  
FIRST CHOICE LABS WEST COAST

CALL TOLL FREE 855-735-7357  
www.firstchoicelabsusa.com

PO BOX 8835 - South, CA 92781  
Fax: 754-889-8678  
fclabswestcoast@aol.com

You can imagine how shocked she was (as was I) when she received the following bill:

3E-81882\*81\*802843-00-11194-85882-ACN 11 N  
07/20/11 09:11:12

UNITEDHEALTHCARE INSURANCE COMPANY  
CLOSKAR SERVICE CENTER  
P.O. BOX 740810  
ATLANTA, GA 30374-0810  
PHONE: 1-888-270-8311  
Visit [www.uyhca.com](http://www.uyhca.com) for self-service

UnitedHealthcare  
A UnitedHealth Group Company  
Page 1 Of 2

**Explanation of Benefits**  
THIS IS NOT A BILL

Date: 04/16/11  
Subscriber Name: [REDACTED]  
Patient Name: [REDACTED]  
Member ID: [REDACTED]  
Group Name: CITRUSVIA FRAGRANCES CORP.  
Group #: [REDACTED]  
Claim Number: 0281475844581

Physician/ Provider	Total Provider Charges	Medical Plan Paid	Participating Provider Discount	Other Insurance Paid	Paid By Consumer Account	Amount You Owe		
[REDACTED]	\$782.44	\$0.00	\$367.75	\$0.00	\$0.00	\$414.69		
<b>Annual Limit Year To Date Remaining</b>								
In Network Deductible	750.00	479.36	270.64					
In Network Out Of Pocket	1,500.00	0.00	1,500.00					
Out Of Network Deductible	1,500.00	479.36	1,020.64					
Out Of Network Out Of Pocket	3,000.00	0.00	3,000.00					
<b>Family limits</b>								
In Network Deductible	1,500.00	1,229.36	270.64					
In Network Out Of Pocket	3,000.00	1,500.00	1,500.00					
Out Of Network Deductible	3,000.00	1,229.36	1,770.64					
Out Of Network Out Of Pocket	6,000.00	1,500.00	4,500.00					
<b>Services Details</b>								
Patient: [REDACTED]		Claim Number: 0281475844581		Service Date: 05/24/11 - 05/24/11				
Service Description/ Remark Codes	Amount Billed	Discount Amount	Not Covered	Amount Approved	Deductible Amount	Co-Pay Amount	% Plan Pays	Health Plan Pays
LABORATORY SERVICES	782.44	367.75	0.00	414.69	414.69	0.00	90%	0.00
UD								
<b>TOTALS</b>	<b>782.44</b>	<b>367.75</b>	<b>0.00</b>	<b>414.69</b>	<b>414.69</b>	<b>0.00</b>		<b>0.00</b>
Your Balance								414.69
Amount You Owe								414.69

As you can see from the top line of numbers, the lab billed her \$782.44 or about ten times the expected payment (not unusual for a hospital lab). The DISCOUNT is only \$367.45 leaving her with a \$414.69 bill for about \$75 worth of labs. She's currently trying to contest the bill because she thinks that it's ridiculous (it is). In the meantime, the hospital where she had these blood tests is running out of patience and they want their money.

31402

RETURN SERVICE REQUESTED

PATIENT NAME: [REDACTED]

Please write your PATIENT ACCOUNT NUMBER on your check to ensure your payment is properly credited to your account.

3000\*\*800Y02TV561011

IF PAYING BY AMERICAN EXPRESS OR AMERICAN EXPRESS, FILL OUT BELOW		
<input type="checkbox"/> AMERICAN EXPRESS	<input type="checkbox"/> VISA	<input type="checkbox"/> AMERICAN EXPRESS
CARD NUMBER		EXPIRATION DATE
SECURITY CODE		ZIP CODE
NOTICE DATE	PAY THIS AMOUNT	ACCOUNT #
07/05/11	\$414.69	[REDACTED]
PAYMENT DUE DATE	SHOW AMOUNT PAID HERE \$	
07/25/11		

Please check box if address is incorrect or insurance information has changed, and indicate changes on reverse side.

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

### YOUR ACCOUNT IS OVERDUE!

Dear [REDACTED],

Our records indicate that your account balance of \$414.69 is overdue.

Your account has gone considerably beyond our normal credit limits. We are reluctant to forward this account for outside collection action, but are obligated to do so unless you respond promptly.

If there is anything we can do to assist you in the payment of your account balance, please write us or call [REDACTED] Monday through Friday 8:30 AM to 4:30 PM. To avoid further collection action, please respond immediately.

For your convenience, we offer the option of payment by Visa, Mastercard and American Express. When paying by credit card, please fill out the credit card information in the box above.

Sincerely,

Billing Department

07/15/11

[REDACTED]

### FINAL NOTICE

PATIENT: [REDACTED]  
 ACCT/MEDICAL RECORD#: [REDACTED]  
 SERVICE DATE: 03/24/11  
 BALANCE DUE: 414.69

Dear [REDACTED],

This letter is being sent to you as a FINAL NOTICE because your account remains unpaid.

If you are unable to pay this balance, please contact our Business Office at [REDACTED] to see if you may be eligible for monthly payment plan or Alameda Hospital Financial Assistance Program.

Failure to respond may result in this account being referred to an outside collection agency within 10 days. If this occurs you will be liable for additional charges such as interest and quite possibly legal fees.

Please disregard this notice if payment in full has already been mailed.

Sincerely,

Collections Department



So what's going on? They have insurance. The bill is going through their insurance companies. Why does the test cost THEM so much more than an insurance company would usually pay? Insurance companies don't negotiate—at least not with groups as small as the lab or radiology department at this hospital. They set a reimbursement rate, which is usually pretty close to what Medicare pays, and we (or the hospital) smiles and says “thank you.” After all, if we're doing it for Medicare for \$75, we'll probably do it for United Health Care (or any other insurance company) for \$80. Why would anyone say “no”?

Maybe United Health Care is just being generous. But probably not—United Health Care is consistently one of MY lowest payers. For example, they pay me \$65 and Blue Shield (the insurance provider in the first example) pays me \$73 for an office visit. For the same visit, Medicare pays me \$79 (that's right, most private insurers pay me LESS than Medicare). So why are they being so nice to hospitals?

I can think of at least two reasons an insurance company might price services so outrageously high on certain policies. First, that would punish anyone who buys inexpensive insurance with a high deductible (both of these patients did). Second, they keep you from finding out how much (little) medical service really cost. Patients with high deductibles pay for most of their own medical care. The insurance companies make sure that these patients see a much higher price than the “real” price that they could pay. Just as with generic prescription drugs, insurance companies, not providers determine the price of everything. They can hide their real costs, and punish you for not buying a more expensive plan.

And it doesn't just change the way patients behave. If an occasional patient has a policy that pays at or near the maximum price charged by the hospital, the hospital is motivated to keep their outrageously high prices. This helps to keep medical care unaffordable to private payers. If these inflated reimbursement rates are only on policies that have very high deductibles, the insurance company will rarely get stuck with the bill. Even at these outrageous prices, most people with private insurance will never need more than \$1,500 of medical care in a year. On occasion, someone with one of these policies will have a serious illness and the insurance will have to pay big, but the insurance companies more than make up for these loses with the increase in premiums they get by maintaining their smokescreen.

What this means is that insurance companies have enormous control over the medical industry. They set all rates of reimbursement for all medical services no matter how trivial. These rates vary greatly from policy to policy even for the same service from the same provider. You've seen many ways they can use this power to control (and profit from) the entire industry. Where else do they use this control? Here are some more examples:

A healthcare provider—hospital, lab, physician, whoever—provides a medical service and informs the patient's insurance company. If all goes well, the insurance company responds (agrees that we did actually provide that service). The response is called an “explanation of benefits (EOB).” The EOB explains what service we are paid for, how much we will be paid, who pays (the patient or the insurance) and what was denied or not allowed. Maybe there'll also be a check, but not only will the amount be less what was billed (remember the amount billed is almost always inflated), it will usually be less than what the insurance allows.

Sometimes a fee is “not covered.” This might mean that the patient is on the hook for the entire amount (without even the discount). Sometimes a fee is “not allowed.” This might mean that provider won't get anything and can't even bill the patient. I can only assume that the first denial is to punish patients who ask for the wrong service and the second is to punish providers who offer the wrong service. Also,

services that are not covered or not allowed vary not just for different insurance companies but for different policies from the same company.

Usually, though, the EOB is a complex explanation of the rules of the game we will have to play to get the money the insurance company has agreed we are owed. Here's where we start to get into the strange language of insurance. If there is a "deductible," that means the patient hasn't had enough medical costs this year to start getting insurance, and I need to go the patient for the full amount (after the discount or "adjustment," of course).

For example, if you have a \$2000 deductible on your policy, the first \$2000 of medical cost is on you EACH YEAR. Some policies have exceptions on their deductibles in that they offer full coverage for physical exams and other preventive services even before the deductible is met. I should also explain here that the amount you pay for any medical service before you meet your deductible, in theory, should be the same as what the insurance company would pay for that service after you meet it (in other words, you get their discount for buying their policy).

If the EOB for this patient for this service for this insurance policy says they've already met their deductible, then we can get into copays and co-insurance: A copayment is a fixed amount (determined, of course by your policy) that you pay up front before you receive a service. This amount will often vary from service to service. For example, an office visit to your primary physician might have a ten dollar copay but a specialist might cost you fifteen dollars and an ER visit fifty dollars. These amounts are usually on your insurance card.

Co-insurance is usually a fixed percentage of what the insurance company determines that the service is worth. For example, if your co-insurance is 20% then, for a \$75 office visit, you would owe fifteen dollars. You would be billed for your co-insurance by your provider after they bill the insurance because, only then does your provider know how much you owe.

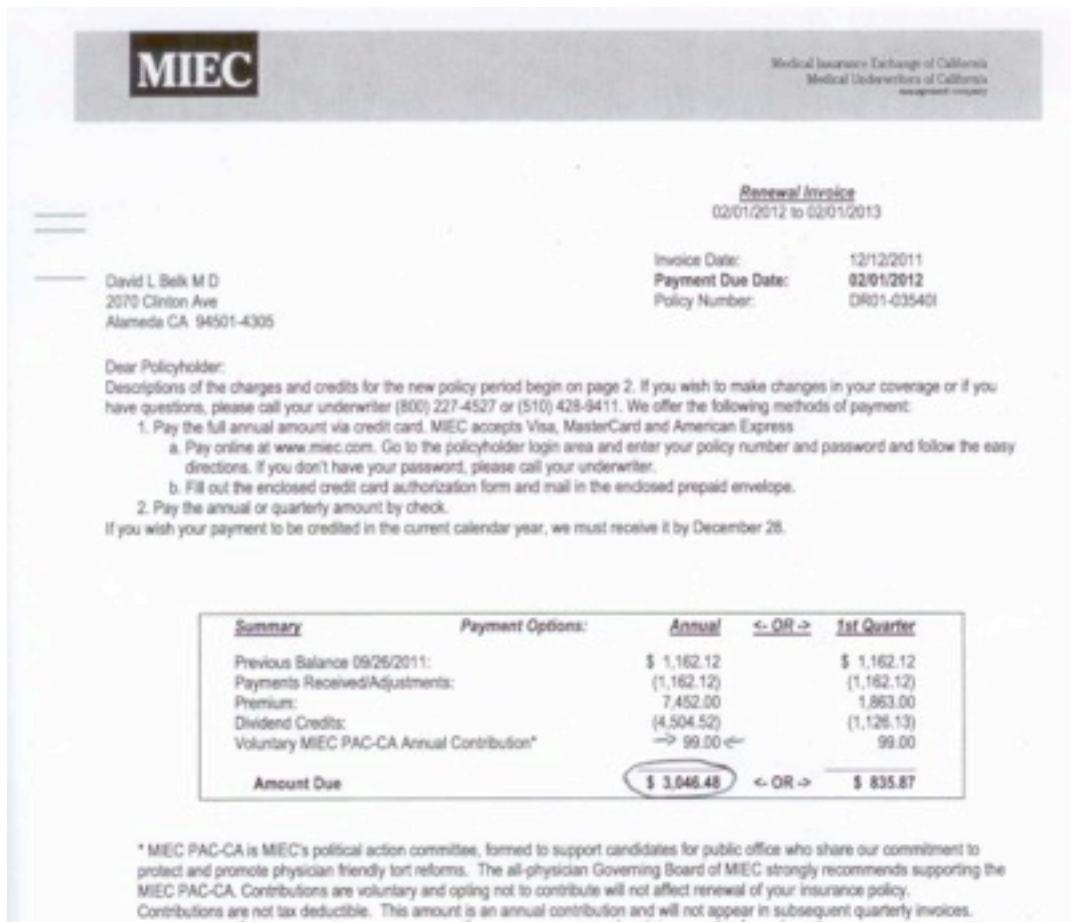
Now, I THINK each insurance company gives me the same amount for the same service, but depending on the plan, I might need to do any number of different things, under any number of different terms, to cobble together that amount. And, by the way, the definitions of the words used on the EOBs aren't even the same for all insurance policies. Each EOB gives its own glossary to explain its own terms.

This doesn't just mean it's very hard for me to get paid (it is). It's very hard for me to know what I'm getting paid, and just as hard for the patient to know what he's paying. And I control all of my own billing. Imagine how much an entire industry could hide in a system that's so confusing. And imagine why they might want to.

# Medical Malpractice: Myths and Realities

When I began writing this website, I had two major goals: provide some transparency to medical costs and dispel some of the many myths about these costs. In a way the second goal may be more important. If most people share a false idea about the cause of a problem then their solutions will be equally misguided. This brings me to the subject of medical malpractice and how much it really costs.

Whenever I ask anyone “how much do you think I pay for my malpractice insurance?” the answer never fails to amuse me. People usually guess anywhere from \$30,000 to \$150,000 per year (as if I could afford that). When I tell them, they’re usually shocked and some people have even gone so far as to tell me I must be wrong. I write the check each quarter. I think I know how much it is. Well, seeing is believing, so here is my malpractice bill for *all* of 2012.



That’s right, **\$2,947.48** for the WHOLE YEAR! (It says \$3046.48 because there is a \$99.00 yearly PAC contribution, which is optional, though they don’t make that obvious on the bill.)

So, why so little? If medical malpractice is so incredibly expensive that it’s breaking the back of healthcare in this Country, why is *my* bill so low? Is it because I’m such an outstanding doctor that my insurance provider long ago recognized that I would never be sued? Well, I’d *like* to think that were true

but, no. I recently surveyed some of the doctors who practice near my office. Many of them have their accountant or biller take care of their bills for them so they were strangely unaware of what they paid and rather surprised when I got them to look at their bills.

I asked the nephrologist, who has an office one floor below me, to open her bill in front of me. She pays \$2,953 a year. Six dollars a year more than I pay and she runs a dialysis unit.

There are two cardiologists who share an office one floor below her. One does angioplasties; which are a very invasive and sometimes dangerous procedure. He pays \$5,500 a year. The other one doesn't do that procedure so he only pays \$3,800.

A pulmonologist, whose office is around the corner from them, pays \$4,200 a year and he oversees an ICU and does bronchoscopies (another invasive and potentially dangerous procedure). Before getting him to look at his bill, he assured me several times that it was twice that amount.

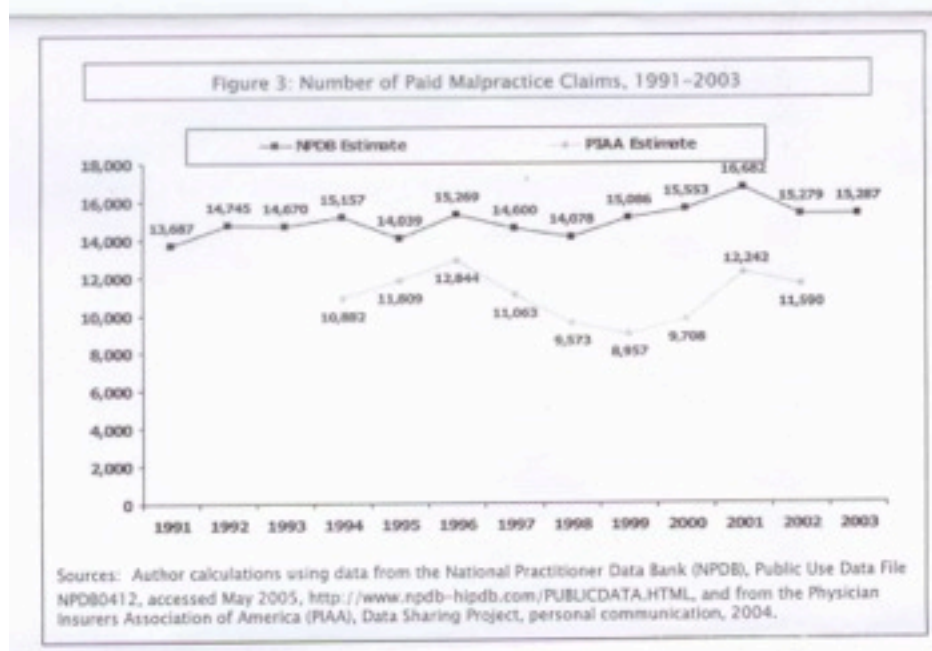
An ophthalmologist I know pays \$3,800 a year and does eye surgery, though he told me that his premiums were cut in half when he stopped doing complicated eye surgeries. Emergency Room physicians (who have a very high exposure to malpractice suits) pay about \$12,000 a year. General surgery: \$18,000, Orthopedic surgery: \$20,000.

Of all the doctors I spoke to, only Obstetrics/Gynecology paid enough in malpractice premiums as to be a burden (surgeons make a lot even by a doctor's standard so most can afford \$18,000-\$20,000 a year). The one Ob/Gyn doctor I asked told me he pays \$40,000 a year (and he's never been sued).

It's easy to see from these figures that medical malpractice premiums don't have much financial impact on me or most of my colleagues. So why are we always being told that medical malpractice is driving up medical costs? Perhaps we should begin with some data on national trends before trying to answer this question (Warning: the following explanation involves statistics).

Researching medical malpractice isn't as easy as it might seem. To get to any actual data I had to fish through an ocean of blogs arguing against tort reform. Still, I managed to find three good references with actual numbers from the Kaiser foundation. The first reference was written in 2005 and gives a very sober explanation of malpractice law in the United States (link provided on website).





The first graph is from page 18 of the first reference. You can see from this graph that malpractice payouts rose steadily through the '90s and, by one estimate, were about \$4.45 billion in 2003. The tables on the next page are from the second and third references (links provided on website). From them you can see that by 2010, the total amount paid in the U.S. for malpractice claims dropped by as much as 25% to \$3.33 billion. Further examination of the 2010 malpractice payouts show that about \$1.2 billion (36%) of these payouts occurred in just three States: New York, Pennsylvania and Florida. If you add Massachusetts, New Jersey and Illinois you can account for 52% of total malpractice dollars paid in 2010 (20% in New York alone!). If you examine the number of paid claims in each State in 2010, again you can see that three States (the first three above) were responsible for 31% of the total paid claims in the U.S. that year.

The second graph is from page 20 of the first reference and you can see there that the total number of claims peaked nationally at 16,682 in 2001. From the table below you can see that they dropped about 40% to 9,894 claims by 2010. Here in California (where I practice) we had only 909 total paid malpractice claims in all of 2010. That's only 909 payouts in a State with over 37 million people and nearly 100,000 doctors! So, it appears as though medical malpractice has rapidly receded in all but a few States.

My personal malpractice premiums reflect this trend. In 2003 (the first year that I paid for my own malpractice insurance) I paid about \$8,500 in premiums for the year. In 2010 it had dropped to just over \$5,000 and now it's just below \$3,000. Apparently medical malpractice suits have nearly disappeared in most States so neither malpractice premiums nor suits appear to have much impact on medical costs. So why are doctors and other healthcare providers constantly complaining about them? In order to answer that, I thought I'd share my personal perspective on the medical malpractice industry and how I believe it really affects most doctors.

## Data in Tables Provided by the Kaiser Foundation

Total Dollars in Paid Claims		Number of paid claims in 2010	
United States	\$3,328,708,700 <sub>1</sub> ****	United States	9,894 <sub>1</sub>
Alabama	\$19,638,750	Alabama	49
Alaska	\$12,748,750	Alaska	18
Arizona	\$49,965,250	Arizona	168
Arkansas	\$14,522,000	Arkansas	50
California	\$187,183,800	California	909**
Colorado	\$41,520,800	Colorado	108
Connecticut	\$58,366,500	Connecticut	109
Delaware	\$17,367,500	Delaware	29
District of Columbia	\$15,862,500	District of Columbia	28
Florida	\$233,141,300**	Florida	838**
Georgia	\$68,124,000	Georgia	185
Hawaii	\$19,942,000	Hawaii	24
Idaho	\$4,612,500	Idaho	16
Illinois	\$195,382,500***	Illinois	312
Indiana	\$64,791,000	Indiana	238
Iowa	\$27,390,500	Iowa	73
Kansas	\$26,359,000	Kansas	160
Kentucky	\$30,358,250	Kentucky	102
Louisiana	\$52,156,500	Louisiana	304
Maine	\$13,971,250	Maine	40
Maryland	\$84,869,250	Maryland	224
Massachusetts	\$136,569,750***	Massachusetts	282
Michigan	\$52,241,250	Michigan	308
Minnesota	\$29,675,300	Minnesota	57
Mississippi	\$14,331,500	Mississippi	73
Missouri	\$51,467,000	Missouri	155
Montana	\$8,351,250	Montana	39
Nebraska	\$9,008,750	Nebraska	43
Nevada	\$13,164,500	Nevada	58
New Hampshire	\$16,967,500	New Hampshire	43
New Jersey	\$188,105,000***	New Jersey	479
New Mexico	\$23,995,800	New Mexico	102
New York	\$667,168,500**	New York	1,373**
North Carolina	\$49,487,750	North Carolina	146
North Dakota	\$1,820,000	North Dakota	14
Ohio	\$79,164,600	Ohio	260
Oklahoma	\$39,562,000	Oklahoma	122
Oregon	\$40,939,250	Oregon	97
Pennsylvania	\$298,788,750**	Pennsylvania	844**
Rhode Island	\$17,185,250	Rhode Island	35
South Carolina	\$28,925,000	South Carolina	127
South Dakota	\$1,940,000	South Dakota	8
Tennessee	\$32,863,500	Tennessee	117
Texas	\$87,022,500	Texas	510
Utah	\$23,819,000	Utah	95
Vermont	\$4,551,250	Vermont	19
Virginia	\$59,850,250	Virginia	149
Washington	\$35,800,000	Washington	120
West Virginia	\$18,772,100	West Virginia	173
Wisconsin	\$55,349,250	Wisconsin	44
Wyoming	\$3,548,250	Wyoming	18

To begin with, I've never actually been sued. I was once named in a case but I had no real involvement in that case and the case was dropped shortly after it was filed for lack of merit. Still, I received a letter of intent and had to phone my insurance provider to tell them what was happening. I've also worked with doctors who've garnered huge profits as "expert" witnesses in a number of medical malpractice cases and I know a few doctors who were dragged through the malpractice process as defendants. Finally, it's impossible to train as a doctor without having the aura of medical malpractice constantly haunt you.

From the moment I entered medical school we were reminded, quite frequently, of the fact that, at some point in our career, we would probably be involved in a malpractice suit. We were taught right from the beginning how to protect ourselves from these inevitable lawsuits. Much of what we were told was good advice in general. For example, we were told that we need to be open and honest with our patients and explain everything as best we can. We were also told to document everything we do and say and why we did it in order to defend our actions in court (most chart notes are written for legal not medical reasons).

The most important thing we were told, though, is that we need to be likeable (or at least not disliked). We were told time and again the one factor that most determines whether a doctor is sued and whether he prevails in a suit is how likeable he is. Patients are far more likely to sue a doctor they don't like and, in any complex case, juries are far more likely to rule against a doctor they don't like. This means that any doctor who had a reputation for having a less than rosy personality risked having malpractice attorneys home in on him like sharks to a bleeding porpoise. To address this, medical schools adopted a national program of intense likeability training for the students. It's called "Introduction to Clinical Medicine" or ICM.

The purpose of ICM is to begin to teach us how to interact with patients from the start. We all formed groups and were instructed to talk about our feelings; how we felt about taking care of patients, how we should feel about patients, how we felt about all of these feelings and so on. We were also taught the basics of interviewing patients and doing physical exams. Then we would meet periodically with standardized patients. Standardized patients were actors and actresses who (as you might have guessed) acted out the role of a patient with a particular problem or complaint. We would take turns interviewing or examining this person while they would deliberately say or do things that would confront us or otherwise make us uncomfortable. Meanwhile the rest of the group watched and then gave us feedback on our performance.

After enduring a number of these performances, we would be given a standardized patient test. The test would go something like this: There would be a number of exam rooms in a hallway. Standing outside each room would be a medical student. The student would read a note on the exam room door giving him instructions on why the patient was there and what needed to be done. When a bell rang, the student entered the room and had 10-15 minutes (time limits would vary on different exams) to complete the expected tasks while being recorded on camera. When the bell rang again, he was to leave the room and go to the next door. A typical exam would have about six to eight such encounters.

In one such encounter (that I still remember vividly) the note on the door stated that the woman inside had recently had a mammogram that showed a lesion that was highly suspicious for malignancy (remember, she was an actress not an actual patient). My tasks were to inform her of the result, explain to her what it meant and then examine her breasts (to see if the mammogram was right??). The woman in the room was more than a little excitable. The second I entered the room she began to talk a mile a minute and I was forced to interrupt her to tell her she might have cancer (she kept cutting me off while I was trying to explain that). When I finally was able to give her the bad news, she went completely ballistic and I had to spend a few minutes calming her down before doing the breast exam (which was awkward to say the least).

So, in summary: I was expected to enter a room, introduce myself to a complete stranger, tell her she might have cancer, calm her down from a hysterical fit, and then ask her to undress so I could examine her breasts. All of this was to be done in fifteen minutes and while a camera was recording me. What's more, the same faculty who designed a test like this was also responsible for teaching us how to be more

likeable! Certainly that was the most extreme example I can remember, but almost all of the encounters we had in these tests were designed to catch us off guard.

I can't blame the medical school faculty too much for what they put us through. Their goal was to teach us to remain professional even while being made uncomfortable and to communicate clearly even when it was very difficult. Their purpose was to train us to avoid being misunderstood as much as possible. As with everything, they just over did it a bit. Unfortunately, as a result of their enthusiasm, most of us were left with an unrealistic impression. We felt that as long as we could communicate everything we thought to someone with no medical training in a way in which they could understand AND get every one of our patients to like us, we had nothing to worry about. Needless to say, most of us were worried.

And there appeared to be plenty to worry about. We heard about malpractice cases everywhere: from doctors who had been sued to "expert" witnesses who made their fortune testifying in multiple suits. There were a number of journals that would arrive in my mail each week presenting the latest cases in medical malpractice as vicarious lessons on how we could protect ourselves from a similar suit. In any bad outcome, the list of things for which we could be sued appeared endless. As examples, we were often told:

- If we prescribe a medication and the patient didn't take it because we didn't explain clearly enough why they needed the medication, they could sue us.
- If we explained why they needed the medication but didn't clearly document our explanation, they could sue us.
- If a patient misses an appointment and we don't call to see why, they could sue us.

And so on. In a business in which bad outcomes are inevitable (everyone will eventually get sick and die in even the best of care) being misunderstood was clearly dangerous. What's more, there was an entire industry making huge profits from our being misunderstood.

And the profits *were* huge but, make no mistake; being sued wasn't about the money; at least not for the doctor who was being sued. To the doctor in question, being sued was no more about the money than a major traffic accident is about the money. A doctor would usually first hear the news of an impending lawsuit by receiving a "letter of intent" in the mail. This letter would contain a lot of colorful language about how the doctor's incompetence, negligence, dishonesty, stupidity and/or otherwise horrendous behavior resulted in death, disability, tremendous pain and suffering, etc...

The doctor in question may or may not have anything to do with the case in question. The plaintiff's attorney has a limited amount of time to file each case so, to avoid missing anyone, he'll just send the same letter to everyone whose name is on the plaintiff's chart no matter how incidental or remote the connection may be (then sort them out later). It's then the duty of the doctor in question to phone their malpractice insurance provider to explain the situation. It's important for us to inform our insurance provider because, in addition to covering any damages, they also provide us with the legal support for our defense. That's not out of the kindness of their hearts of course (remember: they're an insurance company). They simply know that by overseeing our defense, they will likely minimize their loss.

Unfortunately, that doesn't always work to our advantage. The insurance companies protect our interest only to the degree that it coincides with their own. If our malpractice provider believes they're likely to save 50 cents by not fighting the case and just settling out of court; no problem. Our reputation is of no



interest to them. They'll just compensate for our loss by raising our premiums. Also, the advice they give us is aimed primarily at protecting their assets. The first piece of advice a doctor named in a suit will get from their insurance provider is to talk to no one; not their coworkers, friends, family, spouse; NO ONE! Anyone you talk to about any aspect of the case can be called as a witness to testify about what you told them.

In addition to the pure creepiness of being told that anything said in a private conversation with your spouse could be used against you in court, this advice also has the effect of completely isolating you. Medical malpractice cases usually take about two years to make it to court and so for two years you're told you can't talk to anyone while the plaintiff's attorneys take every chance to hurl insults at you about how horrible a doctor you are in letter after letter asking for more details about the case. The insurance companies give this advice for your (and their) protection. They know that if you go around complaining about the case to everyone you know, you might end up saying something that will incriminate you and word might get back to the plaintiff (rumors travel fast).

But this advice also plays into the plaintiffs' hands. After two or more years of being isolated, alienated and insulted, there's a good chance that a doctor (or anyone else) would be feeling a bit hostile. Remember, a key aspect of how juries rule in medical malpractice is how likeable they find the defendant. If the doctor in question starts spouting about how unfairly he's been treated the minute he gets on the witness stand, the jury will likely hate him and the plaintiff's attorney can immediately put a down payment on a new condo.

When the court date arrives the show can begin. Each side; the defense and plaintiff's; attempt to cast the defendant in the starkest image possible. The defense wants the jury to see their client as Marcus Welby while the plaintiff's attorney does everything in his power to cast the defendant as Jack the Ripper. The jury is selected specifically in a manner to ensure they have as little knowledge of medicine as possible (knowledge, as we all know, is nothing more than an invitation to bias). Anyone who presents to a jury pool with any history of medical training would be automatically excluded.

Since the jury has little understanding of any medical issues, it's the duty of "expert" witnesses on each side to educate the jury about the relevant medical issues regarding the case. Expert witnesses are physicians (usually specialists) hired by each side to provide their expert opinion about how the case in question was handled or mishandled. These "experts" have supposedly the highest level of knowledge in their respective fields. Yet, strangely, each team's expertise leads them to the exact opposite conclusion about the defendant's performance than the other team's "expert".

Expert witnesses play a pivotal role in most malpractice cases. Many of the cases that aren't settled out of court require advanced medical knowledge beyond what the jury, judge or attorneys would likely have. Therefore, the testimony of these "experts" is about all anyone in the courtroom can use to render any kind of informed judgment. Because they are so pivotal to the case, these "experts" are treated quite well by both sides. A typical "expert" is paid about \$500 an hour for all hours spent on the case in or out of the courtroom (they even get to log their own hours since their honesty is always beyond question).

There are certain expectations that both sides have of their "experts" (other than, of course, their expertise). They are not to have known or have had any prior contact with either the plaintiff or defendant in any way, whether personal or professional (that would make their testimony appear biased). They are also expected to have testified about equally for both plaintiffs and defendants (again so as not to appear biased). Still, since the benefits are so good, there is always a generous supply of "experts" available to

both sides for any case in spite of these restrictions. The lawyers from each side are often free to pick and choose which “expert” they think will best represent their client. Not surprisingly, each side chooses someone who they think will best relate to the jury. In other words, personality and theatrical skill are the most important aspects of any “expert” witness’ expertise.

After both sides have presented their case, the jury gets to choose whose performance they thought was better. If they side with the defendant, the plaintiff (and the plaintiff’s attorney) goes home with nothing and the defendant’s reputation is spared. His malpractice insurance premiums will still probably go up (being sued, even if it’s unsuccessful, is a sign that someone didn’t like you and to an insurance company, that looks bad). Also, he’s lost two years of his life waiting for his case to make it to court (which he’ll never get back, of course). Still, he gets to go home with the satisfaction that he didn’t fight for his reputation in vain.

If they side with the plaintiff, then begins the penalty phase of the trial to determine the damages that will be reimbursed to the plaintiff. In the penalty phase, the jury decides how much the plaintiff actually lost due to the defendant’s negligence. In many States the damages can be awarded proportionally. For example, if the jury believes that the doctor made a mistake but it was the plaintiff’s actions that caused most of the tragedy (didn’t take prescribed meds, didn’t show up for an appointment, etc...) then the jury might award the plaintiff only a portion of the damages. The doctor might be given 40% of the blame so the plaintiff is awarded 40% of the assessed damages.

To determine the damages, the jury must consider both economic and noneconomic losses the plaintiff sustained as a result of the malpractice. Economic losses are seemingly straightforward and usually include lost wages and ongoing medical expenses. Noneconomic losses are much more subjective. They include factors such as pain, suffering and emotional trauma the patient may have endured. Since these losses can never be quantified objectively, they are probably the most contentious issue in medical malpractice. Personality and theatrics often weigh heavily on how these damages are assessed.

Except for a letter of intent and the resulting conversation with my malpractice provider I have no direct experience with the details I just provided about a medical malpractice trial. That’s just as well. I hope never to experience any of that first hand which is why I’m glad that medical malpractice suits have become far less common than they were ten years ago. That doesn’t mean that I don’t believe physicians should be held accountable; I do. Physicians are no different from any other professional. We’re human beings who are in no way above corruption or conflicts of interest. As with any profession we have our fair share of incompetents, charlatans, con artists and criminals. But medical malpractice is a business driven almost purely by profit through tragedy. Decisions often hinge on the theatrical performance of two competing teams to an audience selected specifically for their lack of knowledge regarding the issue they’re judging. There has to be a better way.

One question that remains is why malpractice dropped so dramatically in the last decade. As it turns out, the answer isn’t very obvious. When I began researching malpractice, I assumed the answer was tort reform. By 2010 tort reform bills had been enacted in 35 States. In some States these bills have had a dramatic effect (*e.g.* Texas) but in other States it’s not so obvious. I noted earlier in this section that more than half the malpractice dollars paid in 2010 were paid in only six States. One of those States; Pennsylvania, passed a supposedly robust tort reform bill in 2003 and yet in 2010 was still ranked second in both number of paid medical malpractice claims and total dollars in paid claims. In California, the story is even more confusing. California did pass a strong tort reform bill that, among other things capped noneconomic damages at \$250,000. But that happened in 1975! Clearly, a number of other factors

occurred since then because California didn't start to see a significant drop in medical malpractice before the year 2000.

Perhaps all of our sensitivity training in medical school helped. It seems hard to believe now that there was a time when medicine was such a paternalistic profession that we were never expected to consult with a patient about any treatment plan or procedure (I'm the doctor, you're the patient was the expected answer to any question). It was once considered unethical even to inform a patient of a bad prognosis (we felt it would be detrimental to their health if they knew they were dying). If it took the threat of malpractice to change all of that and force us to be honest and open about what we're doing then I guess that result was more than welcome.

Another question that remains is: To what degree does the fear of malpractice add to medical costs? Are doctors ordering a lot unnecessary tests and running up medical bills to avoid being sued? It's certainly possible. Fear leads to irrational behavior in any profession. And, if true, I don't know how such an effect could be verified or quantified. It's important to remember, though, that the only time a doctor could be sued for not ordering a test would be if that test would have revealed a problem the doctor missed. In other words; not ordering a test that should have been ordered; which, by the way, is the definition of malpractice.

When I was asking my colleagues about their malpractice premiums I also asked them "In the last five years do you know of anyone who has been sued?" Most answered no and the few who did know someone had to admit it was for a legitimate reason. I have little doubt that most, if not all, of the 909 successful medical malpractice suits in California in 2010 were for legitimate reasons and not just because of misunderstandings or personality issues. As I said before, doctors need to be held accountable as much as anyone else. Certainly more, not less oversight is needed in a profession as important as ours. That being said, I don't miss the threat of being sued for simple misunderstandings any more than I miss the higher premiums I paid a decade ago.

## CONCLUSION: IS HEALTHCARE REALLY SO EXPENSIVE?

My goal for this website (and book) was to try to understand a system that has an enormous financial impact on everyone, but makes almost no sense to anyone. It's a system with hidden costs, enormous mark ups to discourage direct payment and a labyrinth of billing and reimbursement schedules that almost guarantee that no person directly involved could ever understand it. And we've started to see why this system is set up this way, who benefits from it, and who loses. The question is: How did it get this way?

I've only been in practice for about a decade and the system, as it is, began evolving long before my medical career began. Still, I can only guess that decades ago when insurance companies started to pay for medical costs, no one intended for it to end up like this. Insurance companies were originally run by doctors. Their idea was to spread the risk. They had a sense that getting sick usually wasn't fair, so going bankrupt because you were sick probably also wasn't fair. They had the idea that pooling people in advance made it easier on everyone, and improved access to healthcare.

It's a great irony that only a few years later, some business people (people who are very good with money, but not so interested in medicine) realized that they could make a lot of money on health insurance if they created a special insurance plan that excluded the sickest people. In other words, insurance for people who probably didn't need it, which was very different from the original idea of health insurance for everyone, but far more profitable. The idea of preexisting conditions is almost as old as health insurance itself.

Here's one way to look at how the system came to be: People usually try to find occupations that follow what they love, at least in the beginning. Hospitals can be callous in their billing, as we've seen, and doctors like money as much as anyone else, but fundamentally there was a point in their lives when they (doctors and people who run hospitals) decided to get into the profession of helping sick people. Some are genuinely compassionate. Some are biology wonks or technology wonks, or just like the action. But most of them lose interest pretty quickly when they have to start dealing with complicated financial matters like insurance payments.

The first insurance companies were started by doctors, but they couldn't stay in the game when the money professionals started showing. They couldn't compete financially, and they didn't have the mindset to try. So they did what most of us do: focus on the details that interested them (medicine), and left the tedious stuff (finances) to someone who was interested in it (insurance companies). Now the insurance companies could start building a system in their image.

As the system grew and healthcare became more complex, more people came into the health insurance industry who had a good understanding of money but little interest in healthcare. It's no secret that confused people are easier to take advantage of, so layers of confusion were slowly piled on and profits soared. Insurance companies sell nothing more than security against financial risk. If no one really understands what that risk is (because all prices are hidden or deceptive) *then the price of the security (insurance) can be grossly inflated.*

Doctors, hospitals, and other healthcare providers didn't protest as the process slowly grew away from them because, as this started to happen, they too, were making money, and didn't think they needed to worry about it. As the system became less and less transparent, insurance companies were careful to make sure that all of the major players were kept very happy. But you can't keep everyone happy forever, and when things get tight, that's when you start to learn who's running the system. Now, after 30 to 40

years of slowly allowing all of our understanding of the financial transactions to erode, we are left seeing more and more money dumped into a black hole with little understanding of what happens to it.

It's rare to see a discussion about healthcare costs that isn't centered on co-pays, premiums, and deductibles. These are all indirect costs. They tell you almost nothing about the cost of the final product (the medical services that you might need). If the cost of individual components of healthcare are mentioned at all in these conversations, the price given is usually the billing charge. But the billing charge has little to do with what health care costs either. You've seen in almost every section of this discussion that the billing charge is a hugely inflated price that almost no one ever pays.

Why would anyone want us to focus on a price that's almost never paid (unless you don't have insurance, of course)? Well, one reason might be that it makes it look like all that money is really going into paying for our health care. We all know how important an MRI can be, or an Emergency Room visit, and as long as people think an MRI really costs \$4,000, and an ER visit costs \$4,500, maybe they'll resign themselves to paying big insurance premiums, and we can all tell ourselves that it's the only way we can continue to have "the best health care in the world."

But if these charges have nothing to do with reality, then neither do any of the discussions. MRI's and ER visits cost hundreds of dollars, not thousands! This is all a very effective diversion because, if no one ever addresses the real problem, it's unlikely a real solution will ever be proposed. And if you don't want people to find out where their money is going, it helps to have them looking in the wrong place.

What I do know is this: I don't have to buy my own health insurance because my wife gets it through her employer (she only works in my office one day per week). After our children were born, she took time off from work. It was then that we realized how much our policy actually cost since we had to pay for it ourselves while she was on leave. For a family of four with no medical problems, it cost just over \$1,300 a month or \$15,600 a year (for an HMO!). When she re-enrolled this year, it had gone up to \$1,500 a month or \$18,000 per year! For comparison, my malpractice insurance cost me about \$2,950 a year. Liability insurance on our two cars cost \$680 a year. Office insurance for my practice is about \$1,170 a year. My life insurance is \$588 a year and our homeowners insurance on two houses is about \$1,270 a year. In total, ALL of our other insurance policies COMBINED cost just over a third what our health insurance cost ALONE! And this for a family with no medical problems (and free doctor visits).

So where is all of this money going? A number of reasons have been proposed for why the cost of healthcare is rising faster than almost anything else. Is it the aging population? It stands to reason that older people have more healthcare needs. However, almost all of the medical costs for anyone over 65 are covered by Medicare so private insurance companies aren't responsible for these. And part of the reason we're living longer is that we're keeping young people healthier (though no healthier than in other developed countries). Treating blood pressure or high cholesterol early and aggressively, for example, is not only inexpensive, it can postpone a heart attack or stroke (both of which are very expensive) for decades.

Is it the increasing use of technology in medicine? Certainly there have been a lot of technical innovations that have revolutionized medical care in the last 30 years, but this has happened in every industry. Furthermore, technological costs tend to decrease over time. How much does an I-phone cost now as opposed to four years ago? How much more can it do now?

A CT scan or an MRI used to cost thousands of dollars when the technology was new, now they go for only a few hundred. It's true that they are used far more often now than twenty or thirty years ago but it's also true that people are hospitalized for far fewer conditions, hospitalizations are far shorter for a given condition and so is post-surgical recovery time. All of this because most of the medical and technical innovations have managed to decrease, not increase, the total amount of time and resources needed for most patients.

Many of the medical devices that have recently been developed are also very expensive. If there were a way in which I could tell you the price of these I would, but the purchase price of most of them varies from hospital to hospital and is a proprietary secret between the hospital and the device maker. Still, the majority of these are used primarily in Medicare patients so again, they have only a limited effect on the cost of private insurance. Even so, as with other innovations in medicine, most of these devices have resulted in a decreased amount of time the patient spends in the hospital and less total money spent.

Earlier, we saw that the cost of most of the commonly prescribed medications as well as many routine diagnostic tests have become so inexpensive that you would hardly notice them if you added them to your weekly grocery bill. In the medications section, I gave the example of a person with diabetes, high blood pressure, high cholesterol, congestive heart failure, coronary artery disease and an enlarged prostate who could get all of his medications for about \$200 a year. If he takes his medications, follows a strict diet and goes for a walk every day, his conditions are likely to remain stable for years and he'll only need to see the doctor about four times a year. At about \$100 per appointment that's \$400 more a year. Add the cost of blood tests taken before each appointment to check his liver and kidney function, diabetes control and cholesterol and that's another \$300-\$400 a year. So this chronically ill patient with multiple medical problems can be managed most years for a total annual cost of about \$1,000.

Few of my patients under 65 have that many chronic medical problems. Most of them have three or less. Even so, I have a patient with only high blood pressure and high cholesterol and because he has to buy his own insurance and is considered high risk by the insurance companies, his premiums for just his own coverage are \$900 a month. In the 9 years that he's been my patient, he has not run up enough medical bills to ever even meet his \$2,000 deductible. He even buys his medications at Costco so the insurance isn't even involved with that. He's 64 now so, next year he will be eligible for Medicare and, for roughly one third the price, Medicare will cover 80% of his medical expenses for the rest of his life. The private insurance plan that cost nearly \$100,000 over the last decade will be done covering his medical conditions. And they'll have paid hardly anything for his medical care. Again, where is all this money going?

Extended hospitalizations are becoming increasingly rare. The time spent in the hospital is less now than in the past for most diseases. The medications needed to treat HIV are certainly not cheap, but the overall cost of treating HIV has dropped because of these medications. HIV is now a chronic illness that only rarely requires hospitalized care whereas, prior to these drugs, most people with HIV were critically ill and in the hospital for much of the course of their disease (before dying). Even organ transplants are done far more efficiently and with fewer complications than in the past. Some of the anti-rejection medications are now going generic making post-operative treatment less expensive as well. Most specialists I know claim that they get less, not more, for procedures than they received twenty or thirty years ago so, again, where is the money going?

There are patients who have neither Medicare or Medicaid who will get a very serious and expensive illnesses each year but are they really more common than house fires or major traffic accidents? The

insurance needed to cover these (auto and home owners) cost only a fraction of the price of health insurance. And don't let anyone tell you that it's because of malpractice insurance or lawyers! Most people believe that medical malpractice is very expensive, but *my malpractice insurance cost about one sixth the price of our health insurance.*

It's true that health insurance coverage is far more comprehensive than other types of insurance. As I've said, no one would use their car insurance to replace a burned out headlight, buy gasoline, or change the oil. In fact, healthcare is the only industry where insurance is used to pay for practically everything. But this is necessary in large part because even the most trivial expenses in healthcare have such an enormous mark up. If you don't use your health insurance, you could never afford the (unreal) inflated price.

Is it a coincidence that the only industry that uses a third party to handle almost all financial transactions has the highest rate of inflation? Paying someone to pay your bills for you will always result in you paying more (how could it not?). Sometimes people argue that healthcare is so complicated that people could never understand the cost of what it provides (even some of my colleagues in medicine have suggested this). This amazes me. We live in a society where we regularly purchase cars, plane tickets, computers, complicated cell phone plans and a multitude of other goods and services, all of which have multiple factors that contribute to their price. Still a price is given for these goods and services and that price is paid by the consumer. There is no need to bother a third party for any of these other important and complicated financial transactions. So what makes healthcare so special? What about healthcare makes it the only industry in this country where the people involved can't place a true value on what they do?

I'm not arguing that insurance is never needed in healthcare. There are, and probably always will be, many diseases for which almost no one could afford the appropriate treatment. In these cases, catastrophic coverage with a high deductible would probably be enough for most people. But the problem with many of these plans is that insurance companies now purposely inflate the price you will pay for any medical service (see insurance companies). This guarantees several thousand dollars in medical bills anytime someone with one of these plans needs any kind of healthcare. I can only assume that this is a ploy to get people to buy more coverage.

Hospitals, labs, doctors and pharmacies are all complacent in this extortion by billing patients the full price when their insurance won't pay. They (we) are at least somewhat culpable. Their excuse is that they would be underpaid if they didn't continue to play the game the insurance companies force on them. That may be so, but as long as they continue get the majority of their payments from a highly reluctant third party, they will continue to work harder and spend more money to get each dollar. A willing customer gives you cash up front, only a fool would discourage this.

Even though we get our insurance through my wife's employer (and it's very good coverage), it's hardly the best deal for us. The \$1,300 dollars a month that her employer pays to the insurance is almost pure profit for them. Outside of the birth of our two children, (which we covered with one year of premiums), we use them for practically nothing. If my wife's employer offered catastrophic coverage with a high deductible that cost only \$300 a month, my wife could potentially get the extra \$1,000 dollars a month in her paycheck.

What I'm proposing isn't radical. We in the healthcare industry need to place an honest value on everything we do, sell our products only for what they are worth and involve a third party for payment only when absolutely necessary! In what other business would this be considered radical?

But above all, whatever you do, never let anyone tell you that we pay this much because that is what the best healthcare costs. It doesn't. The money isn't spent on caring for your health. And don't let them tell you that this is how the free market works. It's not a market, and it's not free.



## Epilogue: Why are so Many Hospitals Going Bankrupt?

Several times in this discussion I've alluded to the financial troubles of many community hospitals. In my study of hospital financial reports I found that nearly one in four California hospitals lost money overall during the course of the study. The question is why? In a country in which so much money is being dumped into healthcare, why are so many hospitals having trouble making ends meet?

To answer this question we should begin with some numbers.

-In 1985, there were about 7,000 hospitals in the U.S., now there are just under 5,800.

-In that time, the population in the U.S. has increased from 238 million to over 310 million and the median age has increased by about six years.

So, in 25 years our population has increased by 30%, aged six years (on average) but we have about 17% fewer hospitals to take care of us. Does this mean that the remaining hospitals are constantly filled to capacity with surgeries being performed in the hallways? Well... not exactly, or rather, not at all. I made some phone calls (or rather, my receptionist made some calls) to several local hospitals here in the San Francisco Bay Area to see how full they actually were. What we found was a little surprising.

On the morning of October 12, 2011:

-John Muir Hospital; a 572 bed hospital in the East Bay, had 301 patients (about 53% full).

-Alta Bates Hospital had 229 of their 527 beds occupied on that same morning (43% full).

-Summit Hospital had 195 of 399 beds occupied (49% full).

-California Pacific Medical Center in San Francisco had 231 of 382 beds occupied (60% full).

-Even Stanford Hospital had only 430 of 613 beds occupied that morning (70% full).

So in five hospitals in one metropolitan area about half of the beds in each hospital were occupied and over 1100 total beds were empty. To see if this were true with hospitals elsewhere she called a couple in Southern California the next morning.

-Huntington Memorial in Pasadena had 354 of 549 beds occupied (64% full).

-UCLA Hospital had 520 of 918 beds occupied (57% full)

I couldn't ask Heidi to call every hospital in the country (she'd quit) but I felt that the information I got from even these few phone calls reflected what I've been hearing and reading elsewhere: most hospitals are operating at about 50-70% capacity most of the time. So, in a country with fewer hospitals and more people, the remaining hospitals are only about half full. How is this possible? Are people no longer getting sick? And, if so, why do medical costs keep rising? What's going on? To understand what's happening with hospitals now we must first go back in time.

## A Bygone Era

If someone were to ask why a person were in the hospital in 1980 the simple answer would be “because he’s sick” and the meaning of “sick” was pretty much anything the doctor said it was. A person could be hospitalized for a bad cold, a urinary tract infection or fatigue. If someone needed surgery, they would be admitted to the hospital days in advance to “prepare” them for the operation and they certainly wouldn’t go home until they had “recovered” enough. Respite care was another favorite. If a family was about to go on a vacation and grandma or grandpa were too weak or infirm (or just not fun enough) to take with, no problem. Just drop them off at the hospital and they’ll be admitted while everyone else goes to Disneyland.

It became the God-given right for anyone to stay in the hospital for any ailment, real or imagined, until the doctor decided it was time for them to go home. It was also the sworn duty of Medicare and the private insurance companies to pay for these hospitalizations without question or any interference in any decisions about medical care. Hospitals flourished and everyone was happy, but it couldn’t last.

## The Government Giveth and the Government Taketh Away

In 1983 Medicare instituted the policy of reimbursement only for certain Diagnostic Related Groups or DRGs. In this system, Medicare would only reimburse a fixed amount for each of the qualifying diagnoses listed in the DRGs. As you can guess, respite care, fatigue, bad colds and urinary tract infections did not make it on the list. The private insurance companies followed the example in rapid succession (as they always do) so, in a single move, Medicare eliminated a major source of income for most hospitals. It wasn’t just that hospitals could no longer get paid to admit most of the patients they’d been admitting in the past; the patients they were left with were far less profitable. The patient population that they lost had cost almost nothing for their care but generated a lot of revenue.

Hospitals were left with fewer, more expensive patients who required a higher level of care but didn’t provide nearly as much profit. With the profits disappearing, so went all motivation to build new hospitals and all of the old hospitals were hit with a sudden drop in income they couldn’t make up. Over the next twenty years, more than one thousand hospitals found that they couldn’t make ends meet with the new system and went bankrupt. By 2003 the number of hospitals in the U.S. leveled off to about where it is now but, the hospitals that remain are, by no means, having an easy time.

Among the many challenges hospitals now face are simple medical progress. Outpatient surgery centers perform minor surgeries that in the past would warrant a hospital admission. Advances in surgical techniques have transformed major surgeries into minor ones. Infusion centers now give IV chemotherapies and transfusions that were formerly done in hospitals. People are no longer admitted to hospitals for radiation therapy either.

Advances in primary care have also cost hospitals much needed business. Every day I treat high blood pressure, high cholesterol and diabetes with powerful medicines that prevent my patients from having strokes or heart attacks that would result in hospitalizations. Peptic ulcers often required major surgery in the past. Now they are easily treated with over the counter antacids. Newer antibiotics are very potent even in pill form. This reduces the need to hospitalize patients for IV antibiotic therapy for many acute infections.

These are just a few of the many innovations that, although good for society, leave hospitals with a declining patient population (and lower overall healthcare costs). The few patients that continue to need hospitalization are the ones who require the greatest number of resources and are therefore the most expensive to treat.

How else are hospitals being hurt?

In 2003 Congress passed “The Medicare Prescription Drug, Modernization and Improvement Act”. Among other things, this bill allowed seniors to buy into prescription drug plans that resulted in their being overcharged for most of their medications (see Medications I). The act also contained a provision creating the Recovery Audit Contractors or RAC. Their job was to go into hospitals, review the charts for the last three years and retrieve any perceived overcharges.

That’s fair enough on the surface. Medicare has a right to fight overcharges, as much as, anyone else. The problem was the RAC was paid entirely on commission (25-30%) up front so the more “overcharges” they found, the more they were paid. Hospitals had to appeal each individual “overcharge” one at a time (costing them money to fight each appeal) and, originally, the RAC didn’t even have to refund commissions made from cases that were overturned.

In other words, they could cite any chart with a perceived irregularity and collect their commission with no penalty for being wrong. In the meantime, the hospital in question would have to spend even more money (\$1,000-\$2,000) to fight EACH fine. In 2009 hospitals won some concessions from the Center for Medicare and Medicaid Services (CMS) in that they agreed that there was a serious conflict of interest in how the RAC was paid. The system of auditing was revised so that auditors would only get paid AFTER a case against the hospital was won. This made the RAC far less predatory but, by then, the damage was already done. More than \$120 MILLION was “recovered” from California hospitals ALONE.

Now each hospital employs a whole team of case managers who go over each chart every day to make sure that criteria are met for each patient to stay in the hospital. Their job is to insure that no patient ever stays longer than would be reimbursed. They also have to forward chart notes and other clinical evidence to the insurance companies to verify that a patient still belongs in the hospital every day. Obviously, it costs money to have these case managers doing this and that adds to the overall cost of a hospitalization.

If I want to admit a patient to the hospital, I have to verify one of two things in advance: Either the patient needs a treatment for a medical condition that can only be provided in the hospital or the patient needs to be observed in the hospital for a condition that might soon kill him if he were to go home. It’s not always easy to verify these conditions in an office setting since I often won’t know until I get the results of certain tests. Even in an Emergency Room, it might not be obvious after initial testing whether someone is really sick enough to warrant hospitalization by the strict criteria we have now.

No matter, we now have a whole list of “observation” criteria to cover us while we’re determining if a person really needs to be in the hospital. Observation means that the patient can stay in the hospital up to 48 hours while tests are being run to see if he really belongs there. These pseudo-admissions don’t pay the hospital as well as a regular admit (a few hundred dollars a day versus a few thousand for a regular admission) but that’s the price the hospital has to pay for our not knowing everything at a glance.

These criteria for observation-versus regular admission-versus just send them home with aspirin are extremely detailed and numerous enough to fill a book. One such book is “InterQual Level of Care Criteria 2011” and is put out not by the government or an insurance company but rather by a medical

supply company called McKesson. In it, there are 272 pages of very detailed criteria for assigning the level of care a patient should get. This book also has a disclaimer in the beginning (as do most medical texts). The disclaimer states that ...it “cannot alone either resolve medical ambiguities... or provide the sole basis for definitive decisions”. I find that quote interesting since the criteria in that book do provide almost the sole basis for insurance reimbursement.

On occasion, a patient will appear in my office or the ER with a condition that is far too severe to send them home, but who doesn't quite meet the strict criteria spelled out in the book to qualify for hospitalization. I find it annoying that, even in this enlightened age, there are still diseases that haven't taken the time to read all of our text books. No matter. Hospitals now contract full time legal teams to defend the hospital's decision to admit such a patient. This also adds to the overall cost of a hospitalization.

So, as you can see, we've come full circle. Thirty years ago a doctor could admit patients for any reason and keep them in the hospital as long as he wanted without being questioned. Now, my opinion as a doctor means absolutely NOTHING. If I think that a patient should be in the hospital I have to present absolute proof of the necessity in advance. In an ambiguous case, I do have up to 48 hours to prove the patient qualifies. If I don't make my case, it's the hospital that gets docked not me. I am paid about the same amount each day for an observation as I am for a full admit. It's the hospital (who's resources I use for my patient's work-up) that gets about 90% less money if the patient ends up not being “sick enough”.

This brings us to the strange world of doctor versus hospital billing (if it hasn't already been strange enough for you). Very few doctors are actually employed by hospitals. We work as independent providers with hospital privileges. We use the hospitals to treat our patients but we are paid in an entirely separate manner. It's not just that we bill the insurance companies separately, we bill separate divisions of each insurance provider. This means that our reimbursement is not directly tied to the hospital's reimbursement.

Every day that I see a patient in the hospital, I inform the insurance provider that I saw them (with a billing and a diagnosis code) and they pay me. I realize that in the section on office billing I went on for some time about how much trouble they take NOT to pay me. Still, compared to what a hospital has to go through, my tormentors are strictly bush league. My wife learned to chew them up and spit them out years ago. They still try but, mostly, we prevail with them.

The hospitals have a far more sophisticated group of seasoned professionals to deal with. A favorite technique of theirs is to make sure that no reimbursement goes for any medical problem that wasn't documented precisely by the doctor in exactly the way that they (the insurance providers) want it. In other words, it's the duty of the doctor to make sure that every medical diagnosis is documented in exactly the right way or the hospital doesn't get paid. No amount of objective evidence (lab values, treatment, documented patient response, etc...) is good enough. If the doctor didn't chart it in EXACTLY the right way, it didn't happen.

What makes this so clever is that the attention to detail that's required in the hospital chart doesn't affect the doctor's pay at all. When I bill for seeing a patient in the hospital I'm asked one question: Did you see that patient today? If the answer is yes, I am paid. All of this “perfect charting” that is expected of us is purely for the benefit of the hospital.

Most doctors have little understanding or interest in how or whether the hospital they're affiliated with gets paid. Remember, most of us doctors are blissfully unaware of how WE get paid. The hospital's finances are far less of a concern for us. This makes even more work for the case managers. They not only have the responsibility of going through each chart to make sure that each patient meets the criteria to still be in the hospital. They also have to chase doctors around and gently remind them to mention a certain condition in a certain way or ask them to clarify what they mean by certain statements.

Most Doctors don't enjoy having others look over their shoulders. This is especially true for the older ones who were trained in a time when they could do practically anything without question. As you can imagine, doctors and case managers aren't always on the best of terms with each other.

So, to summarize some of the problems hospitals are facing today:

- Almost all hospitals in the U.S. were built in an age before the invention of the personal computer.
- They were built with the intention of taking care of a patient population that would never be hospitalized today.
- The number of patients who need hospitalization has fallen steadily over the years due to increasing restrictions and medical innovations.
- The patients who continue to need hospitalization are, by far, the MOST expensive to take care of.
- Hospitals have to fight harder each year and spend more money to justify the admissions they have and to be paid ANYTHING to take care of them.
- When they are paid, the profit obtained is increasingly diminished.
- The people most responsible for doing what it takes to secure the hospitals reimbursement (doctors) have little knowledge of, or interest in, what the hospital makes.

Considering all of these challenges, I may have asked the wrong question in the title of this section. Instead of asking "Why are hospitals going bankrupt?" maybe I should have asked "Why are any hospitals still left open?" And will there be any in five years?

Hospitals continue to serve a vital function in our society and it would be hard to imagine practicing medicine without them. I wrote this section as an epilogue because, unlike the rest of my website, it didn't deal with the specific medical costs to patients. Instead, it deals with the potential cost to society as a whole. It's unlikely that many new private hospitals will be built any time soon. The enormous cost of building one mixed with the abysmal profits they now provide almost guarantee that almost none will be added to what we have now. Still, the hospitals that remain do an admirable job of taking care of our sickest patients (in spite of the challenges).

It's unlikely that the number of patients that need hospitalization will continue to decline. Medical innovation, for all of its wonders can only postpone the inevitable for so long. As the population in this Country continues to increase and age, we will again begin to fill up all of the hospital beds that were emptied by the recent restrictions and innovations. The question is: Will the hospitals still be there? No business can survive if each service it provides results in a net loss. As hospital finances become increasingly more toxic, and the average reimbursement for taking care of a patient declines, the likelihood of a cascade of hospital closures becomes very real.

In the section on hospital billing, I went to great lengths to demonstrate the bizarre methods that hospitals use to collect what they're owed. This continues to be a problem since the opaqueness, apparent deception and flagrant overcharging in the current process will continue to alienate the very people that hospitals were built to serve. This process needs to be reformed if only because hospital can't afford any more enemies. It's easy to make an argument that hospitals deserve most of their troubles but the fact remains we can't afford to lose them either. Simply waiting for this crisis to unfold (as we have with every other crisis in the past) will only cost us more.