

To fix health insurance, start with billing mess

Article by: Michael J.C. Roth

Sept. 6, 2008

One of the most noted problems' facing the United States is health insurance. Politicians frequently speak out about the many people who have no insurance, and they ponder how our nation will be able to face the rising cost of Medicare. Medicare is an especially fervent topic now as the baby-boomer generation enters retirement. I am a bit older than baby boomers and I became eligible for Medicare last year. I am also fortunate to have a medical insurance benefit from the company from which I retired in 2001. That is my medical insurance situation and it has just given me a very interesting glimpse into the challenge facing our nation.

On June 30 I had a hip-replacement operation that was performed by a San Antonio doctor in hospital here. About the time I returned home, on July 12, I got a detailed bill from the hospital. That bill totaled \$55,241.80. On the bill was noted the fact that I did not have to pay this amount because the hospital was contacting my insurers. I was relieved to read that, but still a bit uneasy over the size of this bill.

Early in August I received from my health insurance company, the one connected to my retirement, a document titled "Explanation of Benefits". It showed the hospital's charge of \$55,241.80. Then there was a block that noted "-(minus) Provider Discount". The amount subtracted (hold onto your hats) was \$41,302.11. That resulted in an "Allowed amount" of \$13,939.69. Of this, Medicare paid \$12,915.69 and my insurance carrier paid \$1,024.00. And there is block on this form titled "Est. Member Responsibility" in which is entered "\$0.00". What an amazing picture!

The most striking thing is that 74.8% of the original bill was forgiven by the hospital. What is going on here?

Years ago I noted a similar pattern when my wife's daughter was hospitalized. I asked the CEO of that hospital how he could run his business if he had to surrender so much revenue. All he would say was "You have to know how to play the game". That statement said to me that a hospital, or a doctor, has to go through a process. It begins with a true determination of how much they must collect for a procedure to cover expenses and provide a profit. Then they must determine what kind of discounting formula health insurers use and that will lead them to the bill they must present to a patient. That bill will be discounted, but only down to the level that provides a profit, and this is one way "how to play the game".

There are other pieces of this puzzle. Numerous doctors who are friends have described how their income peaked over a decade ago and has been steadily declining. A doctor with whom we had dinner last week told me that he is able to collect a bit more than half of what he bills

insurance companies. And I recall an experience I had about 15 years ago. My doctor was going to perform a minor surgery on me and told me that insurance companies insisted it be done in a hospital. So I asked my secretary to call two hospitals and find out how much it would cost to use their facility for this procedure. Both of them told her they had no idea what it would cost. My hip-replacement experience probably explains that long ago answer.

And, finally, a friend called me this week with the news that she's been laid off by a local hospital for whom she has worked for over 18 years. The reason given is too little reimbursement from insurers causing a need to cut costs.

All of this tells me that we have created a morass with our attempts to provide medical insurance. And to begin solving the problem we need to get rid of a system that bills \$55,000 for a \$13,000 procedure.