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My wife is using the term “bionic man” often these days. That’s because after a right hip replacement two years ago, I just had my right knee replaced. I can tell you that there is a major difference in the recovery process for these two procedures, but there are striking similarities in the financial process connected with these surgeries, and, sadly, with the hospital experience.

After my hip surgery I wrote about the unbelievable statement I received from my secondary health insurer. (Since I passed the magic age, my primary health insurance is with Medicare and I have secondary coverage under my retirement from my former employer.) For both the hip and knee I saw the same pattern; an insurance payment that was a fraction of the amount claimed. The statement for my knee has the following “Claim Summary Information”. The total charge for my care was \$69,600. Then, there is a “Provider Discount”, which I am certain is a function of Medicare, of \$55,507 leaving an “Allowed Amount” of \$14,092. Or, in plain English, the hospital and physicians received about 20% of what they billed leaving me with an “Estimated Member Responsibility” of zero dollars.

This is a near-mirror image of the experience with my hip two years ago, but between then and now, just a couple of months ago, there was an interesting piece of news. A cancer clinic, which had been started a few years ago in our Medical Center by a doctor who had broken away from the CTSC, announced it was having to close. The main reason it gave was that a large number of its patients were covered by Medicare and this facility was unable to collect enough to cover its expenses.

The numbers I have now seen twice and the news about this clinic raise some troubling questions. I cannot understand the business model this reveals where service providers bill their customers five times the amount that those customers’ government provided “insurance” will pay. And now we see a significant cancer treatment facility going under because most of its clientele uses that same “insurance”. One must wonder about much of the language used by our politicians as they promoted the new health care bill that is mostly about providing “insurance”. One of their most aggressive points has been criticism of the rates charged by private health insurers, and that is before these politicians begin to force those companies to pay for the care of people with pre-existing conditions. I believe that such a step is a humane and decent thing to do, but that step should be taken only after determining what it really costs. And we all must recognize that paying for treatment of pre-existing medical conditions cannot be done with the business model we call “insurance”.

I actually feel sympathy for the management of the hospital where my surgery took place. A good part of the “Provider Discount” which I noted came out of their pocket. It is obvious that they, just as my surgical team and, in fact, my family physician, with whom I’ve spoken about this, all have to attempt to run their businesses on a revenue stream that is significantly less than they expect. There is simply no easy way out. Corners must be cut or adjustments must be made. If not, they all face the fate of that cancer clinic.