Bitter Pill: Why Medical Bills Are Killing Us

By Steven BrillFeb. 20, 2013

Corrections Appended: February 26, 2013

1. Routine Care, Unforgettable Bills When Sean Recchi, a 42-year-old from Lancaster, Ohio, was told last March that he had non-Hodgkin's lymphoma, his wife Stephanie knew she had to get him to MD Anderson Cancer Center in Houston. Stephanie's father had been treated there 10 years earlier, and she and her family credited the doctors and nurses at MD Anderson with extending his life by at least eight years. Because Stephanie and her husband had recently started their own small technology business, they were unable to buy comprehensive health insurance. For $469 a month, or about 20% of their income, they had been able to get only a policy that covered just $2,000 per day of any hospital costs. "We don't take that kind of discount insurance," said the woman at

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

About a week later, Stephanie had to ask her mother for $35,000 more so Sean could begin the treatment the doctors had decided was urgent. His condition had worsened rapidly since he had arrived in Houston. He was "sweating and shaking with chills and pains," Stephanie recalls. "He had a large mass in his chest that was … growing. He was panicked." Nonetheless, Sean was held for about 90 minutes in a reception area, she says, because the hospital could not confirm that the check had cleared. Sean was allowed to see the doctor only after he advanced MD Anderson $7,500 from his credit card. The hospital says there was nothing unusual about how Sean was kept waiting. According to MD Anderson communications manager Julie Penne, "Asking for advance payment for services is a common, if unfortunate, situation that confronts hospitals all over the United States."

Claudia Susana for TIME

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

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

Why?

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

(**In-Depth Video**: The Exorbitant Prices of Health Care)

Dozens of midpriced items were embedded with similarly aggressive markups, like $283.00 for a “CHEST, PA AND LAT 71020.” That’s a simple chest X-ray, for which MD Anderson is routinely paid $20.44 when it treats a patient on Medicare, the government health care program for the elderly. Every time a nurse drew blood, a “ROUTINE VENIPUNCTURE” charge of $36.00 appeared, accompanied by charges of $23 to $78 for each of a dozen or more lab analyses performed on the blood sample. In all, the charges for blood and other lab tests done on Recchi amounted to more than $15,000. Had Recchi been old enough for Medicare, MD Anderson would have been paid a few hundred dollars for all those tests. By law, Medicare’s payments approximate a hospital’s cost of providing a service, including overhead, equipment and salaries.

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

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

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

The president of MD Anderson is paid like someone running a prosperous business. Ronald DePinho’s total compensation last year was $1,845,000. That does not count outside earnings derived from a much publicized waiver he received from the university that, according to the Houston *Chronicle*, allows him to maintain unspecified “financial ties with his three principal pharmaceutical companies.”

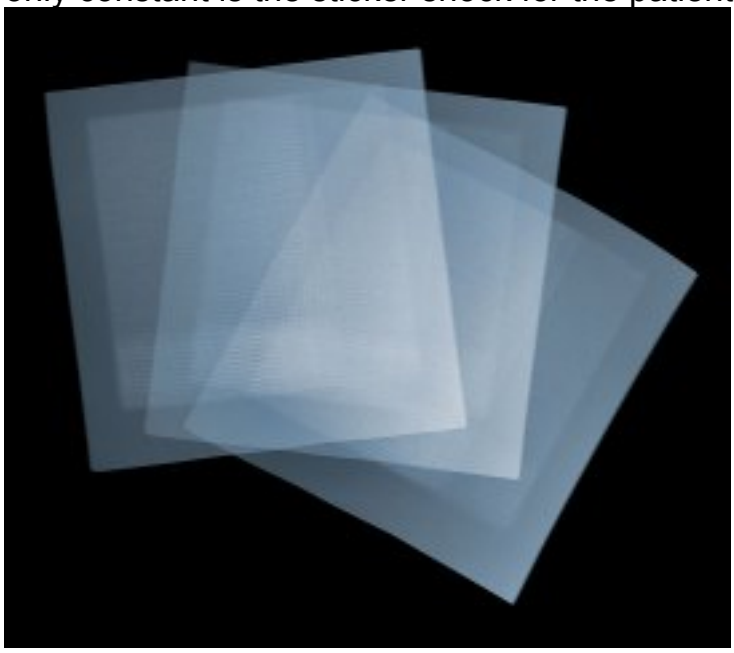
(**SHARE YOUR THOUGHTS:** Are Medical Bills Too High? Tell Us Here)

DePinho’s salary is nearly two and a half times the $750,000 paid to Francisco Cigarroa, the chancellor of entire University of Texas system, of which MD Anderson is a part. This pay structure is emblematic of American medical economics and is reflected on campuses across the

U.S., where the president of a hospital or hospital system associated with a university — whether it's Texas, Stanford, Duke or Yale — is invariably paid much more than the person in charge of the university.

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

When you look behind the bills that Sean Recchi and other patients receive, you see nothing rational — no rhyme or reason — about the costs they faced in a marketplace they enter through no choice of their own. The only constant is the sticker shock for the patients who are asked to pay.



Photograph by Nick Veasey for TIME

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

Yet those who work in the health care industry and those who argue over health care policy seem inured to the shock. When we debate health care policy, we seem to jump right to the issue of who should pay the bills,

blowing past what should be the first question: Why exactly are the bills so high?

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

(**iReport:** Tell Us Your Health Care Story)

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

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

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

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

Walmart.
The Bureau of Labor Statistics projects that 10 of the 20 occupations that will grow the fastest in the U.S. by 2020 are related to health care. America's largest city may be commonly thought of as the world's financial-services capital, but of New York's 18 largest private employers, eight are hospitals and four are banks. Employing all those people in the cause of curing the sick is, of course, not anything to be ashamed of. But the drag on our overall economy that comes with taxpayers, employers and consumers spending so much more than is spent in any other country for the same product is unsustainable. Health care is eating away at our economy and our treasury.
The health care industry seems to have the will and the means to keep it that way. According to the Center for Responsive Politics, the pharmaceutical and health-care-product industries, combined with organizations representing doctors, hospitals, nursing homes, health services and HMOs, have spent $5.36 billion since 1998 on lobbying in Washington. That dwarfs the $1.53 billion spent by the defense and aerospace industries and the $1.3 billion spent by oil and gas interests over the same period. That's right: the health-care-industrial complex spends more than three times what the military-industrial complex spends in Washington.

When you crunch data compiled by McKinsey and other researchers, the big picture looks like this: We're likely to spend $2.8 trillion this year on health care. That $2.8 trillion is likely to be $750 billion, or 27%, more than we would spend if we spent the same per capita as other developed countries, even after adjusting for the relatively high per capita income in the U.S. vs. those other countries. Of the total $2.8 trillion that will be spent on health care, about $800 billion will be paid by the federal government through the Medicare insurance program for the disabled and those 65 and older and the Medicaid program, which provides care for the poor. That $800 billion, which keeps rising far faster than inflation and the gross domestic product, is what's driving the federal deficit. The other $2 trillion will be paid mostly by private health-insurance companies and individuals who have no insurance or who will pay some portion of the bills covered by their insurance. This is what's increasingly burdening businesses that pay for their employees' health insurance and forcing individuals to pay so much in out-of-pocket expenses.

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

The original version of this article misidentified William Powers Jr., the president of the University of Texas system, as the head of the entire

system. That is in fact Francisco Cigarroa, the chancellor of the University of Texas

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

The $21,000 Heartburn Bill One night last summer at her home near Stamford, Conn., a 64-year-old former sales clerk whom I'll call Janice S. felt chest pains. She was taken four miles by ambulance to the emergency room at Stamford Hospital, officially a nonprofit institution. After about three hours of tests and some brief encounters with a doctor, she was told she had indigestion and sent home. That was the good news.

The bad news was the bill: $995 for the ambulance ride, $3,000 for the doctors and $17,000 for the hospital — in sum, $21,000 for a false alarm. Out of work for a year, Janice S. had no insurance. Among the hospital's charges were three "TROPONIN I" tests for $199.50 each. According to a National Institutes of Health website, a troponin test "measures the levels of certain proteins in the blood" whose release from the heart is a strong indicator of a heart attack. Some labs like to have the test done at intervals, so the fact that Janice S. got three of them is not necessarily an issue. The price is the problem. Stamford Hospital spokesman Scott Orstad told me that the $199.50 figure for the troponin test was taken from what he called the hospital's chargemaster. The chargemaster, I learned, is every hospital's internal price list. Decades ago it was a document the size of a phone book; now it's a massive computer file, thousands of items long, maintained by every hospital.

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

(**VIDEO**: The Exorbitant Prices of Health Care)

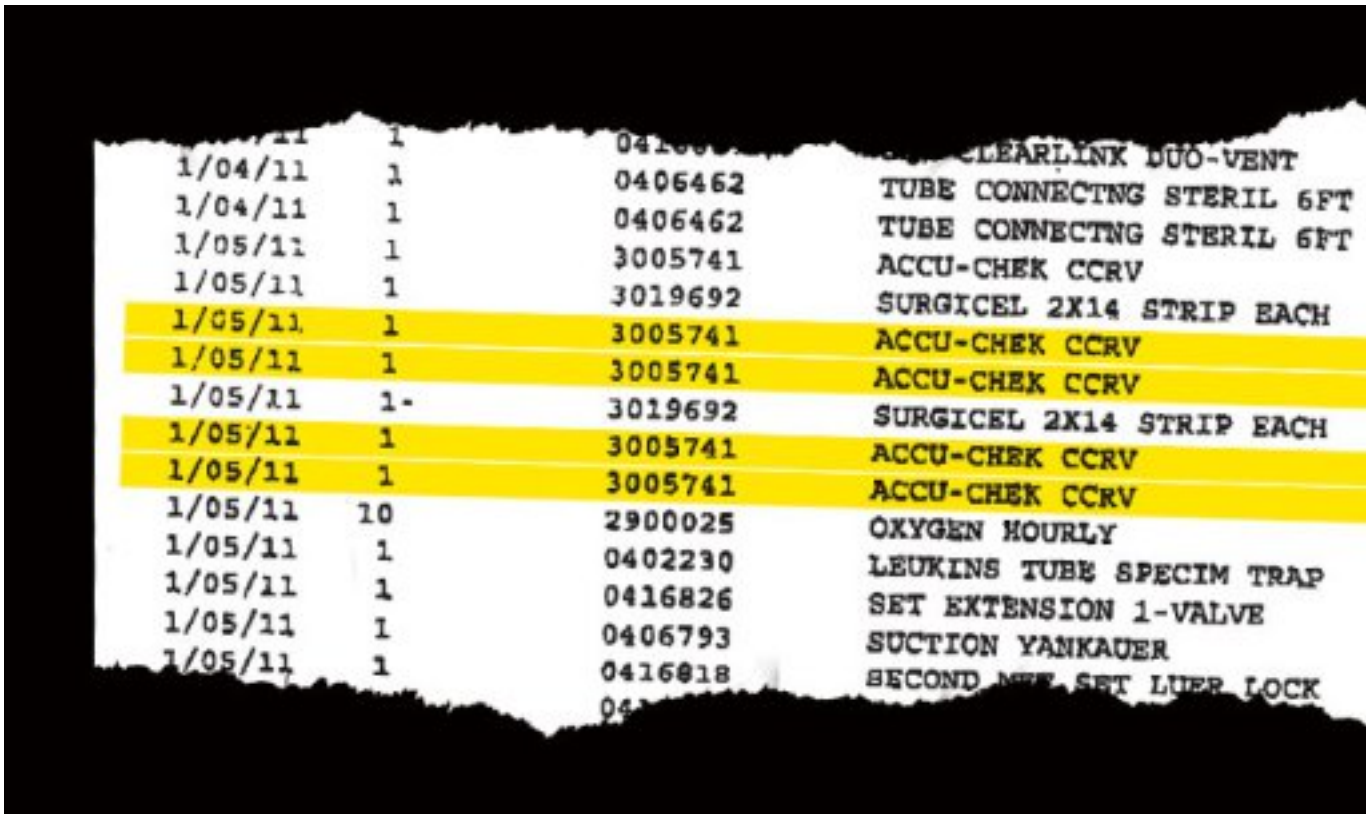
Because she was 64, not 65, Janice S. was not on Medicare. But seeing what Medicare would have paid Stamford Hospital for the troponin test if she had been a year older shines a bright light on the role the chargemaster plays in our national medical crisis — and helps us understand the illegitimacy of that $199.50 charge. That's because

Medicare collects troves of data on what every type of treatment, test and other service costs hospitals to deliver. Medicare takes seriously the notion that nonprofit hospitals should be paid for all their costs but actually be nonprofit after their calculation. Thus, under the law, Medicare is supposed to reimburse hospitals for any given service, factoring in not only direct costs but also allocated expenses such as overhead, capital expenses, executive salaries, insurance, differences in regional costs of living and even the education of medical students.

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

Janice S. was also charged $157.61 for a CBC — the complete blood count that those of us who are *ER* aficionados remember George Clooney ordering several times a night. Medicare pays $11.02 for a CBC in Connecticut. Hospital finance people argue vehemently that Medicare doesn't pay enough and that they lose as much as 10% on an average Medicare patient. But even if the Medicare price should be, say, 10% higher, it's a long way from $11.02 plus 10% to $157.61. Yes, every hospital administrator grouses about Medicare's payment rates — rates that are supervised by a Congress that is heavily lobbied by the American Hospital Association, which spent $1,859,041 on lobbyists in 2012. But an annual expense report that Stamford Hospital is required to file with the federal Department of Health and Human Services offers evidence that Medicare's rates for the services Janice S. received are on the mark. According to the hospital's latest filing (covering 2010), its total expenses for laboratory work (like Janice S.'s blood tests) in the 12 months covered by the report were $27.5 million. Its total charges were $293.2 million. That means it charged about 11 times its costs. As we examine other bills, we'll see that like Medicare patients, the large portion of hospital patients who have private health insurance also get discounts off the listed chargemaster figures, assuming the hospital and insurance company have negotiated to include the hospital in the insurer's network of providers that its customers can use. The insurance discounts are not nearly as steep as the Medicare markdowns, which means that even the discounted insurance-company rates fuel profits at these officially nonprofit hospitals. Those profits are further boosted by payments from the tens of millions of patients who, like the unemployed Janice S., have no insurance or whose insurance does not apply because the patient has exceeded the coverage limits. These patients are asked to pay the chargemaster list prices.

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



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1/05/11	1	0406793	SUCTION YANKAUER
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Test Strips Patient was charged $18 each for Accu-chek diabetes test strips. Amazon sells boxes of 50 for about $27, or 55¢ each

Pay No Attention To the Chargemaster No hospital's chargemaster prices are consistent with those of any other hospital, nor do they seem to be based on anything objective — like cost — that any hospital executive I spoke with was able to explain. "They were set in cement a long time ago and just keep going up almost automatically," says one hospital chief financial officer with a shrug.

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

(**COMMENT NOW**: Are Medical Bills Too High? Tell Us Why)

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

But Janice S. was asked to pay them. Moreover, the chargemaster rates are relevant, even for those unlike her who have insurance. Insurers with the most leverage, because they have the most customers to offer a

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

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

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

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

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

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

According to a McKinsey study of the medical marketplace, a typical piece

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

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

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

The costs associated with high-tech tests are likely to accelerate. McKinsey found that the more CT and MRI scanners are out there, the more doctors use them. In 1997 there were fewer than 3,000 machines available, and they completed an average of 3,800 scans per year. By 2006 there were more than 10,000 in use, and they completed an average of 6,100 per year. According to a study in the *Annals of Emergency Medicine*, the use of CT scans in America's emergency rooms "has more than quadrupled in recent decades." As one former emergency-room doctor puts it, "Giving out CT scans like candy in the ER is the equivalent of putting a 90-year-old grandmother through a pat-down at the airport: Hey, you never know."

Selling this equipment to hospitals — which has become a key profit center for industrial conglomerates like General Electric and Siemens — is one of the U.S. economy's bright spots. I recently subscribed to an online headhunter's listings for medical-equipment salesmen and quickly found an opening in Connecticut that would pay a salary of $85,000 and sales

commissions of up to $95,000 more, plus a car allowance. The only requirement was that applicants have “at least one year of experience selling some form of capital equipment.”
In all, on the day I signed up for that jobs website, it carried 186 listings for medical-equipment salespeople just in Connecticut.

2. Medical Technology’s Perverse Economics

Unlike those of almost any other area we can think of, the dynamics of the medical marketplace seem to be such that the advance of technology has made medical care more expensive, not less. First, it appears to encourage more procedures and treatment by making them easier and more convenient. (This is especially true for procedures like arthroscopic surgery.) Second, there is little patient pushback against higher costs because it seems to (and often does) result in safer, better care and because the customer getting the treatment is either not going to pay for it or not going to know the price until after the fact.
Beyond the hospitals’ and doctors’ obvious economic incentives to use the equipment and the manufacturers’ equally obvious incentives to sell it, there’s a legal incentive at work. Giving Janice S. a nuclear-imaging test instead of the lower-tech, less expensive stress test was the safer thing to do — a belt-and-suspenders approach that would let the hospital and doctor say they pulled out all the stops in case Janice S. died of a heart attack after she was sent home.
“We use the CT scan because it’s a great defense,” says the CEO of another hospital not far from Stamford. “For example, if anyone has fallen or done anything around their head — hell, if they even say the word *head* — we do it to be safe. We can’t be sued for doing too much.”
His rationale speaks to the real cost issue associated with medical-malpractice litigation. It’s not as much about the verdicts or settlements (or considerable malpractice-insurance premiums) that hospitals and doctors pay as it is about what they do to avoid being sued. And some no doubt claim they are ordering more tests to avoid being sued when it is actually an excuse for hiking profits. The most practical malpractice-reform proposals would not limit awards for victims but would allow doctors to use what’s called a safe-harbor defense. Under safe harbor, a defendant doctor or hospital could argue that the care provided was within the bounds of what peers have established as reasonable under the circumstances. The typical plaintiff argument that doing something more, like a nuclear-imaging test, might have saved the patient would then be less likely to prevail.
When Obamacare was being debated, Republicans pushed this kind of commonsense malpractice-tort reform. But the stranglehold that plaintiffs’ lawyers have traditionally had on Democrats prevailed, and neither a safe-

harbor provision nor any other malpractice reform was included.
(**iReport:** Tell Us Your Health Care Story)
Nonprofit Profitmakers To the extent that they defend the chargemaster rates at all, the defense that hospital executives offer has to do with charity. As John Gunn, chief operating officer of Sloan-Kettering, puts it, "We charge those rates so that when we get paid by a [wealthy] uninsured person from overseas, it allows us to serve the poor."
A closer look at hospital finance suggests two holes in that argument. First, while Sloan-Kettering does have an aggressive financial-assistance program (something Stamford Hospital lacks), at most hospitals it's not a Saudi sheik but the *almost* poor — those who don't qualify for Medicaid and don't have insurance — who are most often asked to pay those exorbitant chargemaster prices. Second, there is the jaw-dropping difference between those list prices and the hospitals' costs, which enables these ostensibly nonprofit institutions to produce high profits even after all the discounts. True, when the discounts to Medicare and private insurers are applied, hospitals end up being paid a lot less overall than what is itemized on the original bills. Stamford ends up receiving about 35% of what it bills, which is the yield for most hospitals. (Sloan-Kettering and MD Anderson, whose great brand names make them tough negotiators with insurance companies, get about 50%). However, no matter how steep the discounts, the chargemaster prices are so high and so devoid of any calculation related to cost that the result is uniquely American: thousands of nonprofit institutions have morphed into high-profit, high-profile businesses that have the best of both worlds. They have become entities akin to low-risk, must-have public utilities that nonetheless pay their operators as if they were high-risk entrepreneurs. As with the local electric company, customers must have the product and can't go elsewhere to buy it. They are steered to a hospital by their insurance companies or doctors (whose practices may have a business alliance with the hospital or even be owned by it). Or they end up there because there isn't any local competition. But unlike with the electric company, no regulator caps hospital profits.
Yet hospitals are also beloved local charities.
The result is that in small towns and cities across the country, the local nonprofit hospital may be the community's strongest business, typically making tens of millions of dollars a year and paying its nondoctor administrators six or seven figures. As nonprofits, such hospitals solicit contributions, and their annual charity dinner, a showcase for their good works, is typically a major civic event. But charitable gifts are a minor part of their base; Stamford Hospital raised just over 1% of its revenue from contributions last year. Even after discounts, those $199.50 blood tests and multithousand-dollar CT scans are what really count.

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

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

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

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

Nonetheless, hospitals like Stamford are able to use their sympathetic nonprofit status to push their interests. As the debate over deficit-cutting ideas related to health care has heated up, the American Hospital Association has run daily ads on Mike Allen's Playbook, a popular Washington tip sheet, urging that Congress not be allowed to cut hospital payments because that would endanger the "$39.3 billion" in uncompensated care for the poor that hospitals now provide either through charity programs or because of patients failing to pay their debts. Based on the formula hospitals use to calculate the cost of this charity care, that amounts to approximately 5% of their total revenue for 2010.

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

So, what do these wealthy nonprofits do with all the profit? In a trend similar to what we've seen in nonprofit colleges and universities — where there has been an arms race of sorts to use rising tuition to construct buildings and add courses of study — the hospitals improve and expand facilities (despite the fact that the U.S. has more hospital beds than it can fill), buy more equipment, hire more people, offer more services, buy rival

hospitals and then raise executive salaries because their operations have gotten so much larger. They keep the upward spiral going by marketing for more patients, raising prices and pushing harder to collect bill payments. Only with health care, the upward spiral is easier to sustain. Health care is seen as even more of a necessity than higher education. And unlike in higher education, in health care there is little price transparency — and far less competition in any given locale even if there were transparency. Besides, a hospital is typically one of the community's larger employers if not the largest, so there is unlikely to be much local complaining about its burgeoning economic fortunes.

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

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

Shocked by her bill from Stamford hospital and unable to pay it, Janice S. found a local woman on the Internet who is part of a growing cottage industry of people who call themselves medical-billing advocates. They help people read and understand their bills and try to reduce them. "The hospitals all know the bills are fiction, or at least only a place to start the discussion, so you bargain with them," says Katalin Goencz, a former appeals coordinator in a hospital billing department who negotiated Janice S.'s bills from a home office in Stamford.

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

"I can pretty much always get it down 30% to 50% simply by saying the

patient is ready to pay but will not pay $300 for a blood test or an X-ray," says Goencz. "They hand out blood tests and X-rays in hospitals like bottled water, and they know it."

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

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

A manager at Stamford Emergency Medical Services, which charged Janice S. $958 for the pickup plus $9.38 per mile, says that "our rates are all set by the state on a regional basis" and that the company is independently owned. That's at odds with a trend toward consolidation that has seen several private-equity firms making investments in what Wall Street analysts have identified as an increasingly high-margin business. Overall, ambulance revenues were more than $12 billion last year, or about 10% higher than Hollywood's box-office take. It's not a great deal to pay off $1,000 for a four-mile ambulance ride on the layaway plan or receive a 50% discount on a $199.50 blood test that should cost $15, nor is getting half off on a $7,997.54 stress test that was probably all profit and may not have been necessary. But, says Goencz, "I don't go over it line by line. I just go for a deal. The patient usually is shocked by the bill, doesn't understand any of the language and has bill collectors all over her by the time they call me. So they're grateful. Why give them heartache by telling them they still paid too much for some test or pill?"

SOUND OFF: Are Medical Bills Too High? Tell Us Why

The original version of this article stated that the total annual amount of charity care provided by U.S. hospitals cost them less than half of 1% of their annual revenue. In fact, the uncompensated care hospitals provide, either through charity programs or because of patients failing to pay their debts, amounts to approximately 5% of their total revenue for 2010.

A Slip, a Fall And a $9,400 Bill The billing advocates aren't always successful. just ask Emilia Gilbert, a school-bus driver who got into a fight with a hospital associated with Connecticut's most venerable nonprofit institution, which racked up quick profits on multiple CT scans, then refused to compromise at all on its chargemaster prices. Gilbert, now 66, is still making weekly payments on the bill she got in June 2008 after she slipped and fell on her face one summer evening in the small yard behind her house in Fairfield, Conn. Her nose bleeding heavily, she was taken to the emergency room at Bridgeport Hospital.

Along with Greenwich Hospital and the Hospital of St. Raphael in New Haven, Bridgeport Hospital is now owned by the Yale New Haven Health

System, which boasts a variety of gleaming new facilities. Although Yale University and Yale New Haven are separate entities, Yale–New Haven Hospital is the teaching hospital for the Yale Medical School, and university representatives, including Yale president Richard Levin, sit on the Yale New Haven Health System board.

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

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

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

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

Javier Sirvent for TIME

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

Gilbert's total bill was $9,418.

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

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

"You really can't compare the two jobs," says Yale–New Haven Hospital senior vice president Vincent Petrini. "Comparing hospitals to universities is like apples and oranges. Running a hospital organization is much more complicated." Actually, the four-hospital chain and the university have about the same operating budget. And it would seem that Levin deals with what most would consider complicated challenges in overseeing 3,900 faculty members, corralling (and complying with the terms of) hundreds of millions of dollars in government research grants and presiding over a $19 billion endowment, not to mention admitting and educating 14,000 students spread across Yale College and a variety of graduate schools, professional schools and foreign-study outposts. And surely Levin's responsibilities are as complicated as those of the CEO of Yale New Haven Health's smallest unit — the 184-bed Greenwich Hospital, whose CEO was paid $112,000 more than Levin.

"When I got the bill, I almost had to go back to the hospital," Gilbert recalls. "I was hyperventilating." Contributing to her shock was the fact that although her employer supplied insurance from Cigna, one of the country's leading health insurers, Gilbert's policy was from a Cigna subsidiary called Starbridge that insures mostly low-wage earners. That made Gilbert one of millions of Americans like Sean Recchi who are routinely categorized as having health insurance but really don't have anything approaching meaningful coverage.

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

In September 2009, after a series of fruitless letters and phone calls from its bill collectors to Gilbert, the hospital sued her. Gilbert found a medical-billing advocate, Beth Morgan, who analyzed the charges on the bill and compared them with the discounted rates insurance companies would pay. During two court-required mediation sessions, Bridgeport Hospital's attorney wouldn't budge; his client wanted the bill paid in full, Gilbert and Morgan recall. At the third and final mediation, Gilbert was offered a 20%

discount off the chargemaster fees if she would pay immediately, but she says she responded that according to what Morgan told her about the bill, it was still too much to pay. “We probably could have offered more,” Gedge acknowledges. “But in these situations, our bill-collection attorneys only know the amount we are saying is owed, not whether it is a chargemaster amount or an amount that is already discounted.”

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

The One-Day, $87,000 Outpatient Bill Getting a patient in and out of a hospital the same day seems like a logical way to cut costs. Outpatients don’t take up hospital rooms or require the expensive 24/7 observation and care that come with them. That’s why in the 1990s Medicare pushed payment formulas on hospitals that paid them for whatever ailment they were treating (with more added for documented complications), not according to the number of days the patient spent in a bed. Insurance companies also pushed incentives on hospitals to move patients out faster or not admit them for overnight stays in the first place. Meanwhile, the introduction of procedures like noninvasive laparoscopic surgery helped speed the shift from inpatient to outpatient.

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

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

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

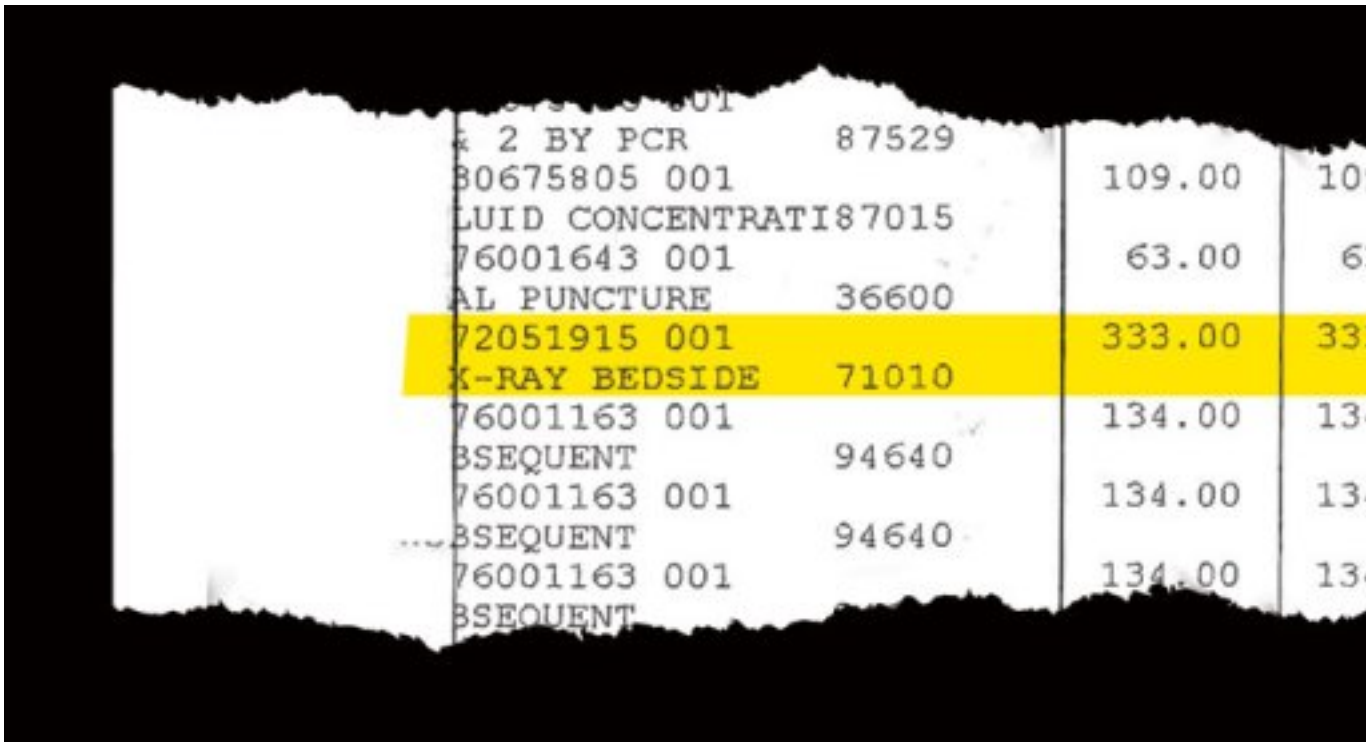
The 2011 outpatient visit of someone I’ll call Steve H. to Mercy Hospital in Oklahoma City illustrates those economics. Steve H. had the kind of relatively routine care that patients might expect would be no big deal: he

spent the day at Mercy getting his aching back fixed.

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

Steve H.'s doctor intended to use a RestoreUltra neurostimulator manufactured by Medtronic, a Minneapolis-based company with $16 billion in annual sales that bills itself as the world's largest stand-alone medical-technology company. "RestoreUltra delivers spinal-cord stimulation through one or more leads selected from a broad portfolio for greater customization of therapy," Medtronic's website promises. I was not able to interview Steve H., but according to Pat Palmer, a medical-billing specialist based in Salem, Va., who consults for the union that provides Steve H.'s health insurance, Steve H. didn't ask how much the stimulator would cost because he had $45,181 remaining on the $60,000 annual payout limit his union-sponsored health-insurance plan imposed. "He figured, How much could a day at Mercy cost?" Palmer says. "Five thousand? Maybe 10?"

Steve H. was about to run up against a seemingly irrelevant footnote in millions of Americans' insurance policies: the limit, sometimes annual or sometimes over a lifetime, on what the insurer has to pay out for a patient's claims. Under Obamacare, those limits will not be allowed in most health-insurance policies after 2013. That might help people like Steve H. but is also one of the reasons premiums are going to skyrocket under Obamacare.



Chest X-Ray Patient was charged $333. the national rate paid by Medicare is $23.83

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

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

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

According to the chief financial officer of another hospital, the wholesale

list price of the Medtronic stimulator is “about $19,000.” Because Mercy is part of a major hospital chain, it might pay 5% to 15% less than that. Even assuming Mercy paid $19,000, it would make more than $30,000 selling it to Steve H., a profit margin of more than 150%. To the extent that I found any consistency among hospital chargemaster practices, this is one of them: hospitals routinely seem to charge 2½ times what these expensive implantable devices cost them, which produces that 150% profit margin. As Steve H. found out when he got his bill, he had exceeded the $45,000 that was left on his insurance policy’s annual payout limit just with the neurostimulator. And his total bill was $86,951. After his insurance paid that first $45,000, he still owed more than $40,000, not counting doctors’ bills. (I did not see Steve H.’s doctors’ bills.)

SOUND OFF: Are Medical Bills Too High? Tell Us Why

Mercy Hospital is owned by an organization under the umbrella of the Catholic Church called Sisters of Mercy. Its mission, as described in its latest filing with the IRS as a tax-exempt charity, is “to carry out the healing ministry of Jesus by promoting health and wellness.” With a chain of 31 hospitals and 300 clinics across the Midwest, Sisters of Mercy uses a bill-collection firm based in Topeka, Kans., called Berlin-Wheeler Inc. Suits against Mercy patients are on file in courts across Oklahoma listing Berlin-Wheeler as the plaintiff. According to its most recent tax return, the Oklahoma City unit of the Sisters of Mercy hospital chain collected $337 million in revenue for the fiscal year ending June 30, 2011. It had an operating profit of $34 million. And that was after paying 10 executives more than $300,000 each, including $784,000 to a regional president and $438,000 to the hospital president.

That report doesn’t cover the executives overseeing the chain, called Mercy Health, of which Mercy in Oklahoma City is a part. The overall chain had $4.28 billion in revenue that year. Its hospital in Springfield, Mo. (pop. 160,660), had $880.7 million in revenue and an operating profit of $319 million, according to its federal filing. The incomes of the parent company’s executives appear on other IRS filings covering various interlocking Mercy nonprofit corporate entities. Mercy president and CEO Lynn Britton made $1,930,000, and an executive vice president, Myra Aubuchon, was paid $3.7 million, according to the Mercy filing. In all, seven Mercy Health executives were paid more than $1 million each. A note at the end of an Ernst & Young audit that is attached to Mercy’s IRS filing reported that the chain provided charity care worth 3.2% of its revenue in the previous year. However, the auditors state that the value of that care is based on the charges on all the bills, not the actual cost to Mercy of providing those services — in other words, the chargemaster value. Assuming that Mercy’s actual costs are a tenth of these chargemaster values — they’re probably less — all of this charity care

actually cost Mercy about three-tenths of 1% of its revenue, or about $13 million out of $4.28 billion.

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

Photograph by Nick Veasey for TIME

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

Wright said the hospital's lawyers had decided that discussing Steve H.'s bill would violate the federal HIPAA law protecting the privacy of patient medical records. I pointed out that I wanted to ask questions only about the hospital's charges for standard items — such as surgical gowns, basic

blood tests, blanket warmers and even medical devices — that had nothing to do with individual patients. “Everything is particular to an individual patient’s needs,” she replied. Even a surgical gown? “Yes, even a surgical gown. We cannot discuss this with you. It’s against the law.” She declined to put me in touch with the hospital’s lawyers to discuss their legal analysis.

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

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

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

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

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

Other doctors, Demske noted, had stretched the conflict of interest beyond consulting fees: “Additionally, physician ownership of medical-device manufacturers and related businesses appears to be a growing trend in the medical-device sector … In some cases, physicians could receive

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

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

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

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

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

Medtronic spokeswoman Donna Marquad says that for competitive reasons, her company will not discuss sales figures or the profit on Steve H.'s neurostimulator. But Medtronic's October 2012 quarterly SEC filing reported that its spine "products and therapies," which presumably include Steve H.'s device, "continue to gain broad surgeon acceptance" and that its cost to make all of its products was 24.9% of what it sells them for. That's an unusually high gross profit margin — 75.1% — for a company that manufactures real physical products. Apple also produces high-end, high-tech products, and its gross margin is 40%. If the neurostimulator enjoys that company-wide profit margin, it would mean that if Medtronic was paid $19,000 by Mercy Hospital, Medtronic's cost was about $4,500 and it made a gross profit of about $14,500 before expenses for sales, overhead and management — including CEO Omar Ishrak's compensation, which was $25 million for the 2012 fiscal year.

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

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

Sean Recchi wasn't as fortunate. His bill — which included not only the aggressively marked-up charge of $13,702 for the Rituxan cancer drug but also the usual array of chargemaster fees for basics like generic Tylenol, blood tests and simple supplies — had one item not found on any other bill

I examined: MD Anderson's charge of $7 each for "ALCOHOL PREP PAD." This is a little square of cotton used to apply alcohol to an injection. A box of 200 can be bought online for $1.91.

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

Before MD Anderson marked up Recchi's Rituxan to $13,702, the profit taking was equally aggressive, and equally routine, at the beginning of the supply chain — at the drug company. Rituxan is a prime product of Biogen Idec, a company with $5.5 billion in annual sales. Its CEO, George Scangos, was paid $11,331,441 in 2011, a 20% boost over his 2010 income. Rituxan is made and sold by Biogen Idec in partnership with Genentech, a South San Francisco–based biotechnology pioneer. Genentech brags about Rituxan on its website, as did Roche, Genentech's $45 billion parent, in its latest annual report. And in an Investor Day presentation last September, Roche CEO Severin Schwann stressed that his company is able to keep prices and margins high because of its focus on "medically differentiated therapies." Rituxan, a cancer wonder drug, certainly meets that test.

SOUND OFF: Are Medical Bills Too High? Tell Us Why

A spokesman at Genentech for the Biogen Idec–Genentech partnership would not say what the drug cost the companies to make, but according to its latest annual report, Biogen Idec's cost of sales — the incremental expense of producing and shipping each of its products compared with what it sells them for — was only 10%. That's lower than the incremental cost of sales for most software companies, and the software companies usually don't produce anything physical or have to pay to ship anything. This would mean that Sean Recchi's dose of Rituxan cost the Biogen Idec–Genentech partnership as little as $300 to make, test, package and ship to MD Anderson for $3,000 to $3,500, whereupon the hospital sold it to Recchi for $13,702.

As 2013 began, Recchi was being treated back in Ohio because he could not pay MD Anderson for more than his initial treatment. As for the

$13,702-a-dose Rituxan, it turns out that Biogen Idec's partner Genentech has a charity-access program that Recchi's Ohio doctor told him about that enabled him to get those treatments free. "MD Anderson never said a word to us about the Genentech program," says Stephanie Recchi. "They just took our money up front."

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

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

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

3. Catastrophic Illness — And the Bills to Match

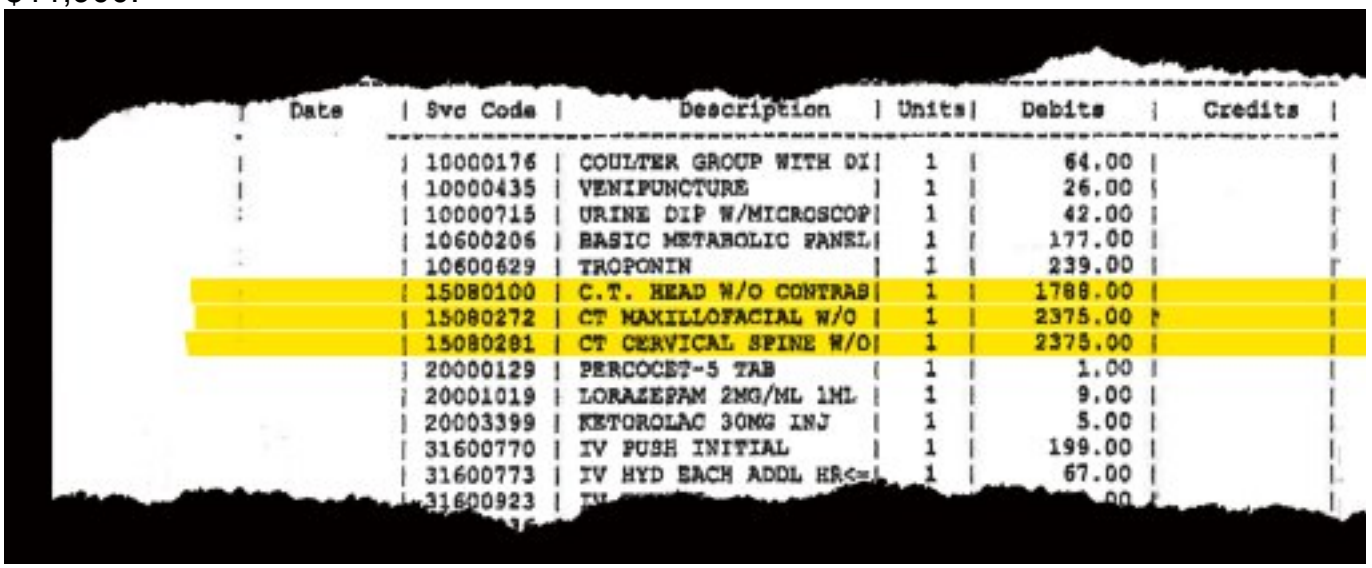
When medical care becomes a matter of life and death, the money demanded by the health care ecosystem reaches a wholly different order of magnitude, churning out reams of bills to people who can't focus on them, let alone pay them. Soon after he was diagnosed with lung cancer in January 2011, a patient whom I will call Steven D. and his wife Alice knew that they were only buying time. The crushing question was, How much is time really worth? As Alice, who makes about $40,000 a year running a child-care center in her home, explained, "[Steven] kept saying he wanted every last minute he could get, no matter what. But I had to be thinking about the cost and how all this debt would leave me and my daughter." By the time Steven D. died at his home in Northern California the following November, he had lived for an additional 11 months. And Alice had collected bills totaling $902,452. The family's first bill — for $348,000 — which arrived when Steven got home from the Seton Medical Center in Daly City, Calif., was full of all the usual chargemaster profit grabs: $18 each for 88 diabetes-test strips that Amazon sells in boxes of 50 for $27.85; $24 each for 19 niacin pills that are sold in drugstores for

about a nickel apiece. There were also four boxes of sterile gauze pads for $77 each. None of that was considered part of what was provided in return for Seton's facility charge for the intensive-care unit for two days at $13,225 a day, 12 days in the critical unit at $7,315 a day and one day in a standard room (all of which totaled $120,116 over 15 days). There was also $20,886 for CT scans and $24,251 for lab work. Alice responded to my question about the obvious overcharges on the bill for items like the diabetes-test strips or the gauze pads much as Mrs. Lincoln, according to the famous joke, might have had she been asked what she thought of the play. "Are you kidding?" she said. "I'm dealing with a husband who had just been told he has Stage IV cancer. That's all I can focus on … You think I looked at the items on the bills? I just looked at the total."

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

The $50,000 that UnitedHealthcare paid to Seton Medical Center was worth about $80,000 in credits because any charges covered by the insurer were subject to the discount it had negotiated with Seton. After that $80,000, Steven and Alice were on their own, not eligible for any more discounts. Four months into her husband's illness, Alice by chance got the name of Patricia Stone, a billing advocate based in Menlo Park, Calif. Stone's typical clients are middle-class people having trouble with insurance claims. Stone felt so bad for Steven and Alice — she saw the blizzard of bills Alice was going to have to sort through — that, says Alice, she "gave us many of her hours," for which she usually charges $100, "for free." Stone was soon able to persuade Seton to write off $297,000 of its $348,000 bill. Her argument was simple: There was no way the D.'s could pay it now or in the future, though they would scrape together $3,000 as a show of good faith. With the couple's $3,000 on top of the $50,000 paid by the UnitedHealthcare insurance, that $297,000 write-off amounted to an 85% discount. According to its latest financial report, Seton applies so many discounts and write-offs to its chargemaster bills that it ends up with only about 18% of the revenue it bills for. That's an average 82% discount, compared with an average discount of about 65% that I saw at the other hospitals whose bills were examined — except for the MD Anderson and Sloan-Kettering cancer centers, which collect about 50% of their chargemaster charges. Seton's discounting practices may explain why it is the only hospital whose bills I looked at that actually

reported a small operating loss — $5 million — on its last financial report. Of course, had the D.'s not come across Stone, the incomprehensible but terrifying bills would have piled up in a box, and the Seton Medical Center bill collectors would not have been kept at bay. Robert Issai, the CEO of the Daughters of Charity Health System, which owns and runs Seton, refused through an e-mail from a public relations assistant to respond to requests for a comment on any aspect of his hospital's billing or collections policies. Nor would he respond to repeated requests for a specific comment on the $24 charge for niacin pills, the $18 charge for the diabetes-test strips or the $77 charge for gauze pads. He also declined to respond when asked, via a follow-up e-mail, if the hospital thinks that sending patients who have just been told they are terminally ill bills that reflect chargemaster rates that the hospital doesn't actually expect to be paid might unduly upset them during a particularly sensitive time. To begin to deal with all the other bills that kept coming after Steven's first stay at Seton, Stone was also able to get him into a special high-risk insurance pool set up by the state of California. It helped but not much. The insurance premium was $1,000 a month, quite a burden on a family whose income was maybe $3,500 a month. And it had an annual payout limit of $75,000. The D.'s blew through that in about two months. The bills kept piling up. Sequoia Hospital — where Steven was an inpatient as well as an outpatient between the end of January and November following his initial stay at Seton — weighed in with 28 bills, all at chargemaster prices, including invoices for $99,000, $61,000 and $29,000. Doctor-run outpatient chemotherapy clinics wanted more than $85,000. One outside lab wanted $11,900.



Date	Svc Code	Description	Units	Debits	Credits
	10000176	COULTER GROUP WITH DI	1	64.00	
	10000435	VENIPUNCTURE	1	26.00	
	10000715	URINE DIP W/MICROSCOP	1	42.00	
	10600206	BASIC METABOLIC PANEL	1	177.00	
	10600629	TROPONIN	1	239.00	
	15080100	C.T. HEAD W/O CONTRAS	1	1788.00	
	15080272	CT MAXILLOFACIAL W/O	1	2375.00	
	15080281	CT CERVICAL SPINE W/O	1	2375.00	
	20000129	PERCOCET-5 TAB	1	1.00	
	20001019	LORAZEPAM 2MG/ML 1ML	1	9.00	
	20003399	KETOROLAC 30MG INJ	1	5.00	
	31600770	IV PUSH INITIAL	1	199.00	
	31600773	IV HYD EACH ADDL HR<=	1	67.00	
	31600923	IV		.00	

CT Scans Patient was charged $6,538 for three ct scans. Medicare would have paid a total of about $825 for all three

Stone organized these and other bills into an elaborate spreadsheet — a

ledger documenting how catastrophic illness in America unleashes its own mini-GDP.

In July, Stone figured out that Steven and Alice should qualify for Medicaid, which is called Medi-Cal in California. But there was a catch: Medicaid is the joint federal-state program directed at the poor that is often spoken of in the same breath as Medicare. Although most of the current national debate on entitlements is focused on Medicare, when Medicaid's subsidiary program called Children's Health Insurance, or CHIP, is counted, Medicaid actually covers more people: 56.2 million compared with 50.2 million. As Steven and Alice found out, Medicaid is also more vulnerable to cuts and conditions that limit coverage, probably for the same reason that most politicians and the press don't pay the same attention to it that they do to Medicare: its constituents are the poor. The major difference in the two programs is that while Medicare's rules are pretty much uniform across state lines, the states set the key rules for Medicaid because the state finances a big portion of the claims. According to Stone, Steven and Alice immediately ran into one of those rules. For people even with their modest income, the D.'s would have to pay $3,000 a month in medical bills before Medi-Cal would kick in. That amounted to most of Alice's monthly take-home pay.

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

Stone then convinced Sequoia that if the hospital wanted to see any of the Medi-Cal money necessary to pay its bills (albeit at the big discount Medi-Cal would take), it should give Steven a "credit" for $15,000 — in other words, write it off. Sequoia agreed to do that for most of the bills. This was clearly a maneuver that Steven and Alice never could have navigated on their own. Covering most of the Sequoia debt was a huge relief, but there were still hundreds of thousands of dollars in bills left unpaid as Steven approached his end in the fall of 2011. Meantime, the bills kept coming.

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

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

Others, including some of the doctors, were more hard-nosed, insisting on

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

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

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

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

SOUND OFF: Are Medical Bills Too High? Tell Us Why

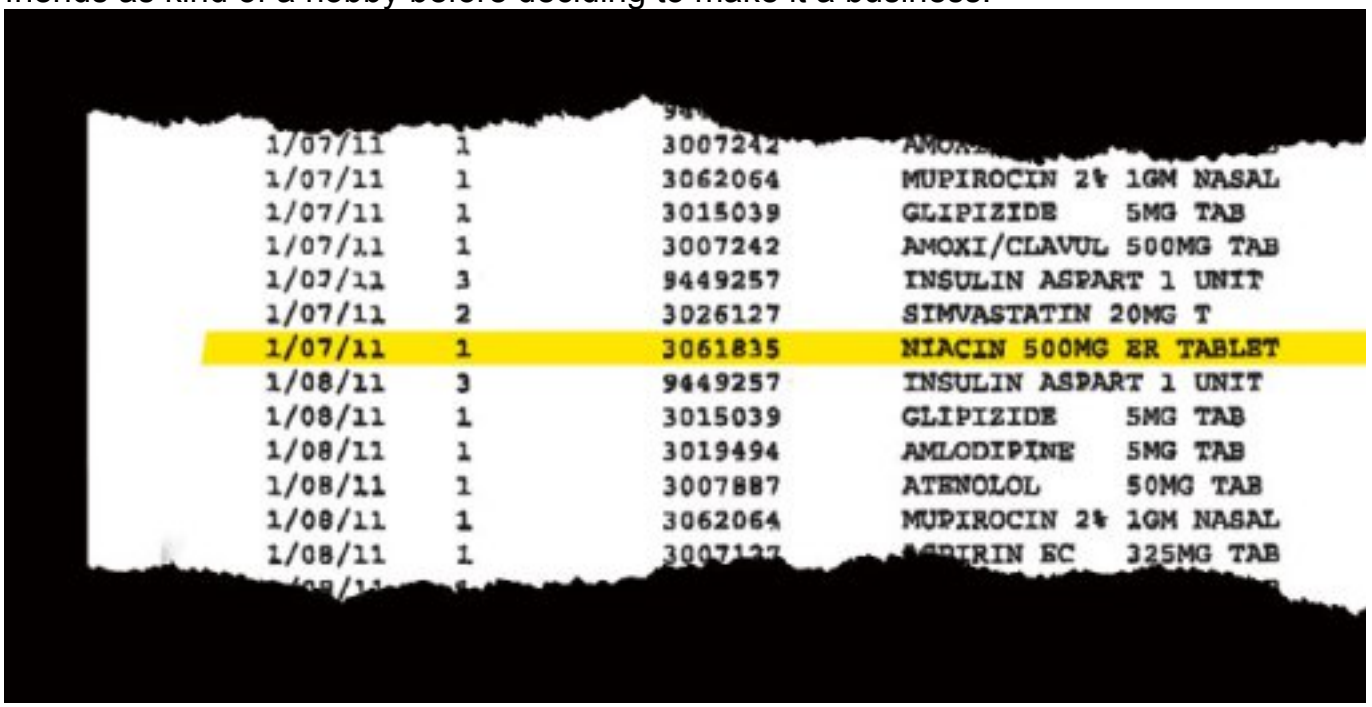
$132,303: The Lab-Test Cash Machine As 2012 began, a couple I'll call Rebecca and Scott S., both in their 50s, seemed to have carved out a comfortable semiretirement in a suburb near Dallas. Scott had successfully sold his small industrial business and was working part time advising other industrial companies. Rebecca was running a small marketing company.

On March 4, Scott started having trouble breathing. By dinnertime he was gasping violently as Rebecca raced him to the emergency room at the University of Texas Southwestern Medical Center. Both Rebecca and her husband thought he was about to die, Rebecca recalls. It was not the time to think about the bills that were going to change their lives if Scott survived, and certainly not the time to imagine, much less worry about, the piles of charges for daily routine lab tests that would be incurred by any patient in the middle of a long hospital stay. Scott was in the hospital for 32 days before his pneumonia was brought under control. Rebecca recalls that "on about the fourth or fifth day, I was sitting around the hospital and bored, so I went down to the business office just to check that they had all the insurance information." She remembered that there was, she says, "some kind of limit on it."

"Even by then, the bill was over $80,000," she recalls. "I couldn't believe it." The woman in the business office matter-of-factly gave Rebecca more bad news: Her insurance policy, from a company called Assurant Health, had an annual payout limit of $200,000. Because of some prior claims Assurant had processed, the S.'s were well on their way to exceeding the limit. Just the room-and-board charge at Southwestern was $2,293 a day. And that was before all the real charges were added. When Scott checked out, his 161-page bill was $474,064. Scott and Rebecca were told they owed $402,955 after the payment from their insurance policy was deducted. The top billing categories were $73,376 for Scott's room; $94,799 for "RESP

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

Then there was the $132,303 charge for "LABORATORY," which included hundreds of blood and urine tests ranging from $30 to $333 each, for which Medicare either pays nothing because it is part of the room fee or pays $7 to $30. Hospital spokesman Russell Rian said that neither Daniel Podolsky, Texas Southwestern Medical Center's $1,244,000-a-year president, nor any other executive would be available to discuss billing practices. "The law does not allow us to talk about how we bill," he explained. Through a friend of a friend, Rebecca found Patricia Palmer, the same billing advocate based in Salem, Va., who worked on Steve H.'s bill in Oklahoma City. Palmer — whose firm, Medical Recovery Services, now includes her two adult daughters — was a claims processor for Blue Cross Blue Shield. She got into her current business after she was stunned by the bill her local hospital sent after one of her daughters had to go to the emergency room after an accident. She says it included items like the shade attached to an examining lamp. She then began looking at bills for friends as kind of a hobby before deciding to make it a business.



1/07/11	1	3007242	AMOX...
1/07/11	1	3062064	MUPIROCIN 2% 1GM NASAL
1/07/11	1	3015039	GLIPIZIDE 5MG TAB
1/07/11	1	3007242	AMOXI/CLAVUL 500MG TAB
1/07/11	3	9449257	INSULIN ASPART 1 UNIT
1/07/11	2	3026127	SIMVASTATIN 20MG T
1/07/11	1	3061835	NIACIN 500MG ER TABLET
1/08/11	3	9449257	INSULIN ASPART 1 UNIT
1/08/11	1	3015039	GLIPIZIDE 5MG TAB
1/08/11	1	3019494	AMLODIPINE 5MG TAB
1/08/11	1	3007887	ATENOLOL 50MG TAB
1/08/11	1	3062064	MUPIROCIN 2% 1GM NASAL
1/08/11	1	3007127	...IRIN EC 325MG TAB

Niacin Tablet Patient was charged $24 per 500-mg tablet of niacin. In drugstores, the pills go for about a nickel each

The best Palmer could do was get Texas Southwestern Medical to provide a credit that still left Scott and Rebecca owing $313,000. Palmer claimed in a detailed appeal that there were also overcharges totaling $113,000 — not because the prices were too high but because the items she singled out should not have been charged for at all. These included $5,890 for all of that saline solution and $65,600 for the management of Scott's oxygen. These items are supposed to be part of the hospital's general room-and-services charge, she argued, so they should not be billed twice.

In fact, Palmer — echoing a constant and convincing refrain I heard from billing advocates across the country — alleged that the hospital triple-billed for some items used in Scott's care in the intensive-care unit. "First they charge more than $2,000 a day for the ICU, because it's an ICU and it has all this special equipment and personnel," she says. "Then they charge $1,000 for some kit used in the ICU to give someone a transfusion or oxygen … And then they charge $50 or $100 for each tool or bandage or whatever that there is in the kit. That's triple billing." Palmer and Rebecca are still fighting, but the hospital insists that the S.'s owe the $313,000 balance. That doesn't include what Rebecca says were "thousands" in doctors' bills and $70,000 owed to a second hospital after Scott suffered a relapse. The only offer the hospital has made so far is to cut the bill to $200,000 if it is paid immediately, or for the full $313,000 to be paid in 24 monthly payments. "How am I supposed to write a check right now for $200,000?" Rebecca asks. "I have boxes full of notices from bill collectors … We can't apply for charity, because we're kind of well off in terms of assets," she adds. "We thought we were set, but now we're pretty much on the edge."

Insurance That Isn't "People, especially relatively wealthy people, always think they have good insurance until they see they don't," says Palmer. "Most of my clients are middle- or upper-middle-class people with insurance."

Scott and Rebecca bought their plan from Assurant, which sells health insurance to small businesses that will pay only for limited coverage for their employees or to individuals who cannot get insurance through employers and are not eligible for Medicare or Medicaid. Assurant also sold the Recchis their plan that paid only $2,000 a day for Sean Recchi's treatment at MD Anderson. Although the tight limits on what their policies cover are clearly spelled out in Assurant's marketing materials and in the policy documents themselves, it seems that for its customers the appeal of having something called health insurance for a few hundred dollars a month is far more compelling than comprehending the details. "Yes, we knew there were some limits," says Rebecca. "But when you see the limits

expressed in the thousands of dollars, it looks O.K., I guess. Until you have an event."

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

Photograph by Nick Veasey for TIME

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

But Obamacare does little to attack the costs that overwhelmed Scott and Rebecca. There is nothing, for example, that addresses what may be the

most surprising sinkhole — the seemingly routine blood, urine and other laboratory tests for which Scott was charged $132,000, or more than $4,000 a day. By my estimates, about $70 billion will be spent in the U.S. on about 7 billion lab tests in 2013. That's about $223 a person for 16 tests per person. Cutting the overordering and overpricing could easily take $25 billion out of that bill. Much of that overordering involves patients like Scott S. who require prolonged hospital stays. Their tests become a routine, daily cash generator. "When you're getting trained as a doctor," says a physician who was involved in framing health care policy early in the Obama Administration, "you're taught to order what's called 'morning labs.' Every day you have a variety of blood tests and other tests done, not because it's necessary but because it gives you something to talk about with the others when you go on rounds. It's like your version of a news hook … I bet 60% of the labs are not necessary."

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

But that's hardly the spectacular profit margin we have seen in other sectors of the medical marketplace. The reason is that the outside companies like Quest, which mostly pick up specimens from doctors and clinics and deliver test results back to them, are not where the big profits are. The real money is in health care settings that cut out the middleman — the in-house venues, like the hospital testing lab run by Southwestern Medical that billed Scott and Rebecca $132,000. In-house labs account for about 60% of all testing revenue. Which means that for hospitals, they are vital profit centers. Labs are also increasingly being maintained by doctors who, as they form group practices with other doctors in their field, finance their own testing and diagnostic clinics. These labs account for a rapidly growing share of the testing revenue, and their share is growing rapidly. These in-house labs have no selling costs, and as pricing surveys repeatedly find, they can charge more because they have a captive consumer base in the hospitals or group practices. They also have an incentive to order more tests because they're the ones profiting from the tests. The *Wall Street Journal* reported last April that a study in the medical journal *Health Affairs* had found that doctors' urology groups with their own labs "bill the federal Medicare program for analyzing 72% more prostate tissue samples per biopsy while detecting fewer cases of cancer than counterparts who send specimens to outside labs."

If anything, the move toward in-house testing, and with it the incentive to do more of it, is accelerating the move by doctors to consolidate into practice groups. As one Bronx urologist explains, "The economics of having your own lab are so alluring." More important, hospitals are aligning with these practice groups, in many cases even getting them to sign

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

4. When Taxpayers Pick Up the Tab

Whether it was Emilia Gilbert trying to get out from under $9,418 in bills after her slip and fall or Alice D. vowing never to marry again because of the $142,000 debt from her husband's losing battle with cancer, we've seen how the medical marketplace misfires when private parties get the bills.

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

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

Medicare made quick work of the $268,227 in bills from the two hospitals, paying just $43,320. Except for $100 in incidental expenses, Alan A. paid nothing because 100% of inpatient hospital care is covered by Medicare. The ManorCare convalescent center, which Alan A. says gave him "good care" in an "O.K. but not luxurious room," got paid $11,982 by Medicare for his three-week stay. That is about $571 a day for all the physical therapy, tests and other services. As with all hospitals in nonemergency situations, ManorCare does not have to accept Medicare patients and their discounted rates. But it does accept them. In fact, it welcomes them and encourages doctors to refer them.

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

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

SOUND OFF: Are Medical Bills Too High? Tell Us Why

The original version of this article stated that the Assurant Health insurance policy of Rebecca and Scott S. had an annual pay limit of $100,000. It was $200,000.

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

With some minor variations each time, Sloan-Kettering's typical bill for each visit is the same as or similar to the $7,346 bill he received during the summer of 2011, which included $340 for a session with the doctor. Assuming eight visits (but only four with the doctor), that makes the annual bill $57,408 a year to keep Alan A. alive. His actual out-of-pocket cost for each session is a fraction of that. For that $7,346 visit, it was about $50.

In some ways, the set of transactions around Alan A.'s Sloan-Kettering care represent the best the American medical marketplace has to offer. First, obviously, there's the fact that he is alive after other doctors gave him up for dead. And then there's the fact that Alan A., a retired chemist of average means, was able to get care that might otherwise be reserved for the rich but was available to him because he had the right insurance. Medicare is the core of that insurance, although Alan A. — as do 90% of those on Medicare — has a supplemental-insurance policy that kicks in and generally pays 90% of the 20% of costs for doctors and outpatient care that Medicare does not cover.

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

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

In addition to a few hundred dollars in miscellaneous items, the two basic Sloan-Kettering charges are $414 per hour for five hours of nurse time for administering the Flebogamma and a $4,615 charge for the Flebogamma. According to Alan A., the nurse generally handles three or four patients at a time. That would mean Sloan-Kettering is billing more than $1,200 an hour for that nurse. When I asked Paul Nelson, Sloan-Kettering's director of financial planning, about the $414-per-hour charge, he explained that 15% of these charges is meant to cover overhead and indirect expenses, 20% is meant to be profit that will cover discounts for Medicare or Medicaid patients, and 65% covers direct expenses. That would still leave the nurse's time being valued at about $800 an hour (65% of $1,200), again assuming that just three patients were billed for the same hour at $414 each. Pressed on that, Nelson conceded that the profit is higher and is meant to cover other hospital costs like research and capital equipment.

Whatever Sloan-Kettering's calculations may be, Medicare — whose patients, including Alan A., are about a third of all Sloan-Kettering patients

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

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

The Cancer Drug Profit Chain It's with the bill for the transfusion that the peculiar economics of American medicine take a different turn, even when Medicare is involved. We have seen that even with big discounts for insurance companies and bigger discounts for Medicare, the chargemaster prices on everything from room and board to Tylenol to CT scans are high enough to make hospital costs a leading cause of the $750 billion Americans overspend each year on health care. We're now going to see how drug pricing is a major contributor to the way Americans overpay for medical care.

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

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

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

Nelson, the Sloan-Kettering head of financial planning, said the price his hospital pays for Alan A.'s dose of Flebogamma is "somewhat higher" than

$1,400, but he wasn't specific, adding that "the difference between the cost and the charge represents the cost of running our pharmacy — which includes overhead cost — plus a markup."

Even assuming Sloan-Kettering's real price for Flebogamma is "somewhat higher" than $1,400, the hospital would be making about 50% profit from Medicare's $2,123 payment. So even Medicare contributes mightily to hospital profit — and drug-company profit — when it buys drugs.

Flebogamma's Profit Margin The Spanish business at the beginning of the Flebogamma supply chain does even better than Sloan-Kettering. Made from human plasma, Flebogamma is a sterilized solution that is intended to boost the immune system. Sloan-Kettering buys it from either Baxter International in the U.S. or, as is more likely in Alan A.'s case, a Barcelona-based company called Grifols.

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

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

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

The difference between the regulatory environment in the U.S. and the environment abroad is so dramatic that McKinsey & Co. researchers reported that overall prescription-drug prices in the U.S. are "50% higher

for comparable products" than in other developed countries. Yet those regulated profit margins outside the U.S. remain high enough that Grifols, Baxter and other drug companies still aggressively sell their products there. For example, 37% of Grifols' sales come from outside North America.

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

According to securities filings of major drug companies, their R&D expenses are generally 15% to 20% of gross revenue. In fact, Grifols spent only 5% on R&D for the first nine months of 2012. Neither 5% nor 20% is enough to have cut deeply into the pharmaceutical companies' stellar bottom-line net profits. This is not *gross* profit, which counts only the cost of producing the drug, but the profit *after* those R&D expenses are taken into account. Grifols made a 32.3% net operating profit after all its R&D expenses — as well as sales, management and other expenses — were tallied. In other words, even counting all the R&D across the entire company, including research for drugs that did not pan out, Grifols made healthy profits. All the numbers tell one consistent story: Regulating drug prices the way other countries do would save tens of billions of dollars while still offering profit margins that would keep encouraging the pharmaceutical companies' quest for the next great drug.

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

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

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

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

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

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

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

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

SOUND OFF: Are Medical Bills Too High? Tell Us Why

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

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

patients deserved to live or die, the critics charged.

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

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

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

Bureaucrats You Can Admire By the numbers, Medicare looks like a government program run amok. After President Lyndon B. Johnson signed Medicare into law in 1965, the House Ways and Means Committee predicted that the program would cost $12 billion in 1990. Its actual cost by then was $110 billion. It is likely to be nearly $600 billion this year. That's due to the U.S.'s aging population and the popular program's expansion to cover more services, as well as the skyrocketing costs of medical services generally. It's also because Medicare's hands are tied when it comes to negotiating the prices for drugs or durable medical equipment. But Medicare's growth is not a matter of those "bureaucrats" that Betsy McCaughey complains about having gone off the rails in how they operate it.

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

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

$1.5 Billion A Day Sloan-Kettering sends Alan A.'s bills to medicare electronically, all elaborately coded according to Medicare's rules.

There are two basic kinds of codes for the services billed. The first is a number identifying which of the 7,000 procedures were performed by a doctor, such as examining a chest X-ray, performing a heart transplant or conducting an office consultation for a new patient (which costs more than a consultation with a continuing patient — coded differently — because it typically takes more time). If a patient presents more complicated challenges, then these basic procedures will be coded differently; for example, there are two varieties of emergency-room consultations.

Adjustments are also made for variations in the cost of living where the doctor works and for other factors, like whether doctors used their own office (they'll get paid more for that) or the hospital. A panel of doctors set up by the American Medical Association reviews the codes annually and recommends updates to Medicare. The process can get messy as the doctors fight over which procedures in which specialties take more time and expertise or are worth relatively more. Medicare typically accepts most of the panel's recommendations.

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

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

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

"When I tell my friends what I do here, it sounds boring, but it's exciting,"

says Diane Kovach, who works at Medicare's Maryland campus and whose title is deputy director of the provider billing group. "We are implementing a program that helps millions and millions of people, and we're doing it in a way that makes every one of us proud," she adds. Kovach, who has been at Medicare for 21 years, operates some of the gears of a machine that reviews the more than 3 million bills that come into Medicare every day, figures out the right payments for each and churns out more than $1.5 billion a day in wire transfers.

Stephen Voss for TIME

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

The part of that process that Kovach and three colleagues, with whom I

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

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

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

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

In Shelbyville, Alan A.'s status as a beneficiary is verified, and then the bill is sent electronically to a data center in Columbia, S.C., operated by another contractor, also a subsidiary of an insurance company. There, the codes are checked for edits, after which Alan A.'s Sloan-Kettering bill goes electronically to a data center in Denver, where the payment instructions are prepared and entered into what Karen Jackson, who supervises Medicare's outside contractors, says is the largest accounting ledger in the world. The whole process takes three days — and that long only because the data is sent in batches.

There are multiple backups to make sure this ruthlessly efficient system isn't just ruthless. Medicare keeps track of and publicly reports the percentage of bills processed "clean" — i.e., with no rejected items — within 30 days. Even the speed with which the contractors answer the widely publicized consumer phone lines is monitored and reported. The

average time to answer a call from a doctor or other provider is 57.6 seconds, according to Medicare's records, and the average time to answer one of the millions of calls from patients is 2 minutes 41 seconds, down from more than eight minutes in 2007. These times might come as a surprise to people who have tried to call a private insurer. That monitoring process is, in turn, backstopped by a separate ombudsman's office, which has regional and national layers.

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

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

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

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

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

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

operating.
This process can “get quite anal,” says the doctor who recently treated me for an ear infection. Although my doctor is on Park Avenue, she, like 96% of all specialists, accepts Medicare patients despite the discounted rates it pays, because, she says, “they pay quickly.” However, she recalls getting bills from Medicare for 21¢ or 85¢ for supposed overpayments.
The DHHS’s inspector general is also on the prowl to protect the Medicare checkbook. It reported recovering $1.2 billion last year through Medicare and Medicaid audits and investigations (though the recovered funds had probably been doled out over several fiscal years). The inspector general’s work is supplemented by a separate, multiagency federal health-care-fraud task force, which brings criminal charges against fraudsters and issues regular press releases claiming billions more in recoveries.
(**SOUND OFF**: Are Medical Bills Too High? Tell Us Why)
This does not mean the system is airtight. If anything, all that recovery activity suggests fallibility, even as it suggests more buttoned-up operations than those run by private insurers, whose payment systems are notoriously erratic.
Too Much Health Care? In a review of other bills of those enrolled in Medicare, a pattern of deep, deep discounting of chargemaster charges emerged that mirrored how Alan A.’s bills were shrunk down to reality. A $121,414 Stanford Hospital bill for a 90-year-old California woman who fell and broke her wrist became $16,949. A $51,445 bill for the three days an ailing 91-year-old spent getting tests and being sedated in the hospital before dying of old age became $19,242. Before Medicare went to work, the bill was chock-full of creative chargemaster charges from the California Pacific Medical Center — part of Sutter Health, a dominant nonprofit Northern California chain whose CEO made $5,241,305 in 2011.
Another pattern emerged from a look at these bills: some seniors apparently visit doctors almost weekly or even daily, for all varieties of ailments. Sure, as patients age they are increasingly in need of medical care. But at least some of the time, the fact that they pay almost nothing to spend their days in doctors’ offices must also be a factor, especially if they have the supplemental insurance that covers most of the 20% not covered by Medicare.
Alan A. is now 89, and the mound of bills and Medicare statements he showed me for 2011 — when he had his heart attack and continued his treatments at Sloan-Kettering — seemed to add up to about $350,000, although I could not tell for sure because a few of the smaller ones may have been duplicates. What is certain — because his insurance company tallied it for him in a year-end statement — was that his total out-of-pocket expense was $1,139, or less than 0.2% of his overall medical bills. Those bills included what seemed to be 33 visits in one year to 11 doctors who

had nothing to do with his recovery from the heart attack or his cancer. In all cases, he was routinely asked to pay almost nothing: $2.20 for a check of a sinus problem, $1.70 for an eye exam, 33¢ to deal with a bunion. When he showed me those bills he chuckled.

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

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

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

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

"One of the benefits attending physicians get from many hospitals is the opportunity to cruise the halls and go into a Medicare patient's room and rack up a few dollars," says a doctor who has worked at several hospitals across the country. "In some places it's a Monday-morning tradition. You go see the people who came in over the weekend. There's always an ostensible reason, but there's also a lot of abuse."

Photograph by Nick Veasey for TIME

Sodium Chloride $84 Hospital charge for standard saline solution. Online, a liter bag costs $5.16

When health care wonks focus on this kind of overdoctoring, they complain (and write endless essays) about what they call the fee-for-service mode, meaning that doctors mostly get paid for the time they spend treating patients or ordering and reading tests. Alan A. didn't care how much time his cancer or heart doctor spent with him or how many tests he got. He cared only that he got better.

Some private care organizations have made progress in avoiding this overdoctoring by paying salaries to their physicians and giving them incentives based on patient outcomes. Medicare and private insurers have yet to find a way to do that with doctors, nor are they likely to, given the current structure that involves hundreds of thousands of private providers billing them for their services.

In passing Obamacare, Congress enabled Medicare to drive efficiencies in

hospital care based on the notion that good care should be rewarded and the opposite penalized. The primary lever is a system of penalties Obamacare imposes on hospitals for bad care — a term defined as unacceptable rates of adverse events, such as infections or injuries during a patient's hospital stay or readmissions within a month after discharge. Both kinds of adverse events are more common than you might think: 1 in 5 Medicare patients is readmitted within 30 days, for example. One Medicare report asserts that "Medicare spent an estimated $4.4 billion in 2009 to care for patients who had been harmed in the hospital, and readmissions cost Medicare another $26 billion." The anticipated savings that will be produced by the threat of these new penalties are what has allowed the Obama Administration to claim that Obamacare can cut hundreds of billions of dollars from Medicare over the next 10 years without shortchanging beneficiaries. "These payment penalties are sending a shock through the system that will drive costs down," says Blum, the deputy administrator of the Centers for Medicare and Medicaid Services.
There are lots of other shocks Blum and his colleagues would like to send. However, Congress won't allow him to. Chief among them, as we have seen, would be allowing Medicare, the world's largest buyer of prescription drugs, to negotiate the prices that it pays for them and to make purchasing decisions on the basis of comparative effectiveness. But there's also the cane that Alan A. got after his heart attack. Medicare paid $21.97 for it. Alan A. could have bought it on Amazon for about $12. Other than in a few pilot regions that Congress designated in 2011 after a push by the Obama Administration, Congress has not allowed Medicare to drive down the price of any so-called durable medical equipment through competitive bidding. This is more than a matter of the 124,000 canes Medicare reports that it buys every year. It's about mail-order diabetic supplies, wheelchairs, home medical beds and personal oxygen supplies too. Medicare spends about $15 billion annually for these goods.
In the areas of the country where Medicare has been allowed by Congress to conduct a competitive-bidding pilot program, the process has produced savings of 40%. But so far, the pilot programs cover only about 3% of the medical goods seniors typically use. Taking the program nationwide and saving 40% of the entire $15 billion would mean saving $6 billion a year for taxpayers.
The Way Out Of the Sinkhole "I was driving through central Florida a year or two ago," says Medicare's Blum. "And it seemed like every billboard I saw advertised some hospital with these big shiny buildings or showed some new wing of a hospital being constructed … So when you tell me that the hospitals say they are losing money on Medicare and shifting costs from Medicare patients to other patients, my reaction is that Central Florida is overflowing with Medicare patients and all those hospitals are

expanding and advertising for Medicare patients. So you can't tell me they're losing money … Hospitals don't lose money when they serve Medicare patients."

If that's the case, I asked, why not just extend the program to everyone and pay for it all by charging people under 65 the kinds of premiums they would pay to private insurance companies? "That's not for me to say," Blum replied.

In the debate over controlling Medicare costs, politicians from both parties continue to suggest that Congress raise the age of eligibility for Medicare from 65 to 67. Doing so, they argue, would save the government tens of billions of dollars a year. So it's worth noting another detail about the case of Janice S., which we examined earlier. Had she felt those chest pains and gone to the Stamford Hospital emergency room a month later, she would have been on Medicare, because she would have just celebrated her 65th birthday.

If covered by Medicare, Janice S.'s $21,000 bill would have been deeply discounted and, as is standard, Medicare would have picked up 80% of the reduced cost. The bottom line is that Janice S. would probably have ended up paying $500 to $600 for her 20% share of her heart-attack scare. And she would have paid only a fraction of that — maybe $100 — if, like most Medicare beneficiaries, she had paid for supplemental insurance to cover most of that 20%.

In fact, those numbers would seem to argue for lowering the Medicare age, not raising it — and not just from Janice S.'s standpoint but also from the taxpayers' side of the equation. That's not a liberal argument for protecting entitlements while the deficit balloons. It's just a matter of hardheaded arithmetic.

As currently constituted, Obamacare is going to require people like Janice S. to get private insurance coverage and will subsidize those who can't afford it. But the cost of that private insurance — and therefore those subsidies — will be much higher than if the same people were enrolled in Medicare at an earlier age. That's because Medicare buys health care services at much lower rates than any insurance company. Thus the best way both to lower the deficit and to help save money for people like Janice S. would seem to be to bring her and other near seniors into the Medicare system before they reach 65. They could be required to pay premiums based on their incomes, with the poor paying low premiums and the better off paying what they might have paid a private insurer. Those who can afford it might also be required to pay a higher proportion of their bills — say, 25% or 30% — rather than the 20% they're now required to pay for outpatient bills.

Meanwhile, adding younger people like Janice S. would lower the overall cost per beneficiary to Medicare and help cut its deficit still more, because

younger members are likelier to be healthier.

From Janice S.'s standpoint, whatever premium she would pay for this age-64 Medicare protection would still be less than what she had been paying under the COBRA plan that she wished she could have kept after the rules dictated that she be cut off after she lost her job.

The only way this would not work is if 64-year-olds started using health care services they didn't need. They might be tempted to, because, as we saw with Alan A., Medicare's protection is so broad and supplemental private insurance costs so little that it all but eliminates patients' obligation to pay the 20% of outpatient-care costs that Medicare doesn't cover. To deal with that, a provision could be added requiring that 64-year-olds taking advantage of Medicare could not buy insurance freeing them from more than, say, 5% or 10% of their responsibility for the bills, with the percentage set according to their wealth. It would be a similar, though more stringent, provision of the kind I've already suggested for current Medicare beneficiaries as a way to cut the cost of people overusing benefits.

If that logic applies to 64-year-olds, then it would seem to apply even more readily to healthier 40-year-olds or 18-year-olds. This is the single-payer approach favored by liberals and used by most developed countries.

Then again, however much hospitals might survive or struggle under that scenario, no doctor could hope for anything approaching the income he or she deserves (and that will make future doctors want to practice) if 100% of their patients yielded anything close to the low rates Medicare pays.

SOUND OFF: Are Medical Bills Too High? Tell Us Why

"If you could figure out a way to pay doctors better and separately fund research … adequately, I could see where a single-payer approach would be the most logical solution," says Gunn, Sloan-Kettering's chief operating officer. "It would certainly be a lot more efficient than hospitals like ours having hundreds of people sitting around filling out dozens of different kinds of bills for dozens of insurance companies." Maybe, but the prospect of overhauling our system this way, displacing all the private insurers and other infrastructure after all these decades, isn't likely. For there would be one group of losers — and these losers have lots of clout. They're the health care providers like hospitals and CT-scan-equipment makers whose profits — embedded in the bills we have examined — would be sacrificed. They would suffer because of the lower prices Medicare would pay them when the patient is 64, compared with what they are able to charge when that patient is either covered by private insurance or has no insurance at all.

That kind of systemic overhaul not only seems unrealistic but is also packed with all kinds of risk related to the microproblems of execution and the macro issue of giving government all that power.

Yet while Medicare may not be a realistic systemwide model for reform, the way Medicare works does demonstrate, by comparison, how the overall health care market doesn't work.

Unless you are protected by Medicare, the health care market is not a market at all. It's a crapshoot. People fare differently according to circumstances they can neither control nor predict. They may have no insurance. They may have insurance, but their employer chooses their insurance plan and it may have a payout limit or not cover a drug or treatment they need. They may or may not be old enough to be on Medicare or, given the different standards of the 50 states, be poor enough to be on Medicaid. If they're not protected by Medicare or they're protected only partly by private insurance with high co-pays, they have little visibility into pricing, let alone control of it. They have little choice of hospitals or the services they are billed for, even if they somehow know the prices before they get billed for the services. They have no idea what their bills mean, and those who maintain the chargemasters couldn't explain them if they wanted to. How much of the bills they end up paying may depend on the generosity of the hospital or on whether they happen to get the help of a billing advocate. They have no choice of the drugs that they have to buy or the lab tests or CT scans that they have to get, and they would not know what to do if they did have a choice. They are powerless buyers in a seller's market where the only sure thing is the profit of the sellers.

Indeed, the only player in the system that seems to have to balance countervailing interests the way market players in a real market usually do is Medicare. It has to answer to Congress and the taxpayers for wasting money, and it has to answer to portions of the same groups for trying to hold on to money it shouldn't. Hospitals, drug companies and other suppliers, even the insurance companies, don't have those worries.

Moreover, the only players in the private sector who seem to operate efficiently are the private contractors working — dare I say it? — under the government's supervision. They're the Medicare claims processors that handle claims like Alan A.'s for 84¢ each. With these and all other Medicare costs added together, Medicare's total management, administrative and processing expenses are about $3.8 billion for processing more than a billion claims a year worth $550 billion. That's an overall administrative and management cost of about two-thirds of 1% of the amount of the claims, or less than $3.80 per claim. According to its latest SEC filing, Aetna spent $6.9 billion on operating expenses (including claims processing, accounting, sales and executive management) in 2012. That's about $30 for each of the 229 million claims Aetna processed, and it amounts to about 29% of the $23.7 billion Aetna pays out in claims.

The real issue isn't whether we have a single payer or multiple payers. It's whether whoever pays has a fair chance in a fair market. Congress has

given Medicare that power when it comes to dealing with hospitals and doctors, and we have seen how that works to drive down the prices Medicare pays, just as we've seen what happens when Congress handcuffs Medicare when it comes to evaluating and buying drugs, medical devices and equipment. Stripping away what is now the sellers' overwhelming leverage in dealing with Medicare in those areas and with private payers in all aspects of the market would inject fairness into the market. We don't have to scrap our system and aren't likely to. But we can reduce the $750 billion that we overspend on health care in the U.S. in part by acknowledging what other countries have: because the health care market deals in a life-or-death product, it cannot be left to its own devices. Put simply, the bills tell us that this is not about interfering in a free market. It's about facing the reality that our largest consumer product by far — one-fifth of our economy — does not operate in a free market.

So how can we fix it?

Changing Our Choices We should tighten antitrust laws related to hospitals to keep them from becoming so dominant in a region that insurance companies are helpless in negotiating prices with them. The hospitals' continuing consolidation of both lab work and doctors' practices is one reason that trying to cut the deficit by simply lowering the fees Medicare and Medicaid pay to hospitals will not work. It will only cause the hospitals to shift the costs to non-Medicare patients in order to maintain profits — which they will be able to do because of their increasing leverage in their markets over insurers. Insurance premiums will therefore go up — which in turn will drive the deficit back up, because the subsidies on insurance premiums that Obamacare will soon offer to those who cannot afford them will have to go up.

Similarly, we should tax hospital profits at 75% and have a tax surcharge on all nondoctor hospital salaries that exceed, say, $750,000. Why are high profits at hospitals regarded as a given that we have to work around? Why shouldn't those who are profiting the most from a market whose costs are victimizing everyone else chip in to help? If we recouped 75% of all hospital profits (from nonprofit as well as for-profit institutions), that would save over $80 billion a year before counting what we would save on tests that hospitals might not perform if their profit incentives were shaved.

To be sure, this too seems unlikely to happen. Hospitals may be the most politically powerful institution in any congressional district. They're usually admired as their community's most important charitable institution, and their influential stakeholders run the gamut from equipment makers to drug companies to doctors to thousands of rank-and-file employees. Then again, if every community paid more attention to those administrator salaries, to those nonprofits' profit margins and to charges like $77 for gauze pads, perhaps the political balance would shift.

We should outlaw the chargemaster. Everyone involved, except a patient who gets a bill based on one (or worse, gets sued on the basis of one), shrugs off chargemasters as a fiction. So why not require that they be rewritten to reflect a process that considers actual and thoroughly transparent costs? After all, hospitals are supposed to be government-sanctioned institutions accountable to the public. Hospitals love the chargemaster because it gives them a big number to put in front of rich uninsured patients (typically from outside the U.S.) or, as is more likely, to attach to lawsuits or give to bill collectors, establishing a place from which they can negotiate settlements. It's also a great place from which to start negotiations with insurance companies, which also love the chargemaster because they can then make their customers feel good when they get an Explanation of Benefits that shows the terrific discounts their insurance company won for them.

But for patients, the chargemasters are both the real and the metaphoric essence of the broken market. They are anything but irrelevant. They're the source of the poison coursing through the health care ecosystem.

We should amend patent laws so that makers of wonder drugs would be limited in how they can exploit the monopoly our patent laws give them. Or we could simply set price limits or profit-margin caps on these drugs. Why are the drug profit margins treated as another given that we have to work around to get out of the $750 billion annual overspend, rather than a problem to be solved?

Just bringing these overall profits down to those of the software industry would save billions of dollars. Reducing drugmakers' prices to what they get in other developed countries would save over $90 billion a year. It could save Medicare — meaning the taxpayers — more than $25 billion a year, or $250 billion over 10 years. Depending on whether that $250 billion is compared with the Republican or Democratic deficit-cutting proposals, that's a third or a half of the Medicare cuts now being talked about.

Similarly, we should tighten what Medicare pays for CT or MRI tests a lot more and even cap what insurance companies can pay for them. This is a huge contributor to our massive overspending on outpatient costs. And we should cap profits on lab tests done in-house by hospitals or doctors.

Finally, we should embarrass Democrats into stopping their fight against medical-malpractice reform and instead provide safe-harbor defenses for doctors so they don't have to order a CT scan whenever, as one hospital administrator put it, someone in the emergency room says the word head. Trial lawyers who make their bread and butter from civil suits have been the Democrats' biggest financial backer for decades. Republicans are right when they argue that tort reform is overdue. Eliminating the rationale or excuse for all the extra doctor exams, lab tests and use of CT scans and MRIs could cut tens of billions of dollars a year while drastically cutting

what hospitals and doctors spend on malpractice insurance and pass along to patients.

Other options are more tongue in cheek, though they illustrate the absurdity of the hole we have fallen into. We could limit administrator salaries at hospitals to five or six times what the lowest-paid licensed physician gets for caring for patients there. That might take care of the self-fulfilling peer dynamic that Gunn of Sloan-Kettering cited when he explained, “We all use the same compensation consultants.” Then again, it might unleash a wave of salary increases for junior doctors.

Or we could require drug companies to include a prominent, plain-English notice of the gross profit margin on the packaging of each drug, as well as the salary of the parent company’s CEO. The same would have to be posted on the company’s website. If nothing else, it would be a good test of embarrassment thresholds.

None of these suggestions will come as a revelation to the policy experts who put together Obamacare or to those before them who pushed health care reform for decades. They know what the core problem is — lopsided pricing and outsize profits in a market that doesn’t work. Yet there is little in Obamacare that addresses that core issue or jeopardizes the paydays of those thriving in that marketplace. In fact, by bringing so many new customers into that market by mandating that they get health insurance and then providing taxpayer support to pay their insurance premiums, Obamacare enriches them. That, of course, is why the bill was able to get through Congress.

Obamacare does some good work around the edges of the core problem. It restricts abusive hospital-bill collecting. It forces insurers to provide explanations of their policies in plain English. It requires a more rigorous appeal process conducted by independent entities when insurance coverage is denied. These are all positive changes, as is putting the insurance umbrella over tens of millions more Americans — a historic breakthrough. But none of it is a path to bending the health care cost curve. Indeed, while Obamacare’s promotion of statewide insurance exchanges may help distribute health-insurance policies to individuals now frozen out of the market, those exchanges could raise costs, not lower them. With hospitals consolidating by buying doctors’ practices and competing hospitals, their leverage over insurance companies is increasing. That’s a trend that will only be accelerated if there are more insurance companies with less market share competing in a new exchange market trying to negotiate with a dominant hospital and its doctors.

Similarly, higher insurance premiums — much of them paid by taxpayers through Obamacare’s subsidies for those who can’t afford insurance but now must buy it — will certainly be the result of three of Obamacare’s best provisions: the prohibitions on exclusions for pre-existing conditions, the

restrictions on co-pays for preventive care and the end of annual or lifetime payout caps.

Put simply, with Obamacare we've changed the rules related to who pays for what, but we haven't done much to change the prices we pay.

When you follow the money, you see the choices we've made, knowingly or unknowingly.

Over the past few decades, we've enriched the labs, drug companies, medical device makers, hospital administrators and purveyors of CT scans, MRIs, canes and wheelchairs. Meanwhile, we've squeezed the doctors who don't own their own clinics, don't work as drug or device consultants or don't otherwise game a system that is so gameable. And of course, we've squeezed everyone outside the system who gets stuck with the bills.

We've created a secure, prosperous island in an economy that is suffering under the weight of the riches those on the island extract.

And we've allowed those on the island and their lobbyists and allies to control the debate, diverting us from what Gerard Anderson, a health care economist at the Johns Hopkins Bloomberg School of Public Health, says is the obvious and only issue: "All the prices are too damn high."