Gouging The Medically Uninsured: A Tale Of Two Bills

A health journalist encounters the gap between what providers charge insured patients and what they charge the uninsured.

by Irene Wielawski

Not long ago my son had surgery to repair four small hernias. They were lined up in a row, extending vertically above his navel. Like so many of the weird things teenage boys come home with, this one left his father and me scratching our heads and, when the drama was over, very grateful for health insurance.

Andrew is a budding Ska trombonist (Ska is a style of music that combines reggae and rock). He had just played his first club gig with a band of high school boys whose performance style calls for energetic dancing while playing horns, drums, guitars, and keyboard as loudly as possible. Andrew gave it his all and, literally, the surgeon told us later, came close to blowing his guts out.

Hernia repair is a routine surgical procedure, and so it was for Andrew. Only after he recovered did we come to appreciate the edge insurance had given us in negotiating the health care system and how differently the system responds to patients without insurance.

Underlying this divide is a Byzantine pricing structure that reflects widespread discounting for patients with insurance, while obscuring the actual value of health services. Health professionals exasperatedly roll their eyes when asked to explain it. “Crazy.” “Government in action.” “A paperwork nightmare.” they say. Less recognized are the inequities this pricing system imposes on those least able to bear up: the medically uninsured. These patients are being charged as much as twice what the rest of us pay for exactly the same medical service.

Irene Wielawski (imw@cloud9.net) is a former health care reporter for the Los Angeles Times. This essay is based in part on material gathered during her five-year evaluation of Reach Out: Physicians’ Initiative to Expand Care to Underserved Americans, a program sponsored by the Robert Wood Johnson Foundation. She currently is writing a book about the program’s grassroots initiatives.
Pricing Run Amok

I would not have paid as close attention to the routine insurance company missives that filled our mailbox in the weeks after Andrew’s surgery had I not, some months earlier, met Frederick Paquette, a sixty-two-year-old uninsured carpenter in Sacramento, California, who also needed hernia surgery. I had interviewed Paquette in my capacity as a medical journalist, tracking a grassroots health reform experiment.

The hardship of being uninsured and having to pay out of pocket for medical treatment is an old story. But since the failure of national health reform, Congress and the Clinton administration have all but abandoned the uninsured, even as their numbers creep steadily upward, rising 40 percent in the past decade to 44.3 million people.

But the current pricing situation, in which those least able to pay are being charged the most, gives the story a cynical new twist. Overcharging the uninsured is one of the many unintended and largely overlooked results of our decade-long obsession with curbing health care costs. Powerful interest groups—government, employers, insurers, hospitals, medical equipment vendors, and health care professionals—have fought vigorously to protect their interests. The uninsured, with no organized voice, emerge as losers.

Health care pricing is famously inconsistent. Urban versus rural, north versus south, slums versus hilltop—each has a different pricing structure. The situation brings to mind one of those houses jerry-rigged with additions to accommodate the space needs of a growing family. The result is, well, space. Unfortunately, the bathrooms are nowhere near the bedrooms, the kitchen is blocked off from the dining room, and Junior has to climb out a window to practice his curve ball against the garage. Space, yes, but in a completely illogical framework for family life.

So goes the tortured history of modern health care pricing, where the true value of any service is hidden behind walls of outdated federal regulation, complex reimbursement formulas, and discounts driven by the competitive marketplace of the 1990s. “It’s like one of those things that just grows and grows and gets adjusted and modified here and there until it is so complicated no one even knows where to begin to fix it,” a seasoned hospital executive told me.

Ironically, it was Medicare—the nation’s first effort to improve access to health care for a vulnerable population—that launched the price inflation so discouraging to today’s working poor. In rolling out this first national insurance program for the elderly in 1965, the
federal government understandably did not want to negotiate with each and every doctor and hospital in the country. So it promulgated a series of rules that tied Medicare payments to a percentage of the average charge in a community or a percentage of the provider’s own average charges, whichever was lower. If Doctor X, Hospital Y, and Laboratory Z had lower charges than the community average, Medicare’s payment formula was a wake-up call to providers to start charging more so that they could get higher Medicare reimbursements. But to make a persuasive case, providers had to raise charges for all patients, not just the elderly.

Medicaid, the government insurance program for the very poor, added another pricing equation to the mix. Unlike Medicare, Medicaid is administered by individual states, which set fees early on according to whatever their legislatures decided to commit from the treasury. Today, states diverge widely in their reimbursements for identical medical services. Poorer states generally pay less, and, within each state, Medicaid generally pays less than Medicare.

To compensate for discounts to Medicare and Medicaid, providers once again sought refuge in inflated charges. This time privately insured patients were the target. In the 1970s and 1980s most private patients had indemnity insurance plans that typically paid 80 percent of full charges, with the patient responsible for the remaining 20 percent. By inflating charges to these insurers, providers were able to use the surplus they collected to offset losses from Medicare and Medicaid as well as for charity care to uninsured patients. Health care managers called it their “Robin Hood” gambit—a means of rationalizing the income stream even as quoted prices diverged ever more sharply from the true cost of doing business. The practice, known as cost shifting, prevailed for nearly two decades. Then private employers got wise to their role in balancing the health care ledger books, and they revolted.

The call to arms was a series of double-digit increases in the cost of employee health benefits during the late 1980s. Companies seeking to account for these premium hikes discovered that they were paying almost a third above the actual cost of medical care for their workers. They demanded relief. In the managed care revolution that ensued, they got it. The cross-subsidy was squeezed out. Insurance
premiums stabilized. And a rash of consolidations and mergers in the managed care industry made new savings possible. As purchasers of services for large blocs of patients, insurers were able to extract their own discounts from health care providers.

The Rub

The depth of these discounts came home to me personally in the form of EOB (explanation of benefit) statements sent by our insurance company for Andrew’s hernia surgery. Because I happened to be tracking Frederick Paquette’s hernia case at the time, it was impossible for me to miss the contrast.

A pediatrician in our medical group saw Andrew the same day I called. The pediatrician thought that the small, soft lumps in Andrew’s upper abdomen were hernias but wanted a surgeon’s opinion. That appointment came a week later. In less than a minute of poking around, the surgeon confirmed epigastric hernias and conveniently scheduled surgery for the next school vacation. Andrew had a smooth recovery and was back to horn playing, baseball, and all the rest within a month. Besides the part of the insurance premium deducted from my husband’s paycheck, the hernia cost us $30—representing copays for physician fees that are required by our managed care plan with Aetna U.S. Healthcare.

Aetna then proceeded to extract its discounts from Andrew’s providers. To wit, the surgeon had billed $2,682 for his services; Aetna paid him $1,392. Our suburban New York hospital charged $2,593 for use of the surgical suite; Aetna paid $2,075. The pediatrician’s $70 bill was knocked down to $37.25. Lab tests and an x-ray billed at $117 got discounted to $5.25.

Frederick Paquette, meanwhile, was making the rounds of Sacramento’s surgeons and hospitals to see about getting his groin hernia repaired. Unlike Andrew, he did not have a referral, having depended upon low-cost public clinics for routine ailments. So right off, he encountered a cool reception that plummeted straight to the bottom line when he disclosed his lack of insurance.

Paquette was quoted full charges even though Sacramento is one of the most deeply discounted managed care markets in the country. Health plans there typically pay $3,000–$3,500 for comprehensive hernia care, including all physician fees and hospital charges. But to Paquette, surgeons quoted charges of $3,000–$5,000 for their services alone—a price range that would double when hospital charges were added. He had hoped to find a doctor willing to let him pay
over time. But front-office staff brusquely insisted on a cash down payment. For hernia repair, it was $1,500.

At the time, Paquette and his wife had about $100 in savings. With no hope of raising the down payment, Paquette instead rigged himself with homemade trusses. His plan was to wait three years until he turned sixty-five and qualified for Medicare.

But the hernia worsened over the next year. Little by little Paquette gave up his carpentry jobs because lifting things hurt too much. Finally he reached a point where even walking was painful. That's when his luck changed, thanks to a charity project in Sacramento called SPIRIT, through which volunteer surgeons repair hernias for free and under whose auspices I met Paquette. Within a few weeks of the operation, he was free from pain and back at work—a testament to the simplicity of the fix both he and Andrew needed from our health care system but which only Andrew got in a timely and caring fashion. Had the SPIRIT project not existed, Paquette might eventually have staggered into an emergency room with a dangerously strangulated bowel at far greater cost to himself and the system than a reasonably priced hernia repair.

A Shameful Comparison

ARGUABLY, PAQUETTE MIGHT HAVE FOUND EVEN REASONABLE PRICES DISCOURAGING. After all, he only had $100 in the bank, and no one seriously entertained his idea of paying for the surgery in installments. But when I look at the price discounts my son received from his providers and compare them with the lousy deals offered Frederick Paquette, my strongest emotion is shame. The pricing formulas that health care insiders deride as a "paperwork nightmare" are more personally punitive to the millions of people without insurance. A joint survey in 1997 by the Henry J. Kaiser Family Foundation and the Commonwealth Fund found that prohibitive cost led 55 percent of the uninsured to postpone care as Paquette did, 30 percent to skip treatment entirely, and 24 percent to not fill prescriptions—all of which can lead to far more complicated and costly illness. And the situation is worsening. The gap in drug prices alone for people with and without health insurance nearly doubled between 1996 and 1999, according to a government study.

I have not met anyone in health care who defends the current system of pricing. Most agree that it just happened and that no one intended for the uninsured to be charged more than everyone else. But people I talked to in my effort to reconcile Andrew's experience with Paquette's surprised me with arguments for the status quo.
The first argument was based on the millions of dollars in uncollectable bills that hospitals and other providers write off every year. Health care pricing is irrelevant, goes this argument, because the uninsured don't pay their bills. But many do. Next to the "uncollectable" column is usually one listing revenue from "self-pay" patients. And price absolutely influences purchasing decisions when the funds are coming out of your own pocket. For people living on very little, the decision to take an ailing child to the doctor can turn on the difference between $70 (the charge posted by Andrew's pediatrician) and $37.50 (the fee negotiated by our insurer).

The second argument was that the uninsured should negotiate their own discounts. Indeed, nothing in law prevents this. I have a friend who asks for discounts all the time, although financial hardship is not his motivation. As a medical malpractice attorney he knows the game so well that he doesn't need an insurance company to do his wrangling. For the unexpected disaster, he carries a major medical policy with a high deductible. For the rest, he offers to pay his doctors in cash whatever they get from insurers—no paperwork, no reimbursement delays. Few refuse the deal.

My attorney friend has little in common with the typical uninsured patient. He has the information, contacts, professional skills, and capital to make the pricing system work in his favor. Imagine Frederick Paquette trying to undertake such negotiations with the surgeons in Sacramento. He couldn't even interest them in an installment plan at full price.

Universal health insurance— in which everyone shared in the discounts—would solve this problem for the uninsured. But who can wait for that? Let's face it. The most recent universal coverage attempt, President Clinton's proposed Health Security Act, failed in 1994, and no political leader since has dared to renew the call. Incremental health reform seems to be the route our nation has chosen, and that has led to some noteworthy accomplishments. People can change jobs without losing their insurance, preexisting health conditions are less of a barrier to coverage, and more children are eligible for government-sponsored insurance. Now let's take a look at health care pricing and see if we can't come up with a way to protect the one in six Americans who lack insurance from being gouged.