EXAMINING THE LACK OF TRANSPARENCY AND CONSUMER-DRIVEN MARKET FORCES IN U.S. HEALTH CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON ENERGY POLICY, HEALTH CARE AND ENTITLEMENTS

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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EXAMINING THE LACK OF TRANSPARENCY AND CONSUMER–DRIVEN MARKET FORCES IN U.S. HEALTH CARE

Thursday, April 25, 2013,

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON ENERGY POLICY, HEALTH CARE & ENTITLEMENTS,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:34 a.m., in Room 2247, Rayburn House Office Building, Hon. James Lankford [chairman of the subcommittee] presiding.

Present: Representatives Lankford, Gosar, McHenry, Walberg, Woodall, Speier, Horsford, Lujan Grisham, and Cummings.

Staff Present: Ali Ahmad, Majority Communications Advisor; Brian Blase, Majority Senior Professional Staff Member; Daniel Bucheli, Majority Assistant Clerk; Michael R. Kiko, Majority Staff Assistant; Scott Schmidt, Majority Deputy Director of Digital Strategy; Jaron Bourke, Minority Director of Administration; Nicholas Kamau, Minority Counsel; Adam Koshkin, Minority Research Assistant; and Safiya Simmons, Minority Press Secretary.

Mr. LANKFORD. The committee will come to order.

I would like to begin this hearing by stating the Oversight mission statement. We exist to secure two fundamental principles: first, that Americans have the right to know the money Washington takes from them is well spent; and, second, Americans deserve an efficient, effective Government that works for them.

Our duty on the Oversight and Government Reform Committee is to protect these rights. Our solemn responsibility is to hold Government accountable to taxpayers, because taxpayers have a right to know what they get from their Government. We will work tirelessly in partnership with citizen watchdogs to deliver the facts to the American people to bring genuine reform to the Federal bureaucracy. This is the mission of Oversight and Government Reform.

Today's hearing will explore the problems that result from the lack of transparency, consumer-driven market forces, and our health care system. Today's hearing features the testimony of two of the witnesses that are here—Ms. Quincy is also coming, as well—who last year wrote important thought-provoking books about the U.S. health care system. Both paint a picture where doctors, nurses, and patients are trapped in a system filled perverse

incentives. When providers and patients act upon these incentives, abundant waste and abuse result.

According to a report last year from the Institute of Medicine, 30 percent of U.S. health care spending, an amount that exceeds $750 billion, was wasted in 2009. Over the past decade, the growth in health care costs almost entirely eliminated income growth for average families. Additionally, medical errors and hospital-acquired infections are a major problem. According to Dr. Makary's testimony, if medical mistakes and preventable infections together were a disease, it would rank as the number three most common cause of death in the U.S., after heart disease and cancer.

Today's hearing will take a close look at the perverse incentives that lead to rampant waste and inappropriate and harmful medical treatment in the United States health care system. Nearly 90 percent of payment of health care services comes directly from third parties. Third-party payment separates the payer of the care from the patient and provides a strong incentive for a doctor to serve the payer of the care rather than serve the patient. The system has also produced a massive bureaucracy focused on claims processing and the creation of management of cumbersome rules. This bureaucracy adds to the expensive health care services and creates frustration among health care practitioners and patients.

A 2009 study in the Archives of Internal Medicine found that 31 percent of doctors are burned out and 51 percent of doctors wouldn't recommend the profession to one of their children.

I look forward to hearing Dr. Goodman's testimony on the implications of the failure of the health care providers to compete on price. I also look forward to hearing about segments of the health care system where there is competition and transparency, and how we can move public policy more in that direction.

Dr. Makary has done service to the Country by speaking up about problems within his profession. Unaccountable, his book, also deals with perverse incentives at the core of the health care system, but is focused on how these incentives lead to substandard care for far too many U.S. hospitals. Here are some examples from his book, and I hope I am not stealing your thunder on this:

In about half the hospitals in the U.S., fewer than half the employees at that hospital would feel comfortable having their own care performed in the unit within which they work.

Twenty-five percent of all hospital patients experience a preventable medical error.

Hospitals make roughly $30,000 more from patients who suffer at least one complication than they do from patients whose procedures go smoothly.

Dr. Makary argues that hospitals and doctors fail to compete on quality because the public does not have the information to be able to separate high quality hospitals from low quality hospitals for various treatments.

I received a letter yesterday from Dr. Keith Smith, which I would like to enter into the record, a physician at the Surgery Center of Oklahoma in Oklahoma City. This hospital is the only place in the Nation where all prices are listed online, and competition has driven up quality and driven down price.

I ask unanimous consent to enter his letter into the record. Without objection, so ordered.

Mr. LANKFORD. Independent experts believe that the Affordable Care Act, despite its name, might very well increase what Americans spend on health care, both in terms of money and in time. Moreover, Obama Care increases Federal Government control over U.S. health care system, increases the third-party payment problem, and reduces consumer choice.

The health care system needs real reform, and the ideal reform would aim to address the two primary concerns highlighted by today's witnesses: reducing the amount of third-party payment in health care and providing patients with additional information related to health care quality. The health care system has to be reoriented toward value and better outcomes, and away from increased utilization and waste.

I now recognize the distinguished ranking member, the gentlelady from California, Ms. Speier, for her opening statement.

Ms. SPEIER. Mr. Chairman, thank you and the witnesses for being here today on a topic that should be front and center because the cost of health care in this Country is one of the huge drivers for personal budgets and for the public budget as well.

We spend a great deal of time talking about who should pay health care bills: the consumer, the insurance company, or the Government. Another question that could be asked is why are health care costs so high.

Mr. Chairman, I want to submit for the record this Time magazine piece, Why Medical Bills Are Killing Us, by Steven Brill, and I am hopeful that we can invite Mr. Brill to come and speak to us here, because he has done an exhaustive study on why the cost of health care is so expensive.

Mr. LANKFORD. Without objection.

Ms. SPEIER. The majority has suggested that shifting more health care onto consumers, what one of the witnesses will call skin in the game, will lead to lower health care costs in the marketplace.

As seen by one of the graphics we are about to put up, consumers already have a great deal of skin in the game. Sixty-two percent of bankruptcies are related to illness or medical bills. Sixty-nine percent of those who have experienced medical-related bankruptcies were insured at the time of their filing.

Health care is not a buyer's market, it is a seller's market. It certainly is not a free market. When you have to go to the emergency room, you can't shop around for the best deal like you would for a new TV, cell phone, or car. When the doctor tells you you need an x-ray and a CAT scan, you don't ask how much it will cost; all you want to know is what is wrong and get a good diagnosis.

The medical economy is clearly a different world than we face in any other parts of our lives. In February, Time magazine ran the story by Steven Brill, The Bitter Pill. Brill undertook an exhaustive examination of the medical bills and the actual hospital costs for eight patients across the United States. The results are shocking and clearly demonstrate how broken our health care delivery system is.

For example, a patient was charged $283 for a single x-ray that would only cost $20.44 if covered by Medicare. The patient was 64 and unable to buy insurance. If he had been one year older, he would have qualified for Medicare. That nonprofit hospital, and I underscore the fact that it is a nonprofit hospital, has a profit margin of 26 percent and paid its president $1.8 million plus what he earned consulting for pharmaceutical companies last year.

A patient at another hospital was charged $199 for a blood test, for which Medicare would have paid $13.94.

In yet another case, a patient was billed $7,997 for a stress test using radioactive dye that cost Medicare $554.

The bottom line: our system ensures that those least able to pay, those with the most skin in the game, are the ones singled out to pay the highest rates.

You have each been provided a copy of the article and I have already requested unanimous consent.

As seen in the next slide, the cost of health care also bears little connection to the quality of the care that is provided. Annual health care spending per person in the United States was higher in 2010 than it was in Australia, Denmark, Japan, Spain and the United Kingdom. But our life expectancy rate ranked at the bottom. So something is fundamentally wrong. We pay the most and we get the least, and the condition of those is reduced.

As Dr. Makary notes in his testimony today, the Institute of Medicine has reported that up to $750 billion, 30 percent of the total health care spending, may be going to over-treatment, unnecessary tests, and/or wasteful spending. In fact, we provide perverse financial incentives to medical providers to provide more services and order more tests under a fee for service system. The more they order, the more they are paid. Increasingly, they have direct financial stakes in CAT scans, MRI, or pathology services they order.

The in-office ancillary service exception and stark prohibition on self-referral has now swallowed the rule. Doctors are encouraged to buy CT and MRI machines, and are instructed by the manufacturers on how many scans they need to provide a break even, and then how many tests they need to order to generate a healthy profit.

Last November, the GAO issued a report on advanced imaging showing a direct correlation between self-referral and higher utilization, costing Medicare at least $109 million in 2010; and that is a very conservative figure. The same problem exists in pathology, radiation, physical therapy, and the GAO will have a similar report coming out on those. I will soon be introducing legislation to close this truck-size loophole and save Medicare billions.

Requiring consumers to have more skin in the game would also do little to address the quality of care patients receive. Medical errors and preventable infections are among the leading causes of death in the United States. This has been one of the dirty little secrets in the health care industry.

The issue of health care transparency is not a new one. I actually carried legislation in California in 2000 that requires general acute care hospitals to adopt a formal plan to eliminate or substantially reduce medication-related errors. I introduced this bill because I

had learned that medication errors increase the cost of a hospital stay by an average of $4,700.

Some in Congress do not like to admit it, but the Affordable Care Act has already gotten the Nation moving in the direction of increased transparency, lower costs, and better outcomes. The Summary of Benefits program created an unprecedented standardized method of communicating health plan information to over 170 million consumers enrolling in private health coverage. The SBC requires providers to give consumers information about health care plans in a uniform layout and in terms they can actually understand.

I realize I am 56 seconds over, but let me just finish with this.

A new study from the Kaiser Family Foundation demonstrates that the slowdown in costs could cut half a trillion dollars in health care costs over the next decade. Larry Levitt, from Kaiser Family Foundation, says, "The run-up to the Affordable Care Act and the initiatives put in place by the law are absolutely having an effect, and that providers and payers see health care reforms coming and they want to get ready to lower their costs."

So we have much to do and I thank the chairman for initiating this hearing so that we can get to the business of making it more affordable for consumers to access health care. I yield back.

Mr. LANKFORD. Thank you.

Members will have seven days to submit opening statements for the record.

We will now recognize our panel today.

Dr. Marty Makary is the Director of Surgical Quality and Safety at Johns Hopkins Hospital and Associate Professor of Health Policy at Johns Hopkins Bloomberg School of Public Health; Dr. John Goodman is the President of the National Center for Policy Analysis; and Ms. Lynn Quincy is the Senior Health Policy Analyst at Consumers Union.

Pursuant to committee rules, all witnesses are sworn in before they testify, so if you would please stand and raise your right hand.

Do you solemnly swear or affirm the testimony you are about to give will be the truth, the whole truth, and nothing but the truth, so help you God?

[Witnesses respond in the affirmative.]

Mr. LANKFORD. Thank you.

Let the record reflect that the witnesses answered in the affirmative.

You may be seated.

In order to allow time for discussion, please limit your testimony to five minutes. Your entire written statement will be made part of the record, as all of you have submitted written testimony as well. When we conclude this portion of it, we will have questions from all the different members that are here and we will have some interaction at that time.

Dr. Makary, you are our first witness and we would be honored to receive your oral testimony now.

WITNESS STATEMENTS

STATEMENT OF MARTY MAKARY, M.D., M.P.H., F.A.C.S.

Dr. MAKARY. Thank you, Mr. Chairman. Thank you, Ranking Member Speier. Thank you, members of the subcommittee for having me, and staff. My name is Marty Makary. I am a surgeon at Johns Hopkins Hospital and I am an associate professor of health policy at the Johns Hopkins Bloomberg School of Public Health.

When I recently asked one of my patients why did you come to this hospital, their answer was because of the parking. That answer embodies what is wrong with American health care. Today we have one-fifth of the U.S. economy, a marketplace of products with no way for consumers to evaluate those products.

While some successful innovations are advancing the science of medicine and the way we deliver care, one problem remains endemic and more costly than ever. It is the wide variation in medical quality in the United States. The Institute of Medicine, as we said, estimates that up to $750 billion, or 30 percent of everything we do, tests, procedures, studies, may be unnecessary, a form of waste.

The cost of the problem is not theoretical or deferred; it is real and immediate. Americans are paying hundreds more for their health insurance this year and they are getting hit with escalating co-pays of $100 to $500 per encounter. I have patients complain about co-pays.

American businesses now cite health care costs as the leading reason they have trouble competing with businesses overseas. And when I talk with business leaders, they consistently tell me that they are frustrated paying more and more for health care without any metrics of performance. Every other contractor they have has some way to measure their performance.

Now, every proposed solution to this unsustainable financial trajectory calls for measuring hospital performance by tracking patient outcomes. So where are these outcomes? Well, much of it lives in federally funded registries with little or no access to the taxpayers that pay for them. In my field of surgery, the national Pancreas Islet Transplant registry, funded by the NIH, tracks patient outcomes. When I do an operation and remove a patient's pancreas, we send it to the laboratory, it is then re-infused into the patient's liver. That transplant operation has many variables that are collected and reported to the national registry.

Now, when I tried to get access to this registry, even as a researcher with resources, I wasn't able to. Yet, this registry is funded by taxpayer dollars. If we had access, we could find out which centers have good outcomes and which centers have bad outcomes. But this data is not available to the public. Similar barriers exist for Medicare and other federally funded registries.

After a lot of work, my research team accessed one Government-funded database, but under the condition that the hospital names are removed. We looked to see whether hospitals are performing common surgical procedures using the minimally invasive, or laparoscopic, method in situations where it has been well established to result in lower wound infection rates, less pain for the patient, and better functional outcomes compared to open surgery.

Here is what we found: Despite lots of evidence, including an extensive Cochrane review in the medical literature, to support lower complication rates of laparoscopy, its use at U.S. hospitals varied widely. In this figure, each dot represents one U.S. hospital, and we graft the variation.

So if you go to a hospital on the left side of the chart, it is highly unlikely that they will use the laparoscopic approach, even though it is associated with lower infections and better outcomes. And if you go to a hospital on the right side of the graph, 80, 90, 100 percent chance, maybe, that you will get that operation using the better method. This wide variation embodies the problem with a system that is not transparent.

The same variation was true of some of the most common procedures in medicine: hysterectomy, colon surgery and others. Patients make choices in a free market where competition exists all right, but the competition exists at the wrong level; it exists at the level of valet parking and billboards, leaving patients uninformed about these differences and outcomes.

Imagine if you, as a patient, were looking for a hospital to have an appendix removed, one of the most common procedures in America, and you could look up a hospital's outcomes, you could look up the complication rate, and you could look up the percent likelihood that that hospital does laparoscopic surgery. You would likely know where to go. It would likely create competition around patient-centered outcomes, not just volume, and drive the entire marketplace towards good value.

Making Government-funded databases open to researchers where hospitals can be identified as over-or under-performing centers is one simple step that could be meaningful and allow the free market to work with the competition at the right level.

My team has compiled a registry of national registries to look at every database out there looking at patient outcomes. There have been no standards and no coordination of registries. We found that there are over 150 national registries that track patient outcomes. One-quarter are taxpayer-funded, yet only three make their data available to the public.

Making public access a condition of taxpayer funding is one simple reform that would allow the market to cut waste. Transparency also needs to be applied to medical errors, sentinel events like never events, retained sponges. This information is being tracked, but it is not public information. If it were, it would allow the market to work.

Finally, transparency can inform patients seeking medical care, create competition, and cut waste in health care. Rewarding hospitals for participation in national registries, public reporting, creating public access to Medicare and ARC databases are important reforms that can realign incentives to focus on what is right.

[Prepared statement of Dr. Makary follows:]

Testimony before Committee on Oversight and Government Reform Subcommittee on Energy Policy, Healthcare and Entitlements

Statement of Martin A. Makary, MD, MPH, FACS
Director, Surgical Quality and Safety, Johns Hopkins Hospital
Director, Pancreas Islet Transplantation Center, Johns Hopkins Hospital
Associate Professor of Health Policy, Johns Hopkins Bloomberg School of Public Health

April 25, 2013

Mr. Chairman, Ranking Member Speier, members of the subcommittee and staff ~ good morning. Thank you for inviting me today. My name is Marty Makary and I am a surgeon at Johns Hopkins and an associate professor of health policy at the Johns Hopkins Bloomberg School of Public Health. I am the primary author of the original scientific publications on the operating room checklist and recently wrote the book *Unaccountable* outlining the national effort to make healthcare safer and more efficient by increasing transparency.

While some innovations in healthcare are making the system better, the broader problems remain endemic and more costly than ever—specifically the wide variations in medical quality. The Institute of medicine states that up to $750 billion, or 30% of the entire healthcare expenditure, may be going to overtreatment, unnecessary tests and other forms of waste in healthcare.

Not only are Americans are paying hundreds more for their health insurance this year, but now they are getting hit with escalating co-pays of $100-$500 per encounter. American businesses cite medical costs as the leading reason they have trouble competing with businesses overseas. And when I talk with business leaders, they consistently tell me they are frustrated paying more and more for healthcare without any metrics of good or bad performance.

Every proposed solution to this unsustainable trajectory calls for measuring hospital performance by tracking patient outcomes. But where are these outcomes?

The answer is that much of it lives in federally-funded registries, with little or no access to the public that that pays for them with their tax dollars.

In my field of surgery, a national Pancreas Islet Transplant registry funded by the NIH tracks patient outcomes. When I do an operation, the patient's information is voluntarily reported to the registry, which has data on which centers are performing well and which are performing poorly. But this data is not available to the public. Similar barriers exist with Medicare data.

After a lot of work, my research team accessed one government-funded databases but with the hospital names removed. We looked to see whether hospitals are performing common surgical operations using the minimally-invasive (laparoscopic) method in

situations where it has been well-established to result in lower infections, less pain and better functional outcomes compared to open surgery. Here's what we found. Despite lots of evidence, including an extensive Cochrane review to support the lower complications with laparoscopy, it's use at U.S. hospitals varies widely. In the case of appendectomy, on the left side of the figure, we see that many U.S. hospitals perform the operations using an open operation, and on the right, hospitals performed most using laparoscopy. The same wide variation was true for some of the most common operations in medicine-- hysterectomy, colon surgery, and others.

When I recently asked a patient of mine, why did you choose Johns Hopkins for your care, she told me "Because of the parking." Patients make choices in a dysfunctional free market where competition exists, but it exists at the wrong level. It exists at the level of billboards and valet parking, leaving patients uniformed about outcomes which are currently being collected. Imagine if you as a patient were looking for a hospital to have your appendix removed and you could see a hospital's outcomes including their surgical complication rate, and what percent of their operations they perform using the laparoscopic operation. It would likely create competition around patient-centered outcomes, and drive the entire marketplace towards good outcomes.

My team has complied a registry of national registries in healthcare. There are over 150 national clinical registries which track patient outcomes. One-quarter are taxpayer funded, yet only 3 make their outcomes available to the public. Making public access a condition of taxpayer funding is one simple reform which would allow the free market to work to cut waste in healthcare.

Transparency also needs to be applied to well-defined medial errors-errors currently tracked by hospitals. If this information were public it would create more accountability, and incentivize improvements. If medical mistakes and preventable infections together were a disease, it would rank as the number #3 most common cause of death in the U.S. We spend a lot of time and money on #1 (cardiovascular disease) and a lot of time and money on #2 (my area of cancer). It's time to address the problem through standardized public reporting.

Most doctors, including myself can testify that we've seen patients harmed and disabled from overtreatment driven by profit motives in medicine. Reasonable size additional salary bonuses based are one thing, but purely volume based quarter-million-dollar bonuses, and harassing emails and text messages from hospital managers about meeting monthly volume targets bring out the worst of American medicine--a driver of the overtreatment epidemic and a contributor to the 46% national physician burnout rate described in a the 2012 Mayo Clinic study.

The state of Maryland recently submitted a proposal to Medicare to allow the state to pay hospitals in a radically different way. The HSCRC Waiver application outlines how the state's hospitals could be paid based on quality and outcomes per beneficiary, rather than by volume. If approved, it would change the profit incentives from a focus on more to better. We need to start rewarding quality, not just quantity.

Rewarding hospitals for participation in national registries and their public reporting option, participation in external peer review, and creating public access to Medicare and AHRQ data are important reforms that will re-align incentives to focus on what's right for the patient.

Transparency can inform patients seeking care, make competition over quality, and cut the waste in medicine that harms our people and burdens our national debt.

Thank you.

Mr. LANKFORD. Dr. Makary, thank you.
Dr. Goodman.

STATEMENT OF JOHN GOODMAN, PH.D.

Mr. GOODMAN. Thank you, Mr. Chairman, members of the committee. Good morning.

If something goes wrong with my iPhone, there are a dozen places in Dallas, Texas that I can go to without any appointment and get high-quality, low-cost care. There are places that will send someone to my condo to repair this iPhone in my home. There is a national repair chain that is called iHospital and the employees are called iDoctors.

But if something happens to my body, the average wait in the United States for a patient to see a new doctor is three weeks. In Boston, where we are told we have universal coverage, the average wait for a patient to see a new doctor is two months. And, amazingly, one out of every five patients that enters a hospital emergency room leaves without ever seeing a doctor because they get tired of waiting.

Now, why is the market so kind to my iPhone and so mean to me? I believe the answer is that this iPhone is produced and sold and repaired in a real market with real prices, where entrepreneurs know they can make millions of dollars if they solve our problems; where over in health care we have so completely suppressed the market for year after year, decade after decade, that no one ever sees a real price for anything, no patient, no doctor, no employee, no employer.

Basically, we like to think in the United States we are different from other countries. That is a myth both on the left and the right. In the United States, we mainly pay for care the way they pay for it in Canada and Britain; we pay with time, and not with money. In Canada you visit a doctor, it is free; in the United States it is almost free. Every time we spend a dollar in the doctor's office, only $0.10 is coming out of our own pocket; $0.90 is coming from a third-party payer, an employer, an insurance company, or Government.

What we have overlooked is that when you suppress the marketplace, when you suppress prices, you elevate the importance of non-price barriers to care. And what are those non-price barriers? Well, how long does it take you on the telephone to get an appointment with a doctor? How many days do you have to wait before you get to see that doctor? How long does it take you to get from your home or office to the doctor's office and back again? And once you are there, how long do you have to wait before you get treated?

There is lots and lots of evidence that those non-price barriers to care are a greater deterrent to people getting care than the fee that the doctor charges. And this isn't just true for middle-class patients, it is also true for low-income patients.

Now, can the market work in health care? My answer is you show me any part of the health care system where the third-party payers aren't, show me a part of health care where there is no Blue Cross, no Medicare, and no employer, and I will show you markets

probably working pretty well. In cosmetic surgery there is no problem with transparency; patients get a package price covering the doctor, the nurse, anesthetist, the facility. They know exactly what they are going to pay in advance.

There is price competition. Over the last 15 years the real price of cosmetic surgery has gone down as the real price of every other kind of surgery has gone up, and this is in the face of an incredible increase in demand, all kinds of technological change of the type that we are told increases prices across everywhere else.

Similarly, in the market for Lasik surgery, you have complete transparency, you have price competition, you have quality competition. Over the last 10 years, the real price of Lasik surgery has come down 25 percent even as other kinds of surgery is going up. Again, huge increase in demand; all kinds of technological change.

In the international market for medical tourism, you can get a package, transparent price for almost every kind of elective surgery. Hospitals in India and Thailand and Singapore not only compete on price, they post their quality ratings; and the kind of information that Dr. Makary said we can't get in American hospitals, Indian hospitals put up on the Internet and they say here is our infection rate, here is our mortality rate, here is our readmission rate, and, by the way, here is what it is at the Cleveland Clinic and the Mayo Clinic. When a hospital does that, you know they are competing on quality.

And then what is not very well known is that we have a domestic market for medical tourism because hospitals don't like to tell us that, so some of the very hospitals that Steven Brill was writing about might very well go to Canada and tell the patients coming down here for a knee replacement or a hip replacement, we not only give you a package price, but it is going to be half of what Blue Cross pays; it is going to be lower than what Medicare pays.

So this is going on. Hospitals can compete for patients; they are competing for patients. So this is not the patients that live near the hospital, it is for foreigners coming to the United States, often to get care that they cannot get in a timely way in their own country.

So, Mr. Chairman, I think that our problems arise because we have suppressed the marketplace, and if we want to solve these problems, we have to allow the market to exist and get the incentives right.

[Prepared statement of Mr. Goodman follows:]

John C. Goodman, Ph.D.
President and CEO
Kellye Wright Fellow

National Center for Policy Analysis

Examining the Lack of Transparency and Consumer Driven Market Forces in U.S. Health Care

House Committee on Oversight and Government Reform
Subcommittee on Energy Policy, Health Care and Entitlements

April 25, 2013

Mr. Chairman and members of the Committee, thank you for the opportunity to testify on this important topic. I am John Goodman, president of the National Center for Policy Analysis (NCPA). A nonprofit, nonpartisan public policy research organization, the NCPA is dedicated to developing and promoting private alternatives to government regulation and control, and solving problems by relying on the strength of the competitive, entrepreneurial private sector. I welcome the opportunity to share my views and look forward to your questions.

The principle problems in health care are well known. The cost is too high; the quality is too low; and access to care is too difficult. The reason for these problems should also be well known: We have replaced the patients with third-party payers (insurance companies, employers, and government) as the principal buyers of care.

The party that pays for care is different from the party that is supposed to benefit. Unfortunately, the interests of the two parties are not always the same.

Lack of Transparency

One consequence of the third-party payer system is the complete suppression of normal market processes. In health care, few people ever see a real price for anything. Employees never see a premium reflecting the real cost of their health insurance. Patients almost never see a real price for their medical care. Even at the family doctor's office, it's hard to discover what anything costs. For something complicated, like a hip replacement, the information is virtually impossible to obtain—at least in advance of the operation.

Although many would like to think that our system is very different from the national health insurance schemes of other countries, the truth is that Americans mainly pay for care the same way people all over the developed world pay for care at the time they receive it—with time, not money.

On the average, every time we spend a dollar at a physician's office, only 10 cents comes out of our own pockets. The rest is paid by third-party payers (insurance companies, employers, and government). As a result, for most people, the time price of care (waiting to get an appointment, getting to and from the doctor's office, waiting in the reception area, waiting in the exam room, etc.) tends to be greater—and probably much greater—than the money price of care.

When patients aren't spending their own money, doctors will not compete for their patronage based on price. When doctors don't compete on price, they won't compete on quality either. The services they offer will be only those services the third parties pay for and only in settings and ways the third parties have blessed.

Misconceptions about Transparency

In a very real sense, there are no prices at a typical physician's office. Medicare pays one rate, Medicaid another, BlueCross yet a third. These payment rates are not real prices, however, and they do not play the same role as prices do in other markets. Yet, there is a tendency on both the political right and the political left to ignore this fact.

The right, for example, issues frequent calls to make prices transparent. A number of proposals would even require doctors and hospitals to post their prices. Yet, what possibly could be gained by posting these rates on the wall? If you are a BlueCross patient, how does knowing what an Aetna patient is paying help you in any way?

On the left, a common view is that health costs are too high because health care prices are too high. They believe that the way to control costs is to push prices down. This idea is actually written into the Affordable Care Act (ACA). All kinds of efficiency ideas are included in the ACA, but when all else fails—and most knowledgeable people believe that all else will fail—the ACA will try to solve the problem of rising Medicare costs by squeezing the providers. Medicare's chief actuary predicts that by the end of the decade, Medicare fees for doctors and hospitals will be substantially lower than Medicaid's and one in seven hospitals will leave the Medicare system.

The problem with this approach is that prices in health care are symptoms of problems, not causes of problems, in the same way that a high body temperature is a symptom of a fever. Just as it would make no sense to try to treat a fever by lowering the body's temperature, it makes no sense to try to control prices while ignoring why they are what they are. Plus, when we treat symptoms rather than their causes, there are inevitably unanticipated negative consequences. For example, if we tried to impose low fees on every provider for all patients, we would begin to drive the most capable doctors out of the system—into alternative pay-cash-for-care services and perhaps even out of health care altogether.

But there is an even more fundamental problem with trying to solve the problem of cost by suppressing prices. The suppression of provider payments is an attempt to shift costs from patients and taxpayers to providers. Even if we get away with it, shifting costs is not the same thing as controlling costs. Doctors are just as much a part of society as patients. Shifting cost from one group to the other makes one group better off and the other worse off. It does not lower the cost of health care for society as a whole, however.

Competition in Health Markets without Third-Party Payers

In those health care markets where third-party payment is nonexistent or relatively unimportant, providers almost always compete for patients based on price. Where there is price competition, transparency is almost never a problem.

All over the country, retail establishments are offering primary care services to cash-paying patients. Because these services arose outside of the third-party payment system, their prices are free market prices. Walk-in clinics, doc-in-the-box clinics, and freestanding emergency care clinics post prices and usually deliver high quality care.

Cosmetic surgery is rarely covered by insurance. Because providers know their patients must pay out of pocket and are price-sensitive, patients can typically (1) find a package price in advance covering all services and facilities, (2) compare prices prior to surgery, and (3) pay a price that has been falling over time in real terms—despite a huge increase in volume and considerable technical innovation (which is blamed for increasing costs for every other type of surgery).

In the market for LASIK surgery, patients face package prices covering all aspects of the procedure. As with cosmetic surgery, whenever there is a price transparency and price competition, the cost tends to be controlled. From 1999 (when eye doctors began performing Lasik in volume) through 2011, the real price of conventional Lasik fell about one-fourth. There is also quality competition — patients can choose traditional LASIK or more advanced custom Wavefront LASIK. The cost of conventional Lasik was about $1,630 per eye in 2011, with most people opting for the more advanced Lasik surgery at an average cost of $2,150 per eye.

Even when providers do not explicitly advertise their quality standards, price competition tends to force product standardization. This reduced variance is often synonymous with quality improvement. Rx.com, for example, initiated the mail-order pharmacy business, competing on price with local pharmacies by creating a national market for drugs. Industry sources maintain that mail-order pharmacies have fewer dispensing errors than conventional pharmacies. Walk-in clinics, staffed by nurses following computerized protocols score better on quality metrics than traditional office-based doctor care and have a much lower variance.

In general, medical services for cash-paying patients have popped up in numerous market niches where third-party payment has left needs unmet. It is surprising how often providers of these services offer the very quality enhancements that critics complain are missing in traditional medical care. Electronic medical records and electronic prescribing, for example, are standard fare for walk-in clinics, concierge doctors, telephone, and email consultation services, and medical tourist facilities in other countries. Twenty-four/seven primary care is also a feature of concierge medicine and the various telephone and email consultation services.

Domestic Medical Tourism

In the international tourism market, where people travel for their care, quality is almost always a factor. Cost is also a factor because the patient is typically paying the entire bill out of pocket. Patients generally get package prices for most types of elective surgery and hospitals generally post their quality metrics online.

Is it possible to replicate this experience in the domestic hospital marketplace? Developments are under way. By one estimate 430,000 nonresidents a year enter the United States for medical care. Canadian patients seeking medical care at U.S. hospitals, for example, are able to get package prices that are about half of what BlueCross patients typically pay.

An essential ingredient in this market is the willingness to travel. If you ask a hospital in your neighborhood to give you a package price on a standard surgical procedure, you will probably be turned down. After the systematic suppression of normal market forces for the better part of a century, hospitals are rarely interested in competing on price for patients they are likely to get as customers anyway.

A traveling patient is a different matter. This is a customer the hospital is not going to get if it doesn't compete. That's why a growing number of U.S. hospitals are willing to give transparent, package prices to out-of-towners; and these prices often are close to the marginal cost of the care they deliver.

North American Surgery has negotiated deep discounts with about two dozen surgery centers, hospitals and clinics across the United States, mainly for Canadians who are unable to get timely care in their own country. The company's cash price for a knee replacement in the United States is $16,000 to $19,000, depending on the facility a patient chooses, making it competitive with facilities in other countries.

But the service is not restricted to foreigners. The same economic principles that apply to the foreign patient who is willing to travel to the United States for surgery also apply to any patient who is willing to travel. That includes U.S. citizens. In other words, you don't have to be a Canadian to take advantage of North American Surgery's ability to obtain low-cost package prices. Everyone can do it.

The implications of all this are staggering. The United States is supposed to have the most expensive medical care found anywhere. Yet many U.S. hospitals are able to offer traveling patients package prices that are competitive with the prices charged by top-rated medical tourist facilities in such places as India, Thailand and Singapore.

All of this illustrates something many readers may already know. Markets in medical care can work and work well — especially when third-party payers are not involved.

Creating a Market for Medical Services

Two relatively new services are facilitating a market for medical services — with price and quality competition, as well as transparency. One is MediBid, which takes a Priceline approach to medical care. Another service, Healthcare Blue Book (HCBB), offers a free service for patients — showing the average price for various procedures in almost every zip code in the country. Moreover, both businesses have created new tools that are valuable for employer plans — especially those with high-deductible health insurance.

MediBid for Individuals

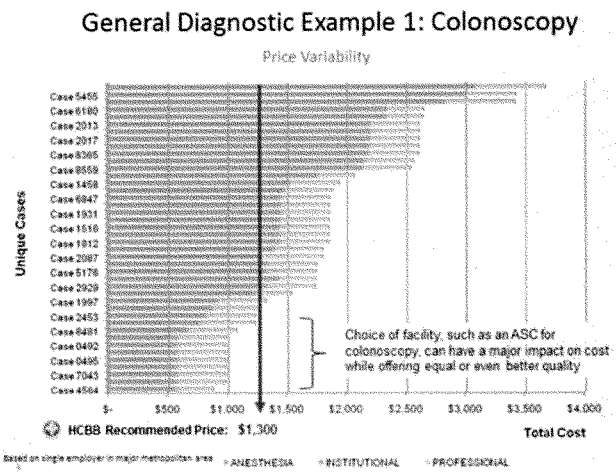
U.S. patients willing to travel and able to pay upfront for care can take advantage of the online service, MediBid. Patients register and request bids or estimates for specific procedures on MediBid's website for the services of, say, a physician, surgeon, dermatologist, chiropractor, dentist or numerous other medical specialties. MediBid-affiliated physicians and other medical providers respond to patient requests and submit competitive bids for the business of patients seeking care. Patients can choose from medical providers in the United States and even some providers outside the country. MediBid facilitates the transaction but the agreement is between doctor and patient, both of whom must come to an agreement on the price and service.

Business at the site is growing. For example, last year the company facilitated:

- More than 50 knee replacements, with an average of five bids per request and some getting as many as 22. The average price was about $12,000, almost one-third of what insurance companies typically pay and about half of Medicare's average price.
- Sixty-six colonoscopies with an average of three bids per request and some getting as many as six. The average price was between $500 and $800, half of what you would ordinarily expect to pay.
- Forty-five knee and shoulder arthroscopic surgeries, with average prices between $4,000 and $5,000.
- Thirty-three hernia repairs with an average price of $3,500.

MediBid for Employer Plans

Following the MediBid model, employers cover no more than the median cost — requiring the employee to pay excess charges if they choose a provider who charges above the median. Take a colonoscopy for example. The price in a large city varies considerably — and the upper estimates approach $9,000 if the procedure is done at an out-of-network hospital. Health plans negotiate network discounts that are lower, but these rates still range from $900-$3,600 in the Midwestern city that was the source of the data in the graph below.



In this example, the recommended price is $1,300 — which is roughly the average price in the area. If the employee chooses a higher cost provider, the employee pays the extra out of pocket. If the price that is lower, the savings are shared between employee and employer. MediBid reports it often helps patients locate colonoscopies prices at less than half of the recommended price.

Healthcare Blue Book for Individuals

Using Healthcare Blue Book, patients can unveil some of the mystery surrounding what is a reasonable medical price. Healthcare Blue Book tracks a range of prices in each zip code based on claims from its health plan clients. Although individuals cannot see the specific price each hospital and clinic charges for each

service, patients can see the average or reasonable price within a given area. For instance, if the Healthcare Blue Book recommended price for a colonoscopy in the area is $1,300, patients know that is a fair price that is widely available. Moreover, patients know that up to one-quarter to one-third of area providers actually charge less.

Healthcare Blue Book for Employer Plans

Healthcare Blue Book is a valuable tool that helps patients identify specific clinics, hospitals and facilities that have the best prices on medical procedures. Healthcare Blue Book displays the median price and a bar graph comparing how costs vary among area hospitals and clinics. In one Midwestern city, a patient seeking a colonoscopy can see that a hospital charges $3,600 compared to an ambulatory surgery center (ASC) that charges less than $1,000. Employees undergoing a colonoscopy at an ASC could realize savings of $2,500 compared to the most expensive facilities.

Allowing Medicare Patients Access to the Marketplace

In proposing a balanced federal budget over the next ten years, House Budget Committee Chairman Paul Ryan proposes to spend the same amount of money on Medicare as will be spent under current law. The difference? Under current law, billions of dollars in reduced Medicare spending will be used to subsidize a new entitlement (ObamaCare). Under Ryan's approach, ObamaCare will be repealed and the Medicare reductions will be used to stop spiraling federal debt.

There are also other differences. Under the administration's health reform law, there is only one effective way to hold Medicare to a lower spending path: reduced fees paid to doctors, hospitals and other providers.

Seniors will become less desirable to providers than welfare mothers from a financial point of view. As they are relegated to the rear of the waiting lines, the elderly and the disabled may have to turn to sources of care that many Medicaid patients turn to today: community health centers and the emergency rooms of safety net hospitals.

In contrast to this archaic approach to controlling costs, the Ryan budget will allow us to achieve savings in a better way. By moving Medicare into to 21st century and allowing beneficiaries to do may of the things that younger patients do routinely, we can reduce costs and leave beneficiaries better off at the same time. Many of these same reforms will help save billions of dollars in Medicaid as well.

A central role in the Ryan budget is played by Medicare Advantage plans. About one in four seniors is enrolled in these plans and studies show that the best of them have lower costs and meet higher quality standards than traditional Medicare. These plans are also proving to be laboratories in which many of the ideas favored by the Obama administration are being tested and vetted, including medical homes, integrated care, coordinated care, etc.

It is surprising, therefore, that the Obama administration plans to cut the funds for these plans, causing about one in every two enrollees to lose coverage in the next few years. By contrast, the Ryan budget envisions giving more seniors the opportunity to enroll, giving the plans much more flexibility than they have today and erecting better rules under which the plans compete for enrollees.

For those who remain in traditional Medicare, there is also much that can be done. Here are 10 suggestions:

Telephone and Email. Many conditions do not require a doctor visit. The ability to consult by phone or electronically could save time and money for seniors and make care more accessible. Medicare should make this option available and contribute toward the costs – paying less than it would pay for an office visit. The price paid by the patient, however, should be the market price that other patients are paying, not an arbitrary fee set by the government.

Walk-In Clinics. Studies show that walk-in clinics are providing high-quality, low-cost care for a fraction of what similar care would cost at a doctor's office or at a hospital emergency room. Medicare should not only pay for these services, it should pay the market price (rather than Medicare's fee schedule price) in order to encourage their expansion to more of the Medicare population. A similar approach for Medicaid would dramatically increase access to care for low-income families all across the country and lower Medicaid's costs at the same time.

Nurses. Not every medical service requires the attention of a medical doctor. Yet, Medicare's current fee schedule discourages the substitution of non-doctor personnel – even though these services are often appropriate and have the potential to greatly lower costs. Medicare (and Medicaid) could actually save money by paying higher fees for services delivered by nurses and other paramedical personnel.

Chronic Care. The current system encourages one-visit-one-illness-treated medicine. This practice raises costs and lowers quality. Instead, physicians' should be encouraged to treat the whole patient on every visit, including all co-morbidities. Here is another instance where Medicare could actually save money by paying higher fees.

Health Savings Accounts. The RAND Corporation finds that these accounts lower costs by as much as 30 percent with no harm to the most vulnerable patients. For seniors, the accounts should be Roth accounts (after tax deposits and tax free withdrawals for any purpose) and in order to expand access to care, patients should be free to pay market prices rather than Medicare's fee schedule for medical services.

Rational Insurance Design. Instead of paying Medigap premiums, a senior should be able to deposit, say, $2,000 a year in a Health Savings Account. The senior would be responsible for the first $2,000 of medical expenses, but would have complete catastrophic protection above that amount.

Concierge Care. Seniors should be able to contract with doctors for all of their primary care services rather than paying on a fee for service basis. Concierge doctors spend more time with their patients, offer more convenient and timely care and serve as agents of their patients in negotiating the complexities of the health care system. There is some evidence that this type of medicine lowers the overall cost of care. Because this potentially saves money for taxpayers, Medicare should be willing to pay a portion of the fee.

Medical Tourism. As noted, Canadian patients who come to the United States for procedures that are not readily available in their own country typically pay half as much as Americans pay. Seniors should also have the option to travel for lower cost, higher quality care and they should be able to share in any money they save taxpayers. Also, when seniors choose to retire in Mexico and other places south of our border, Medicare should cover their medical expenses in those countries. The bill will be a lot lower than if they return to the United States for their care.

Experiments. Is Medicare encouraging the kind of services seniors most want? Would they be willing to pay out of pocket for better care or more convenient care? We cannot know unless we experiment to find out. Most doctors would remain under the current system. But a few doctors should be allowed to experiment with patient-pleasing alternatives.

Innovation. Instead of dictating a fee schedule to the provider community and trying to enforce arbitrary quality standards, Medicare should let the supply side of the market take the lead. Every doctor and every hospital should be free (and even encouraged) to propose alternative ways of being paid. Medicare should be willing to accept any new arrangement that (1) lowers costs to the taxpayers and (2) raises the quality of care patients receive.

Finally, there is nothing in the Ryan budget that would prevent us from rational health reform for the under-65 population. We could replace the existing system of tax subsidies with refundable tax credits that would produce a form of universal coverage without the Rube Goldberg intricacies of ObamaCare and all its perverse incentives.

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THE SATURDAY ESSAY

Updated September 21, 2012, 10:56 p.m. ET

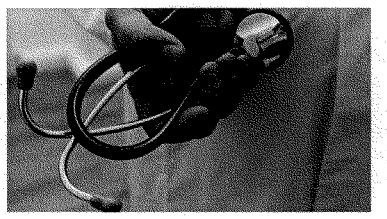
How to Stop Hospitals From Killing Us

Medical errors kill enough people to fill four jumbo jets a week. A surgeon with five simple ways to make health care safer.

By MARTY MAKARY

When there is a plane crash in the U.S., even a minor one, it makes headlines. There is a thorough federal investigation, and the tragedy often yields important lessons for the aviation industry. Pilots and airlines thus learn how to do their jobs more safely.

The world of American medicine is far deadlier: Medical mistakes kill enough people each week to fill four jumbo jets. But these mistakes go largely unnoticed by the world at large, and the medical community rarely learns from them. The same preventable mistakes are made over and over again, and patients are left in the dark about which hospitals have significantly better (or worse) safety records than their peers.



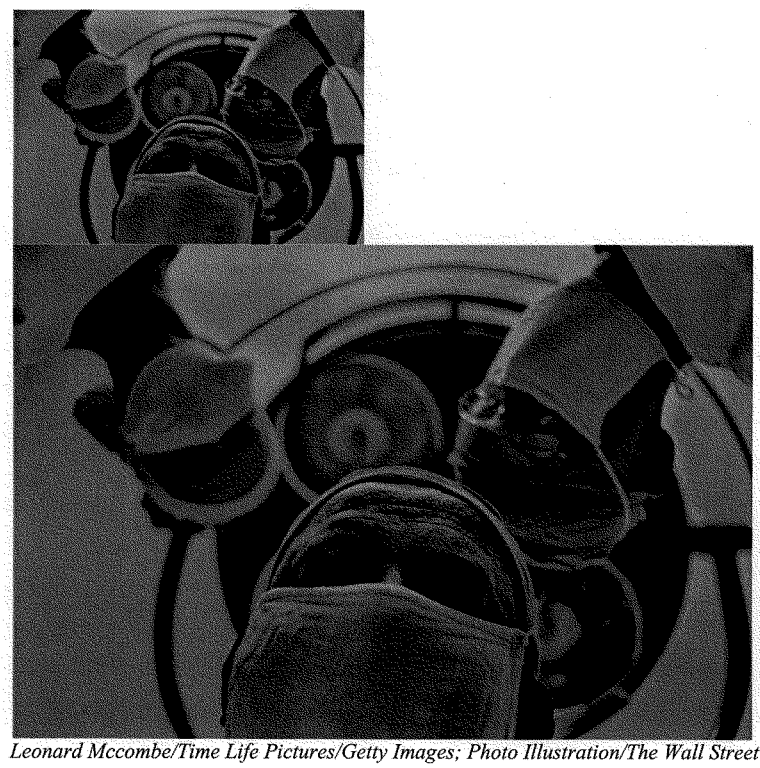
WSJ's Gary Rosen talks to author and surgeon Marty Makary about his ideas for making American hospitals more transparent about their safety records and more accountable for the quality of their care.

As doctors, we swear to do no harm. But on the job we soon absorb another unspoken rule: to overlook the mistakes of our colleagues. The problem is vast. U.S. surgeons operate on the wrong body part as often as 40 times a week. Roughly a quarter of all hospitalized patients will be harmed by a medical error of some kind. If medical errors were a disease, they would be the sixth leading cause of death in America—just behind accidents and ahead of Alzheimer's. The human toll aside, medical errors cost the U.S. health-care system tens of billions a year. Some

20% to 30% of all medications, tests and procedures are unnecessary, according to research done by medical specialists, surveying their own fields. What other industry misses the mark this often?

It does not have to be this way. A new generation of doctors and patients is trying to achieve greater transparency in the health-care system, and new technology makes it more achievable than ever before.

I encountered the disturbing closed-door culture of American medicine on my very first day as a student at one of Harvard Medical School's prestigious affiliated teaching hospitals. Wearing a new white medical coat that was still creased from its packaging, I walked the halls marveling at the portraits of doctors past and present. On rounds that day, members of my resident team repeatedly referred to one well-known surgeon as "Dr. Hodad." I hadn't heard of a surgeon by that name. Finally, I inquired. "Hodad," it turned out, was a nickname. A fellow student whispered: "It stands for Hands of Death and Destruction."



Leonard Mccombe/Time Life Pictures/Getty Images; Photo Illustration/The Wall Street Journal

'Doctors absorb an unspoken rule: to overlook the mistakes of our colleagues.'

Stunned, I soon saw just how scary the works of his hands were. His operating skills were hasty and slipshod, and his patients frequently suffered complications. This was a man who simply should not have been allowed to touch patients. But his bedside manner was impeccable (in fact, I try to emulate it to this day). He was charming. Celebrities requested him for operations. His patients worshiped him. When faced with excessive surgery time and extended hospitalizations, they just chalked up their misfortunes to fate.

Dr. Hodad's popularity was no aberration. As I rotated through other hospitals during my training, I learned that many hospitals have a "Dr. Hodad" somewhere on staff (sometimes more than one). In a business where reputation is everything, doctors who call out other doctors can be targeted. I've seen whistleblowing doctors suddenly assigned to more emergency calls, given fewer resources or simply badmouthed and discredited in retaliation. For me, I knew the ramifications if I sounded the alarm over Dr. Hodad: I'd be called into the hospital chairman's office, a dread scenario if I ever wanted a job. So, as a rookie, I kept my mouth shut. Like the other trainees, I just told myself that my 120-hour weeks were about surviving to become a surgeon one day, not about fixing medicine's culture.

25%

Hospitalized patients who are harmed by medical errors

Source: New England Journal of Medicine

Hospitals as a whole also tend to escape accountability, with excessive complication rates even at institutions that the public trusts as top-notch. Very few hospitals publish statistics on their performance, so how do patients pick one? As an informal exercise throughout my career, I've asked patients how they decided to come to the hospital where I was working (Georgetown, Johns Hopkins, D.C. General Hospital, Harvard and others). Among their answers: "Because you're close to home"; "You guys treated my dad when he died"; "I figured it must be good because you have a helicopter." You wouldn't believe the number of patients who have told me that the deciding factor for them was parking.

There is no reason for patients to remain in the dark like this. Change can start with five relatively simple—but crucial—reforms.

Online Dashboards

Every hospital should have an online informational "dashboard" that includes its rates for infection, readmission (what we call "bounce back"), surgical complications and "never event" errors (mistakes that should never occur, like leaving a surgical sponge inside a patient). The dashboard should also list the hospital's annual volume for each type of surgery that it performs (including the percentage done in a minimally invasive way) and patient satisfaction scores.

The Saturday Essay

- **Why Can't We Sell Charity Like We Sell Perfume?** (9/15/12)
- **Geography Strikes Back** (9/8/12)
- **Are Entitlements Corrupting Us? Yes | No** (9/1/12)
- **Conventional Wisdom** (8/25/12)
- **The Panic Over Fukushima** (8/18/12)
- **Can Syria's Christians Survive?** (8/11/12)
- **Decoding the Science of Sleep** (8/4/12)

A survey of New Yorkers found that approximately 60% look up a restaurant's "performance ratings" before going there. If you won't sit down for a meal before checking Zagat's or Yelp, why shouldn't you be able to do the same thing when your life is at stake?

Nothing makes hospitals shape up more quickly than this kind of public reporting. In 1989, the first year that New York's hospitals were required to report heart-surgery death rates, the death rate by hospital ranged from 1% to 18%—a huge gap. Consumers were finally armed with useful data. They could ask: "Why have a coronary artery bypass graft operation at a place where you have a 1-in-6 chance of dying compared with a hospital with a 1-in-100 chance of dying?"

Instantly, New York heart hospitals with high mortality rates scrambled to improve; death rates declined by 83% in six years. Management at these hospitals finally asked staff what they had to do to make care safer. At some hospitals, the surgeons said they needed anesthesiologists who specialized in heart surgery; at others, nurse practitioners were brought in. At one hospital, the staff reported that a particular surgeon simply wasn't fit to be operating. His mortality rate was so high that it was skewing the hospital's average. Administrators ordered him to stop doing heart surgery. Goodbye, Dr. Hodad.

Safety Culture Scores

Imagine that a surgeon is about to make an incision to remove fluid from a patient's right lung. Suddenly, a nurse breaks the silence. "Wait. Are we doing the right or the left chest? Because it says here left, but that looks like the right side." The surgery was, indeed, supposed to be on the left lung, but an intern had prepped the wrong side. I was that doctor, and that nurse saved us all from making a terrible error. It isn't every hospital where that nurse would have felt confident speaking up—but it's this sort of cultural factor that is so important to safety.

98,000

Annual deaths from medical errors in the U.S.

Source: Institute of Medicine

If anyone knows whether a hospital is safe, it's the people who work there. So my colleagues and I at Johns Hopkins, led by J. Bryan Sexton, administered an anonymous survey of doctors, nurses, technicians and other employees at 60 U.S. hospitals. We found that at one-third of them, most employees believed the teamwork was bad. These aren't hospitals where you or I want to

receive care or see our family members receive care. At other hospitals, by contrast, an impressive 99% of the staff reported good teamwork.

These results correlated strongly with infection rates and patient outcomes. Good teamwork meant safer care. The public needs to have access to such information for every hospital in America.

Cameras

It may come as a surprise to patients, but doctors aren't very good at complying with well-established best practices in their fields. One New England Journal of Medicine study found that only half of all care follows evidence-based guidelines when applicable. Fortunately, there is a technology that could work wonders to improve compliance: cameras.

Corbis

You wouldn't believe the number of patients who have told me their deciding factor in choosing a hospital was parking.

Cameras are already being used in health care, but usually no video is made. Reviewing tapes of cardiac catheterizations, arthroscopic surgery and other procedures could be used for peer-based quality improvement. Video would also serve as a more substantive record for future doctors. The notes in a patient's chart are often short, and they can't capture a procedure the way a video can.

Doug Rex of Indiana University—one of the most respected gastroenterologists in the world—decided to use video recording to check the thoroughness of colonoscopies being performed by doctors in his practice. A thorough colonoscopy requires meticulous scrutiny of every nook and cranny of the colon. Doctors tend to rush through them; as a result, many cancers and precancerous polyps are missed and manifest years later—at later stages.

Without telling his partners, Dr. Rex began reviewing videotapes of their procedures, measuring the time and assigning a quality score. After assessing 100 procedures, he announced to his partners that he would be timing and scoring the videos of their future procedures (even though he had already been doing this). Overnight, things changed radically. The average length of the procedures increased by 50%, and the quality scores by 30%. The doctors performed better when they knew someone was checking their work.

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- **Are We Really Getting Smarter?**
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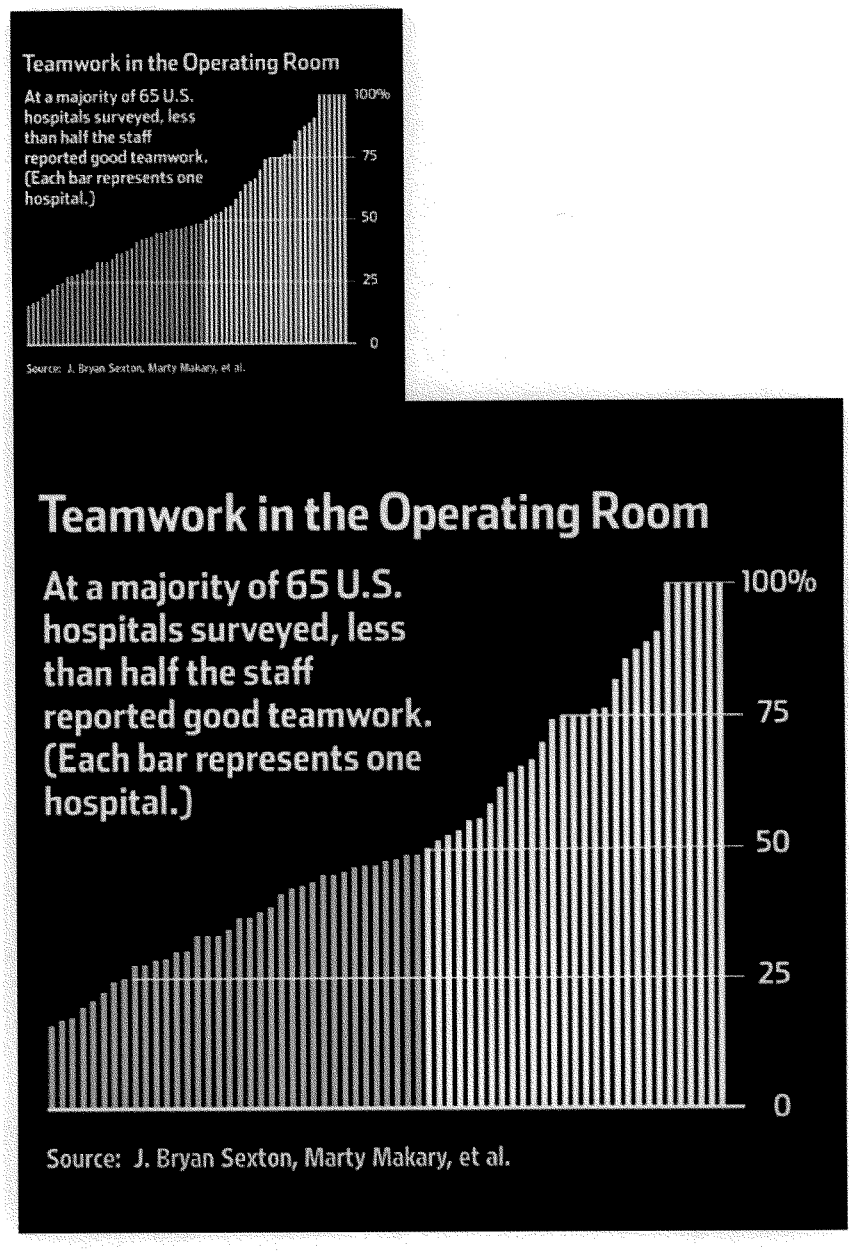
The same sort of intervention has been used for hand washing. A few years ago, Long Island's North Shore University Hospital had a dismal compliance rate with hand washing—under 10%. After installing cameras at hand-washing stations, compliance rose to over 90% and stayed there.

Following Dr. Rex's camera study, he did a follow-up, asking patients if they would like a copy of their procedure video. An overwhelming 81% said yes, and 64% were willing to pay for it. Patients are hungry for transparency.

Open Notes

Sue, a young accountant, came to my office complaining of abdominal pain. She wasn't sure what was causing it. She offered various theories: "Could this be from my Bikram yoga?" "Did my late-night ice cream cause the pain?" "Does having unprotected sex have anything to do with it?" Throughout her visit, I took notes. When we were done, she looked down at them suspiciously.



"What did you write about me?" she asked.

She was concerned that I thought she was either nuts or an ice-cream addict. In the course of our conversation, I also learned that she wasn't quite sure why I was recommending an ultrasound, though I thought I had told her.

I decided to start dictating my notes with the patient listening in at the end of his or her visit. "I also have high blood pressure," was a correction one older patient blurted out. Another said, "My prior surgery was actually on the right, not the left side." Another patient interrupted me and said, "No, I said I take 20 milligrams, not 25 milligrams, of Lipitor." Being able to review your doctor's notes in writing might be even better than my method, particularly if you could add your own comments, perhaps via the Web.

Harvard doctor-researchers Jan Walker and Tom Delbanco are using "open notes" at Harvard and Beth Israel Hospital in Boston, and my hometown hospital, Geisinger Medical Center in Pennsylvania, has begun giving patients online access to their doctors' notes. So far, both patients and doctors love it.

No More Gagging

Though there are many signs that health care is moving toward increased transparency, there is also some movement backward. Increasingly, patients checking in to see doctors are being asked to sign a gag order, promising never to say anything negative about their physician online or elsewhere. In addition, if you are the victim of a medical mistake, hospital lawyers will make never speaking publicly about your injury a condition of any settlement.

We need more open dialogue about medical mistakes, not less. It wouldn't be going too far to suggest that these types of gag orders should be banned by law. They are utterly contrary to a patient's right to know and to the concept of learning from our errors.

Political partisans can debate the role of government in fixing health care, but for either public or private approaches to work, transparency is the crucial prerequisite. To make transparency effective, government must play a role in making fair and accurate reports available to the public. In doing so, it will unleash the power of the free market as patients are better able to take charge of their own care. When hospitals have to compete on measures of safety, all of them will improve how they serve their patients.

Transparency can also help to restore the public's trust. Many Americans feel that medicine has become an increasingly secretive, even arrogant, industry. With more transparency—and the accountability that it brings—we can address the cost crisis, deliver safer care and improve how we are seen by the communities we serve. To do no harm going forward, we must be able to learn from the harm we have already done.

—Dr. Makary, a surgeon at Johns Hopkins Hospital and a developer of the surgical checklists adopted by the World Health Organization, is the author of "Unaccountable: What Hospitals Won't Tell You and How Transparency Can Revolutionize Health Care," published this month by Bloomsbury Press.

Mr. LANKFORD. Thank you, Dr. Goodman.
Ms. Quincy.

STATEMENT OF LYNN QUINCY

Ms. QUINCY. Thank you. Chairman Lankford, Ranking Member Speier, and members of the subcommittee, thank you for the opportunity to testify today. My name is Lynn Quincy. I am a senior health policy analyst with Consumer Reports and I have personally led a number of research efforts designed to test consumer disclosures.

I would like to start off with a profound apology for being late; there was asymmetrical information in the marketplace and I did not realize I would need 15 minutes to get from the curb into this room. So sorry about that.

It is really a pleasure to be here today because improving transparency of quality and prices in the health care marketplace is an issue that we can all get behind. Better transparency is likely to mean greater consumer engagement, empowerment, confidence, and better health from improved practice patterns by providers and better informed consumers.

However, I want to offer two cautions as part of my testimony today. One is we can all point to consumer information or a disclosure that has confused more than helped. So I will give you, as an example, HIPAA privacy notices have not proven to move the market very much, but those mile per gallon stickers on cars are fabulous.

So when we talk about transparency, I want us to talk about getting it right.

Can I have my next slide?

[Slide.]

Ms. QUINCY. One of the barriers to getting transparency right is that the information is too dense. As an April Fool's joke, an online retailer changed their terms and conditions text so that people who clicked yes would be selling their immortal souls.

Click the next one, please.

[Slide.]

Ms. QUINCY. Eighty-eight percent of the people at this shopping site wanted to get on with their shopping and they agreed to sell their souls.

So I think that is not the outcome we are looking for. There are other problems.

May I have the next slide, please?

[Slide.]

Ms. QUINCY. Which is if you have transparency, but you don't know which bit of transparency to believe, you have not yet been helped as a consumer. I borrowed this slide from an excellent presentation by Kaiser Health News and, as you can see, there are myriad outfits out there, including Consumer Reports, measuring hospital quality.

Next slide, please.

[Slide.]

Ms. QUINCY. They may not agree on the quality of a hospital, so, again, we have not yet helped consumers.

In my written testimony I provide much more detailed examples of how we go about getting transparency right, and I hope that will be part of the focus of this subcommittee.

But the good news is this is achievable. We have lots and lots of information about how to do transparency right by consumer testing, other things that I won't get into, and we know that the benefits of doing it far outweigh the costs. So there is actually no reason not to do more with transparency in all these realms. So that is great news.

Let me move on. The one thing I want to be careful about, though, is to not overstate what we get when we improve transparency, and I specifically want to talk about price transparency. We do have a market where there is no third-party payer for health care in the United States, and that is our 50 million uninsured. And they would sit here and tell you that the market is not working right for them. So there are two lessons we can extract from this: one, better price transparency by itself is not going to fix our problems; we need to do more than just make prices more transparent.

Let me stop, because I am running out of time.

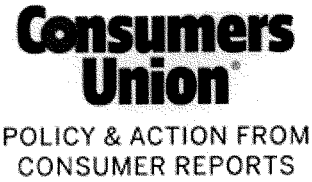
In my testimony, I talk about some of the reasons why price transparency alone isn't going to achieve all the policy goals that we wish it would. A key one is that right now consumers actually associate higher prices with better quality. So they are inclined, if they were given price information and that was the main determination of how they were making their choice, they might actually choose the higher price services, driving up health care costs, which is the outcome that we don't want.

Again, we have a ready solution, which is to do that original fundamental research which says how do we talk about prices with consumers? Perhaps we really don't want the price, but instead we want the value; we need to put value measures in front of them so that they don't assume that higher price is a signal for higher quality but, instead, we really told them something about the quality of the services that they are shopping for.

We also have to keep in mind that many services are not shoppable. The opening statement by Ms. Speier told us that there are lots of services out there for which you really have to rely on your physician to navigate those treatment choices.

I will stop here, and I really look forward to the discussion. Thank you.

[Prepared statement of Ms. Quincy follows:]



Written Testimony of

Lynn Quincy

Senior Policy Analyst with
Consumers Union

Successful Policies to Improve Health Care Transparency Will Be Grounded in Best Practices and a Real World Assessment of Policy Limits

Submitted to

U.S. House of Representatives
Committee on Oversight and Government Reform
Subcommittee on Energy Policy, Health Care and Entitlements

April 25, 2013

Introduction

Consumers Union, the policy and advocacy arm of *Consumer Reports,*[1] appreciates this opportunity to provide testimony on the topic of consumers and health care transparency.

Improving the public transparency of quality and prices in the health care market – including health plans, health care providers and treatments – would be of great benefit to consumers. These benefits are likely to include:

- greater consumer engagement, empowerment and confidence
- better health from improved practice patterns by hospitals, physicians and other health care providers and better informed consumers

While such transparency is necessary, it may not be sufficient to lower costs or to create a better functioning marketplace.

The focus of my testimony will be to offer two cautions.

> One: we must understand and acknowledge the complex process of getting from the "idea of transparency" to an actual consumer or provider-facing piece of information for which there is wide spread awareness, ready understanding and that compels the recipient to act on the information.
>
> Two: there are limits to what improved information about health care prices for treatments can achieve – we must be realistic about those limits.

By offering these two cautions, we hope to provide a real world framework that facilitates constructive policy work in the area of increased health care transparency.

New Transparency Requirements Must Be Effective

We can all point to consumer disclosures that confuse more than help consumers (HIPAA privacy notices) and consumer disclosures that have had a tremendous impact on everyday lives (nutrition facts panel on food, MPG stickers on cars).

The truth is it isn't easy to introduce new transparency requirements that achieve their policy goals. Fortunately, we know a lot about how to be successful – we just don't consistently apply the lessons.[2]

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[1] Consumer Reports is the world's largest independent product-testing organization. Using its more than 50 labs, auto test center, and survey research center, the nonprofit rates thousands of products and services annually. Founded in 1936, Consumer Reports has over 8 million subscribers to its magazine, website, and other publications. Its advocacy division, Consumers Union, works for health reform, food and product safety, financial reform, and other consumer issues in Washington, D.C., the states, and in the marketplace.

[2] For example, the Agency for Healthcare Research and Quality produced a three part report series on *Best Practices in Public Reporting* to provide practical approaches to designing public reports that make health care performance information clear, meaningful, and usable by consumers.

The first step is to agree on what constitutes "success." Some public reporting is ignored by most consumers but is still extremely effective because it motivates new behaviors on the part of providers.

The next step is to account for all the steps that must be achieved in order for the consumer or provider to take appropriate action. Consumer information can't merely be transparent. It must be crafted and conveyed so that consumers **act** appropriately on it. For example, these steps might include:

- Consumer is aware of the information
- It is easy to find information when they need it
- The relevance of the information to them is immediately evident
- Information is written in an understandable way, as demonstrated by consumer testing
- Consumer trusts the information and is confident that it will help them
- Consumer can use the information to make decisions and complete tasks
- The overall design supports the goals of the communication
- Feedback mechanisms are in place so communications success can be measured

Too often, some but not all of these steps are followed. For example, a disclosure may be nicely written in plain language, but the consumer isn't aware of it.[3,4] Or the consumer doesn't know how to act on the information.[5] Or the information is accurate but consumers don't trust the source. Using data that is out-of-date can reduce the relevance of the information for the consumer.[6] Consumers suffer from information overload. If potentially useful information is embedded in a mass of useless data or text, we haven't helped them.

The only way to get usable, nuanced data about how consumers respond to information is to conduct consumer testing. Yet this step is rarely incorporated into the development process or required by legislation. As an example: when asked what "health plan quality" means to them, many consumers told us they think it refers to the comprehensiveness of the benefits[7], whereas policymakers and others intend it to mean health plan quality (HEDIS) measures and consumer experience (CAHPS) scores.

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http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/pubrptguide1.html See also: Hibbard et al, "An Experiment Shows That A Well-Designed Report On Costs And Quality Can Help Consumers Choose High-Value Health Care," *Health Affairs*, March 2012.

[3] http://www.naic.org/documents/committees_jt_bd_lim_med_ben_related_docs_consumer_alert.pdf

[4] Consumers Union, *Early Experience With a New Consumer Benefit: The Summary of Benefits and Coverage Form*, February 2013. http://www.consumersunion.org/wp-content/uploads/2013/03/Early_Experience_Report.pdf

[5] http://www.nytimes.com/2012/01/22/sunday-review/hard-truths-about-disclosure.html?pagewanted=all

[6] Typically, health care information is one to two years old before the public sees it. Health statistics, University of Chicago Library, http://www.lib.uchicago.edu/e/su/med/healthstat/

[7] Unpublished results from focus group testing sponsored by *Consumer Reports*.

If disclosures of any type are to work as intended, the disclosure must go through a high quality development effort. This development effort and a requirement for measurable outcomes (through testing or feedback mechanisms) should accompany every consumer-facing or provider-facing disclosure requirement affecting consumers over a certain number or having to do with transactions over a certain value.

Limits Of Increased Price Transparency

Everyone can get behind better, more usable information about the price of health care treatments. Ideally, this information would:

- be the final price paid by the consumer;
- enable consumers to price compare alternative treatments/drugs or devices and/or alternative providers and venues; and
- indicate whether this was the right or the fair price, or – even better – be a summary measure indicating the value of the treatment (price+quality).

However, a lot of claims are made about the benefits of better price transparency. It is important that policymaking in this area be grounded in a realistic assessment of what will and won't be accomplished by better price transparency. For the reasons stated below, better transparency around health care prices may not lead to lower costs or better functioning markets.

Not all health care is "shoppable"

While it is feasible to do comparison shopping for elective procedures (LASIK, cosmetic surgery) and non-urgent care, a lot of health care is complex and/or urgent. At a certain point, consumers can not choose between alternate, complex treatments just because they featuring different price tags. In these cases, they must rely on trained providers to evaluate the overall benefits of the alternate approaches. The majority of health care costs are tied up with the latter type of patient. The five percent of the population with the highest spending are responsible for nearly half of all spending.[8]

Consumers Are Starting With A Bias Against Shopping By Price—And May Erroneously Equate High Price With High Quality

A large segment of consumers would prefer not to make their treatment decisions based on cost – at least under certain scenarios.[9] Focus group testing identified four barriers to patients' taking cost into account: a preference for what they perceive as the best care, regardless of expense; inexperience with making trade-offs between health and money; a lack of interest in costs borne by insurers and society as a whole; and a willingness to act

[8] NIHCM Foundation, *The Concentration Of Health Care Spending*, July 2012.
[9] Roseanna Sommers et al, "Focus Groups Highlight That Many Patients Object To Clinicians' Focusing On Costs," *Health Affairs*, February 2013.

in their own self-interest although they recognize that by doing so, they are depleting limited resources.

Research confirms that consumers, faced solely with cost information, often assume that a provider charging more provides better care.[10] Ironically, if we only provide price information, we may inadvertently steer consumers to higher priced services. Instead of focusing on price transparency, we need to move towards tested measures of quality and value.

Price Per Procedure May Not Be Useful

The price for a medical procedure (CPT code) sends an incomplete consumer signal. Knowing the price of an individual procedure tells the consumer nothing about the complete bundle of procedures and other costs that makes up the treatment, nothing about the long run cost of choosing one treatment regime over the other and nothing about the non-price dimensions of the decision such as safety, quality, convenience, and other outcomes.

Which Price Should Be Displayed?

The median market price for a service may still be the wrong price. There's plenty of evidence to suggest that even if we reference the median price in the market, we may still be overpaying.[11] Given the health and financial impact on families, ideally the price of health care would be close to the cost of providing the treatment and would exclude excessive profit taking. Billed charges and reimbursements paid do not reflect cost. The cost of using a resource (e.g., a physician, piece of equipment, or area of space) is the same whether it is reimbursed poorly or highly. A better price would be the one that signals to the consumer this is a fair price.

Price Transparency Won't Overcome Market Concentration of Providers

Provider market power is a key factor driving the pricing of services in the health care market.[12] And consumers have no market power, even if armed with price information. History shows us that large payers (like Medicare and CalPERS) are much more effective in reining in price increases than individual consumers. So let's be sure to put our policy muscle where it will have the biggest impact, if we want to meaningfully address the upward trend in health care prices.

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[10] Hibbard, et al. Op cit.
[11] Steven Brill, "Bitter Pill: Why Medical Bills are Killing Us," *Time*, March 2013.
[12] For example, see the Catalyst for Payment Reform, *Provider Market Power in the U.S. Health Care Industry: Assessing its Impact and Looking Ahead, 2012* http://www.catalyzepaymentreform.org/images/documents/Market_Power.pdf or Massachusetts Attorney General's report on the role of provider market power in the negotiation of contracts with insurers: http://www.mass.gov/ago/docs/healthcare/2011-hcctd-full.pdf

Mr. LANKFORD. Thank you, and thanks to all of you.

Dr. Makary, let me ask you a little bit about the Federal registries. You bring up a unique issue in health care right now, and that is the transparency side that all of us have talked about. Why? Why aren't the Federal registries public? Why can't a researcher get those and have comparables? I understand why the patient's name is not connected; that is obvious.

But the ability to be able to compare hospital to hospital, procedure to procedure; and I have even dealt with some researchers that want to just study across a particular effectiveness of a certain procedure that happens and wants the mortality rate, and they are not able to be able to research that as well. Why?

Dr. MAKARY. I honestly think there are no villains in this game; it is just that historically we have had very raw and unsophisticated metrics that run the risk of punishing those that take on the high-risk cases and rewarding those that discriminate against them. I appreciate that as a pancreas surgeon that takes on some of the most high-risk cases that no other surgeon in the Country will touch. I appreciate the need for risk adjustment.

But the databases have matured now. We can give good patient outcome results using physician-authored formulas that come from the American College of Surgeons that appropriately account for a patient being obese or diabetic or elderly, or having other risk factors, and come up with a composite score or a performance level.

And that makes this an exciting time because if we handle the data appropriately, which many groups can, we can learn a lot from these databases. If you are going to deliver a baby, you want to know which hospital has a 40 percent C-section rate in Washington, D.C. and which one has an 8 percent C-section rate? I think fundamentally, as this data is being tracked and we can, in a mature way, come up with outcomes for each hospital, we, as a society, are faced with the dilemma do we believe the public has a right to know about the quality of their hospital. I think they do.

Mr. LANKFORD. Dr. Goodman, you have wrote extensively and talked extensively about HSAs and about some of the funding mechanisms of individuals engaging into their own health care choices. You talked, as well, about medical tourism. The hospital that I mentioned earlier in Oklahoma City that is a flat-rate price, that lists their prices and puts them out there, when I spoke to the physician there, first thing he said was, when we opened and put our prices online, we were surprised to the know the Canadians showed up first; and their hospital was flooded with Canadians coming because they saw the price online and made the flight to save the time to be able to do it.

Obviously, those are wealthier individuals that are able to make that transition, but the medical tourism of moving around, once people saw the price, does affect things. But they also want to know the quality. It is not just the price, but it is the quality.

So engaging in the price aspect of it and the individual being involved, what have you done in your research on that?

Mr. GOODMAN. I think the most important change we can make in our health care system to encourage price competition and quality competition would be to allow everybody to have a flexible health savings account. And before there were health savings ac-

counts, basically the tax law encouraged us to give all our money to the insurance company, because all that could be paid by employer with pretax dollars, and any money we put in a bank account got taxed.

Now, we do have the health savings accounts and 27 million Americans have them, but those rules are very restrictive. We should have a very flexible account that wraps around any third-party plan and then let the market determine how much should be paid by the patient and how much by the third-party payer. And I think that most primary care and most diagnostic testing, along with some other services, ought to be paid for by patients from an account which they own and control. That would radically change the market for primary care overnight. You would see the number of walk-in clinics would triple and quadruple just within weeks if people could go in those clinics and pay the market price. And that is the best way, by the way, to control costs in Medicare and Medicaid.

Mr. LANKFORD. I have a friend of mine who told me, about a week ago, that she went in for a diagnostic test. They started the procedure, it was a routine thing for her. She has not been to the doctor at all this year, so asked about what the price would be, and they said, we don't know what the price would be, and went through the whole rigamarole, figured out what it would be with her insurance, and said she would pay $1,600 because she hasn't met her deductible yet. She said, well, what if I just pay cash and we don't file this with the insurance at all? They said, oh, that price we can give you, it is $600. And it was this incredible shift that has occurred in the way the prices work, and we have to find some way to be able to get plain prices out there so that people can engage with that.

With that, I would like to yield to the ranking member, Ms. Speier.

Ms. SPEIER. Thank you, Mr. Chairman.

In Mr. Brill's article, he spends a lot of time talking about this foreign object called a charge master which every hospital has. It is a book of fiction that only applies to people who come into the hospital who don't have insurance; who aren't Medicare, who aren't Medicaid, and they get slapped with these exorbitant prices for services that are rendered, much like the example you just used, Mr. Chairman.

So I guess I am interested in knowing what your opinions are about these charge masters. Should we just get rid of them? They only penalize those who are uninsured; those who are working poor; those who aren't eligible for Medicaid, aren't eligible for Medicare, and don't have health insurance. Any comments?

Mr. GOODMAN. Well, yes, they are fiction, and they are a holdover from the old cost-plus system where all those prices figure into how the hospital gets reimbursed one way or another by Medicare and Medicaid, and then by the private insurers. No, it would be much better if hospitals competed on price and competed on quality. Right now, all they are doing is maximizing against reimbursement formulas; and everything they do on their charge master is designed, there is some computer program helping them use that to maximize against the third-party payer formulas. So it is a very

inefficient system and the uninsured patient who gets caught up in it is confronted with that bill and thinks those are real prices. They are not real prices and nobody should pay them, quite frankly.

Ms. SPEIER. Dr. Makary, you put up a slide that I thought was quite informative on laparoscopic surgery and how those that still use open surgery versus those who use laparoscopic. Is there any distinction being made between rural and urban? Are you seeing more laparoscopic in urban and less in rural areas?

Dr. MAKARY. Interestingly, we don't see a difference in rural versus urban areas. We don't see a difference in large academic versus smaller hospitals. It tends to be a regional variation. It tends to be the way somebody is trained. It tends to be a preference of the individual provider. Even within an institution some providers may do it open and some laparoscopic.

Ms. SPEIER. Older physicians using open versus laparoscopic?

Dr. MAKARY. We didn't study the age of physicians, but we know that younger folks, especially those who grew up with Nintendo and video games, are a little more skilled with laparoscopic surgery.

Ms. SPEIER. Okay. None of you really kind of focused on this issue of ancillary medical services in which a physician has an interest and then refers patients to them. I think Atul Gawande did a piece called The Cost Conundrum some years ago and looked at El Paso, Texas and McAllen, Texas, and the Medicare patient in McAllen, Texas, more than $14,000 was being spent per year on them; only $7,000 a year on an El Paso Medicare patient. And when he really dug down, he found out that it was the physicians who own the hospitals in McAllen, Texas and the home health services and the other ancillary medical services that was causing this twofold cost differential in Medicare.

Do any of you have comments on self-referral or the fact that physician ownership of these services has an impact?

Mr. GOODMAN. Well, I think Gawande sort of missed the boat on comparing those two cities, because while it is true that Medicare spends a lot more in McAllen than it does in El Paso, it is also true the private sector spends a lot less in McAllen than in El Paso. And what I think is going on is that almost everybody in McAllen doesn't have any private insurance, and Medicaid in Texas pays very little. So I think what they are doing is they are just shifting every cost they can to Medicare. Bad for us as Federal taxpayers; probably good for them locally.

The whole issue of what does the doctor own and what can he use, I think the incentives are very perverse. I don't really think the best answer is to tell the doctor he can't have that kind of equipment or he can't own it. I think the best answer is to encourage a real market and let competition determine what services he is going to offer and what services he is not.

Ms. SPEIER. I am running out of time.

Ms. Quincy?

Ms. QUINCY. I think there are a number of studies that confirm what he found, which is that when you have physician ownership, you do see more tests. You see that ancillary service used much more often. It could go up by like 200 percent, the usage, and it does cost more. The Affordable Care Act does include a trans-

parency provision that says that doctors, if they are self-referring, they have to reveal that. But I suspect that will be necessary, but insufficient in this case; that we need more than just transparency.

Ms. SPEIER. Sort of like selling your soul online, right?

Ms. QUINCY. Well, if this subcommittee would just require testing of that disclosure.

Ms. SPEIER. Thank you. My time has been depleted.

Mr. LANKFORD. Thank you.

Dr. Gosar.

Mr. GOSAR. Thank you very, very much.

Dr. Makary, just to let you know, I am a dentist. Very different parameters versus physicians in cost escalation. Definitely a little expensive to provide, but very different tracks, medicine versus dentistry. I am also from Arizona, a very aggressive State dental board versus a very lenient medical board. So I think you know where I am going to go on this.

You have seen patients that have seen and are going to see an inferior doctor. There seems to be some type of aspect in which we are protecting bad doctors. Can you elaborate on that?

Dr. MAKARY. Right now, if you lose your license in a State, the common next step is that the physician will jump to another State and apply to get a medical license. Now, the State can inquire with the National Practitioner Data Bank whether or not there has been a prior action, but in doing the research for the book Unaccountable, I learned that some States don't want to pay the fee, even though it is less than $10 to run the inquiry. They argue they can't afford it for all their doctors.

So about half of all physicians who lose their license because of some atrocious immediate suspension because of a category called immediate harm to the public, they go to another State and set up their shop; and it is probably one of those things where if we just had more coordination of care we could prevent those thousands of patients that are seeing these doctors from the risk.

Mr. GOSAR. And isn't there a timely factor here? I mean, it almost has to be an outrageous, egregious action to even get it on to the medical or into the public, isn't that true?

Dr. MAKARY. Absolutely. And most of us will be sued at one point in our careers. Being sued is certainly not a marker of quality, even though it is reported to the data bank. But the category immediate loss of license because of a threat to the public, that is something I think should have coordination, just as the FAA does for pilots.

Mr. GOSAR. I agree. You argue that doctors spend very little time, now, with patients, so it is almost what they call a patient shuffle, a turning mechanism, so to speak. Can you tell us, from the perspective of docs, I talk to a lot of them, they are burned out based upon the way the parameters are being compensated. Because then I am going to come back to you, Mr. Goodman, because I want some follow-up questions in regards to that.

Can you tell me a little bit about that mechanism and the way physicians are burning out?

Dr. MAKARY. Forty-six percent of us are burned out according to a national Mayo Clinic trial that just came out last year. Now, what drives doctors to burn out is not the patient care; they love

the patient care. We love the patient care. It is the quotas that we get harassed with by emails on a monthly basis; it is the targets; it is the pressure to see 15 patients in a two hour window. This is not the type of medicine that my father practiced in his career, and it is the sort of thing that is resulting in many doctors not recommending the profession to their offspring.

Mr. GOSAR. So, Dr. Goodman, we have talked about market factors, and something that has not been put out here is the Government is part of those market factors, because since the conception of rates from HHS and CMS, we have an artificial market; and I think the Government plays a part in it, because all we are doing is cost-shifting. Because when you look at our medical aspects, we have lots of specialties; no primary care docs because there is no reimbursement mechanism, we have priced them out of the aspects.

Part of that aspect is sharing of information, particularly with our third-party payers. I think they are part of the solution, but right now they are part of the problem. They share our information. Can you address maybe looking at the true cost of medicine and looking at insurers not being able to use collaborative actuarials?

Mr. GOODMAN. Yes, I think that is bad and I think your premise is correct. The reason the market has been suppressed is because of government action, much of it at the State level, going back for decades. The answer is to find ways to liberate the marketplace. And I think the walk-in clinics, for example, perfect example. In Dallas, Texas, if you have an earache or sore throat, you walk into the Minute Clinic, there is a posted transparent price, it is $75. But Medicaid only pays half that, so none of the Medicaid patients can go to the walk-in clinic; they all have to go to the emergency room or to the community health center, where they will wait a long time for care.

So I think a very good thing to do in Medicare and in Medicaid is let those patients pay the market price, whatever it is, and reimburse at that market price, because it is a lot cheaper than what the doctor is charging or the emergency room, and we would, overnight, greatly improve access to care for the low income population.

Mr. GOSAR. Okay, I am running out of time. I will wait until my second round.

Mr. LANKFORD. Thank you.

Very distinguished ranking member of the full committee, Mr. Cummings.

Mr. CUMMINGS. Thank you very much.

Dr. Makary, I listened to what you said a moment ago, what one of your patients said about the parking. Let me tell you something, as a resident of Baltimore for 62 years and as one whose family member just had surgery at Hopkins, people come to Hopkins for more reasons than parking. It is the greatest hospital, in my mind, in the world. So you come from a very prestigious hospital, and I am very familiar with Hopkins; it is smack dab in the middle of my district.

I was trying to size up your testimony with Ms. Quincy's, because she said something that was very interesting. You talk about transparency, but I think about the people that come to my office,

and I could give them data, but I want to make sure they are not so overwhelmed with data or they even know how to read the data. There are people in Congress that don't know how to read data, with law degrees.

So I am just trying to figure out how do you size that up. You follow what I am saying? In other words, I want to be practical. Sometimes policy is not connected with practicality. But I agree with everything you said, except the parking. But help me with that. You follow what I am saying?

Dr. MAKARY. Absolutely. And I agree with you. Now, there is a good model.

Mr. CUMMINGS. And you are going to have to talk fast, because I have to talk to Dr. Goodman.

Dr. MAKARY. The heart surgeons in the Country got all of their data, their outcomes data together and delivered it to Consumer Reports, that put it on their website; they have the brand recognition. And you can look up the star rating for a heart center in the United States. So it is possible to distill it down in a user-friendly way to patients.

Mr. CUMMINGS. Okay.

Dr. MAKARY. Just like the C-section rate.

Mr. CUMMINGS. Dr. Goodman, you argue that, in place of the ACA, health care reform could be better achieved by depending on informed individual consumers who would be responsible for shopping for price and quality care and, of course, the bill. Mr. Goodman, you call that skin in the game. Dr. Goodman, I am sorry. I call that shifting costs to consumers. As seen in this slide, medical expenses are the number one cause of bankruptcies in America. According to the Administrative Office of U.S. Courts on behalf of Federal Judiciary, 1.3 million petitions for bankruptcy were filed last year; 62 percent of bankruptcies are the result of health-related illnesses or medical bills; 69 percent of those had medical insurance.

I want to tell you, when I practiced law, people were very reluctant to file for bankruptcy for a lot of reasons, and usually it was a last resort. So, Dr. Goodman, you suggested that a uniform fixed dollar subsidy of $2,500 for every adult and $1,500 for every child is appropriate. Now, I wonder what would you say to the millions of Americans who have been driven into bankruptcy because they already had more skin in the game than they could handle? What about them? And I also want you to comment on the 22.3 percent uninsured rate in your area and how that plays in with all you are saying.

Mr. GOODMAN. Okay. I believe in universal coverage, and I believe the Federal Government ought to make it possible for everyone to have health insurance, affordable health insurance. I think that could be done with a refundable tax credit the right way, instead of the bizarre way we are doing it under the ACA.

Skin in the game is not really a phrase I ever use. What I believe is that there is a certain amount of money that people are going to have to spend on health care, and it should not all be given to the HMO, because if it is all given to the HMO, then it will decide how the money is spent, and I think patients need to play a role in deciding what kind of care they get.

I think the bankruptcy study you are referring to is a junk study, and it has been looked at and there are better studies. And there are people who go bankrupt for medical bills. There are people in Canada who go bankrupt because they have medical problems, and the bankruptcy rate in Canada is not that much different from what it is in the United States; not a good thing, but that is a distraction.

Mr. CUMMINGS. Well, I don't like distractions. I would like for you, since you have better numbers, I would like for you to get them to us, because we need to get to the agencies that are putting this out to make sure that they are not putting out untrue statements.

Mr. GOODMAN. I would be happy to do that.

Mr. CUMMINGS. All right. Thank you very much.

Mr. LANKFORD. Thank you.

Let me submit to the record there is a study that has been put out by Diana Roth that deals with that same number that said Department of Justice study and the Federal Reserve listing on it dealing with that, and I will be willing to certainly enter it into the record as well. Good chance to talk through that.

Mr. Woodall, you are recognized for questions.

Mr. WOODALL. Thank you, Mr. Chairman.

I appreciate you all being here. This is one of the nearest and dearest issues to my heart. I just am curious, as we are debating so much in Congress about what the future of the American health care system is, do any one of you agree that the health care system will provide the kind of care that we want it to provide at a cost that we, as a Nation, can afford if we don't improve transparency in the process? Can we keep going, Ms. Quincy, as we are or must we do better?

Ms. QUINCY. We must do better.

Mr. WOODALL. Dr. Goodman?

Mr. GOODMAN. Yes, but I think that forcing transparency on the system without changing what the third-party payers are doing is not going to change very much.

Mr. WOODALL. I certainly agree with you. In fact, I might define transparency as eliminating third-party payers from my life so that I can actually experience those costs.

From a practitioner's perspective, doctor, any belief that we can get by with the same amount of transparency or less going forward?

Dr. MAKARY. No. I think the only way to improve the health care system is to get at this 30 percent of it that may be unnecessary.

Mr. WOODALL. I certainly agree with the ranking member of the full committee. You can get overwhelmed with data. I have a medical savings account and I am out there making tough decisions. I am not a doctor; I am a lawyer, and I have to go out and sort these things out.

I will confess, Ms. Quincy, as much as I fail to agree with so much of the policy statement that Consumers Union puts out, I love your magazine, and probably every day in the school library from age 14 to 18 I read every copy that came through; and the biggest purchase in my life at that time would have been an automobile. And it is complicated; it is kind of a life and death issue

in some ways. Something looks really nice, but it turns out, when it hits a curb, it falls apart and your head goes through the windshield.

And you all helped me sort through those life and death decisions; complicated, big dollar decisions. Sometimes folks chose the less expensive, more dangerous varieties for their life; other folks chose the more expensive, safer, and bells and whistle along the way. Why won't that model work in a health care world?

Ms. QUINCY. I think there are a couple reasons. One is we are talking about purchasing a product where the spending in a year could exceed $100,000, as opposed to the $10,000 for a used car that is being spread across five or six years. And we are also talking about absolutely essential purchases, because they alleviate pain, they increase quality of life, they prolong life; whereas, in some cases you may have an option other than a car, you may have public transportation.

So I think most people feel that this market is different from other markets where the commodities are more fungible.

Mr. WOODALL. There is no question, I think you are right, that most people do feel that way. I just question whether or not they are right. You have made the very accurate point that some of these are more expensive than others. I use you for tooth whitening toothpaste as much as I use you for automobiles. You have managed to do things at all ends of the consumer spectrum today. I don't know why we wouldn't succeed at that going forward.

I think about my grandparents, who died surrounded by people who loved them in their home. There was a choice about health care. These were not life and death decisions about which they had no choice; these were life and death decisions about which they had great choice, and they made those decisions. I have a great fortune of having physicians in the family who help guide us through those. I do worry about where folks go to get that information.

Dr. Goodman, I think about Medicare Part D, for example. I wasn't in Congress then; I would have voted no then. I am not in favor of new Federal entitlements. But I remember folks saying very much what Ms. Quincy just said, that these are life and death decisions, these are very expensive decisions, and these are too complicated for the American people to sort out. I think the data today suggests that Medicare Part D has been successful with individuals sorting out their own decisions.

Mr. GOODMAN. Well, it has been. It seems enormously complicated, however. Remember, we still have third-parties and the Government determining everything. But the Minute Clinic, that is the real free market. Nobody tells the Minute Clinic what it has to make public and what it doesn't. But if it doesn't do it in a way that people can understand, no one goes in the clinic. So they are making lots of money, they are spreading all over the Country because they give people information in a way that they can understand. And, by the way, all the records are electronic and they can prescribe electronically.

Mr. WOODALL. No question, Dr. Goodman, it is complicated, and no question, as Ms. Quincy pointed out, it is so hard most folks can't fathom how we can get it done. But I think about folks in the actual provision of the business, doctor, and my family members

who are docs and docs in my communities, people who are really questioning whether they are going to stay in the business or not and, more importantly, questioning whether they are maximizing their ability to make a difference in people's lives. And at some point the system we have today is actually diminishing the quality of individuals' lives and care, rather than improving it. Have you had a similar experience?

Dr. MAKARY. Absolutely. There is a debate going on right now within U.S. hospitals: Should we pay doctors a relatively flat amount, maybe with a small bonus for innovation or quality, or do we give them gigantic bonuses, quarter of a million dollars, half a million dollars, for pure volume? And the CEO of the Cleveland Clinic and the head of Kaiser have come out saying that they believe it is unethical to pay doctors based on volume. Other hospitals are going the other direction. And I think that contributes to the doctor burnout.

Mr. WOODALL. I thank you all.

Thank you, Mr. Chairman.

Mr. LANKFORD. Thank you.

Mr. Horsford.

Mr. HORSFORD. Thank you very much, Mr. Chairman. I appreciate this panel and the very important information on the provisions of the Affordable Care Act that are being discussed today. One of which I want to touch on right now is the summary of benefits and coverage program created what is an unprecedented standardized method of communicating health plan information to the over 170 million consumers enrolling in private health coverage. The SBC requires providers to give consumers information about health care plans in a uniform layout and in terms they can understand, meaning consumers can make educated decisions about which plan is best for them. And I know, as I talk to my constituents, as I talk to small business owners, this is something that is very important, is having people be more educated about the decisions they make.

We are fortunate to have a witness who is an expert in this. Ms. Quincy, I understand that you, while working with the Consumer Union and the National Association of Insurance Commissioners, conducted extensive research both to determine what information would be most useful to include in the SBC and determine how effective the programs were after implementation, is that correct?

Ms. QUINCY. Mostly, yes. The Affordable Care Act itself included some requirements that we started with as to what should be in the SBC, and if I have a chance I will tell you about key one that illustrates a lot of points being made today.

Mr. HORSFORD. Please, elaborate. What are some of those features?

Ms. QUINCY. Okay. Well, one thing I will say to start is that this particular provision is absolutely beloved; it ranked higher than subsidies for health insurance premiums when Kaiser Family Foundation did a poll, because consumers do feel they need help picking among health plans because the information isn't standardized. But I know we are moving quickly.

If I could have the next slide.

[Slide.]

Ms. QUINCY. One of the required features, and one where the consumer testing produced the greatest surprise, was around this page, which is a page called coverage examples, and it includes three pieces of information that consumers have never seen before. One, it shows how much medical care costs for the medical scenarios displayed. And that is something that consumers don't know; they don't understand how truly expensive medical care is, and that is why, in today's market, they might buy a policy with a $20,000 annual benefit limit, not realizing they are very underprotected, may end up in bankruptcy.

Second, it gives a bottom line for what all those myriad cost-sharing provisions actually mean to the consumer. By the time you weigh the deductible cost-sharing, blah, blah, blah, what does it actually mean if you have a baby? What do you have to pay? Consumers can't figure that out. I couldn't even figure it out when I was trying to create these for testing.

Third, and the surprise, it shows what the plan pays for coverage for that medical scenario. And that may seem like a residual; it proved to be very important because consumers do not want to shop for health insurance, they would rather shop for cars, it is more fun. And they kind of forget the value associated with having health insurance. And when they saw, on this breast cancer example, which is what we tested and is not in the form today, $100,000 service for a year, they went from saying I am not going to buy that plan because that deductible looks so high, to saying, you know what, that is chump change compared to what that plan is paying on my behalf. And I can show you the videotape.

So the bottom line is here is A, consumer testing tells us what we need to know and we shouldn't be guessing; B, it is powerful. We could be moving the market just by working with this form and doing more with it.

I will stop there so I don't use all the time. Thank you so much.

Mr. HORSFORD. So, in your opinion and based on the testimony that you have given, would you say that the SBC is an effective criteria to meet those improved communication and education provisions of the law?

Ms. QUINCY. I think that the SBC fills a great need. I actually do hope it will be improved over time. I think that one thing that did not happen is the form was not designed by a designer; and I have told HHS that we need to get a designer in here to tune it up a little bit. That is the nature of disclosures; ideally, they improve over time. But there is a report in my written testimony that I link to that says how well received this was by consumers, so we are doing great so far.

Mr. HORSFORD. Any other recommendations or steps that you think this committee should take?

Ms. QUINCY. Well, with respect to this form in particular, yes. The form that consumers see today only has two of the three examples you see before you; it is missing the expensive breast cancer example. And that was the most impactful and it needs to be brought back.

Second, a change was made at the regulatory level to go from real world prices to Medicare prices. So you will see that having a baby is $10,000 in this slide.

If you go to the next slide, or the previous one.

[Slide.]

Ms. QUINCY. Now it is $7,540. That is not a real world price. And I can, afterwards, give you a whole list of things I would love for this committee to do.

Mr. HORSFORD. Mr. Chairman, may I ask, do we have a copy of those slides?

Mr. LANKFORD. We can certainly get a copy of those slides. They will be included in the record as well.

Mr. HORSFORD. Thank you very much.

Mr. LANKFORD. Absolutely.

Ms. Lujan Grisham.

Ms. LUJAN GRISHAM. Thank you, Mr. Chairman. I have to say that when you come into these committees this late, you often end up repeating many of the fine points and questions. I am actually going to dovetail on my fabulous colleague, Mr. Horsford.

Ms. Quincy, I really appreciate describing that we have great first steps, including making sure that we have more transparency and we are driving folks to a consumer-based marketplace through the exchanges in the Affordable Care Act, but that health care information is complicated and that even the folks who have tried in a variety of before the Affordable Care Act have made many attempts to make billing information.

Anybody who has tried to read a Medicare statement, for example, it used to take me months to train doctors and other health care professionals to be able to navigate explanation of benefits and Medicare bills to figure out whether or not those Medicare beneficiaries still have to pay, have reached a deductible, what that 20 percent is or isn't, whether it is a covered service. So it is, it is very complicated to navigate and I think that these are important first steps.

But I want to talk to you. Mr. Horsford got you to identify other things that we could be doing to make this more transparent, which will make consumers better able to make productive choices. Let's talk a little bit about how that would translate into creating better price structures and helping consumers help us make sure that we don't have price discrimination and overcharges in the system. Do you have any suggestions about how we might do that?

Ms. QUINCY. Yes. Some, I think, low-hanging fruit, if you will, things fairly easy to achieve. One of the things that stops consumers from using the price information that is on the marketplace today is it is by CPT code, so a single procedure. And they don't bring the knowledge to the table that tells us what is the actual full bundle of procedures that I need to know. This is why they might get tripped up with respect to out-of-network charges, because they don't realize there is an anesthesiologist charge that goes with this surgical charge. So, anyway, we need to provide them within formation that is already bundled into the entire set of services that they are going to need.

Second, we have to link those things with value. We should not be showing price information alone. And that is pretty tricky, but I think it can be done. I also think that underlying all of this, like the testimony of others, is great information about comparative effectiveness. What are the right treatments? When you are choosing

among treatment alternatives, you, frankly, don't want to do it on the basis of price; you want to know which is going to give you, the patient, the best outcomes. And we have that information in some places, but not where we should. It is shameful that that information is not always available to us.

I will stop there just so you have enough time.

Ms. LUJAN GRISHAM. And thank you very much.

This is for anyone on the panel and, again, I apologize if these issues were covered before my attendance here at this morning's hearing. And, again, I am in favor of as much transparency and not so in favor that I think this is over-simplistic to say that just a free marketplace kind of transparency environment makes this easy.

As I said, I come from this with experience helping the Seniors Saving Medicare project; Operation Restore Trust, where we were really looking at ways to really understand what is going on; long-term care ombudsmen programs, helping folks understand what services they ought to be getting in nursing homes. And it is so complicated that the best way I could do it would be to train accountants and really looking at folks.

I am not, for example, able to figure out, when my engine light goes on, just exactly what is wrong with my car. Nor am I able to navigate it when the mechanic tries to explain it to me. And when you are sick, you are not in a position to shop, and Americans are sicker than everybody else. And I just like these responses that we are not dealing with a patient population, no matter how sophisticated we are, that can navigate fairly just because people are more transparent. I do disagree with these statements and why. Anyone on the panel.

Mr. GOODMAN. Well, I think the best way to get transparency is to do something like what Walmart is going to do with all its employees; it is going to have seven Centers of Excellence. You want to get on a plane, go to those Centers of Excellence for your elective surgery. They will cover all the costs. If you want to go to some other hospital, you have to pay the extra marginal costs. So that makes every employee of Walmart very aware that there is going to be an expense for going to another hospital or another health center. And then once they do that, in places where there are a lot of Walmart employees, the other hospitals are going to say, hey, we can't get customers here with the CPT codes that nobody understands; so if we want to compete with the Mayo Clinic and other health centers, we better come up with a package price that people can understand and quality measurements that they can understand.

It is on the provider side that we are going to solve these problems, not on the buyer side.

Ms. LUJAN GRISHAM. Thank you, Mr. Chairman. My time is up, so I will yield back, but there is plenty more to debate on this issue. Thank you very much.

Mr. LANKFORD. Good. We will hang around for a second round of questioning, if you would like to be able to stay engaged in that as well.

Let me come around for a second time around on a few things. For all of us, we want the best in possible patient care. That is what this is all about. It is an individual the best and possible pa-

tient care. It is also best possible price not only for the individual that is paying it, but in the cases where the Federal Government is involved in health care, also for the Federal Government as well. But it is about the patient at the center core of this.

Dr. Goodman, you have done a lot of work on cost issues. What would you propose as the most significant things that we could do that both improves patient care or takes good attention to individuals, but also good attention to price?

Mr. GOODMAN. Well, again, I think we have all of these clinics that are opening up, all the Minute Clinics, the walk-in clinics, we have the doc-in-the-boxes, we have the freestanding emergency room clinics, and they really are in a free market and they do offer posted prices. The mistake we are making in our public programs, in Medicare and Medicaid, is that we are not allowing the patients to pay those prices; instead, we dictate what Medicare is going to pay, we dictate what Medicaid is going to pay.

We don't need to do all that if we have a market that is functioning and if the price looks like it is way below what we would otherwise pay. So there are a few simple things that we could do that I think would greatly expand access to care, particularly for low-income folks.

Mr. LANKFORD. All right, but that is for basic data care; that is the flu, that is an earache, that is a broken bone. That is for simple things. What about when we step into more complicated?

Mr. GOODMAN. For more complicated, just to pick up on the Walmart example, other employers are looking at structuring their insurance so that if you go to a high-quality, low-cost facility, they pay everything; if you want to go someplace else, you pay the extra cost out of your own pocket. Then that puts enormous pressure on the provider side of the market to begin to compete with bundled prices, with quality information; and I think you are going to see a lot more of that. Right now, in Dallas, Texas, there is not a single hospital that is not in Blue Cross's network. It doesn't matter how good the hospital is, how bad, what its mortality rate; they cover everybody. That is not the way to get to where you want to be.

Mr. LANKFORD. What about for the individual? I mean, all those assume employer or a larger company that they are involved in. What about for a small business owner, himself and his wife or her husband own the business and that is it?

Mr. GOODMAN. Well, I believe in the very flexible health savings account to wrap around any third-party plan, and I really think the ideal way to structure it is to put enough money into the account so that people can pay for their primary care, for their diagnostic tests. If something really expensive happens, then the plan pays for it.

But carve out whole areas of care, especially all the diagnostic tests, and say, look, you can have this. We are not going to argue with you about how often you can have a mammogram or a pap smear or PSA test; we are going to put money into an account and you decide how often you get these and you decide if you can find a better way and higher quality testing. That would change a lot.

Mr. LANKFORD. We are all in the middle of the transition to the Affordable Care Act and we are all kind of watching the Administration right now trying to implement things. There are a lot of

guesses what it will look like both on price on insurance and how it is going to work, and exchanges and State versus Federal. All these dynamics are out there. You are doing a tremendous amount of research on this as well.

Based on just typical behavior of individuals, there is this sense that individuals will stay out of the insurance market until they are sick because they have guaranteed coverage at this point, and that they will then step in and pick up coverage as soon as they become sick. Are you tracking with that or where are we with any of that? Do you think that will affect premiums? Do you think that is a likely behavior?

Mr. GOODMAN. I think it is going to be a huge problem, and it is going to be made worse if the application form is 21 pages long, and it is going to make worse if the HHS continues to not use systems that are already out there. E–Health has insured 3 million people on a private exchange. HHS is not using that private exchange. I think that is a huge mistake. They are going to go hire navigators who will not be insurance brokers; they have to be trained. And the fines for being uninsured are small and they don't apply to millions of people, and it appears that the IRS can't do much to enforce them except withhold refunds, so the insurance companies are very, very worried that only sick people will sign up, and it is a legitimate worry.

Mr. LANKFORD. Okay.

I now yield to Ms. Speier.

Ms. SPEIER. Thank you, Mr. Chairman.

Dr. Goodman, you are an unabashed proponent of HSAs. We have heard it five or six times this morning. The GAO has indicated that the average adjusted gross income for those aged 19 to 64 who have either made a contribution to or withdrawal from an HSA have an income of about $139,000 a year, compared to the average filer, who is making about $57,000 a year. So the persons who are accessing HSAs are people who have more money, people who have the ability to squirrel away money. So I don't think HSAs are the answer, and that is the model on which you describe much of your commentary.

So I guess my question to you is if we don't have HSAs, if the majority of Americans don't access HSAs because they don't have extra money, we have lots of unemployed people; we have lots of people who are just making it, who don't have $5,000 to set aside in an HSA, how are we going to make sure that they have health coverage under your concept?

Mr. GOODMAN. Well, I am not talking about extra money, I am talking about the money that is put aside for them by an employer or by the Government; and I am saying it should not all, in my opinion, go to the third-party payer. But I am perfectly willing to allow the market to work, and if people want to join an HMO and give all the premium dollars to HMO and let it make the decisions, I am willing to allow that to happen. That is basically what happens in the Medicare Advantage plan.

But I would like to see people have the option not to give all the money to the insurance company, to retain part of it in an account that they own and control; and I would especially like to see the opportunity for people to carve out whole areas of care that they

will be responsible for and an employer puts money into the account. And I think this could be a real interesting way to approach the whole issue of chronic illness.

In the Medicaid program, of all places, we have something called cash and counseling, where the homebound Medicaid disabled are managing their own budgets.

Ms. SPEIER. All right, thank you. I need to go on and ask Ms. Quincy.

Ms. Quincy, what has your experience been with these HSAs and high deductible plans, and their ability to really cover people?

Ms. QUINCY. I think that the evidence associated with these plans completely comports with what theory would predict; they are excellent vehicles for people who are either very well off and/or healthy. In fact, there is some data from the IRS that indicates that they are actually used to do long-term retirement savings, because it is another tax advantage way to save for your retirement. And there is nothing wrong with that.

I do think we need to be careful and state so that we know it will not solve all of our health issues. I think there is a role for it, but you have already made the point better than I have that there are many, many families for whom they are very cash-strapped, they have no liquidity, and they may be also time-constrained; they are just not in a position to shop all these services and manage this large account. I just think the evidence is overwhelming that that is the case.

Ms. SPEIER. All right. I have a question for each of you now. There is still a lot of pushback on the Affordable Care Act, still people that want to undo it. I think it is counterproductive at this point. I think it is here to stay. I think that what we should be doing is making sure that it works. And I know for some of you that is a hard concept to put your arms around because you just don't support it. But having said that, there are issues that we have to address in the Affordable Care Act around cost containment, because the bill does not address that; and our job in Congress right now should be looking at where the areas we can impose cost containment, because a fee-for-service model is antiquated.

So, with that, Dr. Makary, let's start with you.

Dr. MAKARY. I appreciate your comment, Congresswoman. Even the authors of the Affordable Care Act, at the time that it was passed, said more work needs to be done, and it was recognized that it was not all-inclusive of the changes that need to be made in health care; and, of course, no law is ever perfect. Right now, dealing with the cost crisis, it appears that transparency is the most common-sense, logical, and low-cost way to allow the free market to come around outcomes. But if we just talk about price transparency, I do worry it is a very dangerous business, because it will simply force the market to provide the lowest price.

We have all talked about the importance of value and outcomes, but where are these outcomes? They live in these registries. And I think if Medicare is going to reward things, they should reward registry participation and public reporting in these registries.

Mr. LANKFORD. I am going to ask unanimous consent to extend for another minute to allow the folks to be able to answer that question.

Mr. GOODMAN. I personally put together something called the Health Roundtable, and it includes the business roundtable, includes the drug companies, insurance companies. Basically, I said to them, I don't care where you were three years ago; some of you supported it, some of you didn't, but I used the very words you used: It is here; we have to find a way to make it work. So you all know better than Congress knows where the train wrecks are. Let's identify them; let's do this in a bipartisan way. So we would love to have your input on this because one party can't do this next time around; it has to be both parties.

Ms. QUINCY. Constraining health care costs is probably the thorniest dilemma that we all face; it is very complex and hard to do. I would actually be a bit more charitable towards the Affordable Care Act. It doesn't solve the problem, but it contains just about all the seeds of policy solutions that we would explore. I won't enumerate them here, even though I wish I could, but perhaps in some of the later questioning we could dig into some of those provisions. Like there is a new large payer, which we have all agreed is how you move the market, by having large payers; rate review; and other issues.

Mr. LANKFORD. Dr. Gosar.

Mr. GOSAR. I disagree. I want opportunity and I want choice, and that is inherent to me, and I have done it for 25 years. I built individual insurance models for patients day in and day out, so I want choice. And we can't solve this problem without involving the patient in this decision process.

But the market is broken, and it has been broken from the Government entity, it has been broken from the insurance entity, and it has been broken from the hospitals entity; all the way around. In fact, I always share this: Who has been on the Government dole the longest for dictated health care systems? Actually, it is the Native Americans; and they are rebelling like light years. They do not want it; they do not like it. They want to have an individually based health care model. And they are exempt, by the way, from the ACA, and they are actually building some of the better health care systems around are being built right now.

So I want to look, Dr. Goodman, at the system, because I think we are built upon a flawed system based upon reimbursement rates dictated by CMS and HHS, as well going through an insurance industry. Would you agree with me that we can get back to some kind of competitive model and look at real costs, instead of being able to cost-shift? Because that is what we are doing right now, we are just cost-shifting one to the next, to the next, to the next; and that is why you see some of this churning that goes on.

Mr. GOODMAN. Yes. I would go further. We are never going to solve the problem of cost as long as you have every patient and every doctor having a self-interest in making spending higher. So if you want to solve the problem, we have to get the economic incentives right, and health savings accounts is one way of getting incentives right for the patient. And if you were more creative about that idea, you could do the same thing in chronic care, long-

term care. There are a lot of things we could do to get patients good incentives, and we can also do it on the provider side.

Mr. GOSAR. But you are your health care, are you not? You, the patient, you are your health care.

Mr. GOODMAN. Okay.

Mr. GOSAR. You inherit your health, right?

Mr. GOODMAN. Right.

Mr. GOSAR. So you have to take an active participation in that aspect to drive it. So it is upon us to educate people in the genetics that we hold.

Would you not also agree, Dr. Makary?

Mr. MAKARY. Yes.

Mr. GOSAR. So we have to involve them along those lines.

Let me ask you a question. So we have this Affordable Care Act, so they say, and then we have an SGR. Does that make sense? How do you have an SGR and then you have reformed health care, and you still have an SGR sitting out there because what you are doing is you are trying to reimburse physicians for not being paid appropriately. How does that work?

Dr. MAKARY. The Affordable Care Act addressed coverage in one way; it didn't address the SGR, which desperately needs to be reformed, and it didn't address the long-term cost crisis in a comprehensive way. There is only one thing that units every physician in the United States, and that is we want the SGR changed.

Mr. GOSAR. Very, very, very interesting. And going back to choice, in the Affordable Care Act, what we are seeing in its implementations you are seeing also in compliance; hospitals buying up private sectors, Dr. Makary. Does this help or hurt rural health care implementation?

Dr. MAKARY. Well, even before the Affordable Care Act there was a trend which I have been concerned about: massive consolidation in health care. Do we want our cities and some States controlled by one hospital corporation? There were 86 hospital mergers acquisitions and last year, representing a record in U.S. history. I think we all believe that it is going to hurt medical prices if there is only one player in town.

Mr. GOSAR. So the question Ms. Quincy was talking about, large payer, that seems anti-anecdotal. There is this big move to big insurance, big hospitals, big medical groups. That is kind of contradictory to what we would solve it with, right?

Dr. MAKARY. Well, I like shopping for a cell phone with Verizon, Sprint and AT&T; and if there were only one carrier, I guarantee the price would be higher.

Mr. GOSAR. That is what I found in dentistry, and I found that in life as well. Let me ask you the next thing. Talk to me about the new doctor. They are very different. You alluded to it in your conversation. We are producing a physician that is very heavy in debt, I mean between $200,000 and $300,000. So their opportunities are very limited in how they can repay that. Can you elaborate a little bit on that, Dr. Makary?

Dr. MAKARY. Doctors are getting crushed right now. Malpractice premiums are going up; their Medicare payments are going down; their overheads are going up; and then there is this pressure to do more with less, and that is why we are seeing this tremendous dis-

satisfaction. And I think we have to look at the SGR. And these young doctors, they want to be honest and transparent, because that generation has very little tolerance for a lack of transparency in other aspects of their life, so they are more likely to disclose errors to patients at the bedside and they are more likely to look at national registries and say why aren't these available to the taxpayers when they fund it.

Mr. GOSAR. Thank you.

Mr. LANKFORD. Mr. Horsford.

Mr. HORSFORD. Thank you, Mr. Chairman.

Dr. Goodman, I do have to just respond a little bit to your statement prior. Replacing the Affordable Care Act with a model like Walmart has for a Center of Excellence, it may work for Walmart, and I am not going to make a judgment on that, but it is not going to work for millions of Americans in places like my district.

Just by way of example, my district in Nevada covers seven counties, it is 52,000 square miles; it is both rural and urban. I have rural parts of my district that have no medical services whatsoever, or public transportation. So to expect them to somehow navigate or be able to get to a Center of Excellence, I would take some objection to. And small businesses who can't get the same volume prices as Walmart I don't think would be advantaged.

But I really appreciate my colleague, Representative Gosar, as a dentist because I found that it is not the doctors, per se, that are the problem. The problem, in my opinion, are the insurance companies. Until recently, insurance companies spent a substantial portion of consumers' premium dollars on profits, including executive salaries and marketing. For example, in 1993, insurance companies typically spent 95 percent of customers' premiums on medical benefits, the so-called medical loss ratio.

But by 2009 many insurance companies were routinely denying policy claims and dropping coverage for nearly 3 million Americans. That allowed them to stop spending so much on health care and start keeping a greater share of premiums for profits and executive salaries; and only about 85 percent of premiums were spent on medical benefits. By comparison, the Government-run Medicare system put 97 percent of premiums into medical benefits.

So, according to one study, profits for the 10 largest U.S. insurance companies jumped 250 percent, 250 percent between 2000 and 2009. Now, I have no problem with the free market, and I think that people are entitled to a profit. But in health care, should we have 250 percent of insurance company profit when people do not have access to quality health care in America?

Ms. Quincy, way back in 2009, was it legal for private health insurers to deny coverage and keep premiums for profit and executive salaries?

Ms. QUINCY. Yes.

Mr. HORSFORD. Is it legal for insurers to do that, or has something changed now?

Ms. QUINCY. Well, many things have changed. Some changes have already occurred, like restricting the medical loss ratio to a certain range, 80 percent for individually insured and small group products and 85 for large group products. This is already in place; we can already see the evidence of how well this policy is working.

But in 2014, of course, things change fundamentally and people can no longer be denied or charged more because they have a pre-existing condition, mostly through no fault of their own; and that is the fundamental change that consumers really want to embrace. It is just not fair; it is unethical.

Mr. HORSFORD. So is there evidence that the MLR is actually driving down health insurance premiums?

Ms. QUINCY. There seems to be. We just have one good year of experience with it so far. Also, when you look at MLR, you have to realize it is also being coupled with a much better rate review process, and those two things together we have observed, again, in our first year that rate requests were being reduced or withdrawn, and there is a study out there that shows there does appear to be a benefit. And, again, we are talking about greater transparency here between the MLR requirements and the rate review process.

Mr. HORSFORD. Just quickly. Dr. Goodman's website suggests that the MLR will result in higher premiums and increased profits for insurance companies. What do you say to that?

Ms. QUINCY. Well, I think it depends how real world you are going to get. In the realm of theory you could say there is a scenario whereby MLR might increase profits, but in the real world, where we have competition among health plans, you can't arbitrarily increase your medical claims in order to increase your profits while still maintaining your MLR. You wouldn't fare very well in the marketplace.

Mr. LANKFORD. Thank you.

Quick follow-up question on that, Ms. Quincy, just to clarify. Are you suggesting that next year premiums will be lower for individuals for insurance, with that statement?

Ms. QUINCY. Well, if you are you trying to get me to say what we know about premiums?

Mr. LANKFORD. No, just the statement about the MLR and that the premiums have gone down. I am just trying to clarify is that total premiums or just in that one area?

Ms. QUINCY. I am so sorry. Are you asking me to clarify what we already know about premiums for the prior year or are you asking about 2014?

Mr. LANKFORD. No, no, no. 2014, yes.

Ms. QUINCY. Okay. Well, we have lots of studies on this, and premiums will be going up for some people and down for others. And that is before subsidies.

Mr. LANKFORD. Okay.

Clarifying question as well, Dr. Goodman. You and Ms. Speier talked about something and you brought up a cash and counseling program. I just wanted you to be able to clarify what that is and how that works.

And then I am going to see if there are any other quick questions, then we will close down the hearing from there.

Mr. GOODMAN. Well, it is a remarkable program because it deals with the most vulnerable of our citizens, and these are Medicaid disabled patients. They are allowed to manage their own budget. It is a program initially funded by the Robert Wood Johnson Foundation.

By the way, other countries are doing this too. I was testifying about two years ago and I brought this up, and Senator Rockefeller said, well, what does that have to do with health savings accounts? And I said, well, that is just a health savings account for poor people. So after the hearing he came up to me and he said, you don't understand, health savings accounts is a Republican idea. And I said, well, let's call them Rockefeller accounts. Then we will all be happy.

Mr. LANKFORD. So how do they work and where do they come from? How old are they? This is a pilot that currently exists?

Mr. GOODMAN. Yes, in just about every State, I believe. The patient manages the money. Initially it was just custodial services, but now it is real health care. And they can hire and fire people who provide them with services, so if they don't like what they are getting from one provider, they can go to another.

Mr. LANKFORD. Any other clarifying questions? Any follow-up?

Ms. Quincy, Dr. Goodman, Dr. Makary, thank you for being here and thanks for all you have submitted and the work you have put into this, both the books, the research people. Dr. Makary, I saw an article that you put out in The Wall Street Journal. I would like to enter this into the record as well. Ask unanimous consent to do that. So ordered.

Mr. LANKFORD. You are doing a lot to push Americans to think about health care in different ways and to be able to encourage us to do some of those things as well. So I thank you for the research that you continue to do and we will look forward to continuing this conversation in the days ahead.

With that, this committee is adjourned.

[Whereupon, at 12:05 p.m., the subcommittee was adjourned.]

4/25/13

To the honorable Congressman, James Lankford:

As you know The Surgery Center of Oklahoma, in a radical move four years ago, began to display our surgical prices online, prices which are one sixth to one tenth traditional hospital charges for the same procedures. We did this to make ourselves more known to patients who were motivated consumers (those with high deductibles, no insurance, or covered by a self-funded company plan) and also to expose the dysfunctional price fixing arrangements that characterize health pricing in this country. The first patients to take advantage of our pricing were Canadians and they continue to utilize our facility in Oklahoma City. Currently, patients from all over the country now travel to our facility and other facilities in Oklahoma City that have embraced price transparency, making Oklahoma City a medical tourist destination and the epicenter of medical price deflation.

Our pricing has even helped patients who have not travelled to Oklahoma, but rather, have used our online pricing just a short plane ride away to leverage better pricing from their local medical markets. I receive 3-5 emails a week now from patients who have taken advantage of our pricing in this way. One Georgia man recently paid $4000 for his recent prostate surgery at his local hospital after having originally been quoted $40,000, using our pricing as his leverage. This Georgia hospital now finds itself in a competitive price market whether they like it or not. I continue to be amused at the amounts of money we have saved patients even when we are not doing their surgery.

Because our facility is physician-owned we are able to customize not only the medical care the patients receive, but their financial arrangements as well, operating more like a not for profit facility than many who claim this tax-exempt label. I believe that a physician cannot, after all, simultaneously claim to be a patient's advocate on the one hand and bankrupt them as a facility owner with the other hand. Our model of complete physician ownership and control brings a quality-accountability to patients that is absent in non-physician owned facility models. Indeed, this arrangement results in an intense policing of the entire medical staff, as no physician owner wants to share liability with an unethical or incompetent colleague.

The national media, most recently the John Stossel Show, which actually airs a story on our facility tonight, has shown an intense interest in price transparency, partly because the topic of the cost of healthcare was never addressed in the Obamacare debate. The focus was rather the push to make sure everyone bought insurance products many didn't want or need.

Our goal, already partly accomplished, is to start a price war, one which will lower the price of medical care to such low levels, that people in this country will show a renewed interest in catastrophic insurance, rather than the perverse first dollar coverage arrangement that is currently so widespread. We also would hope that as free market competition will raise the quality bar and lower prices as it has in every other industry, Americans will also begin to seriously question the role of the federal government in this industry.

G. Keith Smith, M.D.

Today's hearing will explore the problems that results from the lack of transparency and consumer-driven market forces in our health care system. Today's hearing features the testimony of two witnesses who last year wrote important, thought-provoking books about the U.S. health care system.

Both books paint a picture where doctors, nurses, and patients are trapped in a system filled with perverse incentives. When providers and patients act upon these incentives, abundant waste and abuse result. According to a report last year from the Institute of Medicine, 30 percent of U.S. health care spending, an amount that exceeds $750 billion, was wasted in 2009.

Over the past decade, the growth in health care costs almost entirely eliminated income growth for average families.

Additionally, medical errors and hospital-acquired infections are a major problem. According to Dr. Makary's testimony, if medical mistakes and preventable infections together were a disease, it would rank as the number 3 most common cause of death in the U.S., after heart disease and cancer.

Today's hearing will take a close look at the perverse incentives that lead to rampant waste and inappropriate and harmful medical treatment in the U.S. health care system.

Nearly 90 percent of payment of health care services comes directly from third parties. Third party payment separates the payer of the care from the patient and provides a strong incentive for the doctor to serve the payer of the care rather than the patient.

This system has also produced a massive bureaucracy focused on claims processing and the creation and management of cumbersome rules. This bureaucracy adds to the expense of health care services and creates frustration among health care practitioners and patients. A 2009 study in the *Archives of Internal Medicine* found that 31% of doctors are burned out and 51% of doctors wouldn't recommend the profession to one of their children.

I look forward to hearing Dr. Goodman's testimony and the implications of the failure of health care providers to compete on price. I also look forward to hearing about segments of the health care system where there is competition and transparency and how we can move public policy more in that direction.

Dr. Makary has done a service to the country by speaking up about problems within his profession. *Unaccountable* also deals with the perverse incentives at the core of the health care system, but its focus is on how these incentives lead to substandard care at far too many U.S. hospitals.

Here are some examples from his book:

- In about half of hospitals in the U.S., fewer than half of employees at that hospital report that they "would feel comfortable having their own care performed in the unit in which they work."

- 25% of all hospitalized patients experience a preventable medical error.

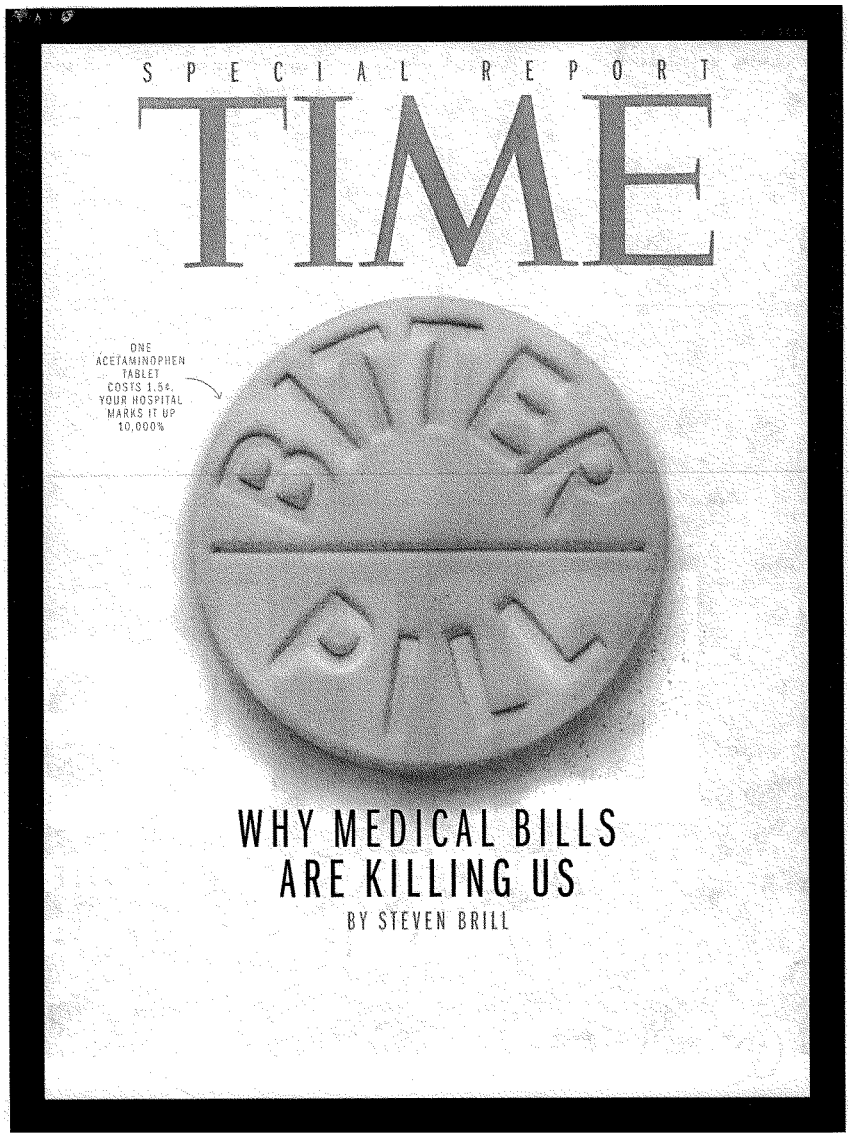
- Hospitals make roughly $30,000 more from patients who suffer at least one complication than they do from patients whose procedures go smoothly.

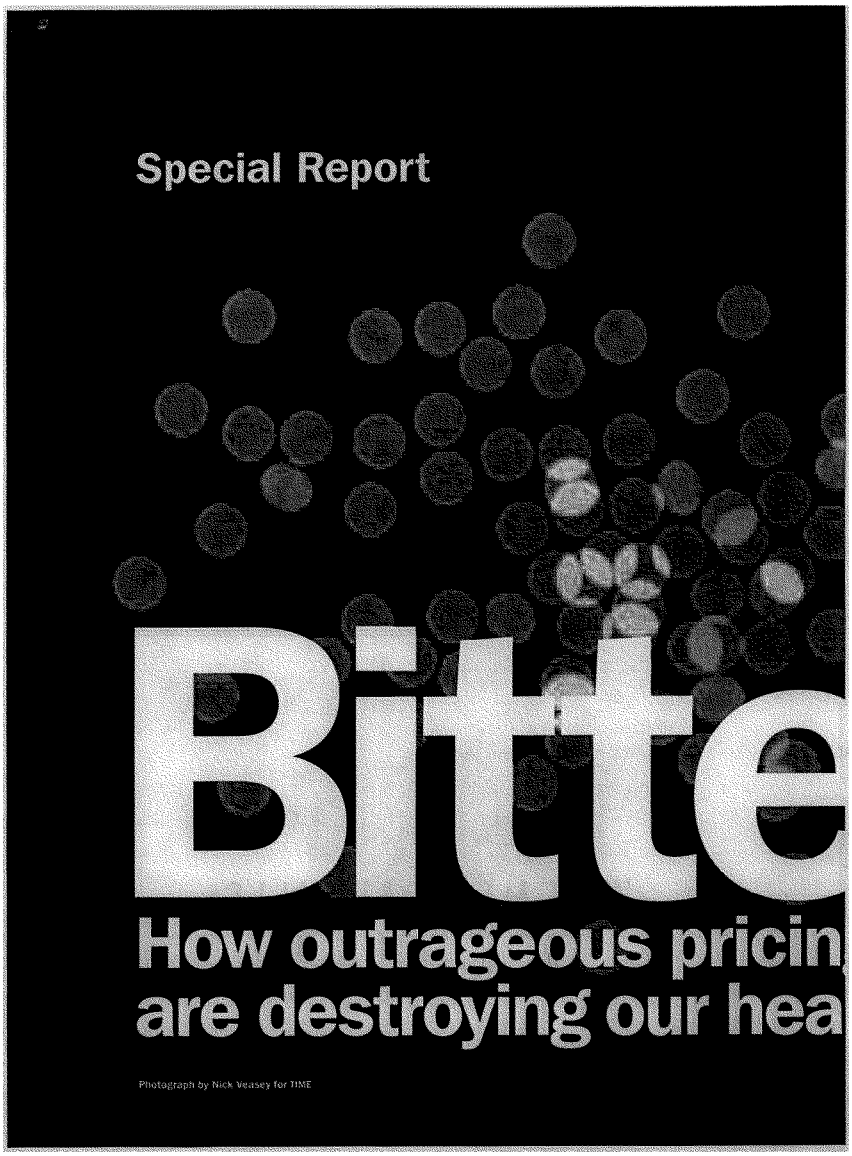
Dr. Makary argues that hospitals and doctors fail to compete on quality because the public does not have the information to be able to separate high quality hospitals from low quality hospitals for various treatments.

I received a letter yesterday from Dr. Keith Smith, a Physician at the Surgery Center of Oklahoma in Oklahoma City. His hospital is the only place in the nation where all prices are listed online and competition has driven up quality and driven down price. I ask unanimous consent to enter his letter into the record, without objection, so moved.

Independent experts believe that the Affordable Care Act, despite its name, will increase what Americans spend on health care, both in terms of money and time. Moreover, Obamacare increases federal government control over the U.S. health care system, increases third party payment, and reduces consumer choice.

The health care system needs real reform, and the ideal reform would aim to address the two primary concerns highlighted by today's witnesses – reducing the amount of third party payment in health care and providing patients with additional information related to health care quality. The health care system has to be reoriented toward value and better outcomes and away from increased utilization and waste.


SPECIAL REPORT
TIME
ONE ACETAMINOPHEN TABLET COSTS 1.5¢. YOUR HOSPITAL MARKS IT UP 10,000%
BITTER PILL
WHY MEDICAL BILLS ARE KILLING US
BY STEVEN BRILL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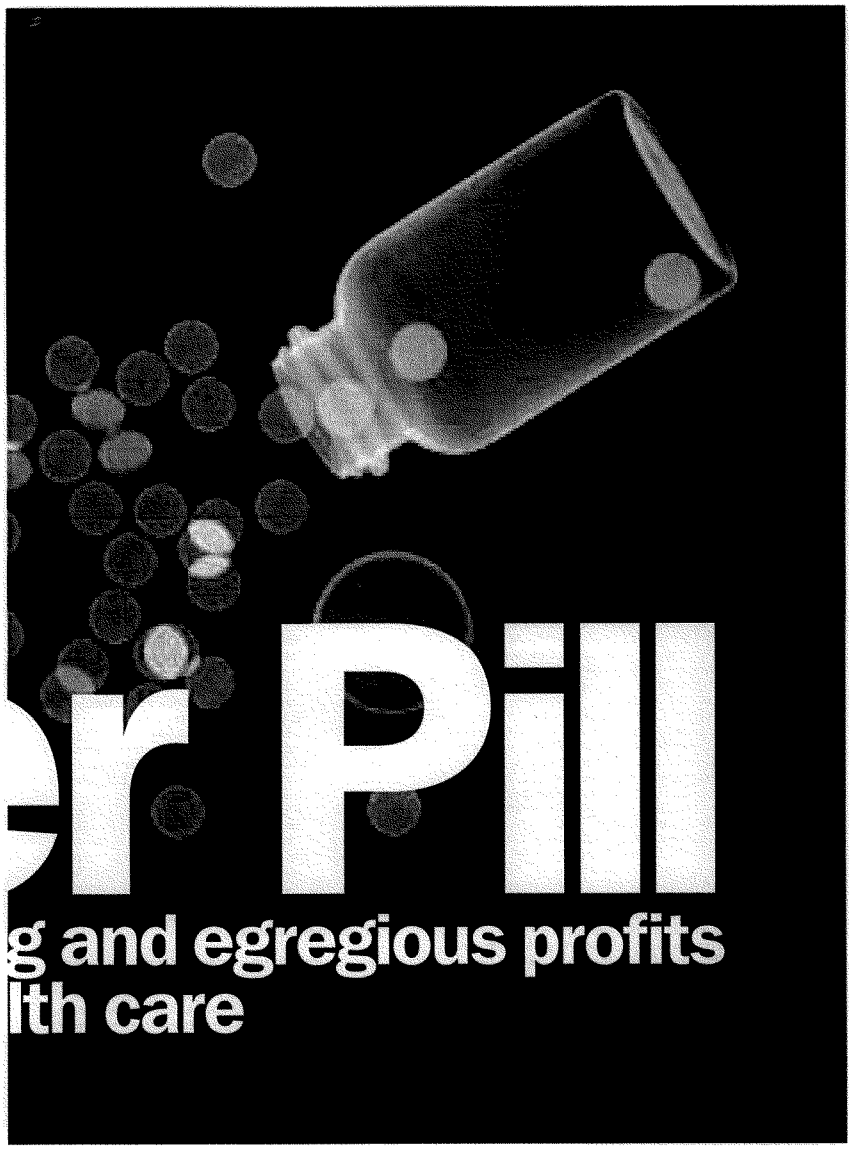
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Routine Care, Unforgettable Bills

WHEN SEAN RECCHI, A 42-YEAR-OLD FROM LANCASTER, Ohio, was told last March that he had non-Hodgkin's lymphoma, his wife Stephanie knew she had to get him to MD Anderson Cancer Center in Houston. Stephanie's father had been treated there 10 years earlier, and she and her family credited the doctors and nurses at MD Anderson with extending his life by at least eight years.

Because Stephanie and her husband had recently started their own small technology business, they were unable to buy comprehensive health insurance. For $469 a month, or about 20% of their income, they had been able to get only a policy that covered just $2,000 per day of any hospital costs. "We don't take that kind of discount insurance," said the woman at MD Anderson when Stephanie called to make an appointment for Sean.

Stephanie was then told by a billing clerk that the estimated cost of Sean's visit—just to be examined for six days so a treatment plan could be devised—would be $48,900, due in advance. Stephanie got her mother to write her a check. "You do anything you can in a situation like that," she says. The Recchis flew to Houston, leaving Stephanie's mother to care for their two teenage children.

About a week later, Stephanie had to ask her mother for $35,000 more so Sean could begin the treatment the doctors had decided was urgent. His condition had worsened rapidly since he had arrived in Houston. He was "sweating and shaking with chills and pains," Stephanie recalls. "He had a large mass in his chest that was ... growing. He was panicked."

Nonetheless, Sean was held for about 90 minutes in a reception area, she says, because the hospital could not confirm that the check had cleared. Sean was allowed to see the doctor only after he advanced MD Anderson $7,500 from his credit card. The hospital says there was nothing unusual about how Sean was kept waiting. According to MD Anderson communications manager Julie Penne, "Asking for advance payment for services is a common, if unfortunate, situation that confronts hospitals all over the United States."

The total cost, in advance, for Sean to get his treatment plan and initial doses of chemotherapy was $83,900.

Why?

The first of the 344 lines printed out across eight pages of his hospital bill—filled with indecipherable numerical codes and acronyms—seemed innocuous. But it set the tone for all that followed. It read, "1 ACETAMINOPHE TABS 325 MG." The charge was only $1.50, but it was for a generic version of a Tylenol pill. You can buy 100 of them on Amazon for $1.49 even without a hospital's purchasing power.

Dozens of midpriced items were embedded with similarly aggressive markups, like $283.00 for a "CHEST, PA AND LAT 71020." That's a simple chest X-ray, for which MD Anderson is routinely paid $20.44 when it treats a patient on Medicare, the government health care program for the elderly.

Every time a nurse drew blood, a "ROUTINE VENIPUNCTURE" charge of $36.00 appeared, accompanied by charges of $23 to $78 for each of a dozen or more lab analyses performed on the blood sample. In all, the charges for blood and other lab tests done on Recchi amounted to more than $15,000. Had Recchi been old enough for Medicare, MD Anderson would have been paid a few hundred dollars for all those tests. By law, Medicare's payments approximate a hospital's cost of providing a service, including overhead, equipment and salaries.

On the second page of the bill, the markups got bolder. Recchi was charged $13,702 for "1 RITUXIMAB INJ 660 MG." That's an injection of 660 mg of a cancer wonder drug called Rituxan. The average price paid by all hospitals for this dose is about $4,000, but MD Anderson probably gets a volume discount that would make its cost $3,000 to $3,500. That means the nonprofit cancer center's paid-in-advance markup on Recchi's lifesaving shot would be about 400%.

When I asked MD Anderson to comment on the charges on Recchi's bill, the cancer center released a written statement that said in part, "The issues related to health care finance are complex for patients, health care providers, payers and government entities alike ... MD Anderson's clinical billing and collection practices are similar to those of other major hospitals and academic medical centers."

The hospital's hard-nosed approach pays off. Although it is officially a nonprofit unit of the University of Texas, MD Anderson has revenue that exceeds the cost of the world-class care it provides by so much that its operating profit for the fiscal year 2010, the most recent annual report it filed with the U.S. Department of Health and Human Services, was $531 million. That's a profit margin of 26% on revenue of $2.05 billion, an astounding result for such a service-intensive enterprise.[1]

THE PRESIDENT OF MD ANDERSON IS PAID LIKE SOMEONE running a prosperous business. Ronald DePinho's total compensation last year was $1,845,000. That does not count outside earnings derived from a much publicized waiver he

1. Here and elsewhere I define *operating profit* as the hospital's excess of revenue over expenses, plus the amount it lists on its tax return for depreciation of assets—because depreciation is an accounting expense, not a cash expense. John Gunn, chief operating officer of Memorial Sloan-Kettering Cancer Center, calls this the "fairest way" of judging a hospital's financial performance

Sean Recchi

Diagnosed with non-Hodgkin's lymphoma at age 42. **Total cost, in advance, for Sean's treatment plan and initial doses of chemotherapy: $83,900.** Charges for blood and lab tests amounted to more than $15,000; with Medicare, they would have cost a few hundred dollars

received from the university that, according to the Houston *Chronicle*, allows him to maintain unspecified "financial ties with his three principal pharmaceutical companies."

DePinho's salary is nearly triple the $674,350 paid to William Powers Jr., the president of the entire University of Texas system, of which MD Anderson is a part. This pay structure is emblematic of American medical economics and is reflected on campuses across the U.S., where the president of a hospital or hospital system associated with a university—whether it's Texas, Stanford, Duke or Yale—is invariably paid much more than the person in charge of the university.

I got the idea for this article when I was visiting Rice University last year. As I was leaving the campus, which is just outside the central business district of Houston, I noticed a group of glass skyscrapers about a mile away lighting up the evening sky. The scene looked like Dubai. I was looking at the Texas Medical Center, a nearly 1,300-acre, 280-building complex of hospitals and related medical facilities, of which MD Anderson is the lead brand name. Medicine had obviously become a huge business. In fact, of Houston's top 10 employers, five are hospitals, including MD Anderson with 19,000 employees; three, led by ExxonMobil with 14,000 employees, are energy companies. How did that happen, I wondered. Where's all that money coming from? And where is it going? I have spent the past seven months trying to find out by analyzing a variety of bills from hospitals like MD Anderson, doctors, drug companies and every other player in the American health care ecosystem.

WHEN YOU LOOK BEHIND THE BILLS THAT SEAN RECCHI AND other patients receive, you see nothing rational—no rhyme or reason—about the costs they faced in a marketplace they enter through no choice of their own. The only constant is the sticker shock for the patients who are asked to pay.

Yet those who work in the health care industry and those who argue over health care policy seem inured to the shock. When we debate health care policy, we seem to jump right to the issue of who should pay the bills, blowing past what should be the first question: Why exactly are the bills so high?

What are the reasons, good or bad, that cancer means a half-million- or million-dollar tab? Why should a trip to the emergency room for chest pains that turn out to be indigestion bring a bill that can exceed the cost of a semester of college? What makes a single dose of even the most wonderful wonder drug cost thousands of dollars? Why does simple lab work done during a few days in a hospital cost more than a car? And what is so different about the medical ecosystem that causes technology advances to drive bills up instead of down?

Recchi's bill and six others examined line by line for this article offer a closeup window into what happens when powerless buyers—whether they are people like Recchi or big health-insurance companies—meet sellers in what is the ultimate seller's market.

The result is a uniquely American gold rush for those who provide everything from wonder drugs to canes to high-tech implants to CT scans to hospital bill-coding and collection services. In hundreds of small and midsize cities across the country—from Stamford, Conn., to Marlton, N.J., to Oklahoma City—the American health care market has transformed tax-exempt "nonprofit" hospitals into the towns' most profitable businesses and largest employers, often presided over by the regions' most richly compensated executives. And in our largest cities, the system offers lavish paychecks even to midlevel hospital managers, like the 14 administrators at New York City's Memorial Sloan-Kettering Cancer Center who are paid over $500,000 a year, including six who make over $1 million.

For every member of Congress, there are more than seven lobbyists working for various parts of the health care industry

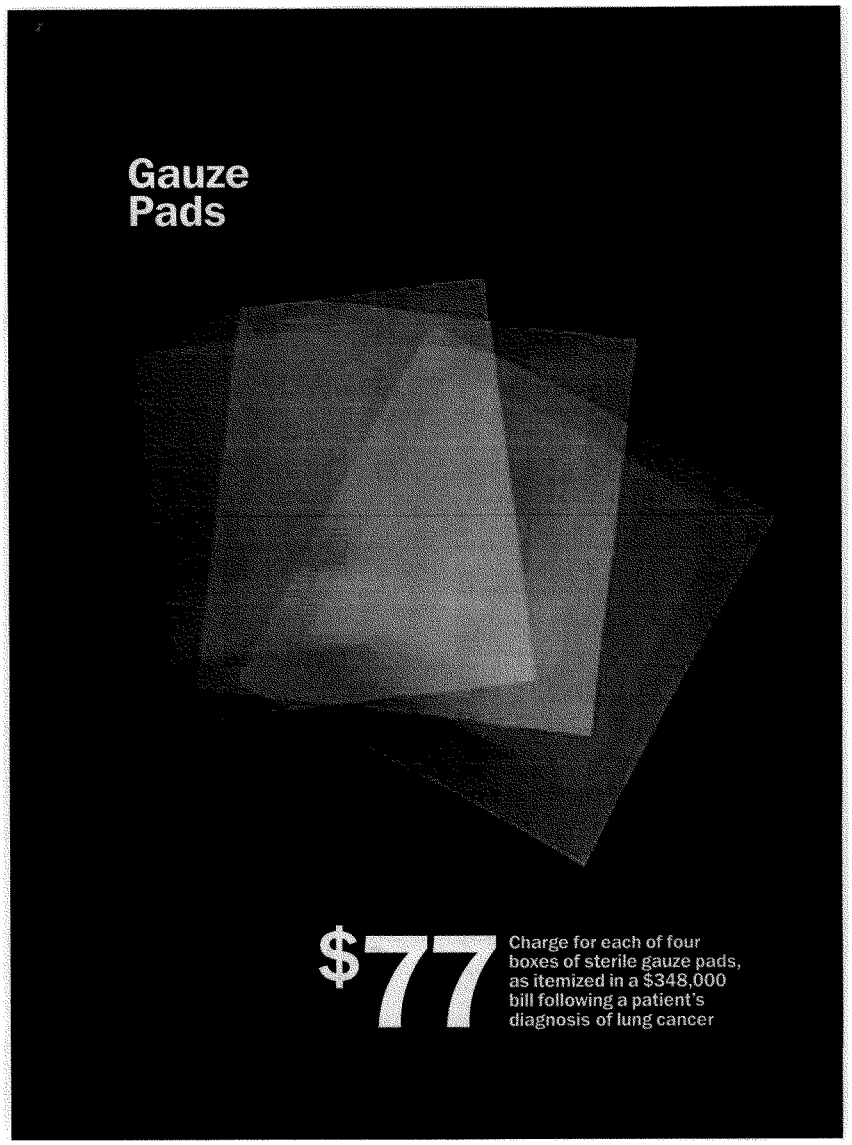
Taken as a whole, these powerful institutions and the bills they churn out dominate the nation's economy and put demands on taxpayers to a degree unequaled anywhere else on earth. In the U.S., people spend almost 20% of the gross domestic product on health care, compared with about half that in most developed countries. Yet in every measurable way, the results our health care system produces are no better and often worse than the outcomes in those countries.

According to one of a series of exhaustive studies done by the McKinsey & Co. consulting firm, we spend more on health care than the next 10 biggest spenders combined: Japan, Germany, France, China, the U.K., Italy, Canada, Brazil, Spain and Australia. We may be shocked at the $60 billion price tag for cleaning up after Hurricane Sandy. We spent almost that much last week on health care. We spend more every year on artificial knees and hips than what Hollywood collects at the box office. We spend two or three times that much on durable medical devices like canes and wheelchairs, in part because a heavily lobbied Congress forces Medicare to pay 25% to 75% more for this equipment than it would cost at Walmart.

The Bureau of Labor Statistics projects that 10 of the 20 occupations that will grow the fastest in the U.S. by 2020 are related to health care. America's largest city may be commonly thought of as the world's financial-services capital, but of New York's 18 largest private employers, eight are hospitals and four are banks. Employing all those people in the cause of curing the sick is, of course, not anything to be ashamed of. But the drag on our overall economy that comes with taxpayers, employers and consumers spending so much more than is spent in any other country for the same product is unsustainable. Health care is eating away at our economy and our treasury.

The health care industry seems to have the will and the means to keep it that way. According to the Center for Responsive Politics, the pharmaceutical and health-care-product industries, combined with organizations representing doctors, hospitals, nursing homes, health services and HMOs, have spent $5.36 billion since 1998 on lobbying in Washington. That dwarfs the $1.53 billion spent by the defense and aerospace industries and the $1.3 billion spent by oil and gas interests over the same period. That's right: the health-care-industrial complex spends more than three times what the military-industrial complex spends in Washington.

WHEN YOU CRUNCH DATA COMPILED BY MCKINSEY AND OTHER researchers, the big picture looks like this: We're likely to spend $2.8 trillion this year on health care. That $2.8 trillion is likely to be $750 billion, or 27%, more than we would spend if we spent the same per capita as other developed countries, even after adjusting for the relatively high per capita income in the U.S. vs. those other countries. Of the total $2.8 trillion that will be spent on health care, about $800 billion will be paid by the federal government through the Medicare insurance program for the disabled and those 65 and older


Gauze
Pads
$77
Charge for each of four boxes of sterile gauze pads, as itemized in a $348,000 bill following a patient's diagnosis of lung cancer

and the Medicaid program, which provides care for the poor. That $800 billion, which keeps rising far faster than inflation and the gross domestic product, is what's driving the federal deficit. The other $2 trillion will be paid mostly by private health-insurance companies and individuals who have no insurance or who will pay some portion of the bills covered by their insurance. This is what's increasingly burdening businesses that pay for their employees' health insurance and forcing individuals to pay so much in out-of-pocket expenses.

Breaking these trillions down into real bills going to real patients cuts through the ideological debate over health care policy. By dissecting the bills that people like Sean Recchi face, we can see exactly how and why we are overspending, where the money is going and how to get it back. We just have to follow the money.

The $21,000 Heartburn Bill

ONE NIGHT LAST SUMMER AT HER HOME NEAR STAMFORD, Conn., a 64-year-old former sales clerk whom I'll call Janice S. felt chest pains. She was taken four miles by ambulance to the emergency room at Stamford Hospital, officially a nonprofit institution. After about three hours of tests and some brief encounters with a doctor, she was told she had indigestion and sent home. That was the good news.

The bad news was the bill: $995 for the ambulance ride, $3,000 for the doctors and $17,000 for the hospital—in sum, $21,000 for a false alarm.

Out of work for a year, Janice S. had no insurance. Among the hospital's charges were three "TROPONIN I" tests for $199.50 each. According to a National Institutes of Health website, a troponin test "measures the levels of certain proteins in the blood" whose release from the heart is a strong indicator of a heart attack. Some labs like to have the test done at intervals, so the fact that Janice S. got three of them is not necessarily an issue. The price is the problem.

Stamford Hospital spokesman Scott Orstad told me that the $199.50 figure for the troponin test was taken from what he called the hospital's chargemaster. The chargemaster, I learned, is every hospital's internal price list. Decades ago it was a document the size of a phone book; now it's a massive computer file, thousands of items long, maintained by every hospital.

Stamford Hospital's chargemaster assigns prices to everything, including Janice S.'s blood tests. It would seem to be an important document. However, I quickly found that although every hospital has a chargemaster, officials treat it as if it were an eccentric uncle living in the attic. Whenever I asked, they deflected all conversation away from it. They even argued that it is irrelevant. I soon found that they have good reason to hope that outsiders pay no attention to the chargemaster or the process that produces it. For there seems to be no process, no rationale, behind the core document that is the basis for hundreds of billions of dollars in health care bills.

Because she was 64, not 65, Janice S. was not on Medicare. But seeing what Medicare would have paid Stamford Hospital for the troponin test if she had been a year older shines a bright light on the role the chargemaster plays in our national medical crisis—and helps us understand the illegitimacy of that $199.50 charge. That's because Medicare collects troves of data on what every type of treatment, test and other service costs hospitals to deliver. Medicare takes seriously the notion that nonprofit hospitals should be paid for all their costs but actually be nonprofit after their calculation. Thus, under the law, Medicare is supposed to reimburse hospitals for any given service, factoring in not only direct costs but also allocated expenses such as overhead, capital expenses, executive salaries, insurance, differences in regional costs of living and even the education of medical students.

It turns out that Medicare would have paid Stamford $13.94 for each troponin test rather than the $199.50 Janice S. was charged.

Janice S. was also charged $157.61 for a CBC—the complete blood count that those of us who are *ER* aficionados remember George Clooney ordering several times a night. Medicare pays $11.02 for a CBC in Connecticut. Hospital finance people argue vehemently that Medicare doesn't pay enough and that they lose as much as 10% on an average Medicare patient. But even if the Medicare price should be, say, 10% higher, it's a long way from $11.02 plus 10% to $157.61.

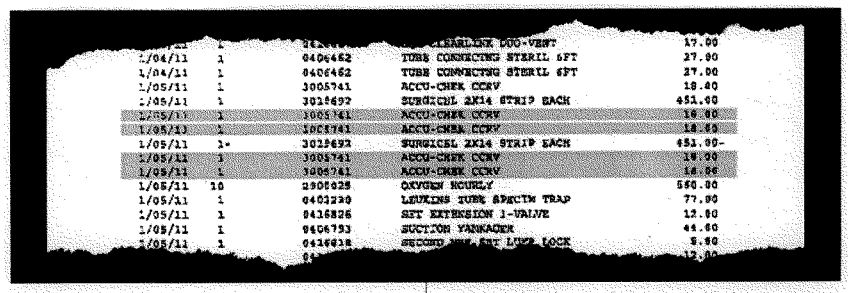
Yes, every hospital administrator grouses about Medicare's payment rates—rates that are supervised by a Congress that is heavily lobbied by the American Hospital Association, which spent $1,859,041 on lobbyists in 2012. But an annual expense report that Stamford Hospital is required to file with the federal Department of Health and Human Services offers evidence that Medicare's rates for the services Janice S. received are on the mark. According to the hospital's latest filing (covering 2010), its total expenses for laboratory work (like Janice S.'s blood tests) in the 12 months covered by the report were $27.5 million. Its total charges were $293.2 million. That means it charged about 11 times its costs.

As we examine other bills, we'll see that like Medicare patients, the large portion of hospital patients who have private health insurance also get discounts off the listed chargemaster figures, assuming the hospital and insurance company have negotiated to include the hospital in the insurer's network of providers that its customers can use. The insurance discounts are not nearly as steep as the Medicare markdowns, which means that even the discounted insurance-company rates fuel profits at these officially nonprofit hospitals. Those profits are further boosted by payments from the tens of millions of patients who, like the unemployed Janice S., have no insurance or whose insurance does not apply because the patient has exceeded the coverage limits. These patients are asked to pay the chargemaster list prices.

If you are confused by the notion that those least able to pay are the ones singled out to pay the highest rates, welcome to the American medical marketplace.

Pay No Attention To the Chargemaster

NO HOSPITAL'S CHARGEMASTER PRICES ARE CONSISTENT with those of any other hospital, nor do they seem to be based on anything objective—like cost—that any hospital executive I spoke with was able to explain. "They were set in cement a long time ago and just keep going up almost automatically,"



			[illegible] DOC-VENT	17.00
1/04/11	1	0406462	TUBE CONNECTING STERIL 6FT	27.00
1/04/11	1	0406462	TUBE CONNECTING STERIL 6FT	27.00
1/05/11	1	3005741	ACCU-CHEK CCRV	18.40
1/05/11	1	3012697	SURGICEL 2X14 STRIP EACH	451.00
1/05/11	1	3005741	ACCU-CHEK CCRV	18.40
1/05/11	1	3005741	ACCU-CHEK CCRV	18.40
1/05/11	1*	3012697	SURGICEL 2X14 STRIP EACH	451.00-
1/05/11	1	3005741	ACCU-CHEK CCRV	18.40
1/05/11	1	3005741	ACCU-CHEK CCRV	18.40
1/05/11	10	2900028	OXYGEN HOURLY	560.00
1/05/11	1	0401230	LEVKINS TUBE &PECIM TRAP	77.00
1/05/11	1	0416826	SET EXTENSION 1-VALVE	12.80
1/05/11	1	0406793	SUCTION YANKAUER	44.60
1/05/11	1	0416028	SECOND [illegible] LOCK LOCK	5.80
	8*			12.00

says one hospital chief financial officer with a shrug.

At Stamford Hospital I got the first of many brush-offs when I asked about the chargemaster rates on Janice S.'s bill. "Those are not our real rates," protested hospital spokesman Orstad when I asked him to make hospital CEO Brian Grissler available to explain Janice S.'s bill, in particular the blood-test charges. "It's a list we use internally in certain cases, but most people never pay those prices. I doubt that Brian [Grissler] has even seen the list in years. So I'm not sure why you care."

Orstad also refused to comment on any of the specifics in Janice S.'s bill, including the seemingly inflated charges for all the lab work. "I've told you I don't think a bill like this is relevant," he explained. "Very few people actually pay those rates."

But Janice S. was asked to pay them. Moreover, the chargemaster rates are relevant, even for those unlike her who have insurance. Insurers with the most leverage, because they have the most customers to offer a hospital that needs patients, will try to negotiate prices 30% to 50% above the Medicare rates rather than discounts off the sky-high chargemaster rates. But insurers are increasingly losing leverage because hospitals are consolidating by buying doctors' practices and even rival hospitals. In that situation—in which the insurer needs the hospital more than the hospital needs the insurer—the pricing negotiation will be over discounts that work down from the chargemaster prices rather than up from what Medicare would pay. Getting a 50% or even 60% discount off the chargemaster price of an item that costs $13 and lists for $199.50 is still no bargain. "We hate to negotiate off of the chargemaster, but we have to do it a lot now," says Edward Wardell, a lawyer for the giant health-insurance provider Aetna Inc.

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

The expensive technology deployed on Janice S. was a bigger factor in her bill than the lab tests. An "NM MYO REST/SPEC EJCT MOT MUL" was billed at $7,997.54. That's a stress test using a radioactive dye that is tracked by an X-ray computed tomography, or CT, scan. Medicare would have paid Stamford $554 for that test.

JANICE S. WAS CHARGED AN ADDITIONAL $872.44 JUST FOR the dye used in the test. The regular stress test patients are more familiar with, in which arteries are monitored electronically with an electrocardiograph, would have cost far less—$1,200 even at the hospital's chargemaster price. (Medicare would have paid $96 for it.) And although many doctors view the version using the CT scan as more thorough, others consider it unnecessary in most cases.

Test Strips PATIENT WAS CHARGED $18 EACH FOR ACCU-CHEK DIABETES TEST STRIPS. AMAZON SELLS BOXES OF 50 FOR ABOUT $27, OR 55¢ EACH

According to Jack Lewin, a cardiologist and former CEO of the American College of Cardiology, "It depends on the patient, of course, but in most cases you would start with a standard stress test. We are doing too many of these nuclear tests. It is not being used appropriately ... Sometimes a cardiogram is enough, and you don't even need the simpler test. But it usually makes sense to give the patient the simpler one first and then use nuclear for a closer look if there seem to be problems."

We don't know the particulars of Janice S.'s condition, so we cannot know why the doctors who treated her ordered the more expensive test. But the incentives are clear. On the basis of market prices, Stamford probably paid about $250,000 for the CT equipment in its operating room. It costs little to operate, so the more it can be used and billed, the quicker the hospital recovers its costs and begins profiting from its purchase. In addition, the cardiologist in the emergency room gave Janice S. a separate bill for $600 to read the test results on top of the $342 he charged for examining her.

According to a McKinsey study of the medical marketplace, a typical piece of equipment will pay for itself in one year if it carries out just 10 to 15 procedures a day. That's a terrific return on capital equipment that has an expected life span of seven to 10 years. And it means that after a year, every scan ordered by a doctor in the Stamford Hospital emergency room would mean pure profit, less maintenance costs, for the hospital. Plus an extra fee for the doctor.

Another McKinsey report found that health care providers in the U.S. conduct far more CT tests per capita than those in any other country—71% more than in Germany, for example, where the government-run health care system offers none of those incentives for overtesting. We also pay a lot more for each test, even when it's Medicare doing the paying. Medicare reimburses hospitals and clinics an average of four times as much as Germany does for CT scans, according to the data gathered by McKinsey.

Medicare's reimbursement formulas for these tests are regulated by Congress. So too are restrictions on what Medicare can do to limit the use of CT and magnetic resonance imaging

(MRI) scans when they might not be medically necessary. Standing at the ready to make sure Congress keeps Medicare at bay is, among other groups, the American College of Radiology, which on Nov. 14 ran a full-page ad in the Capitol Hill–centric newspaper *Politico* urging Congress to pass the Diagnostic Imaging Services Access Protection Act. It's a bill that would block efforts by Medicare to discourage doctors from ordering multiple CT scans on the same patient by paying them less per test to read multiple tests of the same patient. (In fact, six of *Politico*'s 12 pages of ads that day were bought by medical interests urging Congress to spend or not cut back on one of their products.)

The costs associated with high-tech tests are likely to accelerate. McKinsey found that the more CT and MRI scanners are out there, the more doctors use them. In 1997 there were fewer than 3,000 machines available, and they completed an average of 3,800 scans per year. By 2006 there were more than 10,000 in use, and they completed an average of 6,100 per year.

According to a study in the *Annals of Emergency Medicine*, the use of CT scans in America's emergency rooms "has more than quadrupled in recent decades." As one former emergency-room doctor puts it, "Giving out CT scans like candy in the ER is the equivalent of putting a 90-year-old grandmother through a pat-down at the airport: Hey, you never know."

Selling this equipment to hospitals—which has become a key profit center for industrial conglomerates like General Electric and Siemens—is one of the U.S. economy's bright spots. I recently subscribed to an online headhunter's listings for medical-equipment salesmen and quickly found an opening in Connecticut that would pay a salary of $85,000 and sales commissions of up to $95,000 more, plus a car allowance. The only requirement was that applicants have "at least one year of experience selling some form of capital equipment."

In all, on the day I signed up for that jobs website, it carried 186 listings for medical-equipment salespeople just in Connecticut.

2

Medical Technology's Perverse Economics

UNLIKE THOSE OF ALMOST ANY OTHER AREA WE CAN THINK of, the dynamics of the medical marketplace seem to be such that the advance of technology has made medical care more expensive, not less. First, it appears to encourage more procedures and treatment by making them easier and more convenient. (This is especially true for procedures like arthroscopic surgery.) Second, there is little patient pushback against higher costs because it seems to (and often does) result in safer, better care and because the customer getting the treatment is either not going to pay for it or not going to know the price until after the fact.

Hurricane Sandy is costing $60 billion to clean up. We spend nearly that much on health care every week

Beyond the hospitals' and doctors' obvious economic incentives to use the equipment and the manufacturers' equally obvious incentives to sell it, there's a legal incentive at work. Giving Janice S. a nuclear-imaging test instead of the lower-tech, less expensive stress test was the safer thing to do—a belt-and-suspenders approach that would let the hospital and doctor say they pulled out all the stops in case Janice S. died of a heart attack after she was sent home.

"We use the CT scan because it's a great defense," says the CEO of another hospital not far from Stamford. "For example, if anyone has fallen or done anything around their head—hell, if they even say the word *head*—we do it to be safe. We can't be sued for doing too much."

His rationale speaks to the real cost issue associated with medical-malpractice litigation. It's not as much about the verdicts or settlements (or considerable malpractice-insurance premiums) that hospitals and doctors pay as it is about what they do to avoid being sued. And some no doubt claim they are ordering more tests to avoid being sued when it is actually an excuse for hiking profits. The most practical malpractice-reform proposals would not limit awards for victims but would allow doctors to use what's called a safe-harbor defense. Under safe harbor, a defendant doctor or hospital could argue that the care provided was within the bounds of what peers have established as reasonable under the circumstances. The typical plaintiff argument that doing something more, like a nuclear-imaging test, might have saved the patient would then be less likely to prevail.

When Obamacare was being debated, Republicans pushed this kind of commonsense malpractice-tort reform. But the stranglehold that plaintiffs' lawyers have traditionally had on Democrats prevailed, and neither a safe-harbor provision nor any other malpractice reform was included.

Nonprofit Profitmakers

TO THE EXTENT THAT THEY DEFEND THE CHARGEMASTER rates at all, the defense that hospital executives offer has to do with charity. As John Gunn, chief operating officer of Sloan-Kettering, puts it, "We charge those rates so that when we get paid by a [wealthy] uninsured person from overseas, it allows us to serve the poor."

A closer look at hospital finance suggests two holes in that argument. First, while Sloan-Kettering does have an aggressive financial-assistance program (something Stamford Hospital lacks), at most hospitals it's not a Saudi sheik but the *almost* poor—those who don't qualify for Medicaid and don't have insurance—who are most often asked to pay those exorbitant chargemaster prices. Second, there is the jaw-dropping difference between those list prices and the hospitals' costs, which enables these ostensibly nonprofit institutions to produce high profits even after all the discounts. True, when the discounts to Medicare and private insurers are applied, hospitals end up being paid a lot less overall than what is itemized on the original bills. Stamford ends up receiving about 35% of what it bills, which is the yield for most hospitals. (Sloan-Kettering and

MD Anderson, whose great brand names make them tough negotiators with insurance companies, get about 50%).

However, no matter how steep the discounts, the chargemaster prices are so high and so devoid of any calculation related to cost that the result is uniquely American: thousands of nonprofit institutions have morphed into high-profit, high-profile businesses that have the best of both worlds. They have become entities akin to low-risk, must-have public utilities that nonetheless pay their operators as if they were high-risk entrepreneurs. As with the local electric company, customers must have the product and can't go elsewhere to buy it. They are steered to a hospital by their insurance companies or doctors (whose practices may have a business alliance with the hospital or even be owned by it). Or they end up there because there isn't any local competition. But unlike with the electric company, no regulator caps hospital profits.

Yet hospitals are also beloved local charities.

The result is that in small towns and cities across the country, the local nonprofit hospital may be the community's strongest business, typically making tens of millions of dollars a year and paying its nondoctor administrators six or seven figures. As nonprofits, such hospitals solicit contributions, and their annual charity dinner, a showcase for their good works, is typically a major civic event. But charitable gifts are a minor part of their base; Stamford Hospital raised just over 1% of its revenue from contributions last year. Even after discounts, those $199.50 blood tests and multithousand-dollar CT scans are what really count.

Thus, according to the latest publicly available tax return it filed with the IRS, for the fiscal year ending September 2011, Stamford Hospital—in a midsize city serving an unusually high 50% share of highly discounted Medicare and Medicaid patients—managed an operating profit of $63 million on revenue actually received (after all the discounts off the chargemaster) of $495 million. That's a 12.7% operating profit margin, which would be the envy of shareholders of high-service businesses across other sectors of the economy.

Its nearly half-billion dollars in revenue also makes Stamford Hospital by far the city's largest business serving only local residents. In fact, the hospital's revenue exceeded all money paid to the city of Stamford in taxes and fees. The hospital is a bigger business than its host city.

There is nothing special about the hospital's fortunes. Its operating profit margin is about the same as the average for all nonprofit hospitals, 11.7%, even when those that lose money are included. And Stamford's 12.7% was tallied after the hospital paid a slew of high salaries to its management, including $744,000 to its chief financial officer and $1,860,000 to CEO Grissler.

In fact, when McKinsey, aided by a Bank of America survey, pulled together all hospital financial reports, it found that the 2,900 nonprofit hospitals across the country, which are exempt from income taxes, actually end up averaging higher operating profit margins than the 1,000 for-profit hospitals after the for-profits' income-tax obligations are deducted. In health care, being nonprofit produces more profit.

Nonetheless, hospitals like Stamford are able to use their sympathetic nonprofit status to push their interests. As the debate over deficit-cutting ideas related to health care has heated up, the American Hospital Association has run daily ads on Mike Allen's Playbook, a popular Washington tip sheet, urging that Congress not be allowed to cut hospital payments because that would endanger the "$39.3 billion" in care for the poor that hospitals now provide. But that $39.3 billion figure is calculated on the basis of chargemaster prices. Judging from the difference I saw in the bills examined between a typical chargemaster price and what Medicare says the item cost, this would mean that this $39.3 billion in charity care cost the hospitals less than $3 billion to provide. That's less than half of 1% of U.S. hospitals' annual revenue and includes bad debt that the hospitals did not give away willingly in any event.

Under Internal Revenue Service rules, nonprofits are not prohibited from taking in more money than they spend. They just can't distribute the overage to shareholders—because they don't have any shareholders.

So, what do these wealthy nonprofits do with all the profit? In a trend similar to what we've seen in nonprofit colleges and universities—where there has been an arms race of sorts to use rising tuition to construct buildings and add courses of study—the hospitals improve and expand facilities (despite the fact that the U.S. has more hospital beds than it can fill), buy more equipment, hire more people, offer more services, buy rival hospitals and then raise executive salaries because their operations have gotten so much larger. They keep the upward spiral going by marketing for more patients, raising prices and pushing harder to collect bill payments. Only with health care, the upward spiral is easier to sustain. Health care is seen as even more of a necessity than higher education. And unlike in higher education, in health care there is little price transparency—and far less competition in any given locale even if there were transparency. Besides, a hospital is typically one of the community's larger employers if not the largest, so there is unlikely to be much local complaining about its burgeoning economic fortunes.

In December, when the New York *Times* ran a story about how a deficit deal might threaten hospital payments, Steven Safyer, chief executive of Montefiore Medical Center, a large nonprofit hospital system in the Bronx, complained, "There is no such thing as a cut to a provider that isn't a cut to a beneficiary ... This is not crying wolf."

Actually, Safyer seems to be crying wolf to the tune of about $196.8 million, according to the hospital's latest publicly available tax return. That was his hospital's operating profit, according to its 2010 return. With $2.586 billion in revenue—of which 99.4% came from patient bills and 0.6% from fund-raising events and other charitable contributions—Safyer's business is more than six times as large as that of the Bronx's most famous enterprise, the New York Yankees. Surely, without cutting services to beneficiaries, Safyer could cut what have to be some of the Bronx's better non-Yankee salaries: his own, which was $4,065,000, or those of his chief financial officer ($3,243,000), his executive vice president ($2,220,000) or the head of his dental department ($1,798,000).

25% of Americans surveyed said they or a household member have skipped a recommended medical test or treatment because of the cost

SHOCKED BY HER BILL FROM STAMFORD HOSPITAL AND unable to pay it, Janice S. found a local woman on the Internet who is part of a growing cottage industry of people who call themselves medical-billing advocates. They help people read and understand their bills and try to reduce them. "The hospitals all know the bills are fiction, or at least only a place

to start the discussion, so you bargain with them," says Katalin Goencz, a former appeals coordinator in a hospital billing department who negotiated Janice S.'s bills from a home office in Stamford.

Goencz is part of a trade group called the Alliance of Claim Assistant Professionals, which has about 40 members across the country. Another group, Medical Billing Advocates of America, has about 50 members. Each advocate seems to handle 40 to 70 cases a year for the uninsured and those disputing insurance claims. That would be about 5,000 patients a year out of what must be tens of millions of Americans facing these issues—which may help explain why 60% of the personal bankruptcy filings each year are related to medical bills.

"I can pretty much always get it down 30% to 50% simply by saying the patient is ready to pay but will not pay $300 for a blood test or an X-ray," says Goencz. "They hand out blood tests and X-rays in hospitals like bottled water, and they know it."

After weeks of back-and-forth phone calls, for which Goencz charged Janice S. $97 an hour, Stamford Hospital cut its bill in half. Most of the doctors did about the same, reducing Janice S.'s overall tab from $21,000 to about $11,000.

But the best the ambulance company would offer Goencz was to let Janice S. pay off its $995 ride in $25-a-month installments. "The ambulances never negotiate the amount," says Goencz.

A manager at Stamford Emergency Medical Services, which charged Janice S. $958 for the pickup plus $9.38 per mile, says that "our rates are all set by the state on a regional basis" and that the company is independently owned. That's at odds with a trend toward consolidation that has seen several private-equity firms making investments in what Wall Street analysts have identified as an increasingly high-margin business. Overall, ambulance revenues were more than $12 billion last year, or about 10% higher than Hollywood's box-office take.

It's not a great deal to pay off $1,000 for a four-mile ambulance ride on the layaway plan or receive a 50% discount on a $199.50 blood test that should cost $15, nor is getting half off on a $7,997.54 stress test that was probably all profit and may not have been necessary. But, says Goencz, "I don't go over it line by line. I just go for a deal. The patient usually is shocked by the bill, doesn't understand any of the language and has bill collectors all over her by the time they call me. So they're grateful. Why give them heartache by telling them they still paid too much for some test or pill?"

A Slip, a Fall And a $9,400 Bill

THE BILLING ADVOCATES AREN'T ALWAYS SUCCESSFUL. JUST ask Emilia Gilbert, a school-bus driver who got into a fight with a hospital associated with Connecticut's most venerable nonprofit institution, which racked up quick profits on multiple CT scans, then refused to compromise at all on its chargemaster prices.

Gilbert, now 66, is still making weekly payments on the bill she got in June 2008 after she slipped and fell on her face one summer evening in the small yard behind her house in Fairfield, Conn. Her nose bleeding heavily, she was taken to the emergency room at Bridgeport Hospital.

In 2010, 45% of working adults in small firms had problems paying medical bills or accrued medical debt

Along with Greenwich Hospital and the Hospital of St. Raphael in New Haven, Bridgeport Hospital is now owned by the Yale New Haven Health System, which boasts a variety of gleaming new facilities. Although Yale University and Yale New Haven are separate entities, Yale–New Haven Hospital is the teaching hospital for the Yale Medical School, and university representatives, including Yale president Richard Levin, sit on the Yale New Haven Health System board.

"I was there for maybe six hours, until midnight," Gilbert recalls, "and most of it was spent waiting. I saw the resident for maybe 15 minutes, but I got a lot of tests."

In fact, Gilbert got three CT scans—of her head, her chest and her face. The last one showed a hairline fracture of her nose. The CT bills alone were $6,538. (Medicare would have paid about $825 for all three.) A doctor charged $261 to read the scans.

Gilbert got the same troponin blood test that Janice S. got—the one Medicare pays $13.94 for and for which Janice S. was billed $199.50 at Stamford. Gilbert got just one. Bridgeport Hospital charged 20% more than its downstate neighbor: $239.

Also on the bill were items that neither Medicare nor any insurance company would pay anything at all for: basic instruments and bandages and even the tubing for an IV setup. Under Medicare regulations and the terms of most insurance contracts, these are supposed to be part of the hospital's facility charge, which in this case was $908 for the emergency room.

Gilbert's total bill was $9,418.

"We think the chargemaster is totally fair," says William Gedge, senior vice president of payer relations at Yale New Haven Health System. "It's fair because everyone gets the same bill. Even Medicare gets exactly the same charges that this patient got. Of course, we will have different arrangements for how Medicare or an insurance company will not pay some of the charges or discount the charges, but everyone starts from the same place." Asked how the chargemaster charge for an item like the troponin test was calculated, Gedge said he "didn't know exactly" but would try to find out. He subsequently reported back that "it's an historical charge, which takes into account all of our costs for running the hospital."

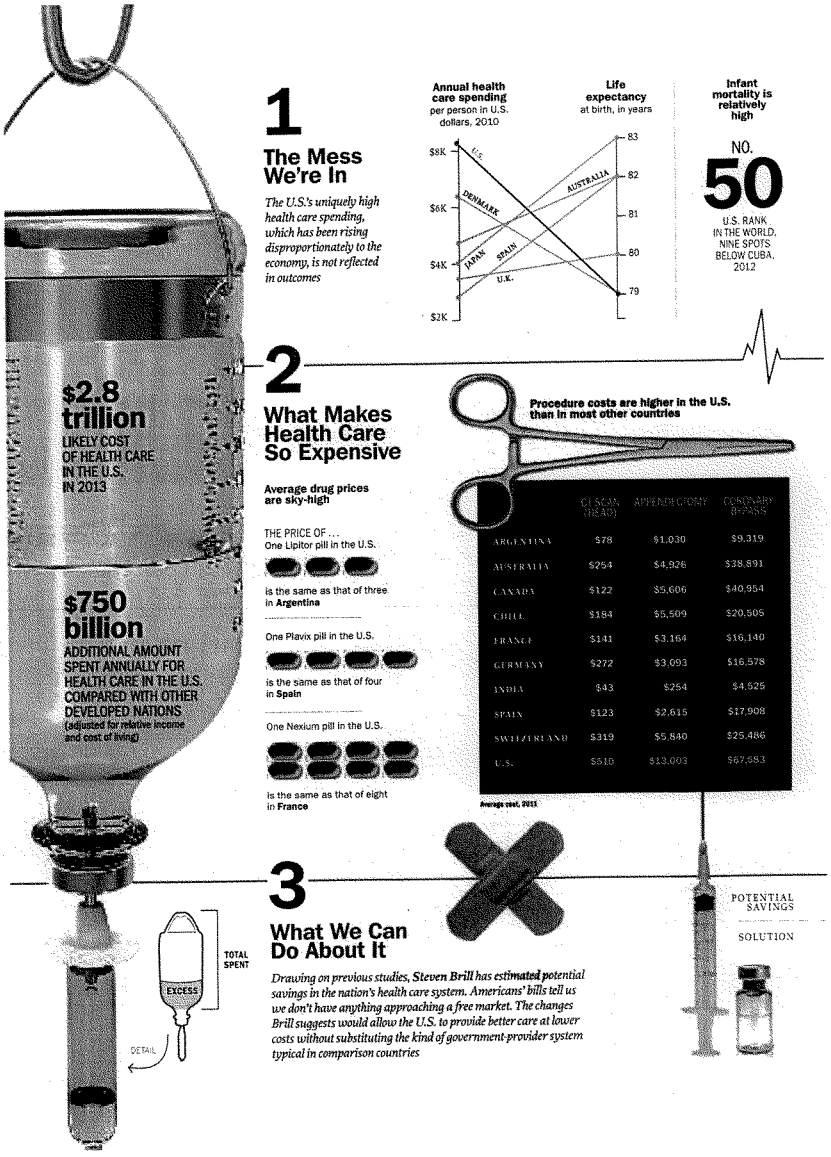
Bridgeport Hospital had $420 million in revenue and an operating profit of $52 million in 2010, the most recent year covered by its federal financial reports. CEO Robert Trefry, who has since left his post, was listed as having been paid $1.8 million. The CEO of the parent Yale New Haven Health System, Marna Borgstrom, was paid $2.5 million, which is 58% more than the $1.6 million paid to Levin, Yale University's president.

"You really can't compare the two jobs," says Yale–New Haven Hospital senior vice president Vincent Petrini. "Comparing hospitals to universities is like apples and oranges. Running a hospital organization is much more complicated." Actually, the four-hospital chain and the university have about the same operating budget. And it would seem that Levin deals with what most would consider complicated challenges in overseeing 3,900 faculty members, corralling (and complying with the terms of) hundreds of millions of dollars in government research grants and presiding over a $19 billion endowment, not to mention admitting and educating 14,000 students spread across Yale College and a

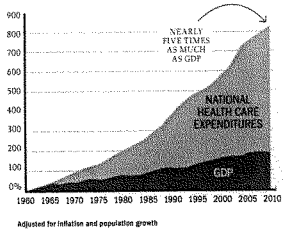
Photograph by Javier Sirvent for TIME

Emilia Gilbert

Slipped and fell in June 2008 and was taken to the emergency room. **She is still paying off the $9,418 bill from that hospital visit in weekly installments.** Her three CT scans cost $6,538. Medicare would have paid about $825 for all three


$2.8 trillion
LIKELY COST OF HEALTH CARE IN THE U.S. IN 2013
$750 billion
ADDITIONAL AMOUNT SPENT ANNUALLY FOR HEALTH CARE IN THE U.S. COMPARED WITH OTHER DEVELOPED NATIONS
(adjusted for relative income and cost of living)
TOTAL SPENT
EXCESS
DETAIL
1
The Mess We're In
The U.S.'s uniquely high health care spending, which has been rising disproportionately to the economy, is not reflected in outcomes
Annual health care spending
per person in U.S. dollars, 2010
$8K
$6K
$4K
$2K
U.S.
DENMARK
JAPAN
SPAIN
U.K.
AUSTRALIA
Life expectancy
at birth, in years
83
82
81
80
79
Infant mortality is relatively high
NO.
50
U.S. RANK IN THE WORLD, NINE SPOTS BELOW CUBA, 2012
2
What Makes Health Care So Expensive
Average drug prices are sky-high
THE PRICE OF ...
One Lipitor pill in the U.S.
is the same as that of three in Argentina
One Plavix pill in the U.S.
is the same as that of four in Spain
One Nexium pill in the U.S.
is the same as that of eight in France
Procedure costs are higher in the U.S. than in most other countries
CT SCAN (HEAD)
APPENDECTOMY
CORONARY BYPASS
ARGENTINA $78 $1,030 $9,319
AUSTRALIA $254 $4,926 $38,891
CANADA $122 $5,606 $40,954
CHILE $184 $5,509 $20,505
FRANCE $141 $3,164 $16,140
GERMANY $272 $3,093 $16,578
INDIA $43 $254 $4,525
SPAIN $123 $2,615 $17,908
SWITZERLAND $319 $5,840 $25,486
U.S. $510 $13,003 $67,983
Average cost, 2011
3
What We Can Do About It
Drawing on previous studies, Steven Brill has estimated potential savings in the nation's health care system. Americans' bills tell us we don't have anything approaching a free market. The changes Brill suggests would allow the U.S. to provide better care at lower costs without substituting the kind of government-provider system typical in comparison countries
POTENTIAL SAVINGS
SOLUTION

Health spending has maintained a steep climb
Percentage growth since 1960



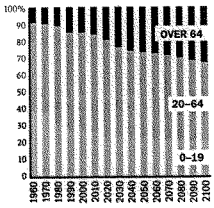
Adjusted for inflation and population growth

Health care is a major factor in personal finance

69%
of those who've experienced medically related bankruptcy were insured at the time of their filing

62%
of bankruptcies are related to illness or medical bills

The aging U.S. population will require more care



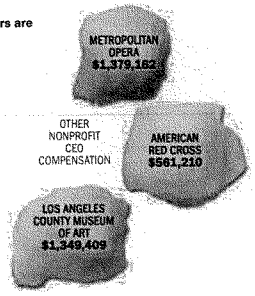
Percentage of total population

Nonprofit hospitals are making big bucks ...
Top 10 largest nonprofit hospitals*

HOSPITAL NAME	OPERATING PROFIT	CEO COMPENSATION
University of Pittsburgh Medical Center Presbyterian	$769,700,054	$5,975,462
Cleveland Clinic	$572,298,875	$2,564,214
Barnes-Jewish Hospital, St. Louis	$489,696,091	$2,335,882
New York–Presbyterian/Weill Cornell Medical Center	$383,477,548	$4,356,039
Indiana University Health Methodist Hospital, Indianapolis	$360,836,468	$2,080,779
Florida Hospital Orlando	$352,017,588	$2,925,356
Orlando Regional Medical Center	$250,843,745	$2,244,110
Montefiore Medical Center–Moses Division Hospital, Bronx, N.Y.	$196,868,926	$4,065,194
Methodist University Hospital, Memphis	$151,910,728	$2,180,962
Norton Hospital, Louisville, Ky.	$118,101,911	$2,206,401

*Hospital size by number of beds. Most recent available profits and salaries. Operating profit is defined as excess of revenue over expenses, plus the amount listed on tax returns for depreciation of assets. In some cases, salaries refer to those of the president or CEO of the parent health system

... and hospital leaders are receiving big pay



Includes all salaries, bonuses, deferred compensation and other payments, most recent available

The industry spends heavily on lobbying Congress
Total, 1998–2012

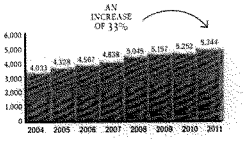
$5.36 billion

Lobbying by the pharmaceutical and health-care-products industries and organizations representing doctors, hospitals, nursing homes, health services and HMOs

$1.53 billion

Amount spent on lobbying by defense interests in the same period

More outpatient care allows for more procedures
Number of ambulatory surgery centers



$94 billion
Control prescription-drug prices, which make up 10% of U.S. health care costs. Studies show that drug prices in the U.S. are, on average, 50% higher than in other developed nations

$84 billion
Recapture 75% of profits from hospitals, whose expenses are about a third of health care costs, by taxing them and regulating their prices or ensuring real competition and transparency and the end of the chargemaster

$74 billion
Cut 5% from hospital and physician costs by reducing the overordering of tests and other procedures—sometimes used only to prevent medical-malpractice lawsuits

$50 billion
Spending on outpatient clinics and labs owned by doctors could be cut by a third by regulating fees or taxing profits

$30 billion
Use transparency, price controls and whatever else it takes—the Affordable Care Act included a 2.3% tax on medical devices—to bring the overall gross profit margins of medical-device makers like Medtronic down to 50%

$28 billion
Allow and fund comparative-effectiveness evaluations in decisions to prescribe drugs, tests and medical devices

Sources, these pages: World Bank; CIA World Factbook; McKinsey & Co.; American Journal of Medicine; U.S. Population Division; International Federation of Health Plans; Becker Hospital Review; IRS; Center for Responsive Politics; Centers for Medicare and Medicaid Services; Kaiser Family Foundation

Sources, other pages: Center for Responsive Politics; Kaiser Family Foundation; Commonwealth Fund; Journal of Family Practice; Employee Benefit Research Institute; McKinsey & Co.; ASP Research Institute

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PHOTOS: GETTY IMAGES

variety of graduate schools, professional schools and foreign-study outposts. And surely Levin's responsibilities are as complicated as those of the CEO of Yale New Haven Health's smallest unit—the 184-bed Greenwich Hospital, whose CEO was paid $112,000 more than Levin.

"WHEN I GOT THE BILL, I ALMOST HAD TO GO BACK TO THE hospital," Gilbert recalls. "I was hyperventilating." Contributing to her shock was the fact that although her employer supplied insurance from Cigna, one of the country's leading health insurers, Gilbert's policy was from a Cigna subsidiary called Starbridge that insures mostly low-wage earners. That made Gilbert one of millions of Americans like Sean Recchi who are routinely categorized as having health insurance but really don't have anything approaching meaningful coverage.

Starbridge covered Gilbert for just $2,500 per hospital visit, leaving her on the hook for about $7,000 of a $9,400 bill. Under Connecticut's rules (states set their own guidelines for Medicaid, the federal-state program for the poor), Gilbert's $1,800 a month in earnings was too high for her to qualify for Medicaid assistance. She was also turned down, she says, when she requested financial assistance from the hospital. Yale New Haven's Gedge insists that she never applied to the hospital for aid, and Gilbert could not supply me with copies of any applications.

In September 2009, after a series of fruitless letters and phone calls from its bill collectors to Gilbert, the hospital sued her. Gilbert found a medical-billing advocate, Beth Morgan, who analyzed the charges on the bill and compared them with the discounted rates insurance companies would pay. During two court-required mediation sessions, Bridgeport Hospital's attorney wouldn't budge; his client wanted the bill paid in full, Gilbert and Morgan recall. At the third and final mediation, Gilbert was offered a 20% discount off the chargemaster fees if she would pay immediately, but she says she responded that according to what Morgan told her about the bill, it was still too much to pay.

"We probably could have offered more," Gedge acknowledges. "But in these situations, our bill-collection attorneys only know the amount we are saying is owed, not whether it is a chargemaster amount or an amount that is already discounted."

On July 11, 2011, with the school-bus driver representing herself in Bridgeport superior court, a judge ruled that Gilbert had to pay all but about $500 of the original charges. (He deducted the superfluous bills for the basic equipment.) The judge put her on a payment schedule of $20 a week for six years. For her, the chargemaster prices were all too real.

The One-Day, $87,000 Outpatient Bill

GETTING A PATIENT IN AND OUT OF A HOSPITAL THE SAME day seems like a logical way to cut costs. Outpatients don't take up hospital rooms or require the expensive 24/7 observation and care that come with them. That's why in the 1990s Medicare pushed payment formulas on hospitals that paid them for whatever ailment they were treating (with more added for documented complications), not according to the number of days the patient spent in a bed. Insurance companies also pushed incentives on hospitals to move patients out faster or not admit them for overnight stays in the first place. Meanwhile, the introduction of procedures like noninvasive laparoscopic surgery helped speed the shift from inpatient to outpatient.

23% of patients surveyed reported missing doses of medication because of difficulties related to insurance

By 2010, average days spent in the hospital per patient had declined significantly, while outpatient services had increased even more dramatically. However, the result was not the savings that reformers had envisioned. It was just the opposite.

Experts estimate that outpatient services are now packed with so much hidden profit that about two-thirds of the $750 billion annual U.S. overspending identified by the McKinsey research on health care comes in payments for outpatient services. That includes work done by physicians, laboratories and clinics (including diagnostic clinics for CT scans or blood tests) and same-day surgeries and other hospital treatments like cancer chemotherapy. According to a McKinsey survey, outpatient emergency-room care averages an operating profit margin of 15% and nonemergency outpatient care averages 35%. On the other hand, inpatient care has a margin of just 2%. Put simply, inpatient care at nonprofit hospitals is, in fact, almost nonprofit. Outpatient care is wildly profitable.

"An operating room has fixed costs," explains one hospital economist. "You get 10% or 20% more patients in there every day who you don't have to board overnight, and that goes straight to the bottom line."

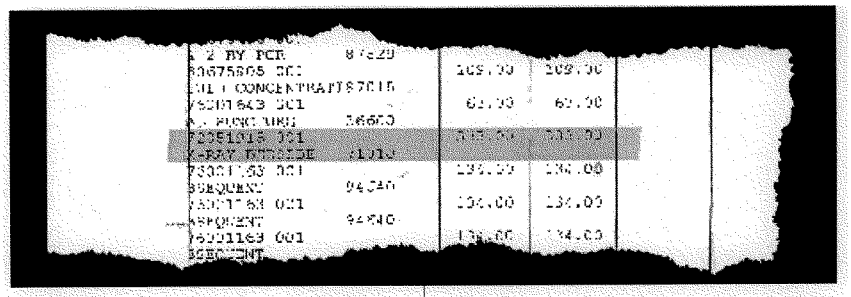
The 2011 outpatient visit of someone I'll call Steve H. to Mercy Hospital in Oklahoma City illustrates those economics. Steve H. had the kind of relatively routine care that patients might expect would be no big deal: he spent the day at Mercy getting his aching back fixed.

A blue collar worker who was in his 30s at the time and worked at a local retail store, Steve H. had consulted a specialist at Mercy in the summer of 2011 and was told that a stimulator would have to be surgically implanted in his back. The good news was that with all the advances of modern technology, the whole process could be done in a day. (The latest federal filing shows that 63% of surgeries at Mercy were performed on outpatients.)

Steve H.'s doctor intended to use a RestoreUltra neurostimulator manufactured by Medtronic, a Minneapolis-based company with $16 billion in annual sales that bills itself as the world's largest stand-alone medical-technology company. "RestoreUltra delivers spinal-cord stimulation through one or more leads selected from a broad portfolio for greater customization of therapy," Medtronic's website promises.

I was not able to interview Steve H., but according to Pat Palmer, a medical-billing specialist based in Salem, Va., who consults for the union that provides Steve H.'s health insurance, Steve H. didn't ask how much the stimulator would cost because he had $45,181 remaining on the $60,000 annual payout limit his union-sponsored health-insurance plan imposed. "He figured, How much could a day at Mercy cost?" Palmer says. "Five thousand? Maybe 10?"

Steve H. was about to run up against a seemingly irrelevant footnote in millions of Americans' insurance policies: the limit, sometimes annual or sometimes over a lifetime, on what the insurer has to pay out for a patient's claims.



Chest X-Ray PATIENT WAS CHARGED $333. THE NATIONAL RATE PAID BY MEDICARE IS $23.83

Under Obamacare, those limits will not be allowed in most health-insurance policies after 2013. That might help people like Steve H. but is also one of the reasons premiums are going to skyrocket under Obamacare.

Steve H.'s bill for his day at Mercy contained all the usual and customary overcharges. One item was "MARKER SKIN REG TIP RULER" for $3. That's the marking pen, presumably reusable, that marked the place on Steve H.'s back where the incision was to go. Six lines down, there was "STRAP OR TABLE 8X27 IN" for $31. That's the strap used to hold Steve H. onto the operating table. Just below that was "BLNKT WARM UPPER BDY 42268" for $32. That's a blanket used to keep surgery patients warm. It is, of course, reusable, and it's available new on eBay for $13. Four lines down there's "GOWN SURG ULTRA XLG 95121" for $39, which is the gown the surgeon wore. Thirty of them can be bought online for $180. Neither Medicare nor any large insurance company would pay a hospital separately for those straps or the surgeon's gown; that's all supposed to come with the facility fee paid to the hospital, which in this case was $6,289.

In all, Steve H.'s bill for these basic medical and surgical supplies was $7,882. On top of that was $1,837 under a category called "Pharmacy General Classification" for items like bacitracin ($108). But that was the least of Steve H.'s problems.

The big-ticket item for Steve H.'s day at Mercy was the Medtronic stimulator, and that's where most of Mercy's profit was collected during his brief visit. The bill for that was $49,237.

According to the chief financial officer of another hospital, the wholesale list price of the Medtronic stimulator is "about $19,000." Because Mercy is part of a major hospital chain, it might pay 5% to 15% less than that. Even assuming Mercy paid $19,000, it would make more than $30,000 selling it to Steve H., a profit margin of more than 150%. To the extent that I found any consistency among hospital chargemaster practices, this is one of them: hospitals routinely seem to charge 2½ times what these expensive implantable devices cost them, which produces that 150% profit margin.

As Steve H. found out when he got his bill, he had exceeded the $45,000 that was left on his insurance policy's annual payout limit just with the neurostimulator. And his total bill was $86,951. After his insurance paid that first $45,000, he still owed more than $40,000, not counting doctors' bills. (I did not see Steve H.'s doctors' bills.)

Mercy Hospital is owned by an organization under the umbrella of the Catholic Church called Sisters of Mercy. Its mission, as described in its latest filing with the IRS as a tax-exempt charity, is "to carry out the healing ministry of Jesus by promoting health and wellness." With a chain of 31 hospitals and 300 clinics across the Midwest, Sisters of Mercy uses a bill-collection firm based in Topeka, Kans., called Berlin-Wheeler Inc. Suits against Mercy patients are on file in courts across Oklahoma listing Berlin-Wheeler as the plaintiff.

According to its most recent tax return, the Oklahoma City unit of the Sisters of Mercy hospital chain collected $337 million in revenue for the fiscal year ending June 30, 2011. It had an operating profit of $34 million. And that was after paying 10 executives more than $300,000 each, including $784,000 to a regional president and $438,000 to the hospital president.

That report doesn't cover the executives overseeing the chain, called Mercy Health, of which Mercy in Oklahoma City is a part. The overall chain had $4.28 billion in revenue that year. Its hospital in Springfield, Mo. (pop. 160,660), had $880.7 million in revenue and an operating profit of $319 million, according to its federal filing. The incomes of the parent company's executives appear on other IRS filings covering various interlocking Mercy nonprofit corporate entities. Mercy president and CEO Lynn Britton made $1,930,000, and an executive vice president, Myra Aubuchon, was paid $3.7 million, according to the Mercy filing. In all, seven Mercy Health executives were paid more than $1 million each.

A note at the end of an Ernst & Young audit that is attached to Mercy's IRS filing reported that the chain provided charity care worth 3.2% of its revenue in the previous year. However, the auditors state that the value of that care is based on the charges on all the bills, not the actual cost to Mercy of providing those services—in other words, the chargemaster value. Assuming that Mercy's actual costs are a tenth of these chargemaster values—they're probably less—all of this charity care actually cost Mercy about three-tenths of 1% of its revenue, or about $13 million out of $4.28 billion.

Mercy's website lists an 18-member media team; one member, Rachel Wright, told me that neither CEO Britton nor anyone else would be available to answer questions about compensation, the hospital's bill-collecting activities through Berlin-Wheeler or Steve H.'s bill, which I had sent her (with his name and the date of

his visit to the hospital redacted to protect his privacy).

Wright said the hospital's lawyers had decided that discussing Steve H.'s bill would violate the federal HIPAA law protecting the privacy of patient medical records. I pointed out that I wanted to ask questions only about the hospital's charges for standard items—such as surgical gowns, basic blood tests, blanket warmers and even medical devices—that had nothing to do with individual patients. "Everything is particular to an individual patient's needs," she replied. Even a surgical gown? "Yes, even a surgical gown. We cannot discuss this with you. It's against the law." She declined to put me in touch with the hospital's lawyers to discuss their legal analysis.

Hiding behind a privacy statute to avoid talking about how it prices surgeons' gowns may be a stretch, but Mercy might have a valid legal reason not to discuss what it paid for the Medtronic device before selling it to Steve H. for $49,237. Pharmaceutical and medical-device companies routinely insert clauses in their sales contracts prohibiting hospitals from sharing information about what they pay and the discounts they receive. In January 2012, a report by the federal Government Accountability Office found that "the lack of price transparency and the substantial variation in amounts hospitals pay for some IMD [implantable medical devices] raise questions about whether hospitals are achieving the best prices possible."

A lack of price transparency was not the only potential market inefficiency the GAO found. "Although physicians are not involved in price negotiations, they often express strong preferences for certain manufacturers and models of IMD," the GAO reported. "To the extent that physicians in the same hospitals have different preferences for IMDs, it may be difficult for the hospital to obtain volume discounts from particular manufacturers."

"Doctors have no incentive to buy one kind of hip or other implantable device as a group," explains Ezekiel Emanuel, an oncologist and a vice provost of the University of Pennsylvania who was a key White House adviser when Obamacare was created. "Even in the most innocent of circumstances, it kills the chance for market efficiencies."

The circumstances are not always innocent. In 2008, Gregory Demske, an assistant inspector general at the Department of Health and Human Services, told a Senate committee that "physicians routinely receive substantial compensation from medical-device companies through stock options, royalty agreements, consulting agreements, research grants and fellowships."

The assistant inspector general then revealed startling numbers about the extent of those payments: "We found that during the years 2002 through 2006, four manufacturers, which controlled almost 75% of the hip- and knee-replacement market, paid physician consultants over $800 million under the terms of roughly 6,500 consulting agreements."

Other doctors, Demske noted, had stretched the conflict of interest beyond consulting fees: "Additionally, physician ownership of medical-device manufacturers and related businesses appears to be a growing trend in the medical-device sector ... In some cases, physicians could receive substantial returns while contributing little to the venture beyond the ability to generate business for the venture."

In 2010, Medtronic, along with several other members of a medical-technology trade group, began to make the potential conflicts transparent by posting all payments to physicians on a section of its website called Physician Collaboration. The voluntary move came just before a similar disclosure regulation promulgated by the Obama Administration went into effect governing any doctor who receives funds from Medicare or the National Institutes of Health (which would include most doctors). And the nonprofit public-interest-journalism organization ProPublica has smartly organized data on doctor payments on its website (http://projects.propublica.org/docdollars). The conflicts have not been eliminated, but they are being aired, albeit on searchable websites rather than through a requirement that doctors disclose them to patients directly.

But conflicts that may encourage devices to be overprescribed or that lead doctors to prescribe a more expensive one instead of another are not the core problem in this marketplace. The more fundamental disconnect is that there is little reason to believe that what Mercy Hospital paid Medtronic for Steve H.'s device would have had any bearing on what the hospital decided to charge Steve H. Why would it? He did not know the price in advance.

Besides, studies delving into the economics of the medical marketplace consistently find that a moderately higher or lower price doesn't change consumer purchasing decisions much, if at all, because in health care there is little of the price sensitivity found in conventional marketplaces, even on the rare occasion that patients know the cost in advance. If you were in pain or in danger of dying, would you turn down treatment at a price 5% or 20% higher than the price you might have expected—that is, if you'd had any informed way to know what to expect in the first place, which you didn't?

The question of how sensitive patients will be to increased prices for medical devices recently came up in a different context. Aware of the huge profits being accumulated by devicemakers, Obama Administration officials decided to recapture some of the money by imposing a 2.39% federal excise tax on the sales of these devices as well as other medical technology such as CT-scan equipment. The rationale was that getting back some of these generous profits was a fair way to cover some of the cost of the subsidized, broader insurance coverage provided by Obamacare—insurance that in some cases will pay for more of the devices. The industry has since geared up in Washington and is pushing legislation that would repeal the tax. Its main argument is that a 2.39% increase in prices would so reduce sales that it would wipe out a substantial portion of what the industry claims are the 422,000 jobs it supports in a $136 billion industry.

That prediction of doom brought on by this small tax contradicts the reams of studies documenting consumer price insensitivity in the health care marketplace. It also ignores profit-margin data collected by McKinsey that demonstrates that devicemakers have an open field in the current medical ecosystem. A 2011 McKinsey survey for medical-industry clients reported that devicemakers are superstar performers in a booming medical economy. Medtronic, which performed in the middle of the group, delivered an amazing compounded annual return of 14.95% to shareholders from 1990 to 2010. That means $100 invested in the company in 1990 was worth $1,622 20 years later. So if the extra 2.39% would be so disruptive to the market for products like Medtronic's that it would kill sales, why would the industry

Photograph by Nick Veasey for TIME

$108
Charge for the common antibiotic ointment that appeared on a patient's bill under the hard-to-parse category "Pharmacy General Classification"
Bacitracin

pass it along as a price increase to consumers? It hardly has to, given its profit margins.

Medtronic spokeswoman Donna Marquad says that for competitive reasons, her company will not discuss sales figures or the profit on Steve H.'s neurostimulator. But Medtronic's October 2012 quarterly SEC filing reported that its spine "products and therapies," which presumably include Steve H.'s device, "continue to gain broad surgeon acceptance" and that its cost to make all of its products was 24.9% of what it sells them for.

That's an unusually high gross profit margin—75.1%—for a company that manufactures real physical products. Apple also produces high-end, high-tech products, and its gross margin is 40%. If the neurostimulator enjoys that company-wide profit margin, it would mean that if Medtronic was paid $19,000 by Mercy Hospital, Medtronic's cost was about $4,500 and it made a gross profit of about $14,500 before expenses for sales, overhead and management—including CEO Omar Ishrak's compensation, which was $25 million for the 2012 fiscal year.

Mercy's Bargain

WHEN PAT PALMER, THE MEDICAL-BILLING SPECIALIST WHO advises Steve H.'s union, was given the Mercy bill to deal with, she prepared a tally of about $4,000 worth of line items that she thought represented the most egregious charges, such as the surgical gown, the blanket warmer and the marking pen. She restricted her list to those she thought were plainly not allowable. "I didn't dispute nearly all of them," she says. "Because then they get their backs up."

The hospital quickly conceded those items. For the remaining $83,000, Palmer invoked a 40% discount off chargemaster rates that Mercy allows for smaller insurance providers like the union. That cut the bill to about $50,000, for which the insurance company owed 80%, or about $40,000. That left Steve H. with a $10,000 bill.

Sean Recchi wasn't as fortunate. His bill—which included not only the aggressively marked-up charge of $13,702 for the Rituxan cancer drug but also the usual array of chargemaster fees for basics like generic Tylenol, blood tests and simple supplies—had one item not found on any other bill I examined: MD Anderson's charge of $7 each for "ALCOHOL PREP PAD." This is a little square of cotton used to apply alcohol to an injection. A box of 200 can be bought online for $1.91.

We have seen that to the extent that most hospital administrators defend such chargemaster rates at all, they maintain that they are just starting points for a negotiation. But patients don't typically know they are in a negotiation when they enter the hospital, nor do hospitals let them know that. And in any case, at MD Anderson, the Recchis were made to pay every penny of the chargemaster bill up front because their insurance was deemed inadequate. That left Penne, the hospital spokeswoman, with only this defense for the most blatantly abusive charges for items like the alcohol squares: "It is difficult to compare a retail store charge for a common product with a cancer center that provides the item as part of its highly specialized and personalized care," she wrote in an e-mail. Yet the hospital also charges for that "specialized and personalized" care through, among other items, its $1,791-a-day room charge.

Before MD Anderson marked up Recchi's Rituxan to $13,702, the profit taking was equally aggressive, and equally routine, at the beginning of the supply chain—at the drug company. Rituxan is a prime product of Biogen Idec, a company with $5.5 billion in annual sales. Its CEO, George Scangos, was paid $11,331,441 in 2011, a 20% boost over his 2010 income. Rituxan is made and sold by Biogen Idec in partnership with Genentech, a South San Francisco–based biotechnology pioneer.

Genentech brags about Rituxan on its website, as did Roche, Genentech's $45 billion parent, in its latest annual report. And in an Investor Day presentation last September, Roche CEO Severin Schwann stressed that his company is able to keep prices and margins high because of its focus on "medically differentiated therapies." Rituxan, a cancer wonder drug, certainly meets that test.

A spokesman at Genentech for the Biogen Idec–Genentech partnership would not say what the drug cost the companies to make, but according to its latest annual report, Biogen Idec's cost of sales—the incremental expense of producing and shipping each of its products compared with what it sells them for—was only 10%. That's lower than the incremental cost of sales for most software companies, and the software companies usually don't produce anything physical or have to pay to ship anything.

This would mean that Sean Recchi's dose of Rituxan cost the Biogen Idec–Genentech partnership as little as $300 to make, test, package and ship to MD Anderson for $3,000 to $3,500, whereupon the hospital sold it to Recchi for $13,702.

As 2013 began, Recchi was being treated back in Ohio because he could not pay MD Anderson for more than his initial treatment. As for the $13,702-a-dose Rituxan, it turns out that Biogen Idec's partner Genentech has a charity-access program that Recchi's Ohio doctor told him about that enabled him to get those treatments free. "MD Anderson never said a word to us about the Genentech program," says Stephanie Recchi. "They just took our money up front."

Genentech spokeswoman Charlotte Arnold would not disclose how much free Rituxan had been dispensed to patients like Recchi in the past year, saying only that Genentech has "donated $2.85 billion in free medicine to uninsured patients in the U.S." since 1985. That seems like a lot until the numbers are broken down. Arnold says the $2.85 billion is based on what the drugmaker sells the product for, not what it costs Genentech to make. On the basis of Genentech's historic costs and revenue since 1985, that would make the cost of these donations less than 1% of Genentech's sales—not something likely to take the sizzle out of CEO Severin's Investor Day.

Nonetheless, the company provided more financial support than MD Anderson did to Recchi, whose wife reports that he "is doing great. He's in remission."

Penne of MD Anderson stressed that the hospital provides its own financial aid to patients but that the state legislature restricts the assistance to Texas residents. She also said MD Anderson "makes every attempt" to inform patients of drug-company charity programs and that 50 of the hospital's 24,000 inpatients and outpatients, one of whom was from outside Texas, received charitable aid for Rituxan treatments in 2012.

3

Catastrophic Illness—And the Bills to Match

WHEN MEDICAL CARE BECOMES A MATTER OF LIFE AND death, the money demanded by the health care ecosystem reaches a wholly different order of magnitude, churning out reams of bills to people who can't focus on them, let alone pay them.

Soon after he was diagnosed with lung cancer in January 2011, a patient whom I will call Steven D. and his wife Alice knew that they were only buying time. The crushing question was, How much is time really worth? As Alice, who makes about $40,000 a year running a child-care center in her home, explained, "[Steven] kept saying he wanted every last minute he could get, no matter what. But I had to be thinking about the cost and how all this debt would leave me and my daughter."

By the time Steven D. died at his home in Northern California the following November, he had lived for an additional 11 months. And Alice had collected bills totaling $902,452.

The family's first bill—for $348,000—which arrived when Steven got home from the Seton Medical Center in Daly City, Calif., was full of all the usual chargemaster profit grabs: $18 each for 88 diabetes-test strips that Amazon sells in boxes of 50 for $27.85; $24 each for 19 niacin pills that are sold in drugstores for about a nickel apiece. There were also four boxes of sterile gauze pads for $77 each. None of that was considered part of what was provided in return for Seton's facility charge for the intensive-care unit for two days at $13,225 a day, 12 days in the critical unit at $7,315 a day and one day in a standard room (all of which totaled $120,116 over 15 days). There was also $20,886 for CT scans and $24,251 for lab work.

CT Scans PATIENT WAS CHARGED $6,538 FOR THREE CT SCANS. MEDICARE WOULD HAVE PAID A TOTAL OF ABOUT $825 FOR ALL THREE

Alice responded to my question about the obvious overcharges on the bill for items like the diabetes-test strips or the gauze pads much as Mrs. Lincoln, according to the famous joke, might have had she been asked what she thought of the play. "Are you kidding?" she said. "I'm dealing with a husband who had just been told he has Stage IV cancer. That's all I can focus on ... You think I looked at the items on the bills? I just looked at the total."

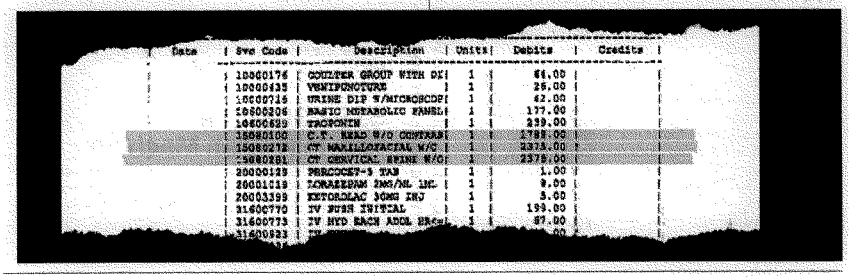
Steven and Alice didn't know that hospital billing people consider the chargemaster to be an opening bid. That's because no medical bill ever says, "Give us your best offer." The couple knew only that the bill said they had maxed out on the $50,000 payout limit on a UnitedHealthcare policy they had bought through a community college where Steven had briefly enrolled a year before. "We were in shock," Alice recalls. "We looked at the total and couldn't deal with it. So we just started putting all the bills in a box. We couldn't bear to look at them."

The $50,000 that UnitedHealthcare paid to Seton Medical Center was worth about $80,000 in credits because any charges covered by the insurer were subject to the discount it had negotiated with Seton. After that $80,000, Steven and Alice were on their own, not eligible for any more discounts.

Four months into her husband's illness, Alice by chance got the name of Patricia Stone, a billing advocate based in Menlo Park, Calif. Stone's typical clients are middle-class people having trouble with insurance claims. Stone felt so bad for Steven and Alice—she saw the blizzard of bills Alice was going to have to sort through—that, says Alice, she "gave us many of her hours," for which she usually charges $100, "for free."

Stone was soon able to persuade Seton to write off $297,000 of its $348,000 bill. Her argument was simple: There was no way the D.'s could pay it now or in the future, though they would scrape together $3,000 as a show of good faith. With the couple's $3,000 on top of the $50,000 paid by the UnitedHealthcare insurance, that $297,000 write-off amounted to an 85% discount.

According to its latest financial report, Seton applies so many discounts and write-offs to its chargemaster bills that it ends up with only about 18% of the revenue it bills for. That's an average 82% discount, compared with an average discount of about 65% that I saw at the



Date	Svc Code	Description	Units	Debits	Credits
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	10000435	VENIPUNCTURE	1	25.00	
	10000716	URINE DIP W/MICROSCOPE	1	42.00	
	10000206	BASIC METABOLIC PANEL	1	177.00	
	10000829	TROPONIN	1	239.00	
	15080100	C.T. HEAD W/O CONTRAS	1	1781.00	
	15080272	CT MAXILLOFACIAL W/C	1	2373.00	
	15080281	CT CERVICAL SPINE W/O	1	2378.00	
	20000129	PERCOCET-5 TAB	1	1.00	
	20001119	LORAZEPAM 2MG/ML INJ.	1	9.00	
	20003398	KETOROLAC 30MG INJ	1	3.00	
	31600770	IV PUSH INITIAL	1	193.00	
	31600773	IV HYD EACH ADDL HR	1	87.00	
	31600823	IV	1	.00	

other hospitals whose bills were examined—except for the MD Anderson and Sloan-Kettering cancer centers, which collect about 50% of their chargemaster charges.

Seton's discounting practices may explain why it is the only hospital whose bills I looked at that actually reported a small operating loss—$5 million—on its last financial report.

Of course, had the D.'s not come across Stone, the incomprehensible but terrifying bills would have piled up in a box, and the Seton Medical Center bill collectors would not have been kept at bay. Robert Issai, the CEO of the Daughters of Charity Health System, which owns and runs Seton, refused through an e-mail from a public relations assistant to respond to requests for a comment on any aspect of his hospital's billing or collections policies. Nor would he respond to repeated requests for a specific comment on the $24 charge for niacin pills, the $18 charge for the diabetes-test strips or the $77 charge for gauze pads. He also declined to respond when asked, via a follow-up e-mail, if the hospital thinks that sending patients who have just been told they are terminally ill bills that reflect chargemaster rates that the hospital doesn't actually expect to be paid might unduly upset them during a particularly sensitive time.

To begin to deal with all the other bills that kept coming after Steven's first stay at Seton, Stone was also able to get him into a special high-risk insurance pool set up by the state of California. It helped but not much. The insurance premium was $1,000 a month, quite a burden on a family whose income was maybe $3,500 a month. And it had an annual payout limit of $75,000. The D.'s blew through that in about two months.

The bills kept piling up. Sequoia Hospital—where Steven was an inpatient as well as an outpatient between the end of January and November following his initial stay at Seton—weighed in with 28 bills, all at chargemaster prices, including invoices for $99,000, $61,000 and $29,000. Doctor-run outpatient chemotherapy clinics wanted more than $85,000. One outside lab wanted $11,900.

Stone organized these and other bills into an elaborate spreadsheet—a ledger documenting how catastrophic illness in America unleashes its own mini-GDP.

In July, Stone figured out that Steven and Alice should qualify for Medicaid, which is called Medi-Cal in California. But there was a catch: Medicaid is the joint federal-state program directed at the poor that is often spoken of in the same breath as Medicare. Although most of the current national debate on entitlements is focused on Medicare, when Medicaid's subsidiary program called Children's Health Insurance, or CHIP, is counted, Medicaid actually covers more people: 56.2 million compared with 50.2 million.

As Steven and Alice found out, Medicaid is also more vulnerable to cuts and conditions that limit coverage, probably for the same reason that most politicians and the press don't pay the same attention to it that they do to Medicare: its constituents are the poor.

The major difference in the two programs is that while Medicare's rules are pretty much uniform across state lines, the states set the key rules for Medicaid because the state finances a big portion of the claims. According to Stone, Steven and Alice immediately ran into one of those rules. For people even with their modest income, the D.'s would have to pay $3,000 a month in medical bills before Medi-Cal would kick in. That amounted to most of Alice's monthly take-home pay.

Medi-Cal was even willing to go back five months, to February, to cover the couple's mountain of bills, but first they had to come up with $15,000. "We didn't have anything close to that," recalls Alice.

Stone then convinced Sequoia that if the hospital wanted to see any of the Medi-Cal money necessary to pay its bills (albeit at the big discount Medi-Cal would take), it should give Steven a "credit" for $15,000—in other words, write it off. Sequoia agreed to do that for most of the bills. This was clearly a maneuver that Steven and Alice never could have navigated on their own.

Covering most of the Sequoia debt was a huge relief, but there were still hundreds of thousands of dollars in bills left unpaid as Steven approached his end in the fall of 2011. Meantime, the bills kept coming.

"We started talking about the cost of the chemo," Alice recalls. "It was a source of tension between us ... Finally," she says, "the doctor told us that the next one scheduled might prolong his life a month, but it would be really painful. So he gave up."

By the one-year anniversary of Steven's death, late last year, Stone had made a slew of deals with his doctors, clinics and other providers whose services Medi-Cal did not cover. Some, like Seton, were generous. The home health care nurse ended up working for free in the final days of Steven's life, which were over the Thanksgiving weekend. "He was a saint," says Alice. "He said he was doing it to become accredited, so he didn't charge us."

Others, including some of the doctors, were more hard-nosed, insisting on full payment or offering minimal discounts. Still others had long since sold the bills to professional debt collectors, who, by definition, are bounty hunters. Alice and Stone were still hoping Medi-Cal would end up covering some or most of the debt.

As 2012 closed, Alice had paid out about $30,000 of her own money (including the $3,000 to Seton) and still owed $142,000—her losses from the fixed poker game that she was forced to play in the worst of times with the worst of cards. She was still getting letters and calls from bill collectors. "I think about the $142,000 all the time. It just hangs over my head," she said in December.

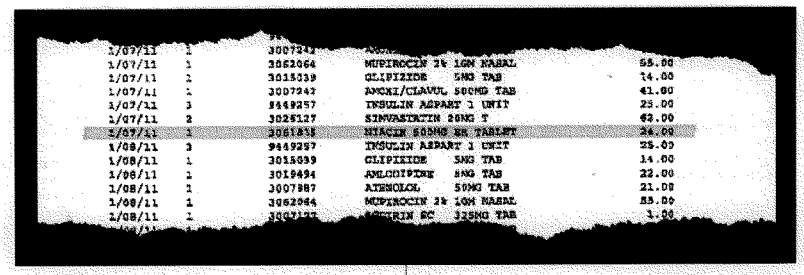
One lesson she has learned, she adds: "I'm never going to remarry. I can't risk the liability."[2]

53% of Americans surveyed said they plan to work longer than they would otherwise to continue to receive health insurance through their employer

$132,303: The Lab-Test Cash Machine

AS 2012 BEGAN, A COUPLE I'LL CALL REBECCA AND SCOTT S., both in their 50s, seemed to have carved out a comfortable semiretirement in a suburb near Dallas. Scott had

2. In early February, Alice told TIME that she had recently eliminated "most of" the debt through proceeds from the sale of a small farm in Oklahoma her husband had inherited and after further payments from Medi-Cal and a small life-insurance policy



1/07/11	1	3007242	[illegible]	
1/07/11	1	3062064	MUPIROCIN 2% 1GM NASAL	55.00
1/07/11	2	3015039	GLIPIZIDE 5MG TAB	14.00
1/07/11	1	3007242	AMOXI/CLAVUL 500MG TAB	41.00
1/07/11	3	9449257	INSULIN ASPART 1 UNIT	25.00
1/07/11	2	3026127	SIMVASTATIN 20MG T	42.00
1/07/11	1	3061858	NIACIN 500MG ER TABLET	24.00
1/08/11	3	9449257	INSULIN ASPART 1 UNIT	25.00
1/08/11	1	3015039	GLIPIZIDE 5MG TAB	14.00
1/08/11	1	3019494	AMLODIPINE 5MG TAB	22.00
1/08/11	1	3007987	ATENOLOL 50MG TAB	21.00
1/08/11	1	3062064	MUPIROCIN 2% 1GM NASAL	55.00
1/08/11	1	3007155	[illegible]RIN EC 325MG TAB	1.00

Niacin Tablet PATIENT WAS CHARGED $24 PER 500-MG TABLET OF NIACIN. IN DRUGSTORES, THE PILLS GO FOR ABOUT A NICKEL EACH

successfully sold his small industrial business and was working part time advising other industrial companies. Rebecca was running a small marketing company.

On March 4, Scott started having trouble breathing. By dinnertime he was gasping violently as Rebecca raced him to the emergency room at the University of Texas Southwestern Medical Center. Both Rebecca and her husband thought he was about to die, Rebecca recalls. It was not the time to think about the bills that were going to change their lives if Scott survived, and certainly not the time to imagine, much less worry about, the piles of charges for daily routine lab tests that would be incurred by any patient in the middle of a long hospital stay.

Scott was in the hospital for 32 days before his pneumonia was brought under control.

Rebecca recalls that "on about the fourth or fifth day, I was sitting around the hospital and bored, so I went down to the business office just to check that they had all the insurance information." She remembered that there was, she says, "some kind of limit on it."

"Even by then, the bill was over $80,000," she recalls. "I couldn't believe it."

The woman in the business office matter-of-factly gave Rebecca more bad news: Her insurance policy, from a company called Assurant Health, had an annual payout limit of $100,000. Because of some prior claims Assurant had processed, the S.'s were well on their way to exceeding the limit.

Just the room-and-board charge at Southwestern was $2,293 a day. And that was before all the real charges were added. When Scott checked out, his 161-page bill was $474,064. Scott and Rebecca were told they owed $402,955 after the payment from their insurance policy was deducted.

The top billing categories were $73,376 for Scott's room; $94,799 for "RESP SERVICES," which mostly meant supplying Scott with oxygen and testing his breathing and included multiple charges per day of $134 for supervising oxygen inhalation, for which Medicare would have paid $17.94; and $108,663 for "SPECIAL DRUGS," which included mostly not-so-special drugs such as "SODIUM CHLORIDE .9%." That's a standard saline solution probably used intravenously in this case to maintain Scott's water and salt levels. (It is also used to wet contact lenses.) You can buy a liter of the hospital version (bagged for intravenous use) online for $5.16. Scott was charged $84 to $134 for dozens of these saline solutions.

Then there was the $132,303 charge for "LABORATORY," which included hundreds of blood and urine tests ranging from $30 to $333 each, for which Medicare either pays nothing because it is part of the room fee or pays $7 to $30. Hospital spokesman Russell Rian said that neither Daniel Podolsky, Texas Southwestern Medical Center's $1,244,000-a-year president, nor any other executive would be available to discuss billing practices. "The law does not allow us to talk about how we bill," he explained.

Through a friend of a friend, Rebecca found Patricia Palmer, the same billing advocate based in Salem, Va., who worked on Steve H.'s bill in Oklahoma City. Palmer—whose firm, Medical Recovery Services, now includes her two adult daughters—was a claims processor for Blue Cross Blue Shield. She got into her current business after she was stunned by the bill her local hospital sent after one of her daughters had to go to the emergency room after an accident. She says it included items like the shade attached to an examining lamp. She then began looking at bills for friends as kind of a hobby before deciding to make it a business.

The best Palmer could do was get Texas Southwestern Medical to provide a credit that still left Scott and Rebecca owing $313,000.

Palmer claimed in a detailed appeal that there were also overcharges totaling $113,000—not because the prices were too high but because the items she singled out should not have been charged for at all. These included $5,890 for all of that saline solution and $65,600 for the management of Scott's oxygen. These items are supposed to be part of the hospital's general room-and-services charge, she argued, so they should not be billed twice.

In fact, Palmer—echoing a constant and convincing refrain I heard from billing advocates across the country—alleged that the hospital triple-billed for some items used in Scott's care in the intensive-care unit. "First they charge more than $2,000 a day for the ICU, because it's an ICU and it has all this special equipment and personnel," she says. "Then they charge $1,000 for some kit used in the ICU to give someone a transfusion or oxygen ... And then they charge

IN PAGE

$50 or $100 for each tool or bandage or whatever that there is in the kit. That's triple billing."

Palmer and Rebecca are still fighting, but the hospital insists that the S.'s owe the $313,000 balance. That doesn't include what Rebecca says were "thousands" in doctors' bills and $70,000 owed to a second hospital after Scott suffered a relapse.

The only offer the hospital has made so far is to cut the bill to $200,000 if it is paid immediately, or for the full $313,000 to be paid in 24 monthly payments. "How am I supposed to write a check right now for $200,000?" Rebecca asks. "I have boxes full of notices from bill collectors ... We can't apply for charity, because we're kind of well off in terms of assets," she adds. "We thought we were set, but now we're pretty much on the edge."

Insurance That Isn't

"PEOPLE, ESPECIALLY RELATIVELY WEALTHY PEOPLE, ALWAYS think they have good insurance until they see they don't," says Palmer. "Most of my clients are middle- or upper-middle-class people with insurance."

Scott and Rebecca bought their plan from Assurant, which sells health insurance to small businesses that will pay only for limited coverage for their employees or to individuals who cannot get insurance through employers and are not eligible for Medicare or Medicaid. Assurant also sold the Recchis their plan that paid only $2,000 a day for Sean Recchi's treatment at MD Anderson.

Although the tight limits on what their policies cover are clearly spelled out in Assurant's marketing materials and in the policy documents themselves, it seems that for its customers the appeal of having something called health insurance for a few hundred dollars a month is far more compelling than comprehending the details. "Yes, we knew there were some limits," says Rebecca. "But when you see the limits expressed in the thousands of dollars, it looks O.K., I guess. Until you have an event."

Millions of plans have annual payout limits, though the more typical plans purchased by employers usually set those limits at $500,000 or $750,000—which can also quickly be consumed by a catastrophic illness. For that reason, Obamacare prohibited lifetime limits on any policies sold after the law passed and phases out all annual dollar limits by 2014. That will protect people like Scott and Rebecca, but it will also make everyone's premiums dramatically higher, because insurance companies risk much more when there is no cap on their exposure.

BUT OBAMACARE DOES LITTLE TO ATTACK THE COSTS THAT overwhelmed Scott and Rebecca. There is nothing, for example, that addresses what may be the most surprising sinkhole—the seemingly routine blood, urine and other laboratory tests for which Scott was charged $132,000, or more than $4,000 a day.

By my estimates, about $70 billion will be spent in the U.S. on about 7 billion lab tests in 2013. That's about $223 a person for 16 tests per person. Cutting the overordering and overpricing could easily take $25 billion out of that bill.

Much of that overordering involves patients like Scott S. who require prolonged hospital stays. Their tests become a routine, daily cash generator. "When you're getting trained as a doctor," says a physician who was involved in framing health care policy early in the Obama Administration, "you're taught to order what's called 'morning labs.' Every day you have a variety of blood tests and other tests done, not because it's necessary but because it gives you something to talk about with the others when you go on rounds. It's like your version of a news hook ... I bet 60% of the labs are not necessary."

The country's largest lab tester is Quest Diagnostics, which reported revenues in 2012 of $7.4 billion. Quest's operating income in 2012 was $1.2 billion, about 16.2% of sales.

But that's hardly the spectacular profit margin we have seen in other sectors of the medical marketplace. The reason is that the outside companies like Quest, which mostly pick up specimens from doctors and clinics and deliver test results back to them, are not where the big profits are. The real money is in health care settings that cut out the middleman—the in-house venues, like the hospital testing lab run by Southwestern Medical that billed Scott and Rebecca $132,000. In-house labs account for about 60% of all testing revenue. Which means that for hospitals, they are vital profit centers.

Labs are also increasingly being maintained by doctors who, as they form group practices with other doctors in their field, finance their own testing and diagnostic clinics. These labs account for a rapidly growing share of the testing revenue, and their share is growing rapidly.

These in-house labs have no selling costs, and as pricing surveys repeatedly find, they can charge more because they have a captive consumer base in the hospitals or group practices.

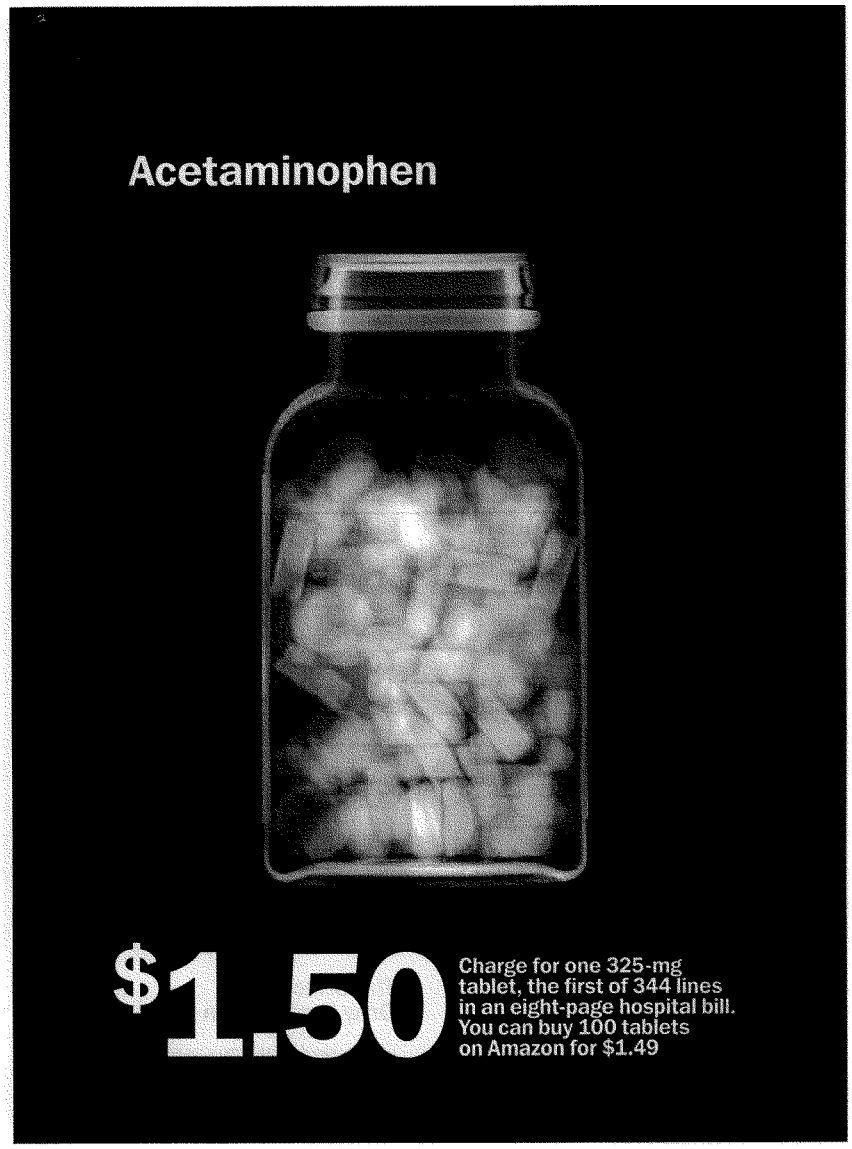
They also have an incentive to order more tests because they're the ones profiting from the tests. The *Wall Street Journal* reported last April that a study in the medical journal *Health Affairs* had found that doctors' urology groups with their own labs "bill the federal Medicare program for analyzing 72% more prostate tissue samples per biopsy while detecting fewer cases of cancer than counterparts who send specimens to outside labs."

If anything, the move toward in-house testing, and with it the incentive to do more of it, is accelerating the move by doctors to consolidate into practice groups. As one Bronx urologist explains, "The economics of having your own lab are so alluring."

More important, hospitals are aligning with these practice groups, in many cases even getting them to sign noncompete clauses requiring that they steer all patients to the partner hospital.

Some hospitals are buying physicians' practices outright; 54% of physician practices were owned by hospitals in 2012, according to a McKinsey survey, up from 22% 10 years before. This is primarily a move to increase the hospitals' leverage in negotiating with insurers. An expensive by-product is that it brings testing into the hospitals' high-profit labs.

Photograph by Nick Veasey for TIME


Acetaminophen
$1.50
Charge for one 325-mg tablet, the first of 344 lines in an eight-page hospital bill. You can buy 100 tablets on Amazon for $1.49

4

When Taxpayers Pick Up the Tab

WHETHER IT WAS EMILIA GILBERT TRYING TO GET OUT FROM under $9,418 in bills after her slip and fall or Alice D. vowing never to marry again because of the $142,000 debt from her husband's losing battle with cancer, we've seen how the medical marketplace misfires when private parties get the bills.

When the taxpayers pick up the tab, most of the dynamics of the marketplace shift dramatically.

In July 2011, an 88-year-old man whom I'll call Alan A. collapsed from a massive heart attack at his home outside Philadelphia. He survived, after two weeks in the intensive-care unit of the Virtua Marlton hospital. Virtua Marlton is part of a four-hospital chain that, in its 2010 federal filing, reported paying its CEO $3,073,000 and two other executives $1.4 million and $1.7 million from gross revenue of $633.7 million and an operating profit of $91 million. Alan A. then spent three weeks at a nearby convalescent-care center.

Medicare made quick work of the $268,227 in bills from the two hospitals, paying just $43,320. Except for $100 in incidental expenses, Alan A. paid nothing because 100% of inpatient hospital care is covered by Medicare.

The ManorCare convalescent center, which Alan A. says gave him "good care" in an "O.K. but not luxurious room," got paid $11,982 by Medicare for his three-week stay. That is about $571 a day for all the physical therapy, tests and other services. As with all hospitals in nonemergency situations, ManorCare does not have to accept Medicare patients and their discounted rates. But it does accept them. In fact, it welcomes them and encourages doctors to refer them.

Health care providers may grouse about Medicare's fee schedules, but Medicare's payments must be producing profits for ManorCare. It is part of a for-profit chain owned by Carlyle Group, a blue-chip private-equity firm.

ABOUT A DECADE AGO, ALAN A. WAS DIAGNOSED WITH non-Hodgkin's lymphoma. He was 78, and his doctors in southern New Jersey told him there was little they could do. Through a family friend, he got an appointment with one of the lymphoma specialists at Sloan-Kettering. That doctor told Alan A. he was willing to try a new chemotherapy regimen on him. The doctor warned, however, that he hadn't ever tried the treatment on a man of Alan A.'s age.

The treatment worked. A decade later, Alan A. is still in remission. He now travels to Sloan-Kettering every six weeks to be examined by the doctor who saved his life and to get a transfusion of Flebogamma, a drug that bucks up his immune system.

With some minor variations each time, Sloan-Kettering's typical bill for each visit is the same as or similar to the $7,346 bill he received during the summer of 2011, which included $340 for a session with the doctor.

Assuming eight visits (but only four with the doctor), that makes the annual bill $57,408 a year to keep Alan A. alive. His actual out-of-pocket cost for each session is a fraction of that. For that $7,346 visit, it was about $50.

In some ways, the set of transactions around Alan A.'s Sloan-Kettering care represent the best the American medical marketplace has to offer. First, obviously, there's the fact that he is alive after other doctors gave him up for dead. And then there's the fact that Alan A., a retired chemist of average means, was able to get care that might otherwise be reserved for the rich but was available to him because he had the right insurance.

Medicare is the core of that insurance, although Alan A.—as do 90% of those on Medicare—has a supplemental-insurance policy that kicks in and generally pays 90% of the 20% of costs for doctors and outpatient care that Medicare does not cover.

Here's how it all computes for him using that summer 2011 bill as an example.

Not counting the doctor's separate $340 bill, Sloan-Kettering's bill for the transfusion is about $7,006.

In addition to a few hundred dollars in miscellaneous items, the two basic Sloan-Kettering charges are $414 per hour for five hours of nurse time for administering the Flebogamma and a $4,615 charge for the Flebogamma.

According to Alan A., the nurse generally handles three or four patients at a time. That would mean Sloan-Kettering is billing more than $1,200 an hour for that nurse. When I asked Paul Nelson, Sloan-Kettering's director of financial planning, about the $414-per-hour charge, he explained that 15% of these charges is meant to cover overhead and indirect expenses, 20% is meant to be profit that will cover discounts for Medicare or Medicaid patients, and 65% covers direct expenses. That would still leave the nurse's time being valued at about $800 an hour (65% of $1,200), again assuming that just three patients were billed for the same hour at $414 each. Pressed on that, Nelson conceded that the profit is higher and is meant to cover other hospital costs like research and capital equipment.

Whatever Sloan-Kettering's calculations may be, Medicare—whose patients, including Alan A., are about a third of all Sloan-Kettering patients—buys into none of that math. Its cost-based pricing formulas yield a price of $302 for everything other than the drug, including those hourly charges for the nurse and the miscellaneous charges. Medicare pays 80% of that, or $241, leaving Alan A. and his private insurance company together to pay about $60 more to Sloan-Kettering. Alan A. pays $6, and his supplemental insurer, Aetna, pays $54.

Bottom line: Sloan-Kettering gets paid $302 by Medicare for about $2,400 worth of its chargemaster charges, and Alan A. ends up paying $6.

The Cancer Drug Profit Chain

IT'S WITH THE BILL FOR THE TRANSFUSION THAT THE PECULiar economics of American medicine take a different turn, even when Medicare is involved. We have seen that even

with big discounts for insurance companies and bigger discounts for Medicare, the chargemaster prices on everything from room and board to Tylenol to CT scans are high enough to make hospital costs a leading cause of the $750 billion Americans overspend each year on health care. We're now going to see how drug pricing is a major contributor to the way Americans overpay for medical care.

By law, Medicare has to pay hospitals 6% above what Congress calls the drug company's "average sales price," which is supposedly the average price at which the drugmaker sells the drug to hospitals and clinics. But Congress does not control what drugmakers charge. The drug companies are free to set their own prices. This seems fair in a free-market economy, but when the drug is a one-of-a-kind lifesaving serum, the result is anything but fair.

Applying that formula of average sales price plus the 6% premium, Medicare cuts Sloan-Kettering's $4,615 charge for Alan A.'s Flebogamma to $2,123. That's what the drugmaker tells Medicare the average sales price is plus 6%. Medicare again pays 80% of that, and Alan A. and his insurer split the other 20%, 10% for him and 90% for the insurer, which makes Alan A.'s cost $42.50.

In practice, the average sales price does not appear to be a real average. Two other hospitals I asked reported that after taking into account rebates given by the drug company, they paid an average of $1,650 for the same dose of Flebogamma, and neither hospital had nearly the leverage in the cancer-care marketplace that Sloan-Kettering does. One doctor at Sloan-Kettering guessed that it pays $1,400. "The drug companies give the rebates so that the hospitals will make more on the drug and therefore be encouraged to dispense it," the doctor explained. (A spokesperson for Medicare would say only that the average sales price is based "on manufacturers' data submitted to Medicare and is meant to include rebates.")

Nelson, the Sloan-Kettering head of financial planning, said the price his hospital pays for Alan A.'s dose of Flebogamma is "somewhat higher" than $1,400, but he wasn't specific, adding that "the difference between the cost and the charge represents the cost of running our pharmacy—which includes overhead cost—plus a markup." Even assuming Sloan-Kettering's real price for Flebogamma is "somewhat higher" than $1,400, the hospital would be making about 50% profit from Medicare's $2,123 payment. So even Medicare contributes mightily to hospital profit—and drug-company profit—when it buys drugs.

Flebogamma's Profit Margin

THE SPANISH BUSINESS AT THE BEGINNING OF THE FLEBOgamma supply chain does even better than Sloan-Kettering.

Made from human plasma, Flebogamma is a sterilized solution that is intended to boost the immune system. Sloan-Kettering buys it from either Baxter International in the U.S. or, as is more likely in Alan A.'s case, a Barcelona-based company called Grifols.

In its half-year 2012 shareholders report, Grifols featured a picture of the Flebogamma plasma serum and its packaging—"produced at the Clayton facility, North Carolina," according to the caption. Worldwide sales of all Grifols products were reported as up 15.2%, to $1.62 billion, in the first half of 2012. In the U.S. and Canada, sales were up 20.5%. "Growth in the sales... of the main plasma derivatives" was highlighted in the report, as was the fact that "the cost per liter of plasma has fallen." (Grifols operates 150 donation centers across the U.S. where it pays plasma donors $25 apiece.)

Grifols spokesman Christopher Healey would not discuss what it cost Grifols to produce and ship Alan A.'s dose, but he did say that the company's average cost to produce its bioscience products, Flebogamma included, was approximately 55% of what it sells them for. However, a doctor familiar with the economics of cancer-care drugs said that plasma products typically have some of the industry's higher profit margins. He estimated that the Flebogamma dose for Alan A.—which Sloan-Kettering bought from Grifols for $1,400 or $1,500 and sold to Medicare for $2,135—"can't cost them more than $200 or $300 to collect, process, test and ship."

In Spain, as in the rest of the developed world, Grifols' profit margins on sales are much lower than they are in the U.S., where it can charge much higher prices. Aware of the leverage that drug companies—especially those with unique lifesaving products—have on the market, most developed countries regulate what drugmakers can charge, limiting them to certain profit margins. In fact, the drugmakers' securities filings repeatedly warn investors of tighter price controls that could threaten their high margins—though not in the U.S.

The difference between the regulatory environment in the U.S. and the environment abroad is so dramatic that McKinsey & Co. researchers reported that overall prescription-drug prices in the U.S. are "50% higher for comparable products" than in other developed countries. Yet those regulated profit margins outside the U.S. remain high enough that Grifols, Baxter and other drug companies still aggressively sell their products there. For example, 37% of Grifols' sales come from outside North America.

More than $280 billion will be spent this year on prescription drugs in the U.S. If we paid what other countries did for the same products, we would save about $94 billion a year. The pharmaceutical industry's common explanation for the price difference is that U.S. profits subsidize the research and development of trailblazing drugs that are developed in the U.S. and then marketed around the world. Apart from the question of whether a country with a health-care-spending crisis should subsidize the rest of the developed world—not to mention the question of who signed Americans up for that mission—there's the fact that the companies' math doesn't add up.

According to securities filings of major drug companies, their R&D expenses are generally 15% to 20% of gross revenue. In fact, Grifols spent only 5% on R&D for the first nine months of 2012. Neither 5% nor 20% is enough to have cut deeply into the pharmaceutical companies' stellar bottom-line *net* profits. This is not *gross* profit, which counts only the cost of producing the drug, but the profit *after* those R&D expenses are taken into account. Grifols made a 32.3% net operating profit after all its R&D expenses—as well as sales, management and other expenses—were tallied. In other words, even counting all the R&D across the entire company, including research for drugs that did not pan out,

Of New York City's 18 largest private employers, eight are hospitals and four are banks

Grifols made healthy profits. All the numbers tell one consistent story: Regulating drug prices the way other countries do would save tens of billions of dollars while still offering profit margins that would keep encouraging the pharmaceutical companies' quest for the next great drug.

Handcuffs On Medicare

OUR LAWS DO MORE THAN PREVENT THE GOVERNMENT from restraining prices for drugs the way other countries do. Federal law also restricts the biggest single buyer—Medicare—from even trying to negotiate drug prices. As a perpetual gift to the pharmaceutical companies (and an acceptance of their argument that completely unrestrained prices and profit are necessary to fund the risk taking of research and development), Congress has continually prohibited the Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services from negotiating prices with drugmakers. Instead, Medicare simply has to determine that average sales price and add 6% to it.

Similarly, when Congress passed Part D of Medicare in 2003, giving seniors coverage for prescription drugs, Congress prohibited Medicare from negotiating.

Nor can Medicare get involved in deciding that a drug may be a waste of money. In medical circles, this is known as the comparative-effectiveness debate, which nearly derailed the entire Obamacare effort in 2009.

Doctors and other health care reformers behind the comparative-effectiveness movement make a simple argument: Suppose that after exhaustive research, cancer drug A, which costs $300 a dose, is found to be just as effective as or more effective than drug B, which costs $3,000. Shouldn't the person or entity paying the bill, e.g. Medicare, be able to decide that it will pay for drug A but not drug B? Not according to a law passed by Congress in 2003 that requires Medicare to reimburse patients (again, at average sales price plus 6%) for any cancer drug approved for use by the Food and Drug Administration. Most states require insurance companies to do the same thing.

Peter Bach, an epidemiologist at Sloan-Kettering who has also advised several health-policy organizations, reported in a 2009 *New England Journal of Medicine* article that Medicare's spending on the category dominated by cancer drugs ballooned from $3 billion in 1997 to $11 billion in 2004. Bach says costs have continued to increase rapidly and must now be more than $20 billion.

With that escalating bill in mind, Bach was among the policy experts pushing for provisions in Obamacare to establish a Patient-Centered Outcomes Research Institute to expand comparative-effectiveness research efforts. Through painstaking research, doctors would try to determine the comparative effectiveness not only of drugs but also of procedures like CT scans.

However, after all the provisions spelling out elaborate research and review processes were embedded in the draft law, Congress jumped in and added eight provisions that restrict how the research can be used. The prime restriction: Findings shall "not be construed as mandates for practice guidelines, coverage recommendations, payment, or policy recommendations."

With those 14 words, the work of Bach and his colleagues was undone. And costs remain unchecked.

"Medicare could see the research and say, Ah, this drug works better and costs the same or is even cheaper," says Gunn, Sloan-Kettering's chief operating officer. "But they are not allowed to do anything about it."

Along with another doomed provision that would have allowed Medicare to pay a fee for doctors' time spent counseling terminal patients on end-of-life care (but not on euthanasia), the Obama Administration's push for comparative effectiveness is what brought opponents' cries that the bill was creating "death panels." Washington bureaucrats would now be dictating which drugs were worth giving to which patients and even which patients deserved to live or die, the critics charged.

The loudest voice sounding the death-panel alarm belonged to Betsy McCaughey, former New York State lieutenant governor and a conservative health-policy advocate. McCaughey, who now runs a foundation called the Committee to Reduce Infection Deaths, is still fiercely opposed to Medicare's making comparative-effectiveness decisions. "There is comparative-effectiveness research being done in the medical journals all the time, which is fine," she says. "But it should be used by doctors to make decisions—not by the Obama bureaucrats at Medicare to make decisions for doctors."

Bach, the Sloan-Kettering doctor and policy wonk, has become so frustrated with the rising cost of the drugs he uses that he and some colleagues recently took matters into their own hands. They reported in an October op-ed in the New York *Times* that they had decided on their own that they were no longer going to dispense a colorectal-cancer drug called Zaltrap, which cost an average of $11,063 per month for treatment. All the research shows, they wrote, that a drug called Avastin, which cost $5,000 a month, is just as effective. They were taking this stand, they added, because "the typical new cancer drug coming on the market a decade ago cost about $4,500 per month (in 2012 dollars); since 2010, the median price has been around $10,000. Two of the new cancer drugs cost more than $35,000 each per month of treatment. The burden of this cost is borne, increasingly, by patients themselves—and the effects can be devastating."

The CEO of Sanofi, the company that makes Zaltrap, initially dismissed the article by Bach and his Sloan-Kettering colleagues, saying they had taken the price of the drug out of context because of variations in the required dosage. But four weeks later, Sanofi cut its price in half.

Bureaucrats You Can Admire

BY THE NUMBERS, MEDICARE LOOKS LIKE A GOVERNMENT program run amok. After President Lyndon B. Johnson signed Medicare into law in 1965, the House Ways and Means Committee predicted that the program would cost $12 billion in 1990. Its actual cost by then was $110 billion. It is likely to be nearly $600 billion this year. That's due to

Photograph by Stephen Voss for TIME

Jonathan Blum

'When hospitals say they are losing money on Medicare, my reaction is that Central Florida is overflowing with Medicare patients and all those hospitals are expanding and advertising for Medicare patients,' says Blum, deputy administrator of the Centers for Medicare and Medicaid Services. **'Hospitals don't lose money when they serve Medicare patients.'**

the U.S.'s aging population and the popular program's expansion to cover more services, as well as the skyrocketing costs of medical services generally. It's also because Medicare's hands are tied when it comes to negotiating the prices for drugs or durable medical equipment. But Medicare's growth is not a matter of those "bureaucrats" that Betsy McCaughey complains about having gone off the rails in how they operate it.

In fact, seeing the way Alan A.'s bills from Sloan-Kettering were vetted and processed is one of the more eye-opening and least discouraging aspects of a look inside the world of medical economics.

The process is fast, accurate, customer-friendly and impressively high-tech. And it's all done quietly by a team of nonpolitical civil servants in close partnership with the private sector. In fact, despite calls to privatize Medicare by creating a voucher system under which the Medicare population would get money from the government to buy insurance from private companies, the current Medicare system is staffed with more people employed by private contractors (8,500) than government workers (700).

$1.5 Billion A Day

SLOAN-KETTERING SENDS ALAN A.'S BILLS TO MEDICARE electronically, all elaborately coded according to Medicare's rules.

There are two basic kinds of codes for the services billed. The first is a number identifying which of the 7,000 procedures were performed by a doctor, such as examining a chest X-ray, performing a heart transplant or conducting an office consultation for a new patient (which costs more than a consultation with a continuing patient—coded differently—because it typically takes more time). If a patient presents more complicated challenges, then these basic procedures will be coded differently; for example, there are two varieties of emergency-room consultations. Adjustments are also made for variations in the cost of living where the doctor works and for other factors, like whether doctors used their own office (they'll get paid more for that) or the hospital. A panel of doctors set up by the American Medical Association reviews the codes annually and recommends updates to Medicare. The process can get messy as the doctors fight over which procedures in which specialties take more time and expertise or are worth relatively more. Medicare typically accepts most of the panel's recommendations.

The second kind of code is used to pay the hospital for its services. Again, there are thousands of codes based on whether the person checked in for brain surgery, an appendectomy or a fainting spell. To come up with these numbers, Medicare takes the cost reports—including allocations for everything from overhead to nursing staff to operating-room equipment—that hospitals across the country are required to file for each type of service and pays an amount equal to the composite average costs.

The hospital has little incentive to overstate its costs because it's against the law and because each hospital gets paid not on the basis of its own claimed costs but on the basis of the average of every hospital's costs, with adjustments made for regional cost differences and other local factors. Except for emergency services, no hospital has to accept Medicare patients and these prices, but they all do.

The use of CT scans in American emergency rooms has more than quadrupled in recent decades

Similar codes are calculated for laboratory and diagnostic tests like CT scans, ambulance services and, as we saw with Alan A.'s bill, drugs dispensed.

"When I tell my friends what I do here, it sounds boring, but it's exciting," says Diane Kovach, who works at Medicare's Maryland campus and whose title is deputy director of the provider billing group. "We are implementing a program that helps millions and millions of people, and we're doing it in a way that makes every one of us proud," she adds.

Kovach, who has been at Medicare for 21 years, operates some of the gears of a machine that reviews the more than 3 million bills that come into Medicare every day, figures out the right payments for each and churns out more than $1.5 billion a day in wire transfers.

The part of that process that Kovach and three colleagues, with whom I spent a morning recently, are responsible for involves overseeing the writing and vetting of thousands of instructions for coders, who are also private contractors, employed by HP, General Dynamics and other major technology companies. The codes they write are supposed to ensure that Medicare pays what it is supposed to pay and catches anything in a bill that should not be paid.

For example, hundreds of instructions for code changes were needed to address Obamacare's requirement that certain preventive-care visits, such as those for colonoscopies or contraceptive services, no longer be subject to Medicare's usual outpatient co-pay of 20%. Adding to the complexity, the benefit is limited to one visit per year for some services, meaning instructions had to be written to track patient timelines for the codes assigned to those services.

When performing correctly, the codes produce "edits" whenever a bill is submitted with something awry on it—if a doctor submits two preventive-care colonoscopies for the same patient in the same year, for example. Depending on the code, an edit will result in the bill's being sent back with questions or being rejected with an explanation. It all typically happens without a human being reading it. "Our goal at the first stage is that no one has to touch the bill," says Leslie Trazzi, who focuses on instructions and edits for doctors' claims.

Alan A.'s bills from Sloan-Kettering are wired to a data center in Shelbyville, Ky., run by a private company (owned by WellPoint, the insurance company that operates under the Blue Cross and Blue Shield names in more than a dozen states) that has the contract to process claims originating from New York and Connecticut. Medicare is paying the company about $323 million over five years—which, as with the fees of other contractors serving other regions, works out to an average of 84¢ per claim.

In Shelbyville, Alan A.'s status as a beneficiary is verified, and then the bill is sent electronically to a data center in Columbia, S.C., operated by another contractor, also a subsidiary of an insurance company. There, the codes are checked for edits, after which Alan A.'s Sloan-Kettering bill goes electronically to a data center in Denver, where the payment instructions are prepared and entered into what Karen Jackson, who

supervises Medicare's outside contractors, says is the largest accounting ledger in the world. The whole process takes three days—and that long only because the data is sent in batches.

There are multiple backups to make sure this ruthlessly efficient system isn't just ruthless. Medicare keeps track of and publicly reports the percentage of bills processed "clean"—i.e., with no rejected items—within 30 days. Even the speed with which the contractors answer the widely publicized consumer phone lines is monitored and reported. The average time to answer a call from a doctor or other provider is 57.6 seconds, according to Medicare's records, and the average time to answer one of the millions of calls from patients is 2 minutes 41 seconds, down from more than eight minutes in 2007. These times might come as a surprise to people who have tried to call a private insurer. That monitoring process is, in turn, backstopped by a separate ombudsman's office, which has regional and national layers.

Beyond that, the members of the House of Representatives and the Senate loom as an additional 535 ombudsmen. "We get calls every day from congressional offices about complaints that a beneficiary's claim has been denied," says Jonathan Blum, the deputy administrator of CMS. As a result, Blum's agency has an unusually large congressional liaison staff of 52, most of whom act as caseworkers trying to resolve these complaints.

All the customer-friendliness adds up to only about 10% of initial Medicare claims' being denied, according to Medicare's latest published *Composite Benchmark Metric Report*. Of those initial Medicare denials, only about 20% (2% of total claims) result in complaints or appeals, and the decisions in only about half of those (or 1% of the total) end up being reversed, with the claim being paid.

The astonishing efficiency, of course, raises the question of whether Medicare is simply funneling money out the door as fast as it can. Some fraud is inevitable—even a rate of 0.1% is enough to make headlines when $600 billion is being spent. It's also possible that people can game the system without committing outright fraud. But Medicare has multiple layers of protection against fraud that the insurance companies don't and perhaps can't match because they lack Medicare's scale.

According to Medicare's Jackson, the contractors are "vigorously monitored for all kinds of metrics" and required every quarter "to do a lot of data analysis and submit review plans and error-rate-reduction plans."

And then there are the RACs—a wholly separate group of private "recovery audit contractors." Established by Congress during the George W. Bush Administration, the RACs, says one hospital administrator, "drive the doctors and the hospitals and even the Medicare claims processors crazy." The RACs' only job is to review provider bills after they have been paid by Medicare claims processors and look for system errors, like faulty processing, or errors in the bills as reflected in doctor or hospital medical records that the RACs have the authority to audit.

The RACs have an incentive that any champion of the private sector would love. They get no up-front fees but instead are paid a percentage of the money they retrieve. They eat what they kill. According to Medicare spokeswoman Emma Sandoe, the RAC bounty hunters retrieved $797 million in the 2011 fiscal year, for which they were paid 9% to 12.5% of what they brought in, depending on the region where they were operating.

This process can "get quite anal," says the doctor who recently treated me for an ear infection. Although my doctor is on Park Avenue, she, like 96% of all specialists, accepts Medicare patients despite the discounted rates it pays, because, she says, "they pay quickly." However, she recalls getting bills from Medicare for 21¢ or 85¢ for supposed overpayments.

The DHHS's inspector general is also on the prowl to protect the Medicare checkbook. It reported recovering $1.2 billion last year through Medicare and Medicaid audits and investigations (though the recovered funds had probably been doled out over several fiscal years). The inspector general's work is supplemented by a separate, multiagency federal health-care-fraud task force, which brings criminal charges against fraudsters and issues regular press releases claiming billions more in recoveries.

This does not mean the system is airtight. If anything, all that recovery activity suggests fallibility, even as it suggests more buttoned-up operations than those run by private insurers, whose payment systems are notoriously erratic.

44% of low-wage workers at small firms were uninsured in 2010

Too Much Health Care?

IN A REVIEW OF OTHER BILLS OF THOSE ENROLLED IN Medicare, a pattern of deep, deep discounting of charge-master charges emerged that mirrored how Alan A.'s bills were shrunk down to reality. A $121,414 Stanford Hospital bill for a 90-year-old California woman who fell and broke her wrist became $16,949. A $51,445 bill for the three days an ailing 91-year-old spent getting tests and being sedated in the hospital before dying of old age became $19,242. Before Medicare went to work, the bill was chock-full of creative chargemaster charges from the California Pacific Medical Center—part of Sutter Health, a dominant nonprofit Northern California chain whose CEO made $5,241,305 in 2011.

Another pattern emerged from a look at these bills: some seniors apparently visit doctors almost weekly or even daily, for all varieties of ailments. Sure, as patients age they are increasingly in need of medical care. But at least some of the time, the fact that they pay almost nothing to spend their days in doctors' offices must also be a factor, especially if they have the supplemental insurance that covers most of the 20% not covered by Medicare.

Alan A. is now 89, and the mound of bills and Medicare statements he showed me for 2011—when he had his heart attack and continued his treatments at Sloan-Kettering—seemed to add up to about $350,000, although I could not tell for sure because a few of the smaller ones may have been duplicates. What is certain—because his insurance company tallied it for him in a year-end statement—was that his total out-of-pocket expense was $1,139, or less than 0.2% of his overall medical bills. Those bills included what seemed to be 33 visits in one year to 11 doctors who had nothing to do with his recovery from the heart attack or his cancer. In all cases, he was routinely asked to pay almost

nothing: $2.20 for a check of a sinus problem, $1.70 for an eye exam, 33¢ to deal with a bunion. When he showed me those bills he chuckled.

A comfortable member of the middle class, Alan A. could easily afford the burden of higher co-pays that would encourage him to use doctors less casually or would at least stick taxpayers with less of the bill if he wants to get that bunion treated. AARP (formerly the American Association of Retired Persons) and other liberal entitlement lobbies oppose these types of changes and consistently distort the arithmetic around them. But it seems clear that Medicare could save billions of dollars if it required that no Medicare supplemental-insurance plan for people with certain income or asset levels could result in their paying less than, say, 10% of a doctor's bill until they had paid $2,000 or $3,000 out of their pockets in total bills in a year. (The AARP might oppose this idea for another reason: it gets royalties from UnitedHealthcare for endorsing United's supplemental-insurance product.)

Medicare spent more than $6.5 billion last year to pay doctors (even at the discounted Medicare rates) for the service codes that denote the most basic categories of office visits. By asking people like Alan A. to pay more than a negligible share, Medicare could recoup $1 billion to $2 billion of those costs yearly.

Too Much Doctoring?

ANOTHER DOCTOR'S BILL, FOR WHICH ALAN A.'S SHARE WAS 19¢, suggests a second apparent flaw in the system. This was one of 50 bills from 26 doctors who saw Alan A. at Virtua Marlton hospital or at the ManorCare convalescent center after his heart attack or read one of his diagnostic tests at the two facilities. "They paraded in once a day or once every other day, looked at me and poked around a bit and left," Alan A. recalls. Other than the doctor in charge of his heart-attack recovery, "I had no idea who they were until I got these bills. But for a dollar or two, so what?"

The "so what," of course, is that although Medicare deeply discounted the bills, it—meaning taxpayers—still paid from $7.48 (for a chest X-ray reading) to $164 for each encounter.

"One of the benefits attending physicians get from many hospitals is the opportunity to cruise the halls and go into a Medicare patient's room and rack up a few dollars," says a doctor who has worked at several hospitals across the country. "In some places it's a Monday-morning tradition. You go see the people who came in over the weekend. There's always an ostensible reason, but there's also a lot of abuse."

When health care wonks focus on this kind of

Sloan-Kettering

The Profit Of Prestigious Cancer Care

Like MD Anderson's aggressive pricing for Sean Recchi's stay, Sloan-Kettering's markup on drugs like the Flebogamma given to Alan A. is one reason cancer care is so profitable. In 2011, the hospital and research institution of Sloan-Kettering had an operating profit of $406 million even after everything it spent on research and the education of a small army of young cancer doctors.

The cash flow comes from more than just drug markups. It also comes from the high pricing enabled by a great brand and an enterprise that has learned how to expand the reach of its brand.

One of Sloan-Kettering's major revenue sources is the outpatient clinics it has been opening around New York City in recent years so that patients don't have to travel to the busy Upper East Side of Manhattan for the kind of treatments Alan A. gets every six weeks. There is a cancer-screening and treatment outpost (run in partnership with Ralph Lauren's foundation) in Harlem and a chemotherapy clinic in Brooklyn, and clinical-care facilities can also be found in five of the New York City metropolitan area's wealthier suburbs, such as Sleepy Hollow in Westchester County, New York, and Basking Ridge, N.J. A sixth is being constructed in Harrison, another wealthy Westchester town.

Building on the deserved allure of the Sloan-Kettering brand, these outposts eat into the profits of area hospitals, which would otherwise be providing the same high-margin outpatient cancer care either on the basis of what their own doctors prescribed or according to instructions from Sloan-Kettering's specialists. "Sloan-Kettering can open these clinics and treat people 9 to 5 at their [high] rates, and because they've got the brand name, they'll be very successful because they don't have to run a 24/7 operation," complains the president of one hospital in a wealthy suburb north of New York City. "But if those patients need help at midnight on Saturday, they'll end up in our emergency room." That may be true, but Sloan-Kettering's foray beyond the Upper East Side of Manhattan also represents a rare outbreak of competition in the current hospital marketplace.

Sloan-Kettering may be fishing for business in these wealthy suburbs, but it does have a financial-aid process that is both proactive and well publicized to patients seeking care. It provides discounts of varying amounts for those who are uninsured or underinsured and have incomes of less than 500% above the poverty line, which comes out to about $115,000 a year for a family of four. Counselors also help patients get other aid from the state or local government, from research programs or, as happened with Sean Recchi in Ohio, from drug companies.

That still leaves out many people, especially the uninsured or underinsured whose incomes are above $115,000 but well below what they would pay for treatment at Sloan-Kettering. And it undoubtedly leaves others struggling just to meet the co-pays required even with good insurance. Sloan-Kettering chief operating

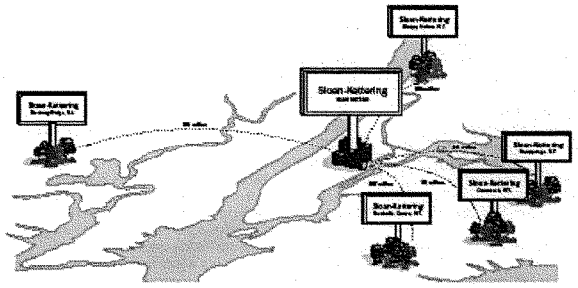
overdoctoring, they complain (and write endless essays) about what they call the fee-for-service mode, meaning that doctors mostly get paid for the time they spend treating patients or ordering and reading tests. Alan A. didn't care how much time his cancer or heart doctor spent with him or how many tests he got. He cared only that he got better.

Some private care organizations have made progress in avoiding this overdoctoring by paying salaries to their physicians and giving them incentives based on patient outcomes. Medicare and private insurers have yet to find a way to do that with doctors, nor are they likely to, given the current structure that involves hundreds of thousands of private providers billing them for their services.

In passing Obamacare, Congress enabled Medicare to drive efficiencies in hospital care based on the notion that good care should be rewarded and the opposite penalized. The primary lever is a system of penalties Obamacare imposes on hospitals for bad care—a term defined as unacceptable rates of adverse events, such as infections or injuries during a patient's hospital stay or readmissions within a month after discharge. Both kinds of adverse events are more common than you might think: 1 in 5 Medicare patients is readmitted within 30 days, for example. One Medicare report asserts that "Medicare spent an estimated $4.4 billion in 2009 to care for patients who had been harmed in the hospital, and readmissions cost Medicare another $26 billion." The anticipated savings that will be produced by the threat of these new penalties are what has allowed the Obama Administration to claim that Obamacare can cut hundreds of billions of dollars from Medicare over the next 10 years without shortchanging beneficiaries. "These payment penalties are sending a shock through the system that will drive costs down," says Blum, the deputy administrator of the Centers for Medicare and Medicaid Services.

There are lots of other shocks Blum and his colleagues would like to send. However, Congress won't allow him to. Chief among them, as we have seen, would be allowing Medicare, the world's largest buyer of prescription drugs, to negotiate the prices that it pays for them and to make purchasing decisions on the basis of comparative effectiveness. But there's also the cane that Alan A. got after his heart attack. Medicare paid $21.97 for it. Alan A. could have bought it on Amazon for about $12. Other than in a few pilot regions that Congress designated in 2011 after a push by the Obama Administration, Congress has not allowed Medicare to drive down the price of any so-called durable medical equipment through competitive bidding.

This is more than a matter of the 124,000 canes Medicare



officer John Gunn says patients not formally in the financial-assistance program might still be offered discounts of some kind and that only "2% or 3% of our patients pay our full list prices"—chargemaster prices that he acknowledges are high "because we have better outcomes."

Most of those asked to pay chargemaster rates, Gunn adds, are "wealthy foreigners, whom we screen and tell in advance what it's likely to cost them." Insurance companies negotiate discounts off of Sloan-Kettering's chargemaster prices, but Gunn acknowledges that his hospital can drive a hard bargain because insurers want "to make sure we are in" their network.

That kind of brand strength produces not only lavish cash flow but also lavish incomes for the nondoctors who work to generate it. Six Sloan-Kettering administrators made salaries of over $1 million in 2010, the most recent year for which the hospital filed its nonprofit tax return. (The 2011 return is "on extension," says Gunn, who was paid $1,531,991 in 2010.) Including those six, 14 made over $500,000.

Compared with their peers at equally venerable nonprofits, these executives are comfortably ensconced in a medical ecosystem that's in a world of its own. For example, Sloan-Kettering listed two development-office executives, or fundraisers, as making $1,483,000 and $844,000. Another venerable New York nonprofit that mines the same field for donors—the Metropolitan Museum of Art—pays its top development officer $345,000. Harvard pays its chief fundraiser $392,000. Asked why salaries at Sloan-Kettering are so much higher than those at nonprofits like the Met and Harvard, Gunn replies, "All of us hospitals have the same compensation consultants, so I guess it's a self-fulfilling prophecy."

Whatever the origins of the compensation rates, the prospectus that Sloan-Kettering's bankers and lawyers used to sell the bonds that helped finance those suburban clinics struck a tone that is at odds with the daily sight of men and women rushing through the halls of Sloan-Kettering doing God's work. The halls may be sprinkled with cheerful posters aimed at patients, but the prospectus is sprinkled with phrases like *market share, improved pricing* and *rate and volume increases*. Then again, the same prospectus describes the core of the business this way: "higher five-year survival rates for cancer patients as compared to other institutions."

reports that it buys every year. It's about mail-order diabetic supplies, wheelchairs, home medical beds and personal oxygen supplies too. Medicare spends about $15 billion annually for these goods.

In the areas of the country where Medicare has been allowed by Congress to conduct a competitive-bidding pilot program, the process has produced savings of 40%. But so far, the pilot programs cover only about 3% of the medical goods seniors typically use. Taking the program nationwide and saving 40% of the entire $15 billion would mean saving $6 billion a year for taxpayers.

The Way Out Of the Sinkhole

"I WAS DRIVING THROUGH CENTRAL FLORIDA A YEAR OR TWO ago," says Medicare's Blum. "And it seemed like every billboard I saw advertised some hospital with these big shiny buildings or showed some new wing of a hospital being constructed ... So when you tell me that the hospitals say they are losing money on Medicare and shifting costs from Medicare patients to other patients, my reaction is that Central Florida is overflowing with Medicare patients and all those hospitals are expanding and advertising for Medicare patients. So you can't tell me they're losing money ... Hospitals don't lose money when they serve Medicare patients."

If that's the case, I asked, why not just extend the program to everyone and pay for it all by charging people under 65 the kinds of premiums they would pay to private insurance companies? "That's not for me to say," Blum replied.

In the debate over controlling Medicare costs, politicians from both parties continue to suggest that Congress raise the age of eligibility for Medicare from 65 to 67. Doing so, they argue, would save the government tens of billions of dollars a year. So it's worth noting another detail about the case of Janice S., which we examined earlier. Had she felt those chest pains and gone to the Stamford Hospital emergency room a month later, she would have been on Medicare, because she would have just celebrated her 65th birthday.

If covered by Medicare, Janice S.'s $21,000 bill would have been deeply discounted and, as is standard, Medicare would have picked up 80% of the reduced cost. The bottom line is that Janice S. would probably have ended up paying $500 to $600 for her 20% share of her heart-attack scare. And she would have paid only a fraction of that—maybe $100—if, like most Medicare beneficiaries, she had paid for supplemental insurance to cover most of that 20%.

In fact, those numbers would seem to argue for lowering the Medicare age, not raising it—and not just from Janice S.'s standpoint but also from the taxpayers' side of the equation. That's not a liberal argument for protecting entitlements while the deficit balloons. It's just a matter of hardheaded arithmetic.

As currently constituted, Obamacare is going to require people like Janice S. to get private insurance coverage and will subsidize those who can't afford it. But the cost of that private insurance—and therefore those subsidies—will be much higher than if the same people were enrolled in Medicare at an earlier age. That's because Medicare buys health care services at much lower rates than any insurance company. Thus the best way both to lower the deficit and to help save money for people like Janice S. would seem to be to bring her and other near seniors into the Medicare system before they reach 65. They could be required to pay premiums based on their incomes, with the poor paying low premiums and the better off paying what they might have paid a private insurer. Those who can afford it might also be required to pay a higher proportion of their bills—say, 25% or 30%—rather than the 20% they're now required to pay for outpatient bills.

Meanwhile, adding younger people like Janice S. would lower the overall cost per beneficiary to Medicare and help cut its deficit still more, because younger members are likelier to be healthier.

From Janice S.'s standpoint, whatever premium she would pay for this age-64 Medicare protection would still be less than what she had been paying under the COBRA plan that she wished she could have kept after the rules dictated that she be cut off after she lost her job.

The only way this would not work is if 64-year-olds started using health care services they didn't need. They might be tempted to, because, as we saw with Alan A., Medicare's protection is so broad and supplemental private insurance costs so little that it all but eliminates patients' obligation to pay the 20% of outpatient-care costs that Medicare doesn't cover. To deal with that, a provision could be added requiring that 64-year-olds taking advantage of Medicare could not buy insurance freeing them from more than, say, 5% or 10% of their responsibility for the bills, with the percentage set according to their wealth. It would be a similar, though more stringent, provision of the kind I've already suggested for current Medicare beneficiaries as a way to cut the cost of people overusing benefits.

If that logic applies to 64-year-olds, then it would seem to apply even more readily to healthier 40-year-olds or 18-year-olds. This is the single-payer approach favored by liberals and used by most developed countries.

Then again, however much hospitals might survive or struggle under that scenario, no doctor could hope for anything approaching the income he or she deserves (and that will make future doctors want to practice) if 100% of their patients yielded anything close to the low rates Medicare pays.

"If you could figure out a way to pay doctors better and separately fund research ... adequately, I could see where a single-payer approach would be the most logical solution," says Gunn, Sloan-Kettering's chief operating officer. "It would certainly be a lot more efficient than hospitals like ours having hundreds of people sitting around filling out dozens of different kinds of bills for dozens of insurance companies." Maybe, but the prospect of overhauling our system this way, displacing all the private insurers and other infrastructure after all these decades, isn't likely. For there would be one group of losers—and these losers have lots of clout. They're the health care providers like hospitals and CT-scan-equipment makers whose profits—embedded in the bills we have examined—would be sacrificed. They would suffer because of the lower prices Medicare would pay them when the patient is 64, compared with what they are able to charge when that patient is either covered by private insurance or has no insurance at all.

That kind of systemic overhaul not only seems unrealistic but is also packed with all kinds of risk related to

Photograph by Nick Veasey for TIME

Sodium Chloride
$84
Hospital charge for standard saline solution. Online, a liter bag costs $5.16

IN PAGE

the microproblems of execution and the macro issue of giving government all that power.

Yet while Medicare may not be a realistic systemwide model for reform, the way Medicare works does demonstrate, by comparison, how the overall health care market doesn't work.

Unless you are protected by Medicare, the health care market is not a market at all. It's a crapshoot. People fare differently according to circumstances they can neither control nor predict. They may have no insurance. They may have insurance, but their employer chooses their insurance plan and it may have a payout limit or not cover a drug or treatment they need. They may or may not be old enough to be on Medicare or, given the different standards of the 50 states, be poor enough to be on Medicaid. If they're not protected by Medicare or they're protected only partly by private insurance with high co-pays, they have little visibility into pricing, let alone control of it. They have little choice of hospitals or the services they are billed for, even if they somehow know the prices before they get billed for the services. They have no idea what their bills mean, and those who maintain the chargemasters couldn't explain them if they wanted to. How much of the bills they end up paying may depend on the generosity of the hospital or on whether they happen to get the help of a billing advocate. They have no choice of the drugs that they have to buy or the lab tests or CT scans that they have to get, and they would not know what to do if they did have a choice. They are powerless buyers in a seller's market where the only sure thing is the profit of the sellers.

Indeed, the only player in the system that seems to have to balance countervailing interests the way market players in a real market usually do is Medicare. It has to answer to Congress and the taxpayers for wasting money, and it has to answer to portions of the same groups for trying to hold on to money it shouldn't. Hospitals, drug companies and other suppliers, even the insurance companies, don't have those worries.

Moreover, the only players in the private sector who seem to operate efficiently are the private contractors working—dare I say it?—under the government's supervision. They're the Medicare claims processors that handle claims like Alan A.'s for 84¢ each. With these and all other Medicare costs added together, Medicare's total management, administrative and processing expenses are about $3.8 billion for processing more than a billion claims a year worth $550 billion. That's an overall administrative and management cost of about two-thirds of 1% of the amount of the claims, or less than $3.80 per claim. According to its latest SEC filing, Aetna spent $6.9 billion on operating expenses (including claims processing, accounting, sales and executive management) in 2012. That's about $30 for each of the 229 million claims Aetna processed, and it amounts to about 29% of the $23.7 billion Aetna pays out in claims.

The real issue isn't whether we have a single payer or multiple payers. It's whether whoever pays has a fair chance in a fair market. Congress has given Medicare that power when it comes to dealing with hospitals and doctors, and we have seen how that works to drive down the prices Medicare pays, just as we've seen what happens when Congress handcuffs Medicare when it comes to evaluating and buying drugs, medical devices and equipment. Stripping away what is now the sellers' overwhelming leverage in dealing with Medicare in those areas and with private payers in all aspects of the market would inject fairness into the market. We don't have to scrap our system and aren't likely to. But we can reduce the $750 billion that we overspend on health care in the U.S. in part by acknowledging what other countries have: because the health care market deals in a life-or-death product, it cannot be left to its own devices.

Put simply, the bills tell us that this is not about interfering in a free market. It's about facing the reality that our largest consumer product by far—one-fifth of our economy—does not operate in a free market.

So how can we fix it?

Changing Our Choices

WE SHOULD TIGHTEN ANTITRUST LAWS RELATED TO HOSPITALS to keep them from becoming so dominant in a region that insurance companies are helpless in negotiating prices with them. The hospitals' continuing consolidation of both lab work and doctors' practices is one reason that trying to cut the deficit by simply lowering the fees Medicare and Medicaid pay to hospitals will not work. It will only cause the hospitals to shift the costs to non-Medicare patients in order to maintain profits—which they will be able to do because of their increasing leverage in their markets over insurers. Insurance premiums will therefore go up—which in turn will drive the deficit back up, because the subsidies on insurance premiums that Obamacare will soon offer to those who cannot afford them will have to go up.

Similarly, we should tax hospital profits at 75% and have a tax surcharge on all nondoctor hospital salaries that exceed, say, $750,000. Why are high profits at hospitals regarded as a given that we have to work around? Why shouldn't those who are profiting the most from a market whose costs are victimizing everyone else chip in to help? If we recouped 75% of all hospital profits (from nonprofit as well as for-profit institutions), that would save over $80 billion a year before counting what we would save on tests that hospitals might not perform if their profit incentives were shaved.

To be sure, this too seems unlikely to happen. Hospitals may be the most politically powerful institution in any congressional district. They're usually admired as their community's most important charitable institution, and their influential stakeholders run the gamut from equipment makers to drug companies to doctors to thousands of rank-and-file employees. Then again, if every community paid more attention to those administrator salaries, to those nonprofits' profit margins and to charges like $77 for gauze pads, perhaps the political balance would shift.

We should outlaw the chargemaster. Everyone involved, except a patient who gets a bill based on one (or worse, gets sued on the basis of one), shrugs off chargemasters as a fiction. So why not require that they be rewritten to reflect a process that considers actual and thoroughly transparent costs? After all, hospitals are supposed to be government-sanctioned institutions accountable to the public. Hospitals love the chargemaster because it gives them a big number to put in front of rich uninsured patients (typically from outside the U.S.) or, as is more likely, to attach to lawsuits or give to bill collectors,

The U.S. has the highest annual per capita spending on hospitalization among developed countries: $2,300 per bed day on average

establishing a place from which they can negotiate settlements. It's also a great place from which to start negotiations with insurance companies, which also love the chargemaster because they can then make their customers feel good when they get an Explanation of Benefits that shows the terrific discounts their insurance company won for them.

But for patients, the chargemasters are both the real and the metaphoric essence of the broken market. They are anything but irrelevant. They're the source of the poison coursing through the health care ecosystem.

We should amend patent laws so that makers of wonder drugs would be limited in how they can exploit the monopoly our patent laws give them. Or we could simply set price limits or profit-margin caps on these drugs. Why are the drug profit margins treated as another given that we have to work around to get out of the $750 billion annual overspend, rather than a problem to be solved?

Just bringing these overall profits down to those of the software industry would save billions of dollars. Reducing drugmakers' prices to what they get in other developed countries would save over $90 billion a year. It could save Medicare—meaning the taxpayers—more than $25 billion a year, or $250 billion over 10 years. Depending on whether that $250 billion is compared with the Republican or Democratic deficit-cutting proposals, that's a third or a half of the Medicare cuts now being talked about.

Similarly, we should tighten what Medicare pays for CT or MRI tests a lot more and even cap what insurance companies can pay for them. This is a huge contributor to our massive overspending on outpatient costs. And we should cap profits on lab tests done in-house by hospitals or doctors.

Finally, we should embarrass Democrats into stopping their fight against medical-malpractice reform and instead provide safe-harbor defenses for doctors so they don't have to order a CT scan whenever, as one hospital administrator put it, someone in the emergency room says the word *head*. Trial lawyers who make their bread and butter from civil suits have been the Democrats' biggest financial backer for decades. Republicans are right when they argue that tort reform is overdue. Eliminating the rationale or excuse for all the extra doctor exams, lab tests and use of CT scans and MRIs could cut tens of billions of dollars a year while drastically cutting what hospitals and doctors spend on malpractice insurance and pass along to patients.

Other options are more tongue in cheek, though they illustrate the absurdity of the hole we have fallen into. We could limit administrator salaries at hospitals to five or six times what the lowest-paid licensed physician gets for caring for patients there. That might take care of the self-fulfilling peer dynamic that Gunn of Sloan-Kettering cited when he explained, "We all use the same compensation consultants." Then again, it might unleash a wave of salary increases for junior doctors.

Or we could require drug companies to include a prominent, plain-English notice of the gross profit margin on the packaging of each drug, as well as the salary of the parent company's CEO. The same would have to be posted on the company's website. If nothing else, it would be a good test of embarrassment thresholds.

None of these suggestions will come as a revelation to the policy experts who put together Obamacare or to those before them who pushed health care reform for decades. They know what the core problem is—lopsided pricing and outsize profits in a market that doesn't work. Yet there is little in Obamacare that addresses that core issue or jeopardizes the paydays of those thriving in that marketplace. In fact, by bringing so many new customers into that market by mandating that they get health insurance and then providing taxpayer support to pay their insurance premiums, Obamacare enriches them. That, of course, is why the bill was able to get through Congress.

Obamacare does some good work around the edges of the core problem. It restricts abusive hospital-bill collecting. It forces insurers to provide explanations of their policies in plain English. It requires a more rigorous appeal process conducted by independent entities when insurance coverage is denied. These are all positive changes, as is putting the insurance umbrella over tens of millions more Americans—a historic breakthrough. But none of it is a path to bending the health care cost curve. Indeed, while Obamacare's promotion of statewide insurance exchanges may help distribute health-insurance policies to individuals now frozen out of the market, those exchanges could raise costs, not lower them. With hospitals consolidating by buying doctors' practices and competing hospitals, their leverage over insurance companies is increasing. That's a trend that will only be accelerated if there are more insurance companies with less market share competing in a new exchange market trying to negotiate with a dominant hospital and its doctors. Similarly, higher insurance premiums—much of them paid by taxpayers through Obamacare's subsidies for those who can't afford insurance but now must buy it—will certainly be the result of three of Obamacare's best provisions: the prohibitions on exclusions for pre-existing conditions, the restrictions on co-pays for preventive care and the end of annual or lifetime payout caps.

Put simply, with Obamacare we've changed the rules related to who pays for what, but we haven't done much to change the prices we pay.

In 2012 the average employer contributed $7,225 in health premiums for each employee who enrolled in the employer's group health plans

WHEN YOU FOLLOW THE MONEY, YOU SEE THE CHOICES we've made, knowingly or unknowingly.

Over the past few decades, we've enriched the labs, drug companies, medical device makers, hospital administrators and purveyors of CT scans, MRIs, canes and wheelchairs. Meanwhile, we've squeezed the doctors who don't own their own clinics, don't work as drug or device consultants or don't otherwise game a system that is so gameable. And of course, we've squeezed everyone outside the system who gets stuck with the bills.

We've created a secure, prosperous island in an economy that is suffering under the weight of the riches those on the island extract.

And we've allowed those on the island and their lobbyists and allies to control the debate, diverting us from what Gerard Anderson, a health care economist at the Johns Hopkins Bloomberg School of Public Health, says is the obvious and only issue: "All the prices are too damn high." ■

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