

# From the President: Hospital Overcharging

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Managed care now severely limits every patient's choice of physician, hospital, and just about every other aspect of medical care. America has largely relinquished its medical decision-making to number-crunching bureaucrats, as a consequence of tax policies favoring employer-purchased health insurance.

Conventional thinking was that by leveling the tax consequences of employer-purchased policies via Health Savings Accounts (HSAs), one would see a shift to high-deductible accounts, which would in turn release patients from the bondage of managed care.

Alas, hospitals have determined to wage economic warfare against any who dare to tread outside managed care. Two years ago, for instance, at Kettering Medical Center (KMC) in Dayton, Ohio, I was billed for services to which a 40 percent discount was applied. If it is true that hospitals routinely offer the managed-care industry 70-80 percent discounts, this means I was still paying nearly twice what the hospital was being paid by managed care.

More recently, this same hospital granted a reduction of only a 28.36 percent to a bill, after many months of wrangling. I have been a member of KMC's medical staff for nearly a quarter of a century and asked for no special favors—I simply wanted to be able to pay the same charges that the hospital has ascertained to be fair and reasonable compensation from everybody else.

Why would KMC differentiate between my money, and managed-care money? It is after all, a nonprofit institution. Why would it deliberately enrich those who are making billions while usurping the sanctity of the patient-physician relationship?

The net annual income of UnitedHealthcare (UHC) was recently made public. It is about \$2.6 billion. Its CEO took home \$124 million. I wonder how much of those huge profits were earned by denying and obstructing the delivery of timely and competent medical care.

Several years ago, a patient requested that I perform a reduction mammoplasty. Neither she nor I were participants in UHC, but her employer contracted with UHC for predetermination of medical necessity. UHC's functionaries determined that it would be a covered procedure only if 1,000 grams of breast tissue or more was to be removed from each breast! Nearly all other insurance companies agree to a 500-gram standard. Since I refused to mutilate this woman's breasts at the whim of the managed-care company,

the procedure was needlessly delayed until UHC, reluctantly, backed off its potentially damaging demands.

In 2005, the Dayton area witnessed another large managed-care organization flexing its muscles. Anthem's demands on a major hospital system were not accommodated, but meant the loss of a major hospital contract at the beginning of the year. The result was predictable: one hospital was highly underutilized while KMC was severely strained to accommodate a huge influx of patients. Some practice areas, especially obstetrics, were so overburdened that both patients and physicians voiced their angst.

With some hapless patients being forced to change hospitals and physicians during such stressful times, one would expect everyone affected—hospitals, physicians, patients—to seek an alternative.

There is a viable alternative: high-deductible insurance combined with an HSA offers patients more choices, and bypasses manipulations by corporations such as Anthem. But in order for it to work, HSA participants must be treated fairly. It seems unconscionable for hospitals to provide deep discounts to insurers that are siphoning huge amounts from the system, while simultaneously denying medical services to those they are contracted to cover! Yet, when patients step outside these entities and take charge of their own medical care, they are quickly hit hard with charges that average as much as 300-500 percent of what the hospital receives from managed care.

I once overheard a conversation in a doctors' lounge: Physician A: "My patient is sick and needs medication X, but her managed care company will not authorize it because of cost." Physician B retorted, "Why not try medication Y?" Physician A then lamented, "That one is too expensive, too." My guess is that the patient never found out that there was a treatment available. It just wasn't available to her!

The primary benefits of HSAs are to recapture control of patient-physician decision-making, and to provide quality medicine in the most economical setting. But what happens just when legislators finally pave the way to wide availability of HSAs? Hospitals block them.

In no other industry do we see price gouging at this level. During times of crisis, if a service station posts and charges prices as little as 20-30 percent above its competitors' prices, regulators investigate. If your car requires body work, will the body shop gouge a privately paying customer by charging 300-500 percent of the amount an insurance company would pay for the same work? Does the body shop care who writes the check?

Why would KMC, a nonprofit entity, care whether a patient writes the check, or an insurer writes the check for an individual's medical care? KMC styles itself as a "faith-based" hospital and proclaims itself to doing the "health ministry of Jesus." It is operated by the Seventh-day Adventist Church, which ironically operates global humanitarian and relief work! Why then, would one of its flagship hospitals resort to price gouging the uninsured and those who wish to direct their own medical care? Why would it steer huge profits to the multibillion-dollar megacorporations that have wreaked such havoc on patients and physicians?

Unfortunately, KMC is not alone in its unfair tactics against the uninsured, self-insured, and public at large. This is standard practice for virtually all hospitals. Is there collusion here? Is this a predetermined plan to corral all of us into the camp of those who will deny and obstruct proper medicine while simultaneously reaping huge profits?

As I see it, there are three possible solutions: (1) legislation to prevent price gouging; (2) litigation (which, distasteful as it is, is being used); (3) stripping hospitals who engage in unfair pricing of their nonprofit status.

Many argue that government should not set hospital prices. I agree. Neither hospitals nor any other entity should be subjected to price controls in a free society. They simply should be prevented from discriminating against their best customers simply because the patients have chosen to roam outside managed-care's turf.

Some warn that such legislation might also be used against physicians, even though, in my experience, physicians make tremendous efforts to reconcile their charges, to avoid unfairness. Most physicians are for-profit entities, who are working to earn a living. Many of the worst hospital culprits are nonprofits that are supposed to be operating for the benefit of the public at large.

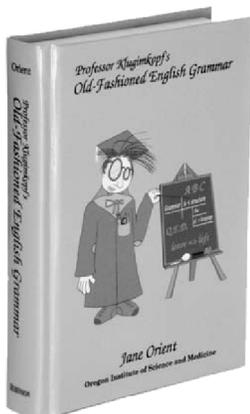
Hospitals that benefit from tax-exempt status as nonprofits should be compelled to act accordingly, to benefit the public and avoid doing harm.

One thing is certain: the problem must be solved—and soon. HSAs will never gain widespread acceptance as long as hospitals are discriminating against patients who use them.

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