From the President:

More on Hospital Overcharging

Kenneth D. Christman, M.D.

The last issue[1] generated some thoughtful queries on hospital overcharging, even amongst-free market proponents. Let's look at some of them:

Q. Wouldn't legislation to correct gross hospital overcharging be harmful to the free market?

A. No, we do not have a free market in medical practice today. A free market is defined in Webster's dictionary as "any market where buying and selling can be carried on without restrictions as to price, etc." What we have is a system of price control. Hospitals are subject to price controls from the government (Medicare and Medicaid). Managed-care plans generally pay only slightly more than the government's controlled price. Those who are uninsured or have Health Savings Accounts (HSAs), however, may pay 400 or 500 percent of those prices!

The free market does not discriminate against buyers. Once the seller has determined what a fair price is for goods or services, having built in a comfortable cushion for expected profits, such prices are good for all buyers. Why should the seller care if the payment is coming from a private checking account or a corporate account? In a free market, as long as the expected payment is made, there is no discrimination based on source of funds, sex, age, religion, etc. In contrast, today's market systematically discriminates against all those who choose to obtain their medical care outside government or Health Maintenance Organization (HMO) price controls.

Q. Is it right to insist that hospitals extend government's price controls to the rest of the population?

A. No. However, hospitals actively solicit HMO business, and contract with HMOs in the reasonable expectation of making a profit. Wouldn't it save hospitals needed resources to stop "negotiating" with these various entities and just have a posted price that applies to everybody? Even better, shouldn't government pay the free-market price as well?

Price controls never work over the long term, and medical care is no exception. Whenever prices are controlled at a level less than the cost, business activity ceases, and a black market develops. It amazes me that systems that have proven to be failures are still being tinkered with in a great country that purports to have "freedom for all."

Years ago, Adam Smith and Karl Marx served up diametrically opposed views on economics. One espoused a free-market system based on supply and demand, while the other promoted strict government controls. Their theories were subjected to a global test that spanned several generations. The test case for government controls crumbled in 1989. Why, then, should the U.S. government persist in employing a system known to fail? One reason is that once government begins regulating the market, more and more regulations are needed to try to correct the adverse effect of the first interventions. Ultimately, it is necessary to start all over. The system we have now cannot last. It is far too obstructive to medical care.

Q. If hospitals are prevented from overcharging a segment of the population, will they not suffer financially?

A. No, as the system in Maryland has shown. Maryland requires hospitals to charge the same rate to all, except for a four percent discount for managed care and an eight percent discount for government programs. Maryland hospitals are not subject to the prospective pricing system (diagnostic related groups or DRGs), but they are still not free to set their own prices, which are determined by a commission. Charges to self-paying patients are much less than in other states. While Maryland does not have a free market, its system shows hospitals can function quite well without charging individual patients prices that are 400 to 500 percent of Medicare and managed care charges.

Q. Are volume discounts part of the free market? Why shouldn't hospitals be allowed to offer larger discounts to HMOs and government?

A. HMOs and government do not execute any mass transactions; patients are still cared for one at a time. There is certainly no less paperwork for government and managed-care patients! Medical care is not like delivering 10,000 articles at a unit cost much lower than for delivering single articles; one cannot do 10,000 heart catheterizations simultaneously to obtain a bulk savings. What government and HMOs gain by controlling large numbers of patients is market clout: the ability to withhold business from anyone who does not agree to their terms. This would raise antitrust issues except that the insurance industry is exempt from antitrust law under the McCarran-Ferguson Act. Nor can one sue the government under antitrust law. Physicians, on the other hand, can be accused of antitrust violations if they act in concert to demand more equitable conditions.

Q. The airlines charge many different prices for the same tickets. Why shouldn't hospitals also be able to set their own prices and vary them?

A. Airline ticket prices may change by the hour, maybe even by the minute, based on the availability of seats. Airlines also find it is

cheaper to sell seats on the internet rather than paying sales agents to take reservations by telephone, and they pass along some savings to the customer. This is the free market at work. However, airlines do not discriminate against segments of the public based on who is paying for the ticket.

Q. Would a law forbidding hospitals to charge a fee greater than the lowest negotiated fee with managed care be a form of price control?

A. I don't think so. If a hospital determines that it can make a reasonable profit at the price charged to a managed-care organization, it should honor such pricing schemes for everybody. The supermarket doesn't charge different prices to different customers. The prices are clearly posted and apply to everybody. The customer selects items based on quality and price, and the cashier does not alter the price based on which checking account or credit card the customer presents.

Q. What about Sam's Club? Don't different people pay different amounts from what is posted?

A. Yes, Sam's price may depend on what type of membership card the customer has purchased. But this is based on an agreement between Sam's and the customer. Contrast this with the situation in which an insurance company agrees, for a certain set figure, to pay all of a subscriber's food costs for a year. Initially, the plan might allow subscribers to choose whichever foods they liked. Imagine that once a sufficiently large part of the population signs up for such a scheme, the insurer goes to the grocery store and demands discounts. Suppose that customers paying for their own food ended up having to pay five times what the insurance company paid. This would not be called a free market, but a rigged one. Eventually, the "insurer" would have to start rationing many items because it would not be able to afford to provide all the items that it has promised. Those who would prefer not to be subject to such rationing would then have to pay multiples of the free-market price.

Hospitals are not allowed to discriminate on the basis of sex, religion, age, or ethnicity. Why should they be permitted to discriminate against those who pay from their own bank account rather than the government's or an insurer's?

Sam's Club does what some cash-based physicians are now doing in charging an up-front fee for access to the care offered by a certain physician or clinic. This is a legitimate practice in a free market.

Q. Aren't hospitals changing their overcharging practices?

A. Kettering Medical Center of Dayton, Ohio, recently announced a change in policy towards those paying cash: they will receive a 20 percent discount! Well, if managed-care plans and the government are receiving 70 to 80 percent discounts, what does this mean?

Q. Won't HSAs, which have tripled in the last 10 months, help to solve this problem?

A. HSAs are a step in the right direction. But almost all of them are tied to some sort of hospital and/or physician panel. Subscribers are still not completely free to choose their physicians and hospitals; they're just paying a much larger share of the costs. Those who go outside the panels may find that they're paying a much larger share of a much greater, highly inflated price. Thus, unless we solve the problem of hospital overcharging, HSAs will avail us nothing.

Q. What should be done?

A. A number of approaches have been suggested, including more public exposure, legislation, litigation, and stripping "nonprofit" hospitals of their tax-exempt status if they grossly overcharge self-paying patients. AAPS encourages physicians to practice independently from the confines of government and managed care. However, what happens when their patients have no option but to use hospital facilities? Are those patients' resources then confiscated by aggressive hospitals? Unfortunately, there are horror stories out there: see WhereTheMoneyGoes.com and HospitalVictims.com.

Kenneth D. Christman, M.D., practices plastic surgery in Dayton, Ohio. He is currently President of AAPS. Contact: KSCDChristman@aol.com.

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