An American Sickness

HOW HEALTHCARE BECAME
BIG BUSINESS AND HOW
YOU CAN TAKE IT BACK

ELISABETH ROSENTHAL
Dedicated to all the patients, doctors, and other healthcare professionals who so generously shared their stories and experiences to bring this book to life. Waiving privacy concerns, they agreed to have their real names appear in print. In the hope of contributing to change in our healthcare system, they spent hours digging up copies of their bills, insurance statements, correspondence, and other documents to provide verification. I’m deeply grateful for their help, commitment, and courage.

They—and all Americans—deserve better, more affordable healthcare.
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INTRODUCTION

Complaint: Unaffordable Healthcare

In the past quarter century, the American medical system has stopped focusing on health or even science. Instead it attends more or less single-mindedly to its own profits.

Everyone knows the healthcare system is in disarray. We’ve grown numb to huge bills. We regard high prices as an inescapable American burden. We accept the drugmakers’ argument that they have to charge twice as much for prescriptions as in any other country because lawmakers in nations like Germany and France don’t pay them enough to recoup their research costs. But would anyone accept that argument if we replaced the word prescriptions with cars or films?

The current market for healthcare just doesn’t deliver. It is deeply, perhaps fatally, flawed. Even market economists themselves don’t believe in it anymore. “It’s now so dysfunctional that I sometimes think the only solution is to blow the whole thing up. It’s not like any market on Earth,” says Glenn Melnick, a professor of health economics and finance at the University of Southern California.

Nearly every expert I’ve spoken with—Republican or Democrat, old or young, adherent of Milton Friedman or Karl Marx—has a theoretical explanation as to why the United States spends nearly 20 percent of its gross domestic product on healthcare—more than twice the average of developed countries. But each one also has a story of personal exasperation about the last time a family member or a loved one was hospitalized or rushed to an emergency room or received an incomprehensible, outrageous bill.

Stephen Parente, Ph.D., a health economist at the University of Minnesota and an adviser to John McCain in the 2008 presidential election, believes that studies overstate the excessive healthcare spending in the United States. But
when he talks about the hospitalization of his elderly mother, his dispassionate academic tone shifts to one I’ve heard thousands of times, brimming with frustration:

There were a dozen doctors all sending separate bills and I couldn’t decipher any of them. They were all large numbers and the insurance paid a tiny fraction. Imagine if a home contractor worked this way? He estimates $125,000 for your kitchen and then takes $10,000 when it’s done? Would anyone ever renovate?

Imagine if you paid for an airplane ticket and then got separate and inscrutable bills from the airline, the pilot, the copilot, and the flight attendants. That’s how the healthcare market works. In no other industry do prices for a product vary by a factor of ten depending on where it is purchased, as is the case for bills I’ve seen for echocardiograms, MRI scans, and blood tests to gauge thyroid function or vitamin D levels. The price of a Prius at a dealership in Princeton, New Jersey, is not five times higher than what you would pay for a Prius in Hackensack and a Prius in New Jersey is not twice as expensive as one in New Mexico. The price of that car at the very same dealer doesn’t depend on your employer, or if you’re self-employed or unemployed. Why does it matter for healthcare?

We live in an age of medical wonders—transplants, gene therapy, lifesaving drugs, and preventive strategies—but the healthcare system remains fantastically expensive, inefficient, bewildering, and inequitable. Faced with disease, we are all potential victims of medical extortion. The alarming statistics are incontrovertible and well known: the United States spends nearly one-fifth of its gross domestic product on healthcare, more than $3 trillion a year, about equivalent to the entire economy of France. For that, the U.S. health system generally delivers worse health outcomes than any other developed country, all of which spend on average about half what we do per person.

Who among us hasn’t opened a medical bill or an explanation of benefits statement and stared in disbelief at terrifying numbers? Who hasn’t puzzled over an insurance policy’s rules of co-payments, deductibles, “in-network” and “out-of-network” payments—only to surrender in frustration and write a check, perhaps under threat of collection? Who hasn’t wondered over, say, a $500 bill for a basic blood test, a $5,000 bill for three stitches in an emergency room, a
$50,000 bill for minor outpatient foot surgery, or a $500,000 bill for three days in the hospital after a heart attack?
Where is all that money going?

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**Before becoming a reporter** for the *New York Times*, I went to Harvard Medical School and then trained and worked as a physician at what is now NewYork-Presbyterian Hospital, a prestigious academic center.* To explore the American system and its ills, I’ve fallen back on the “history and physical,” an organized and disciplined form of record keeping that every doctor uses. The so-called H&P is a remarkable template for understanding complex problems, such as sorting out a patient’s multitude of symptoms, in order to come to the proper diagnosis and to allow for effective treatment. The H&P has predictable components:

- **chief complaint:** What major symptoms does the patient notice?
- **history of the present illness and review of systems:** How did the problem evolve? How has it affected each organ separately?
- **diagnosis and treatment:** What is the underlying cause? What can be done to resolve the patient’s illness or symptoms?

What you are reading right now is the chief complaint: hugely expensive medical care that doesn’t reliably deliver quality results. Part 1 of this book, “History of the Present Illness and Review of Systems,” charts the transformation of American medicine in a little over a quarter century from a caring endeavor to the most profitable industry in the United States—what many experts refer to as a medical-industrial complex. As money became the metric of good medicine, everyone wanted more and cared less about their original mission. The descent happened sector by sector, and we will explore it that way: insurers, then hospitals, doctors, pharmaceutical manufacturers, and so on.

First as the child of an old-fashioned doctor—my father was a hematologist—then as an MD, and finally during my years as a healthcare reporter for the *Times*, I’ve had a lifetime front-row seat to the slow-moving heist. I have spent months poring over financial statements, tax documents, patient charts, and bills trying to explain why, for example, a test that costs $1,000 at one of the nation’s
leading academic hospitals costs $7,000 at some small community hospitals in New Jersey—and the equivalent of only about $100 in Germany and Japan.

These days our treatment follows not scientific guidelines, but the logic of commerce in an imperfect and poorly regulated market, whose big players spend more on lobbying than defense contractors. Financial incentives to order more and do more—to default to the most expensive treatment for whatever ails you—drive much of our healthcare. The central mantra of “innovation” in the past decade has been “patient-centered, evidence-based care.” But isn’t that the very essence of medicine? What other kind of medical care could there be?

ALL THE HARROWING TALES in this book occurred despite the 2010 passage and 2014 enactment of the Patient Protection and Affordable Care Act (the ACA, also known as “Obamacare”). The ACA is not a failure,* as some still assert, but the “affordable” in its name was an overreach to win over votes and public opinion. (Healthcare bills all have happy names affixed for the sell, including the newest mixed bag, the 21st Century Cures Act.) After endless compromises with the medical industry to enable its passage, the ACA was mostly a bill to make sure that every American could have access to health insurance. But it didn’t directly do much, if anything, to control runaway spending or unsavory business practices. Washington being what it is, I doubt we’ll ever see the “Take Back America’s Healthcare” bill or the “Stop Robbing Patients” bill.

Likewise, such tales will no doubt continue under the administration of Donald J. Trump, who vowed to “repeal and replace Obamacare with something better” during the 2016 campaign. As many experts pointed out, the president did not actually have the power to repeal the law, just like that, whole cloth. Within days after the election, he said he would likely keep certain provisions—such as guaranteeing access to insurance for those with preexisting conditions—and would allow for a prolonged grace period so that the twenty-two million people who’d obtained insurance through Obamacare would not go without, while the “better” option could be devised. Whatever its final outlines, that Republican replacement plan (Trumpcare? PatriotCare?) is certain to expose patients to more market forces—meaning it is more imperative than ever to understand the convoluted (il)logic behind the extravagant prices we pay.
It is easy to feel helpless. Our sense of medical urgency combined with bureaucratic confusion is a debilitating cocktail. But we, the patients, can actually do a lot to wrest control of our health from the ledgers of the medical-industrial complex.

Part 2 of this book, ”Diagnosis and Treatment,” offers not only advice and recommendations that will make your insurers, doctors, and hospitals more affordable and responsive to you but also a range of potential, and politically viable, government fixes that would tamp down the costs and the financial crimes imposed on our bodies in the name of health.

The next steps are up to us. There are self-help strategies you can implement tomorrow to reduce your medical expenses, not to mention political solutions that could revamp American healthcare once and for all if you understand how to effectively press for their deployment. They’re not mutually exclusive. We can start now.

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Each market has certain rules that are determined by the conditions, incentives, and regulations under which it operates. Currently, we buy and sell medical encounters and accoutrements like commodities, but how do participants in the marketplace make purchasing choices? Prices are often unknowable and unpredictable; there’s little robust competition for our business; we have scant information on quality to guide our decisions; and very often we lack the power ourselves to even choose.

The rules governing the delivery of healthcare in the United States have grown out of the market’s design. The type of healthcare we get these days is exactly what the market’s financial incentives demand. So we have to get wise to them, and be smarter, far more active participants in this ugly, rough–and–tumble world. More important, we have to change the rules of the game, with different incentives and new types of regulation. I’ve set out the current rules at the end of this introduction. And I’ll be referring to them as you read on. In Part 1, you’ll see how they play out, and their terrible effects on the health and finances of patients, as illustrated by real-life case studies.

The economist Adam Smith spoke of an “invisible hand” with respect to income distribution. But in American healthcare, there’s a different type of invisible hand at work: it’s on the till.
ECONOMIC RULES OF THE DYSFUNCTIONAL MEDICAL MARKET

1. More treatment is always better. Default to the most expensive option.
2. A lifetime of treatment is preferable to a cure.
3. Amenities and marketing matter more than good care.
4. As technologies age, prices can rise rather than fall.
5. There is no free choice. Patients are stuck. And they’re stuck buying American.
6. More competitors vying for business doesn’t mean better prices; it can drive prices up, not down.
7. Economies of scale don’t translate to lower prices. With their market power, big providers can simply demand more.
8. There is no such thing as a fixed price for a procedure or test. And the uninsured pay the highest prices of all.
9. There are no standards for billing. There’s money to be made in billing for anything and everything.
10. Prices will rise to whatever the market will bear.
Part I

HISTORY OF THE PRESENT ILLNESS AND REVIEW OF SYSTEMS
THE AGE OF INSURANCE

Jeffrey Kivi, fifty-three, a chemistry teacher at New York’s prestigious Stuyvesant High School, has a Ph.D. in chemistry and worked as a researcher at the pharmaceutical company Abbott Laboratories for twenty years. He has a good idea of what medical treatment should cost. Since childhood, he has suffered from a condition called psoriatic arthritis, a disease where an overly enthusiastic immune system attacks the skin, causing rashes, and the joints, causing crippling arthritis.

When he was getting his Ph.D. at Purdue University in Indiana, his disease flared up so frequently that he was on high doses of prednisone, a steroid that quells the immune system’s attack on the bone. Even with that, he “had severe problems with [his] feet, ankles, knees, hips, and lower back/sacroiliac joints—often to the point of being unable to work and even walk.”

About fifteen years ago, important new arthritis drugs hit the market. His rheumatologist, Dr. Paula Rackoff, said he was a good candidate. The medicine worked wonders: every six weeks, a drug called Remicade was infused into his veins in an outpatient clinic at Beth Israel Hospital, where Dr. Rackoff practiced. The treatment cost $19,000 each visit, but Mr. Kivi, as a New York City civil servant, has excellent insurance under EmblemHealth. He paid nothing himself. On the new medicine he could stand for many hours teaching his classes and navigate Stuyvesant’s labyrinthine network of hallways. The results were transformative.

Then in 2013 Dr. Rackoff moved her practice about fifteen blocks north to NYU Langone Medical Center. The support services were better and she wanted to practice in a more academic environment, she told her patients. The setup would be more convenient for Mr. Kivi too. Unlike Beth Israel, the NYU
Langone infusion clinic was open nights and weekends, so he didn’t have to find a substitute teacher or use sick time to get his treatment.

At first, he was impressed by the Langone Center for Musculoskeletal Care, where services were distinctly more upmarket. “I thought it might be a bit more expensive,” he said, noting that at NYU he was greeted at the front desk by a patient navigator who walked him to his small private infusion cubicle, equipped with Internet, a television, bottled water, and snacks. (See Rule 3: Amenities and marketing matter more than good care.)

But the charges that started posting on his insurance Web site, as submitted by NYU, shocked him: the first three-hour infusion at the new hospital, in May, was billed at $98,575.98, the second in June at $110,410.82, and from July on they were billed at $132,791.04. It was the same dose as always, in the same form, prescribed by the same doctor.

Both Mr. Kivi and I, independently, spent some weeks trying to get an explanation of the charges from NYU. A pharmacist mixed up the drug. A nurse put the IV into his arm. But beyond that Mr. Kivi just sat occupying a chair for several hours. How did that merit these kinds of bills?

When Mr. Kivi complained to the NYU billing office, a patient-care representative offered a range of nonexplanations:

She tried to tell me that, although she had no idea how much profit NYU is making, she was sure that it couldn’t be all that much. After all, there are shipping costs, storage costs, and other administrative costs associated with a hospital facility. Really? Enough to justify $120,000 billed to EmblemHealth for a single dosage administered? In the end, she said that I should pay no attention to how much money my insurance company was being forced to pay. After all, it’s not costing me anything.

When I tried to pick up the investigation where Mr. Kivi left off, the explanations got even less convincing. The public affairs department told me Mr. Kivi was an “outlier” because he was getting aggressive treatment and he is large. Remicade is dosed according to weight and, at over six feet and nearly four hundred pounds, Mr. Kivi does get a relatively large dose. But even so, the wholesale price of Mr. Kivi’s dose of Remicade should only have been about $1,200, a drug researcher at another hospital told me.
As we slid down the rabbit hole of medical pricing, things only got darker and darker. NYU Langone, it turns out, has a financial interest in Remicade and potentially stands to profit each time the drug is used. One of Remicade’s inventors is Dr. Jan Vilcek, a professor at NYU and an immigrant from Slovakia who donated a share of his patent royalties to Langone Medical Center in gratitude for help reestablishing his career in the United States. NYU sold most of its rights to the royalties in 2007 for $650 million, but it still receives payment if the profits from the drug rise above an undisclosed bar. With charges like $132,000, chances are that the bar will be crossed.

But there was a bigger shocker for Mr. Kivi: instead of taking issue with the price and securing a deep discount, his insurer came through with almost all of the cash. “I was stunned when the first infusion bill finally showed up on my account,” Mr. Kivi wrote to me. “Emblem-Health paid $73,931.98 for the first single infusion!! I couldn’t believe my eyes!! This was for the same drug at the same dosage as I’d always gotten. Nothing had changed. And then it went up to $99,593.27 for subsequent times.” The capitulation so angered Mr. Kivi that he decided to switch to a drug he could give himself at home, though it did not work as well.

(See Rule 10: Prices will rise to whatever the market will bear.)

Emblem was shelling out $1 million a year to NYU Langone for Mr. Kivi’s treatments, and because he is a New York City teacher that means all residents were paying some share with their tax dollars. Why would an insurer pay such an exorbitant price for a drug?

The History: In the Beginning

Claims forms and explanations of benefits now seem as native to medicine as oxygen and water are to the earth, but it is important to remember that health insurance is a relatively novel invention, one whose mission has changed dramatically in recent decades.

The very idea of health insurance is in some ways the original sin that catalyzed the evolution of today’s medical-industrial complex. The people who founded the Blue Cross Association in Texas nearly a century ago had no idea
how their innovation would spin out of control. They intended it to help the sick. And, in the beginning, it did.

A hundred years ago medical treatments were basic, cheap, and not terribly effective. Often run by religious charities, hospitals were places where people mostly went to die. “Care,” such as it was, was delivered at dispensaries by doctors or quacks for minimal fees.

Disease was very time consuming. Without antibiotics and nonsteroidal medicines, or anesthetics and minimally invasive surgery, sickness and injury took much longer to heal. The earliest health insurance policies were designed primarily to compensate for income lost while workers were ill. Long absences were a big problem for companies that depended on manual labor, so they often hired doctors to tend to workers. In the 1890s, lumber companies in Tacoma, Washington, paid two enterprising doctors 50 cents a month to care for employees. It was perhaps one of the earliest predecessors to the type of employer-based insurance found in the United States today.

As medical treatments and knowledge improved in the early twentieth century, the concept of insurance evolved. The archetype for today’s insurance plans was developed at Baylor University Medical Center in Dallas, Texas (now part of Baylor Scott & White Health, since it merged with another health system in 2013, forming a giant healthcare conglomerate), which was founded in 1903 in a fourteen-room mansion by the Baptist Church. A devout cattleman provided the initial $50,000 in funding to open what was then called the Texas Baptist Memorial Sanitarium, “a great humanitarian hospital.” By the 1920s, more and more Texans were coming for treatment. When Justin Ford Kimball, a lawyer who was Baylor’s vice president, found out that the hospital was carrying a huge number of unpaid bills, he offered the local teachers’ union a deal. For $6 a year, or 50 cents a month, teachers who subscribed were entitled to a twenty-one-day stay in the hospital, all costs included. But there was a deductible. The “insurance” took effect after a week and covered the full costs of hospitalization, $5 a day, which is about $105 in 2016 dollars.

Soon, employees for the Dallas Morning News and local radio stations were also signing up for what we today would call catastrophic care insurance. It was a good deal. The cost of a twenty-one-day hospitalization, $525, would have bankrupted many at the time. In that era, given the treatments available, within twenty-one days you were likely dead or cured.

Within a decade, the model spread across the country. Three million people had signed up by 1939 and the concept had been given a name: Blue Cross
Plans. The goal was not to make money, but to protect patient savings and keep hospitals—and the charitable religious groups that funded them—afloat. Blue Cross Plans were then not-for-profit.

Despite this, before World War II, when most treatments were still relatively unsophisticated and cheap, few Americans had health insurance. The invention of effective ventilators, breathing machines that moved air in and out of the lungs, enabled a vast expansion of surgery suites and intensive care units. That meant more people could be saved, including soldiers injured during the war and victims of polio outbreaks.

Transformative technologies rapidly spread across the developed world. Abbott Laboratories made and patented the first intravenous anesthetic, thiopental, in the 1930s. Massachusetts General Hospital started the first anesthesia department in the United States in 1936. The first intensive care unit (ICU) armed with ventilators opened during a polio epidemic in Copenhagen in the early 1940s.

Five dollars a day and a twenty-one-day maximum stay were no longer enough. Insurance with a capital I was increasingly needed. A private industry selling direct to customers could have filled the need—as it has for auto and life insurance. But a quirk of history and some well-meaning policy helped etch in place employer-based health insurance in the United States. When the National War Labor Board froze salaries during and after World War II, companies facing severe labor shortages discovered that they could attract workers by offering health insurance instead. To encourage the trend, the federal government ruled that money paid for employees’ health benefits would not be taxed. This strategy was a win-win in the short term, but in the long term has had some very losing implications.

The policies offered were termed major medical, meaning they paid for extensive care but not routine doctor visits and the like. The original purpose of health insurance was to mitigate financial disasters brought about by a serious illness, such as losing your home or your job, but it was never intended to make healthcare cheap or serve as a tool for cost control. Our expectations about what insurance should do have grown.

Blue Cross and its partner, Blue Shield, were more or less the only major insurers at the time and both stood ever ready to enroll new members. The former covered hospital care and the latter doctors’ visits. Between 1940 and 1955, the number of Americans with health insurance skyrocketed from 10 percent to over 60 percent. That was before the advent of government programs
like Medicare and Medicaid. The Blue Cross/Blue Shield logo became ubiquitous as a force for good across America. According to their charter, the Blues were nonprofit and accepted everyone who sought to sign up; all members were charged the same rates, no matter how old or how sick. Boy Scouts handed out brochures and preachers urged their congregants to join. By some accounts, Blue Cross Blue Shield became, like Walter Cronkite, one of the most trusted brands in postwar America.

But the new demand for health insurance presented a business opportunity and spawned an emerging market with other motivations. Suddenly, at a time when medicine had more of value to offer, tens of millions of people were interested in gaining access and expected their employers to provide insurance so they could do so. For-profit insurance companies moved in, unencumbered by the Blues’ charitable mission. They accepted only younger, healthier patients on whom they could make a profit. They charged different rates, depending on factors like age, as they had long done with life insurance. And they produced different types of policies, for different amounts of money, which provided different levels of protection.

Aetna and Cigna were both offering major medical coverage by 1951. With aggressive marketing and closer ties to business than to healthcare, these for-profit plans slowly gained market share through the 1970s and 1980s. It was difficult for the Blues to compete. From a market perspective, the poor Blues still had to worry about their mission of “providing high quality, affordable health care for all.”

By the 1990s, the Blues, which offered insurance in all fifty states, were hemorrhaging money, having been left to cover the sickest patients. In 1994, after state directors rebelled, the Blues’ board relented and allowed member plans to become for-profit insurers. Their primary motivation was not to charge patients more, but to gain access to the stock market to raise some quick cash to erase deficits. This was the final nail in the coffin of old-fashioned noble-minded health insurance.

Many of the long-suffering Blue plans seized the business opportunity. Blue Cross and Blue Shield of California was particularly aggressive, gobbling up its fellow Blues in a dozen other states. Renamed WellPoint, it is the biggest of the for-profit companies descended from the original nonprofit Blue Cross Blue Shield Association; today it is the second-largest insurer in the United States. Most of its plans still operate under the name Anthem BlueCross BlueShield, but in New York the plans operate under the Emblem brand. The insurer for New
York City teachers, which reimbursed about $100,000 for each of Jeffrey Kivi’s outpatient infusions, has evolved a long way from its not-for-profit mission and $5-a-day hospital payments.

WellPoint’s first priority appears no longer to be its patient/members or even the companies and unions that choose it as an insurer, but instead its shareholders and investors. As in any for-profit enterprise, executives are compensated for how well they perform that financial function and are compensated well. In 2010 WellPoint had intended to hike premiums in California by 39 percent, before an attorney general effectively nixed the plan. **CEO Angela Braly** received total annual compensation of more than $20 million in 2012, despite the fact that she resigned under pressure that year because the company revenues were down. Joe Swedish, the new CEO appointed in 2013, is a longtime healthcare executive who served at the for-profit Hospital Corporation of America. His starting salary and bonus totaled about $5 million, not including stock options.

Then, in August 2014, WellPoint announced that it planned to change its name to Anthem Blue Cross (pending approval by shareholders), presumably to take advantage of whatever nostalgic good feelings patients had retained toward the Blues, **before raising premiums** on some of its California ACA policies by 25 percent in 2015. Dave Jones, California’s vocal insurance commissioner, accused Anthem of “once again imposing an unjustified and unreasonable rate increase on its individual members.” Using his bully pulpit to publicly voice his objections was Jones’s only recourse, since he, like many state insurance commissioners, can make only nonbinding determinations and has no legal authority to deny rates. To express their collective frustration, members gathered signatures for a MoveOn.org petition: “Anthem Blue Cross: Stop Playing Politics with Our Premiums.” They urged their insurer “to stop spending corporate funds on political campaigns, disclose everything it has spent directly or indirectly on political campaigns, and use the money to lower rates for Anthem policyholders and California taxpayers.”

In 1993, before the Blues went for-profit, insurers spent 95 cents out of every dollar of premiums on medical care, which is called their “medical loss ratio.” To increase profits, all insurers, regardless of their tax status, have been spending less on care in recent years and more on activities like marketing, lobbying, administration, and the paying out of dividends. The average medical loss ratio is now closer to 80 percent. Some of the Blues were spending far less than that a
decade into the new century. The medical loss ratio at the Texas Blues, where the whole concept of health insurance started, was just 64.4 percent in 2010.

The framers of the Affordable Care Act tried to curb insurers’ profits and their executives’ salaries, which were some of the highest in the U.S. healthcare industry, by requiring them to spend 80 to 85 percent of every premium dollar on patient care. Insurers fought bitterly against this provision. Its inclusion in the ACA was hailed as a victory for consumers. But even that apparent “demand” was actually quite a generous gift when you consider that Medicare uses 98 percent of its funding for healthcare and only 2 percent for administration.

Why did EmblemHealth agree to pay nearly $100,000 for each of Jeffrey Kivi’s infusions, even though they cost only $19,000 at another hospital just down the street? First, it’s less trouble for insurers to pay it than not. NYU is a big client that insurers don’t want to lose, and an insurer can compensate for the high price in various ways—by raising premiums, co-payments, or deductibles. Second, now that they suddenly have to use 80 to 85 percent rather than, say, 75 percent of premiums on patient care, insurers have a new perverse motivation to tolerate such big payouts. In order to make sure their 15 percent take is still sufficient to maintain salaries and investor dividends, insurance executives have to increase the size of the pie. To cover shortfalls, premiums are increased the next year, passing costs on to the consumers. And 15 percent of a big sum is more than 15 percent of a smaller one. No wonder 2017 premiums for the most common type of ACA plan are slated to rise by double digits in many cities, despite economists’ assurances that the growth of healthcare spending is slowing.

To some extent insurers do better if they negotiate better rates for your care. But that is true only under certain circumstances and in a limited way. “They are methodical money takers, who take in premiums and pay claims according to contracts—that’s their job,” said Barry Cohen, who owns an Ohio-based employee benefits company. “They don’t care whether the claims go up or down twenty percent as long as they get their piece. They’re too big to care about you.”

In fact, history shows that once a procedure is covered by insurance, its sticker price generally goes up because patients are largely insulated from the cost. (For example, when patients had to pay for physical therapy on their own, the cost was likely under $100 a session, significantly less than the $500 an insurer will approve today for a forty-five-minute treatment in a major metropolitan area.) As in Mr. Kivi’s case, insurers often dole out payments for
services that no consumer would countenance—and, worse, they pay repeatedly. Hundreds of insured patients get infusions costing tens of thousands of dollars at NYU Langone; unlike Mr. Kivi, most do not complain about the price tag.

Instead of bargaining for decent prices, insurers refine their messaging to cultivate loyalty, whether or not it is deserved. Explanation of benefits statements tout how much an insurer “saved” you. “You saved 96%!” crowed Cigna about an overpriced one-night hospital stay at NYU Langone, a calculation explained like this: of the hospital’s $99,469 bill (not including doctors’ fees), Cigna paid its negotiated discounted rate of $68,240 and the patient had to contribute $3,018. Is that overwhelming cost really something to be upbeat about?

Once acceptance of health insurance was widespread, a domino effect ensued: hospitals adapted to its financial incentives, which changed how doctors practiced medicine, which revolutionized the types of drugs and devices that manufacturers made and marketed. The money chase was on: no one was protecting the patients.
Heather Pearce Campbell, an attorney, had always relied on Swedish Medical Center in Seattle for her healthcare. She delivered her first child, a son, there in 2012, and when she became pregnant again in 2014, she returned to Swedish for prenatal treatment.

But her first sonogram, in October, revealed an ectopic pregnancy: the embryo was developing in one of the delicate, narrow fallopian tubes, a dangerous, potentially fatal complication. Within a couple of hours, Ms. Campbell was in the OR, where a surgeon removed the tube, along with the embryo and a part of her uterus.

“I was in there way less than one day, so it was pretty surprising to end up seeing a bill for $44,873.90,” said Ms. Campbell of the first bill she received six weeks later, which covered only the hospital portion of the charges. But there was an even bigger surprise on the bill: her entire treatment was labeled simply “miscellaneous.” The cost dwarfed the $25,000 a few years before for her two-day stay after a C-section. The bill indicated that Aetna had paid Swedish its discounted negotiated rate of $17,264.56 for her stay and she was expected to send an additional sum of $875.

For Ms. Campbell, it was a tipping point into outrage and action: “Miscellaneous? Forty-five thousand dollars?” she said. “I’m thinking ‘Wow, is that how they bill?’ That’s a really big number!” She called the hospital and demanded a breakdown of charges. She was told “we don’t normally send those,” but then she pointed out that it was her right, by law. She waited. It never arrived.

When she started getting threatening calls from the hospital demanding payment in January, she protested that she’d never received the itemized bill.
“The woman said, ‘If you want an itemized bill you can drive over right now and get it, otherwise we’re turning you over to collections.’” She filed a complaint concerning “deceptive and obstructive billing practices” with the state attorney general.  

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The cost of hospital services has grown faster than costs in other parts of our healthcare system. From 1997 to 2012, the cost of hospital services grew 149 percent, while the cost of physician services grew 55 percent. The average hospital cost per day in the United States was $4,300 in 2013, more than three times the cost in Australia and about ten times the cost in Spain.  

Why?  

“It’s like asking Willie Sutton why he robs banks: that’s where the money is,” said Dr. David Gifford, a former director of the Rhode Island Department of Health. Market economists I’ve spoken with variously refer to hospitals as “sharks” or “spending machines.” With few if any market forces to effectively curb their behavior, they raise prices as much as they can. Because most hospitals are nonprofit institutions, they have no shareholders to answer to and cannot legally show a “profit”; therefore, they spend excess income on executive compensation and building Zen gardens and marble lobbies.  

A longtime finance executive with major American hospitals describes his field as an extractive industry:  

There is an army of consultants running around hospitals. A whole phalanx of firms is there to improve revenue, improve compensation, and get a piece of the pie. Ten to 15 percent of revenue goes to billing and collection companies and contractors to do things like claims and preapproval—those jobs don’t even exist in Europe. And hospitals go to Wall Street for bond issues to build new wings, so the bankers are at the trough, too. We have so much surplus capacity, which should lead to falling prices. But instead we get the opposite: It’s a market failure, but it follows certain logic. This is not a healthcare system, it’s an industry, and at every point there’s a way to make money.
A Doctor’s View: One Hospital’s Journey from Charity to Profit

Providence Portland Medical Center in Portland, Oregon, has undergone a transformation in the past quarter century, which is typical of hundreds of hospitals in the United States. Like many hospitals, Providence has its roots in nineteenth-century religious charity, and most have retained vestiges in their names: Baptist, Mercy, Methodist, Trinity, Presbyterian, Mount Sinai. Healthcare has become a great way for the Catholic Church, in particular, to collect money. From 2001 to 2011, the number of American hospitals affiliated with the Catholic Church grew by 16 percent, as the number of public and secular nonprofit hospitals dropped 31 percent and 12 percent, respectively. Eight of the ten largest nonprofit hospital systems in the United States have religious affiliations and names.

Providence was founded by nuns from an order in Montreal called the Sisters of Providence. In the 1850s, some of the dedicated sisters traveled for months to establish an outpost in the Pacific Northwest. (An earlier unsuccessful attempt had ended up in what is now Chile.) Once ensconced on the American frontier, in addition to taking in orphans, the sisters made home visits to the sick, and “the community came to rely on these compassionate women in times of illness and death.” By 1858 they had opened St. Joseph Hospital in Fort Vancouver, the first permanent hospital in the region. By 1902 they were running thirty hospitals, orphanages, and schools in the Northwest. “Whatever concerns the poor is always our affair,” said Mother Joseph, the order’s leader during that period.

In 1977 Dr. Frank McCullar, a newly minted pediatrician, accepted a job in the outpatient department at Providence. Though not religious, he had trained, in part, at St. Mary’s Hospital, another Catholic health provider, in Rochester, New York, which had also been staffed by nuns. He was inspired by their sense of calling. Providence also had an impressive national reputation. In 1960 Dr. Albert Starr, a Portland heart surgeon, revolutionized the treatment of heart disease by coinventing and then implanting the first successful artificial heart valve. Millions of patients who would otherwise now be dead have benefited from that discovery. Dr. Starr then opened a heart institute at Providence, where he operated for decades. (He is still, at ninety, chairman of Oregon Health & Science University’s Knight Cardiovascular Institute.) He was a medical rock
star, a hero, a genuine draw. Yet “I never saw him on a billboard,” said Dr. McCullar. “Marketing and advertising were considered unethical and looked down on—it just wasn’t done.” But that and everything else about Providence had changed by the time Dr. McCullar retired from Providence, just a few years ago.

In the 1960s Medicare arrived to cover hospital payments. Between 1968 and 1980 the number of Americans under sixty-five covered by good private insurance was at its peak (about 80 percent, compared with about 67 percent in 2007). Because patients were no longer directly forking out cash or writing checks for their care, hospitals began charging more for their services. The original Blues plan at Baylor had paid by the week for hospitalization, but now hospitals like Providence charged for each service and each encounter. In a world populated by doctors, nurses, and nuns, no one really knew how to figure out how much it cost the hospital to remove an appendix, for example. But there was no harm in aiming high, because insurers usually paid whatever was requested.

With lots of money rolling in, the hospital needed to hire businesspeople to manage it. When Dr. McCullar joined Providence, the emergency room and its associated walk-in clinics had one administrator who paid bills, hired support staff, and took care of patient complaints. Within a decade the number of administrators seemed to be doubling.

In the early 1980s, the increasingly powerful hospital administrators (many of whom sans nuns’ habits held degrees in business or healthcare administration) modified Providence’s “core values” to include “stewardship” of resources in addition to its long-standing guiding principles of “respect,” “compassion,” “justice,” and “excellence.” According to Dr. McCullar, “They paid more attention to the bottom line than to the tradition of medicine.”

By the late 1980s, Providence had hired professional coders to translate doctors’ exams into medical bills. Physicians were given stock phrases to use to describe their exams and told what procedures to perform to ensure better revenue—instruction that became commonplace at many hospitals. The doctors began receiving statements each month that showed how much money their examinations brought in, relative to those of their colleagues. Relations between the administration and the doctors became increasingly testy. The physicians in Dr. McCullar’s group asked to see what the hospital had billed Medicare on their behalf. Some doctors were concerned about overcharging. Others wanted to
make sure they were getting their fair share. Providence refused and threatened to fire those who insisted on disclosure.

By the late 1990s the hospital said it no longer wanted to pay a salary to doctors in the ER and clinics; instead, it would treat them as independent contractors. “That turned us into a business also,” Dr. McCullar said. “We negotiated contracts that stipulated what percent of revenues we deserved.” Providence’s marketers also required the doctors to attend what Dr. McCullar calls “charm school.” The seminars were run by a group of physician consultants who had started the Foundation for Medical Excellence in Portland. “I tried to get the administration to look harder at quality outcomes—like infection rates—but they didn’t, and that’s more expensive.” With canny marketing, Providence grew its business, aggressively advertising cardiac care and a state-of-the-art “stroke center.” A new building was adorned with marble columns and featured a fountain with jumping salmon; after more renovation, granite countertops were added and expensive art was displayed. “It became like the Providence Marriott,” Dr. McCullar said. “I was embarrassed to have poor patients come here.”

When Dr. McCullar arrived in Portland in 1977, Providence comprised two sister hospitals: Providence Medical Center and, across town, St. Vincent. By the time he retired, the Providence Network had absorbed many smaller hospitals and bought the practices of internists, cardiologists, and neurologists. Providence Health & Services is now the third-largest nonprofit hospital system in the United States, operating in Oregon, Washington, California, Alaska, and Montana. In 2013 it had revenues of $2.6 billion and about $2 billion in assets. Its CEO is paid about $3.5 million a year. Yet it still describes itself as “a not-for-profit Catholic health care ministry” continuing “a tradition of caring that the Sisters of Providence began more than 158 years ago.” It lists nuns from Providence Ministries as its “sponsors.” The senior vice president of the health system received a papal medal from John Paul II, the Cross Pro Ecclesia et Pontifice, for his service after he retired in 2001.

In fact, Providence’s “tradition” comprises a weird mix of Mother Teresa and Goldman Sachs: one day it is donating $250,000 to help build a new teaching hospital in Haiti to replace one destroyed by the 2010 earthquake, and the next its new offshoot, Providence Ventures, is announcing the launch of a $150 million venture capital fund, led by a former Amazon executive.
One of the hospitals that Providence Health & Services took into its fold in 2012 was Seattle’s Swedish Medical Center, where Heather Pearce Campbell had surgery for her ectopic pregnancy. The affiliation changed both its medical and its financial practices.

Swedish, a secular hospital, had long offered abortions and contraceptive services. Once under Providence’s Catholic umbrella it would not. To mollify the outraged community, Swedish quickly said it would help underwrite a nearby Planned Parenthood center to perform those services. At a press conference, Lauren Simonds, executive director of NARAL Pro-Choice Washington, asked a hospital spokesman what would happen if a pregnant woman was suffering from a life-threatening emergency, such as an ectopic pregnancy, turned up at its door. The hospital’s reply was boilerplate: Swedish “will provide all emergency services required by women in an emergency situation.” Was it possible that Swedish could no longer itemize a bill for “termination,” even if it was to save Ms. Campbell’s life, and that’s why the services she received were categorized as “miscellaneous”?

The merger is also likely the reason for the improbably escalating prices that Ms. Campbell has noticed on Swedish bills, since a huge conglomerate like Providence Health & Services can throw its weight around in insurance negotiations. (See Rule 7: Economies of scale don’t translate to lower prices. With their market power, big providers can simply demand more.)

Behind the Scenes: How Hospitals Got New Business Models

After two decades with community service organizations and nurses’ unions, Peg Graham went to Yale for a master of public health as well as to Pace University for an MBA to understand the mechanics of hospital finance. For much of the 1980s and 1990s, she then worked at a series of hospitals in New York City. Now semiretired, she gave me one of the textbooks she used early in her career, the fifth edition of The Financial Management of Hospitals, by Howard J. Berman and Lewis E. Weeks, published in 1982. A lens into a bygone era, it portends what was to come at a critical juncture in hospital history. “The financial structure of a hospital, due to legal and philosophical constraints, has
not developed in the same manners as that of the commercial corporation,” the authors noted. At the top of a sample hospital organization chart, they placed the “Board of Trustees,” with “Administration,” “Medical Staff,” and “Ladies Auxiliary” beneath.

“Hospitals are big businesses,” according to Berman and Weeks. “The [philanthropic] benefactor alone cannot subsidize hospital operations.” They argued that an antiquated structure grounded in medicine and philanthropy had to change. And it did. Over the course of her career, Ms. Graham watched with distress as concerns about finance rose to dominate those about patients and healthcare in hospital decision making.

In the 1980s she watched as “head nurses” morphed into “clinical nurse-managers” who were adept in fields like compliance or quality assurance and attuned to the business of medicine. To the chagrin of bedside nurses, this new breed of managers coordinated staffing levels with statistical analyses of payment and calculations of baseline nurse-patient ratios. “What disappeared was the head nurse who fiercely protected the patients on her ward and didn’t give a damn about the financials,” Ms. Graham told me.

Then, Ms. Graham served as a special assistant to a doctor who held an entirely new executive position in hospital infrastructure: the chief medical officer, or CMO. The top of the doctors’ totem pole had traditionally been occupied by the physician in chief and surgeon in chief, older, respected practitioners who ran rounds and were called in to review difficult cases. The CMO was also a physician, but his primary allegiance was to the executive suite, and his mission was to use his professional influence to make the ad hoc practice of medicine by the army of doctors at the hospital function as a profitable business. He and his deputies in each department were in charge of “realizing efficiencies”—like trimming the length of hospital stays and convincing doctors to use one kind of stethoscope or to give their hospitalized patients generic drugs.

The good times were rolling for hospitals between 1967 and 1983, when hospitals set their rates and the patient or his insurer was expected to pay up. Medicare payments to hospitals increased more than tenfold from $3 billion to $37 billion nationwide. Ms. Graham remembers the panic in hospital boardrooms when insurers and employers started to complain about rising prices and pushed back, introducing payment plans more like Baylor’s original price-per-week Blue Cross offering. Medicare had initially paid hospitals their “usual and customary charges,” but in the mid-1980s it began paying according to a
diagnosis related group (DRG). The payment for a hospital stay for an appendectomy or for pneumonia would be a fixed amount depending almost entirely on the diagnosis. The hospital would make money on patients who healed more quickly and efficiently—and lose money on those who did not.

Most commercial insurers never adopted Medicare’s DRG system with its immovable cost constraints. But they also balked in other ways at paying for long, expensive, procedure-filled hospital stays: they hired care managers to review and approve elective surgery as well as negotiators to determine what proportion of the bill they would agree to pay.

That’s how the gap between the big numbers on hospital bills and what any insurer actually pays, which began as a small crack and has evolved into a gaping chasm, came about. The crazy-quilt phenomenon of some patients paying less and some more for exactly the same care evolved the same way: hospital business departments realized if Medicare or a powerful insurer wouldn’t agree to pay a big enough proportion of the rate they wanted, they had the leverage to insist that smaller insurers—and people with no insurance—pay more. (See Rule 8: There is no such thing as a fixed price for a procedure or test. And the uninsured pay the highest prices of all.)

In the early 1990s, with prices and health insurance premiums sometimes increasing 20 percent a year, many employers and the insurers they hired desperately sought to move patients into health maintenance organizations (HMOs) to contain costs. HMOs often received a fixed payment per patient per month. A primary care doctor who served as a gatekeeper for tests, specialists, and hospital care, all within an HMO’s closed network, was assigned to each patient. With business falling off as a result of this “care management,” hospitals could only make money if they were streamlined and cost-effective, and most were not.

In response, hospital CMOs and newly hired business advisers in the late 1990s began pulling together a “chart of accounts”—financial data from the inpatient group, the outpatient group, radiologists, and even, for example, some one-doctor specialty centers for diseases like cancer that had been founded by a grateful patient. Hospitals were finally heeding the warning from Berman and Weeks’s 1982 textbook: “The hospital’s administrator, controller and finance committee need accurate cost finding” just like “the executives of . . . a giant supermarket or a chain of discount department stores.”

HMOs succeeded at containing costs at least for a while. The 1990s were the only decade since the 1940s when U.S. health spending did not increase faster
than the cost of living. But most hospitals dragged their heels in creating quality cost-effective care to attract managed care contracts, and these lackluster offerings tarnished the HMO concept in some parts of the country, perhaps forever. Successful HMOs took permanent root in a few markets, most notably Kaiser Permanente in California. But overall patients hated them, in part because so many were hastily designed and poorly managed. The central office of HIP, the largest HMO in the New York market, routinely left patients on the hook for payment by failing to reimburse hospitals in its network. By the turn of the century, many HMOs had died out, but hospitals and doctors had become far more adept at the business of medicine. Many healthcare management companies have their origins in that era.

Within a few years, the position of the chief medical officer would itself seem out-of-date. According to a 2011 article in the newspaper published by the American Medical Association, more business experience was needed to be a hospital executive: “The chief medical officer remains a common leadership position, but hospitals are creating positions such as chiefs of physician relations, integration and medical informatics. . . . Some physicians may find it worthwhile to receive additional training, such as an MBA or other advanced degree. But on-the-job mentorship or training could be sufficient.”

Enter the Consultants

To ensure that the U.S. healthcare system would grow in a cost-effective way, Congress passed a law in 1974 requiring state health-planning agencies to grant approval before hospitals could build new facilities or indulge in the purchase of expensive technology. The agencies granted a “certificate of need” indicating that the community would benefit from the new investment, for example. The goal was to avoid the duplication of services and overbuilding, which studies had indicated would increase cost.

But in 1987 that federal law was rescinded and over the next decade many states ended or watered down their review programs so that hospitals could buy or build whatever they wanted, so long as there was enough revenue to support it. Medical purchases became an “investment.” “At that point the medical arms
race between hospitals was on,” remembers Paul Levy, a former longtime CEO of Harvard’s Beth Israel Deaconess Medical Center.

Kristen Zeff, a young consultant at Deloitte & Touche in those years, watched the firm’s hospital business grow. At first, hospitals ran on such thin margins that consultants had to offer a pay-for-results model. Deloitte would take a percentage of the increased revenues that were generated through its advice about “strategic pricing”: “We came to them with this proposal that at little up-front cost you can increase the amount you bring in just by manipulating how you bill.”

In 2005 Deloitte hired Tommy Thompson, who had been George W. Bush’s secretary of health and human services for the previous four years, as chairman of its global healthcare practice, thereby lending a big name to its outreach in the new sector. Restructuring a hospital as if it were a steel mill or a chicken processing plant seemed uncouth to some boards, but second-tier hospitals and those straining under financial pressures opened their doors wide to consultants.

Deloitte used teaser projects to entice new clientele: for example, it offered free advice to New York–Cornell Medical Center on how to move up in the “Best Hospitals” rankings. (It declined.) In those days Cornell perennially lagged behind Columbia-Presbyterian Medical Center, with which it later merged (it’s now known as NewYork-Presbyterian). “You could analyze the metrics and see what was the lowest cost and easiest way to do it,” Ms. Zeff recalled.

Hospital reimbursement is essentially a strategic puzzle. Medicare has assigned to every hospital a specific overall cost-to-charge ratio that it deems reasonable to participate in government-sponsored insurance. Raising list prices for one thing means lowering them for another. All hospitals have a master price list—a chargemaster—and adjusting it to maximize income was the focus of Deloitte’s strategy. To squeeze more money from the purse, Deloitte advised hospitals to stop billing for items like gauze rolls, which insurers rarely or never reimbursed, and to boost charges for services like OR time, oxygen therapy, and prescription drugs. It was all about optimizing payment by raising prices on certain items. “While it’s legal, it felt ethically dubious and not good for patients,” reflected Ms. Zeff, who is no longer in the business. “And it certainly increases the cost of healthcare.”

For the business departments of hospitals and doctors on staff, the discovery was transformational. The billed price of an item could be completely decoupled from its actual cost. Items that had previously been included in the charge for the operating room or a hospital day could be billed separately.
Patricia Kaufman was born with a congenital spinal condition that has required multiple upper back surgeries at Long Island Jewish Medical Center, another hospital that worked with Deloitte. She has always been happy with the results. But the bills for her last procedure included a $250,000 fee from an outside plastic surgeon to close up the wound, a service that had always been performed by residents at no charge before.

Some absurdities of strategic billing are well known, such as those $17 charges for a Tylenol pill, but there can be far worse consequences: In one instance, a family was billed for $21,000 after the father had a heart attack in the living room of his home. He was driven by relatives to the hospital only to be declared dead in a wheelchair in the lobby before a single test was done. In another case, a Canadian who wintered in Arizona was charged $210,000 for a failed attempt to take out a hip implant that had become infected. (That total doesn’t include the $28,000 he had to pay for an air ambulance to get him back to Canada, where a successful surgery was performed for free.)

Today just about every hospital employs strategic billing, which is enabled and supported by consultants and healthcare advisory firms, large and small. Deloitte is ranked number one by revenue in all areas of healthcare consulting—life sciences, payer, provider, and government health. In 2014 it announced record revenues of $34.2 billion, fueled by more than 17 percent growth in the sector.

**Strategic Billing 101: Upcoding and Facility Fees Lead to a $3,400 Needle Stick**

Dr. Randy Richards, a surgeon in Tennessee, didn’t think much about the bills his patients received until 2014, when he got stuck with a needle in the operating room. Before the era of HIV and hepatitis, gloves were worn primarily to protect the sterility of the operation. In the 1980s, doctors became far more cautious and by the 1990s all hospitals had strict protocols for reporting such incidents, partly for safety concerns and partly because of the expansion of “risk management” teams whose job it is to make sure hospitals don’t get sued. Today, a needle stick requires a report and an immediate blood test. That is partly to consider starting
medication to prevent an infection from taking hold, and partly to document whether the doctor or nurse had hepatitis or HIV already at the time of exposure, so that disability insurance will be clear about its obligations.

After getting stuck, Dr. Richards reported to the ER in keeping with protocol. But some months later he was shocked by the $1,137 bill from the ER doctor, not to mention the $48 charge to put an oxygen meter on his skin, and a $2,198 fee for hospital services. The brief blood draw had been coded as a level 5 visit, the most intensive, which according to guidelines of the Centers for Medicare and Medicaid Services (CMS) requires a detailed history, extensive management or lab results, and examination of multiple body systems. Dr. Richards wrote to me: “What is written down and what was actually done bear little relation. The net charges are just dissociated from reality. All I needed was a blood draw, nothing else. I have discussed this with ER docs and with the Hospital Administration but they stand by their practices.” The phenomenon known as “upcoding” didn’t come into existence overnight.

Around 2000, the hospital where an internist named Dr. W. had long worked became worried that some doctors were not seeing enough patients or bringing in enough revenue. (Dr. W. cannot use his full name because he is worried about losing his job and health insurance.) The hospital decided it would no longer pay these physicians a fixed salary; instead, they would be compensated in proportion to the relative value units (RVUs) of the care they dispensed. RVUs are a measure of productivity used to determine medical billing.

Generalists like Dr. W. are assigned RVUs primarily according to the complexity of their exams and treatment plans, which are coded on a scale of levels 1 to 5. A simple level 2 visit may yield $60; level 3, $120; level 4, $210; and so on. “What started to happen is lots of pinkeye was billed at a level 4,” he explained. “It may not sound like much—but it adds up.” There was financial incentive: colleagues who were coding expansively could make twice as much—over $300,000 instead of $170,000.

Because many prestigious medical centers have all their medical staff on a salary, they contend that their physicians and surgeons therefore have no incentive to upcode or perform unneeded tests and procedures. But many of the well-known health systems (including the Harvard-affiliated Partners HealthCare, the Henry Ford Health System, Duke Health, and Baylor Scott & White Health) tie those salaries to physicians’ RVUs or sometimes offer “productivity bonuses” based on them. A small number even deduct money from a doctor’s salary if his or her RVUs are too low. In 2015, 71 percent of physician
practices supplemented salary with productivity bonuses. Bonuses can motivate doctors, just as they do bond traders.

Insurers, particularly Medicare, tried to prevent upcoding by spot audits of charts, but hospitals provided helpful assistance to doctors. “It’s like a candy store—all you have to do is check the right boxes,” one doctor told me. “We had software for dictation, and it would even say, ‘You need to check two more boxes for level four.’” A questionnaire filled out by a patient can be labeled as a “health needs assessment,” which is a billable item. Injecting a patient’s bum knee with steroids can be coded as “surgery” costing $1,200. If the doctor uses an ultrasound machine to guide the needle (an unnecessary step because it’s easy to enter the knee space), that’s another $300.

Coding creep grew ever bolder—until it made no sense at all. If needle sticks and eye infections are coded as level 5, what was a crushed chest from a car accident or a heart attack? A Center for Public Integrity (CPI) investigative series in 2012 found a huge increase between 2001 and 2008 in Medicare billing for levels 4 and 5 visits among emergency room patients who were sent home, from a quarter to nearly half of all patients. Meanwhile, the proportion of level 2 visits decreased by about half, to just 15 percent. More than 500 of the 2,400 hospitals in the database billed the two most expensive codes for more than 60 percent of patients. Dr. Donald Berwick, a former Medicare administrator, told the CPI that he believed most doctors were not breaking the law, just “learning how to play the game.”

Dr. Richards’s bill also included a $2,198 “facility fee,” which would not have been there two decades ago. Upcoding by doctors has a multiplier effect on hospital profits, because this hospital-imposed charge for the use of its rooms and equipment—the facility fee—rises with the level of service.

Facility fees were a logical outgrowth of a period of rapid scientific progress in medicine, which allowed many treatments to move to an outpatient setting. Improvements in anesthesia, pain medicine, minimally invasive surgery, and biopsy techniques meant that many procedures and operations could be safely performed without an overnight stay. New medicines to quell the severe nausea of chemotherapy meant patients could receive treatment at an infusion center. Because hospitals had traditionally charged a day rate for inpatients, it made some sense that insurers (including Medicare) had largely accepted their new practice of charging facility fees for major outpatient care as well by the turn of the century.
Then abuse (and sometimes fraud) crept in, since facility fees proved easy to manipulate for gain. There is a lot of leeway in the pricing of something as nebulous as two hours in the endoscopy suite (some fees are billed in fifteen-minute increments). What’s more, facility fees provided a great incentive to stop performing any and all procedures in doctors’ offices and instead use a surgicenter or a hospital outpatient department.

Dr. Ronald Anderson, a Pennsylvania rheumatologist, can inject a bursa with painkillers in his office for about $80. (Bursas are fluid-filled sacs that reduce friction around joints. When they become temporarily inflamed it is called bursitis.) But when one of his patients had the condition treated by an orthopedist at a surgicenter with ultrasound guidance, the bill was almost $5,000, most of which the insurance company paid.

Facility fees are a unique construct of American healthcare and its business model. Hospitals in Europe don’t have them. Nor do other types of businesses in the United States. As Yevgeniy Feyman, currently of the Harvard T. H. Chan School of Public Health, observed in Health Affairs Blog, “When you buy anything—a watch, a car, even groceries—you pay a single price for the goods. The Walgreens down the street doesn’t add a separate charge to cover its rent, utilities, or the cost of refrigeration units.”

Closing Departments: Make Money or Die

The new hospital consultants were experts not just in raising revenues with strategic pricing but also in corporate restructuring. Hospitals traditionally had departments that perennially lost money: emergency rooms, labor and delivery, dialysis centers, drug treatment programs, and outpatient clinics in poorer neighborhoods that served Medicaid populations. These were part of their mission and a moral obligation (importantly, they also receive federal funding to subsidize them). But by the early 2000s, every department had to carry its own weight. The chief medical officer and his advisers were expected to find new profitable lines of treatment and to reevaluate the old money-losing departments to see if they could be “turned around.” If not, the department or the service often had to go. “I have worked in an ER for the past ten-plus years and the
administration was very frank that the ER was expected to generate revenue,” said Jacqui Bush, a nurse in California.

As departments underwent serial financial review, hospitals did away with loss leaders and enhanced their most profitable offerings: orthopedics, cardiac care, a stroke center (revenue from expensive scans), and cancer care (revenue from infusions). They erected electronic billboards promoting the short wait times in the ER—a bizarre notion if, as they all aver, people shouldn’t use high-priced emergency rooms to get elective care.

As obesity rates climbed, medical equipment companies devised new operations using new products to help combat the condition, and bariatric surgery was a boom field. Companies, hospitals, and doctors’ groups lobbied successfully to have insurers pay for it all. Being overweight was rebranded as a disease. Dr. Alfons Pomp, a weight-loss surgeon from Canada, was recruited first by New York’s Mount Sinai Medical Center in 1999 and then by NewYork-Presbyterian / Weill Cornell Medical Center just two miles away in 2003. Each hospital invested heavily to create lucrative bariatric wards: buying new beds, lifts, wheelchairs, and OR tables that could accommodate the bulk of the patients. The returns were exceptional.

New machines were purchased based not on medical necessity or even utility but according to financial calculations. Proton beam therapy was developed to treat the small number of tumors that were hard to reach by other methods. Low-energy proton beam machines have long been used at a few centers to treat rare tumors of the eye. But manufacturers of newer high-energy machines, costing over $100 million, had a bigger market in mind. Originally experts predicted there would be at most a handful of these behemoths scattered around the country, which patients could fly to if their tumors could not otherwise be treated. Since it was a complicated new therapy with unpredictable finances that few patients would need, Medicare reimbursed generously. In short order proton beam therapy was being used on a far wider range of tumors than had ever been intended, despite little evidence that it was superior to cheaper options. Every hospital wanted one and new machines came with billing tips as well as elaborate calculations about how long it would take to recoup the investment. (See Rule 1: More treatment is always better. Default to the most expensive option.) The National Cancer Institute and the American Cancer Society tried unsuccessfully to tame the frenzy with science, to no avail, even though one study of thirty thousand patients with prostate cancer found that “proton beam
therapy provided no long term benefit over traditional radiation therapy, despite far higher costs,” according to a report in the Wall Street Journal.

Bankers, who regarded the purchase as a safe investment, were approaching hospitals and offering to finance the machine. Companies sprang up to help smaller hospitals broker, build, and install proton beam centers. One such company, ProCure, received more than $100 million in equity funding. The result: The British National Health Service sends the few patients whom it deems suitable for high-energy proton beam therapy to the United States for treatment (paying for travel and eight to ten weeks of lodging). There is one proton beam machine in all of Canada, but with plans for aggressive construction under way in the United States, there should be three in Washington, DC, four in Florida, and two in Oklahoma City by 2018.

At the other end of the care-profitability spectrum, many hospitals started outsourcing services like dialysis, which is largely financed by Medicare and therefore less amenable to billing legerdemain. According to a 2006 survey, 31 percent of hospitals said they were already outsourcing dialysis, a trend that has only accelerated.

Typically, the hospitals sold their dialysis practices to large for-profit chains of dialysis centers, like DaVita and Fresenius, which were better able to make do with Medicare reimbursements because of their huge economies of scale. But they also, patients complained, cut costs by using poorly trained technicians to administer treatments rather than nurses. In deals brokered by consultants like Innovative Health Strategies (and backed by private equity investors), hospitals “sold” their patients for $40,000 to $70,000 per head to the big commercial players.

Innovative pitched its appeal to hospitals by underlining the economic advantages: “Today’s challenges require successful healthcare entities to establish new revenue sources to fund new technologies and initiatives. High-functioning dialysis units, often having reached economic maturity, are prime candidates for spin-off to independent dialysis companies.” Dozens of health centers from the University of Pennsylvania to Emory have bought in.

But some corners of medicine yielded little revenue no matter how hard consultants squeezed. Dr. Gene Dorio, a geriatrician, was practicing at a small California hospital that went bankrupt in the early 2000s. Business professionals were brought in to “turn it around.” In 2006 the hospital announced plans to close its transitional care unit, where elderly patients could gain some strength before discharge. The unit was popular and provided invaluable healthcare, as
far as patients and doctors were concerned. Dr. Dorio, a member of the Medical Executive Committee, organized a protest by the hospital’s elderly patrons in the lobby, to no avail. There was no revenue stream to support it, and it closed in 2008.

The Business of Medical Training: Hospitals and Cheap Labor

My three years of medical residency were the most stressful of my life. I was on call every third night, arriving at the hospital at 7 a.m. for rounds and leaving about thirty-six hours later, having perhaps caught a few hours of sleep on a gurney. Life was a seemingly endless cycle of blood draws, deaths, and IVs that needed to be replaced in the middle of the night. I learned how to treat someone with heart disease who was having chest pain; how to stitch up wounds so that they would look pretty when healed; how to snake a central line into a deep vein near the heart though the neck. But I often worked outside my comfort zone and at the very limits of my competency.

Residents have long been the worker bees that keep hospitals going, and debates about who should pay for their training and how much have evolved in tandem with our profitable medical system. Before the 1940s hospitals paid trainee stipends by building their costs into patient charges. After World War II, the GI Bill subsidized training and then the creation of Medicare, in 1965, established that federal and state funds should “to an appropriate extent” cover the purported cost of training future doctors, which was viewed as a public service.

By 2014 hospitals received about $15 billion a year in government subsidies to support graduate medical education, a number that had been “increasing for decades.” These payments include “direct payments” for salaries and supervising physicians, as well as “indirect payments” to compensate for the theoretical inefficiencies and institutional sacrifice involved in training new doctors, such as longer hospitals stays and the need to order more tests for teaching purposes.

The trouble is that studies haven’t provided proof of those purported inefficiencies and sacrifices that merited special compensation. Stays in teaching hospitals are no longer than those in hospitals without residents, for example.
In fact, there is much to suggest that hospitals have turned residencies into another profitable business. The senior supervising doctors, called “voluntary faculty,” are often not paid for their time. The residents are the primary teachers of the medical students assigned to their wards, relieving hospital staff of that burden. What’s more, residents provide much of the hospital’s on-the-ground medical manpower by seeing patients in the ER, assisting in the OR, and drawing blood, to name just a few of their duties. They are learning, yes, but are also effectively low-wage labor.

The median cost to a hospital for each full-time resident in 2013 was $134,803. That includes a salary of between $50,000 and $80,000. Federal support translates into about $100,000 per resident per year. Researchers have calculated that the value of the work each resident performs annually is $232,726. Even without any subsidy having residents is a better than break-even deal.

That explains why, even though the Balanced Budget Act of 1997 placed a cap on the number of residents supported by Medicare subsidies, between 2003 and 2012 the number of residents rose by about 20 percent. The recent growth has been particularly large in subspecialty fields where there are generally already (by many estimates) sufficient numbers of doctors, such as urology and pathology.

The Medicare Payment Advisory Commission (MedPAC) estimates the indirect subsidy hospitals receive for medical trainees may be $3.5 billion higher than deserved. The 2010 National Commission on Fiscal Responsibility and Reform recommended downward adjustments that would save an estimated $6 billion in 2015. President Obama’s 2015 budget called for cuts to education payments of $14.6 billion over ten years. Congress has never acted on any of these proposals.

The American Hospital Association (AHA) has lobbied to hang on to this pot of money and the cheap labor and is even lobbying to facilitate the entry of foreign medical graduates since there are not enough U.S. grads to fill the Medicare-subsidized residency slots in less traditionally lucrative or glamorous specialties, such as nephrology, and in underserved communities.

The AHA, along with the Association of American Medical Colleges, avers that cuts would “jeopardize the ability of teaching hospitals to train the next generation of physicians” and “directly threaten the financial stability of teaching hospitals.”
If Republicans were disingenuous in evoking death panels to discredit the Affordable Care Act, Democrats have been equally so in heeding their local hospitals’ calls for more residents. Senator Bill Nelson (Florida), along with cosponsors Senators Charles Schumer (New York) and Harry Reid (Nevada), introduced the Resident Physician Shortage Reduction Act of 2015, to expand the number of subsidized training positions by fifteen thousand, or 15 percent.

One reason why hospitals have been desperately fighting to get still more residents is that, over the past fifteen years, states and medical societies have passed laws, regulations, and recommendations curtailing the work hours of doctors in training, largely to reduce the rate of medical errors that resulted from fatigue. That may be good for everyone’s well-being, but it creates a staffing problem.

Some hospitals responded by reducing educational activities, such as elective rotations and seminars, so they could have more hours of cheap labor. Many also hired moonlighters. In some instances, the doctors whom hospitals pay at a rate of $10 per hour as residents or fellows (more senior doctors in specialty training) can receive $100 per hour to do the exact same job after hours.

Any physician in practice will attest to just how valuable (in terms of medical knowledge and finance) these doctors in training are. Dr. Paul Aronowitz was the director of training at a highly regarded private hospital in California in 2012, when he decided that several attending doctors should no longer be allowed to have residents care for their patients. He cited “repeated serious complaints” concerning their patient care—one resulted in a death—as well as the failure to adequately supervise the student doctors. The hospital CEO overturned the decision. Without the services of residents, the quality of patient care for the doctors’ patients would certainly suffer, the executive said. Moreover, those doctors would likely leave the hospital and move to another if they couldn’t avail themselves of the residents’ services—taking the $1.5 million they generated annually with them.

The Emergence of Hospital-Hotels

The idea that hospitals can’t afford to train residents without subsidies is hard to believe as their buildings have become ever more opulent and their executives
earn Wall Street–size salaries.

Twenty-five years ago, rooms with four beds were common. Private rooms were rare and traditionally reserved for patients with contagious diseases or who were vulnerable to infection. Now, singles have become the norm despite the fact there is little medical justification and many insurers won’t cover them, leaving patients who had no choice stuck with “single supplement” charges. Private rooms may be more pleasant for patients, but even if an insurer covers a private room, we all pay higher prices and premiums in the future to fund building them.

As healthcare became a business, hospitals could have spent their operating surpluses on raising pay for nurses and orderlies, or reducing list prices for patients. But there was not much commercial incentive to do that. “There are an infinite number of ways to spend: amenities, scanners, higher salaries,” said James Robinson, a health economist at the University of California, Berkeley. “So they build more. They’re like Four Seasons Hotels, with valet parking and chandeliers. Then they go to Congress and say Medicaid and Medicare aren’t paying us enough, my margins are low, the CEO doesn’t make much money compared to the private sector.”

Three years after Nancy Schlichting, MBA, took over the helm of Detroit’s Henry Ford Health System in 2003, she hired a hotel industry executive, Gerard van Grinsven of the Ritz-Carlton Group, to be CEO of its new hospital. Henry Ford West Bloomfield Hospital has all private rooms, including in the emergency department, and patients are assigned a concierge who “guides you from check-in to check out.” In the name of medical care, it provides health coaching and acupuncture through Vita, its wellness center. In the late 1990s, the Henry Ford Health System was losing tens of millions of dollars annually, but by 2013 it was comfortably in the black, with revenues of over $2 billion. “We focused on people and service excellence,” Schlichting said. “Patients ask their docs to admit them here, because they want a hospital that treats them this way.”

The hospital is a perennial top scorer in the Press Ganey ratings, a survey tool that rates the “patient experience” at hospitals. Founded in the 1980s by a medical anthropologist and a statistician, Press Ganey bills itself as continuing “to lead the patient experience industry.” hired by an estimated 50 percent of all U.S. hospitals. In 2015 it filed with the Securities and Exchange Commission for an initial public stock offering.

Customer satisfaction is important and predicts repeat business, but it does not necessarily indicate medical quality. Studies have determined that such
surveys have only a “tenuous” link with patient outcomes. Physicians hate them. But Medicare pays hospitals a bonus for performing well on patient surveys. “So if a patient asks for a test and it won’t hurt, they’ll get it,” one doctor told me. “It’s good for Press Ganey scores. It takes more time and trouble to explain why they don’t need the X-ray.”

As hospitals became lavish, executive salaries did too. Top brass of hospitals received packages that included golden parachutes, cars, and funding for their kids’ education. More than two-thirds of the country’s hospitals are not-for-profit, and IRS rules state that nonprofit CEOs should receive only “reasonable compensation,” which it advises should be determined in part by considering salaries at similar organizations. But, as also occurs in the corporate world, the CEO typically picks the compensation consultant and controls who is on the board.

In most cities the highest-paid nonprofit executive by far runs the local hospital. In 2012 Jeffrey Romoff of the University of Pittsburgh Medical Center earned almost $6.1 million, far more than the university’s president. Delos Cosgrove at the Cleveland Clinic earned $3.17 million. Thomas Priselac at Cedars-Sinai earned $3.85 million. Steven Corwin at NewYork-Presbyterian earned $3.08 million. But salaries are very large even at small community hospitals in New Jersey. In 2012 Audrey Meyers, the CEO of Valley Hospital in Ridgewood, earned $2.18 million. Michael Maron, the CEO of Holy Name Medical Center in Teaneck, was paid $1.83 million. In fact, the CEO of one small nonprofit suburban hospital almost certainly earns more today than Darren Walker, the CEO of the Ford Foundation, which operates in more than one hundred countries and has assets valued at about $12 billion.

Total cash compensation for hospital CEOs grew an average of 24.2 percent from 2011 to 2012 alone, which increasingly includes bonuses as well. No surprise. Those bonuses are typically linked to criteria such as “finance,” “quality,” “profit,” “admissions growth,” and “increase in net funds,” not medical goalposts like reducing blood infections or bedsores and avoiding unneeded procedures.

The Most Profitable Nonprofits: The Evolution of Hospital Charity
In 2014 I spoke at the commencement of the University of Pittsburgh School of Medicine, a revered institution and the home base of Dr. Thomas Starzl, a pioneer of transplant surgery, who has been at the University of Pittsburgh Medical Center (UPMC) since 1981.

I was startled to see the place in the city occupied by the University of Pittsburgh Medical Center, with which the medical school is affiliated. To me Pittsburgh was a steel town, a gritty place associated with Andrew Carnegie and manufacturing. Today, it is a gleaming temple of healthcare. UPMC, with nearly sixty thousand employees, is the largest nongovernmental employer in Pennsylvania. It is by far Pittsburgh’s largest employer, almost six times larger than Mellon Bank. It aggressively markets its services not just in western Pennsylvania (where there are few alternatives) but all over the country and internationally—at least to wealthy paying patients. But like nearly all prestigious American medical centers, the UPMC is nonprofit, so it pays almost no U.S. property or payroll taxes.

Until the 1960s, most hospitals and doctors had to do charitable work. Laws and codes of ethics said sick people should be treated even if they couldn’t pay. By 1969 most Americans were insured, so the IRS defined a new standard for hospitals that wanted to keep their tax-exempt status: these institutions had to provide “charity care and community benefit.”

The government placed the value of the tax advantage to hospitals at $12.6 billion in 2002 and in 2011 at $24.6 billion. How to keep that tax benefit while spending the least amount possible on “charity care and community benefit” has become the job of some hospital accountants and consultants in the business of medicine.

Not-for-profit hospitals are now just as profitable as capitalist corporations, but the excess money flowing in isn’t called “profit”—it’s “operating surplus.” Charity Navigator, a group that rates nonprofit organizations based on their governance and use of donated funds, doesn’t even rate not-for-profit health systems because they function on such a different model.

That is why the city of Pittsburgh wrangled for years with UPMC to get it to pay more taxes. In 2013 the then mayor Luke Ravenstahl filed a lawsuit in the Court of Common Pleas demanding six years’ worth of back payroll taxes and a removal of UPMC’s tax-exempt status. He said it was a case of “the David versus the Goliath,” where the second-largest city in Pennsylvania was David, the underdog.
Cities across the nation nervously watched how the legal action played out. Hospitals tend to have more high-priced legal counsel than cash-strapped cities. In addition to avoiding property taxes as well as federal, state, and local payroll taxes, hospitals can issue tax-exempt bonds for building projects. They can collect tax-deductible donations (a boon when a big donor wants to underwrite a new wing or hand over a valuable piece of art to adorn a lobby).

It’s probably fair for hospitals to be able to count services for low-income patients (Medicaid or uninsured) as “charity care and community benefit,” because that practice brings in less than the cost of treatment. But since 1986, hospitals that care for large numbers of low-income people have already been compensated in other ways. They buy all their pharmaceuticals at a discount, through a federal program. Likewise, Medicare gives them so-called disproportionate share payments, essentially bonuses for treating higher numbers of poor people, who tend to be sicker and less able to pay bills. At least three of the twenty hospitals in the UPMC system collected these payments in 2014.

But beyond that, there is little agreement and much gaming surrounding what can or should count toward the IRS requirement of charity care and community benefit. Before 2010, there was little pretense of specific accounting—hospitals could just attach some brochures to their tax returns to illustrate what they were doing. But in 2010, despite fierce hospital protests, a provision of the Affordable Care Act started requiring the IRS to collect each hospital’s quantitative enumeration of charitable activities and their value.

Every year, on a form called Schedule H (Form 990), they now have to list how much money-losing care they dispense—and how they calculate that number. They also have to list and value what they’ve done gratis to better their communities. And that has given scholars and consumer advocates a window and an opportunity to assess whether they deserved their huge tax breaks.

Recent research shows that many are providing nowhere near the amount of charity care and community benefit that would justify the value of their tax exemption. A survey of the forms conducted by the California Nurses Association concluded that 196 hospitals received “$3.3 billion state and federal tax exemptions and spent only $1.4 billion on charity care—a gap of $1.9 billion.” Three-quarters of the hospitals got more dollars in tax breaks than they spent on benefiting the communities they serve.

UPMC had more than $11 billion in revenues and $10 billion in assets in 2014 and an average 12 percent growth rate in revenues over the last fifteen years. It has demonstrated “strong, consistent financial performance” and has a
superior credit rating. “UPMC is a nonprofit that melds an unwavering community mission with entrepreneurial business models,” its Web site says. It is “building a global health care brand.” It provides “world class care to private-pay patients” in agreements with hospitals in Qatar and China, among other countries.

Many medical centers have strategies for exporting their brands, if not always their standards. New York-Presbyterian Hospital has outreach offices in capitals in Asia and the Middle East—kind of like the U.S. Army recruiting station in Times Square—where paying patients can sign up for operations and treatment in New York. Zhang Lei, a Chinese venture capital billionaire, announced that he was teaming up with the Mayo Clinic “to bring one of America’s best-known health care institutions to China.”

The Pittsburgh Post-Gazette has uncovered many of the relevant numbers on UPMC: it is “Allegheny County’s largest property owner, with 656 acres,” 86 percent of which is tax-exempt. If it were not classified as a nonprofit, “UPMC would owe the city $20 million more in taxes every year.” On its 2014 IRS Form 990, UPMC claimed that about 11 percent of its costs went to charity care and community benefit. But it took credit for vague notions like “spurs the economy,” via direct construction jobs, a commitment to diversity through the hiring of minority contractors, and environmental improvement because it had created an award-winning “healing garden.” It avers a shortfall from treating Medicare patients, which it counts as charity, even though Medicare calculates that it pays hospitals more than it should reasonably cost to dispense care.

But the question of UPMC’s service to Pittsburgh never got a public airing. UPMC quickly responded to Mayor Ravenstahl’s lawsuit with a federal countersuit claiming the city had “violated its right to due process.” Then, in 2014, after a year of court wrangling, a judge dismissed the city’s suit on narrow technical grounds, saying that it should not be suing UPMC as an entity, but instead the health system’s individual member hospitals, which dispense the paychecks, since the major issue centered on payroll taxes.

In July of that year, a new mayor, Bill Peduto, decided the city would abandon its legal efforts and instead try to wrest UPMC’s “fair share” of contributions from the hospital in other ways. He said his team would meet privately with UPMC representatives to determine what that might be. Many other cities have avoided protracted court battles by adopting a similar approach.

In 2001 San Francisco passed its Charity Care Ordinance, in large part because there was a suspicion that one of its major hospitals, California Pacific
Medical Center, was not providing care commensurate to its size. That ordinance, which mandates review of charitable performance in conjunction with approval for new hospital construction, provides a stick the city uses to demand more of its high-end health providers.

Before California Pacific Medical Center could break ground on a new flagship hospital on Cathedral Hill a few years ago, Sutter Health, its parent company, had to negotiate for months about what it would contribute to San Francisco in return. Sutter agreed to continue to operate St. Luke’s, an old hospital in its system that served mostly the poor and uninsured. It agreed to spend at least $86 million per year on charity care, Medicaid, and services for the poor. It would spend $20 million to create a Healthcare Innovation Fund to help the city’s community clinics and $60 million for various programs in affordable housing. It would also spend tens of millions on transit upgrades and pedestrian safety programs. The final package even included a bone that was probably particularly tasty for city budget planners: it agreed to not raise rates charged to health insurers that covered city employees by more than 5 percent annually.

All in all, California Pacific Medical Center was willing to spend $1.1 billion to hang on to its tax-exempt status.

**Observation Status: A New Financial Purgatory in the Hospital**

The idea of admitting a patient for “observation” has long been an important medical tool. Indeed, it was likely far more useful a few decades ago when getting results of cardiac enzymes to see whether someone was having a heart attack took twenty-four hours or before CT scans could determine whether a patient with belly pain had an inflamed appendix and needed a trip to the OR.

But as observation has become less important for diagnosis, it has become more important as a lucrative billing construct, manipulated by hospitals, insurers, and nursing homes. The easy money for Medicare patients is not in inpatient admissions. Medicare pays a bundled rate for those. But outpatient care has no similar limits—the till is open for testing. For hospitals there were other advantages as well: For example, Medicare penalizes hospitals if patients bounce
back thirty days after discharge—the “readmission penalty.” But if they were never officially admitted but were merely under “observation” they couldn’t bounce back!

At first Medicare tolerated the sleight of hand and only pushed back when it noted that, by 2011, 8 percent of people under observation were in the hospital for more than two days. (Observation status does not count toward the three days of inpatient care required for Medicare to pay for a subsequent nursing home or rehabilitation stay.) Beginning on April 1, 2015, it said that observation status could not persist for more than “two midnights.” That ruling prompted articles from consultants with titles like “How Your Hospital Can Succeed Under the Two-Midnight Rule”—meaning in terms of money, of course.

For hospitals and insurers, observation status has benefits. For patients it is a disaster. After Jim Silver, a retired software engineer in Indiana, had a brief fainting episode after a medication change, he was sent via the ER to a hospital room on a hospital ward, under “observation status.” In twenty-four hours, he had an array of tests, including scans, all of which were normal. Only later, he discovered the financial implications. Since the terms of outpatient insurance apply, observation status typically means far larger co-payments. Mr. Silver’s insurer negotiated a rate of $12,000 for the stay. If he had been an inpatient, his insurer would have had to cover the entire amount. With his “observation” status, he said he was on the hook for about 20 percent, or $2,300.

In 2015 President Obama signed a bill requiring hospitals to notify patients receiving more than twenty-four hours of observation care of their status as outpatients and its varied implications. But that notification will come after the fact, when patients are already supine in their hospital bed and can do little about it.