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PERSPECTIVES

All Is Not What It Seems, Or When Is A Dollar A Dime?

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INTRODUCTION

Welcome to the strange and mysterious world of medical billing. If ever there was an industry in which the charges and the payments have no correlation, the medical industry is it.

Medical billing can indeed be quite perplexing. The disparity between what is charged and what is actually paid can be staggering. The concept of "sticker price" in healthcare often doesn't reflect the final amount due, especially with the complexities of insurance networks and out-of-network charges.

This article examines those price disparities and how they evolved into the manner in which our healthcare system determines charges today. In fact, to answer the question of: When is a dollar, a dime, we need look no further than the table below. But (and there's always a big but) the story doesn't end here. The table below doesn't mean that everyone pays 10% on the dollar. If a person ends up being treated at this or any other hospital, and that individual is "out of network" (OON), that person could face a huge co-pay, giving the hospital a windfall. Most hospitals we have researched have discounts ranging from 65% to 90%. This means that while the listed price might be high, the actual payment can be much lower, depending on various factors like insurance agreements and network status.

Medical Center / FY Ending 12/31/2022	
Total Patient Revenue	$4,370,603,459
Discounted	$3,954,756,548
Net Patient Revenues	$415,846,911
Percent of Charges Accepted as Payment	**10%**
Percent Discounted	**90%**

If someone has assets, but no insurance, that person may be faced with being hounded to the point of bankruptcy before the hospital backs off. Or – and this is the kicker – you are in network, but you or your child may need a specialist. Let's say you require the services of a plastic surgeon to repair a facial laceration. Assuming it's after hours, a holiday or a weekend, the hospital will call whoever is on duty and that provider might not be in your network. It sounds crazy. You ask yourself: "I'm at an in-network hospital, how can the doctor be OON?" But it happens.

Consider this real life scenario further. A plastic surgeon's bill was being negotiated after he was called out on a weekend to repair a little girl's face from a fairly significant laceration. This doctor was not in the insured's network, and not inclined to reduce his fee of $40,000.00. He finally relented, and reduced it 25%, down to $30,000.00, but only if he could collect it within 15 days. The girl's parents ended up accepting this but had to access a home equity loan to pay the bill.

Then there are the patients the hospital really likes to see – those injured in some type of accident where there is a third-party liability payer with significant insurance and / or assets. Here the hospital usually looks to collect a significant portion of its charges as it knows the patient can request payment from the insurance company of 100% of the billed amount. In this case, the amount would be 90% more than the hospital's usual collection.

Even when patients go to an in-network hospital, they can still face exorbitant fees if the specialist they need isn't covered by their insurance network. This can lead to significant financial strain, as seen in the case previously mentioned. Negotiating medical bills can be daunting, and it's unfortunate that families sometimes have to resort to extreme measures, like taking out loans, to cover these unexpected costs. It's a stark reminder of the importance of understanding one's insurance coverage and the potential pitfalls of out-of-network care.

You might ask yourself, "how did we get here?" How is it one hospital charges X for a medical procedure, and another hospital charges 5X or maybe even 10X for the same thing. Surely the hospital charging X isn't charging below their cost. And they aren't. To understand how, we need to take a short journey back to the

beginning and a little beyond to see how our medical industry evolved from the horse and buggy doctor paid with chickens, to the $40,000 hospital visit to make sure a little girl isn't scarred for life.

THE EVOLUTION OF THE HEALTH INSURANCE INDUSTRY

The American health insurance system was established and became publicly available in the United States during the Civil War. The plans were accident based, providing insurance coverage for injuries related to travel by railroad or steamboat. With advancements in medicine such as the identification of infectious agents, the development of new medical technologies such as blood pressure meters, radiography, vaccines, and antitoxins, the public trust in medical institutions greatly increased.

The initial insurance companies and laws for health and accident included:

- 1735 - The Friendly Society, the first mutual insurance company in the United States started in Charleston, South Carolina, which quickly went out of business in 1740,
- 1759 - Presbyterian Ministers Fund, one of the first insurance companies in the United States, paid annuities to ministers who paid into the fund if they were sick or ailing or to their families upon the ministers' deaths,
- 1847 - Massachusetts Health Insurance of Boston offered early group medical policies with a comprehensive benefits list,
- 1850 - Franklin Health Assurance Company of Massachusetts begins providing accident insurance,
- Early 20th Century Jones Act - Maritime (allowed seamen injured on the job to get compensation from their employers,
- Early 20th Century: Railroads – Initially railroad insurance primarily covered physical assets such as losses from train derailments and infrastructure damage. Insurance syndicates specifically designated for railroads were created. Eventually, employee liability and third-party coverage was included.
- Early 20th Century: Workers Compensation - According to the Office of Social Security, "the federal government was the first to establish a workers' compensation program, covering its civilian employees with an act that was passed in 1908 to provide benefits for workers engaged in hazardous work. The remaining federal workforce was covered in 1916. Nine states enacted workers' compensation laws in 1911."
- 1929 - The Baylor Plan was developed into what is now known as Blue Cross.

The Depression stalled the insurance development process, but along came World War II and things started to change more rapidly. The three major contributors to these changes were:

- Wage and Price Controls – No raises
- Union Demands – Better benefits
- Rosie the Riveter – For the first time, millions of women entered the workforce.

With wages frozen, the best employers could do is offer health insurance for all the Rosies and their families. But it wasn't a third-party payer system. Rather, Rosie paid the bill and brought the receipt to her employer for reimbursement.

Post-World War II

- Proliferation of employee benefits including health insurance – an employee still pays and is reimbursed by the employee's insurance instead of an employer system.
- Successful health insurance prevented government intervention until the mid-1950s expanding into

the 1960s and beyond. (*Note: In 1946, US President Harry Truman introduced a bill in Congress to completely socialize the medical industry, much like the British had just done. The bill even went so far as to guarantee an income to individuals who were unable to work because of an illness. Strong lobbying by newly formed insurance companies prevented the bill from passing.*)

- 1954 - Birth of Social Security Disability – This was based on the 1946 disability bill which failed in Congress.
- 1965 - Medicare and Medicaid programs introduced.

The 1950s was the calm before the storm, but it was mostly successful. Then along came Medicare. For the first time millions of individuals would be enrolled into a health insurance program, all at once. It really was a monumental task and brought about some special problems, most specifically: How do they pay the anticipated number of medical bills in a timely manner? To meet these obligations Medicare had to figure out the following:

- **The need for uniformity:** Medical providers were used to billing however they felt, including just writing a receipt for a payment and handing it to the patient with no description or indication of what it was for. This was no longer going to work for a simple reason: The patient would not pay the bills. Instead, the doctor would have to send their bill into Medicare who would then pay the doctor. This led to the creation of the Health Care Financing Administration (HCFA) form which doctors and other professionals bill on today, and the Uniform Medical Billing Form (UB04) that medical facilities use for billing.
- **The need for bulk processing:** Luckily, this occurred during the early stages of commercial computing. So, Medicare had some help and didn't have to process all billing by hand, although unlike today, there was still a lot of physical handling to be done.
- **The need for fairness:** This brought about the biggest change. With third-party payment, the medical provider was no longer in control. The third-party payer decided what they would be paid based on various criteria. The reasoning behind this was to make sure a provider in one part of the country wasn't paid significantly more or less than a provider in another part of the country for the exact same service. Medicare turned to the Harvard Business School to help solve this problem. Their solution was the *Relative Value Resource Based System (RVRBS)*, with payments for all services becoming a multiplier of the lowest value of the number one (1). For Harvard to do this, they needed the American Medical Association (AMA) to create an identifier system for everything that would be billed or invoiced. This resulted in the *Current Procedural Terminology (CPT Codes)*. Fairness in billing and payments meant a system based on the community of the United States, with adjustments made for geographical locations based on cost-of-living factors.

MEDICARE AND THE CURRENT PRICING OF HEALTHCARE SERVICES

With Medicare up and running, the insurance companies looked at what they were doing and decided to adopt many of their innovations, including the most important – third-party billing. The adoption of third-party billing by insurance companies marked a major change. By having doctors bill them directly and setting payment terms, insurers gained more control over healthcare costs and services. This change aimed to streamline the billing process but also led to increased

administrative complexities and debates over fair compensation for medical services. This became known as "The beginning of the end!"

With the above in mind, Medicare must know what doctors or other medical providers are charging their patients for whatever service they may render. Medicare must know what it costs providers to render a service, and what amount doctors are reimbursed by payers for a given service.

According to the Center for Medicare and Medicaid Services (CMS), most Medicare-certified providers are required to submit an annual cost report to CMS with facility characteristics, and with cost and charge data by cost center for all patients, not just for those on Medicare. This information assists Medicare in its calculations for provider reimbursements in the following year, based on an average cost-plus basis to reach a national payment, which is geographically adjusted.

The annual cost report submitted by Medicare-certified providers is a crucial part of how Medicare determines reimbursements. By collecting detailed data on costs and charges for all patients, CMS can calculate more accurate reimbursement rates. This process helps maintain a balance between covering the costs of healthcare providers and managing the overall expenses of the Medicare program. It's a complex system, but it's designed to ensure that providers are fairly compensated while keeping healthcare accessible for patients.

That brings us to the present where the healthcare marketplace or business model is highly unusual in that the pricing of medical services is opaque, non-transparent, and with little to no correlation with the actual costs to provide that service. Medical providers can charge whatever they want, even when that list price is nowhere close to what typically gets paid. When billed charges are way out of line with payments, then that is not a true marketplace. Instead, it is reflective of an artificial market that needs critical analysis to determine a value that is consistent with what typically gets paid for similar services.

CONCLUSION

All the above seems to place the medical billing world in Wonderland, where Alice discovered that "down is up, and up is down." It's a land where a charge is not a charge, but a made-up number. It's a land where Joe pays one price, and Bill another, for the exact same service. And this is an open secret. Right there on a bill you may see: "Amount charged $100,000.00 as compared to Amount due $20,000.00." Of course, the amount due number is the variable. It changes based on who is paying. But, what else can one expect where everything in the medical billing world is confusing, surprising, and abnormal? America's medical billing system is, indeed, a strange world.

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