

Chapter Three

Prices Are Higher Here

Prices Are Higher Here

Prices matter a lot.

When you look closely at health care costs for this country, the one point that stands out as the biggest single difference between us and everyone else in the world is prices.

We almost never talk about prices. Until very recently, prices have not been a significant part of the public debate in this country. Medicare has recently triggered some public discussion of actual prices charged in some hospitals by releasing some Medicare data, and a couple of news media outlets have done some very interesting pricing stories -- but that information has only triggered media attention, and it hasn't triggered policy focus in any settings.

Almost no part of the current official health care reform agenda deals with prices or even mentions prices. But when you look at the U.S. health care spending levels and when you compare us to the rest of the world, the single most glaringly obvious thing that stands out as the overwhelming difference between us and everyone else on the planet is the unit prices we pay for care.

If we took the exact same prices that the single payer system in Canada uses to buy each piece of care in Canada and if we directly substituted their prices for the prices we pay today for each piece of care that we buy in the U.S., the truth is we could deliver every single piece of care we deliver today -- changing nothing about the volume of care received by our patients and changing nothing about the type and scope of care delivered today to our patients -- and we could provide all of that care for about forty percent less money.¹¹³ We would spend about the same percentage of our GDP on care as Canada spends on care if we just paid the same prices for each piece of care that the government pays for each piece of care in Canada.

Prices are -- when you look at real numbers -- the overwhelming difference between us and them.

Insurance premiums are based on the average cost of care for insured people. Insurance premiums paid in this country could drop hugely if we used the Canadian fee schedules to pay for care here. If

American insurers suddenly paid Canadian prices for each piece of care, the insurance premiums charged in this country would drop by that same 40 percent, and it would happen instantly. That isn't a speculation or a guess or a hope. It's the law.

The new health care reform law would require that premium reduction to happen if the prices we spend for care went down to those levels, because the new law specifies that insurance premiums have to be based on a percentage of the money that insurers use to buy care. Loss-ratio lows have already caused some insurers to pay rebates to their customers. Using Canadian prices to buy care would increase those rebates hugely.

All Other Countries Have Lower Prices

Prices really are the major financial difference between us and them.

That means that prices are an incredibly important health care cost factor that we need to understand and address as we look at how much money we spend for care and as we try to figure out how to spend less money on care.

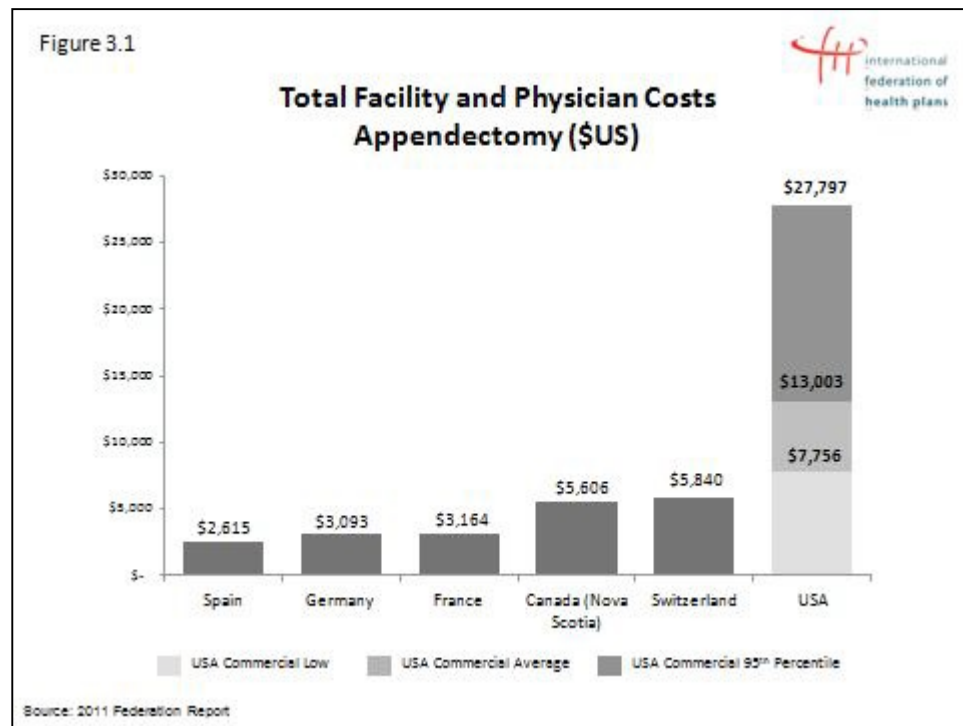
This chapter of this book is intended to put the whole picture about the price situation in this country on the table so that everyone who reads this book can clearly understand this fundamental financial reality and can work to help figure out how to factor prices into the goal of making care more affordable. We need to start by looking at real numbers that show how much we actually pay. The price charts that are included in this chapter show how much we Americans pay for several key pieces of care compared to the amount that is paid in other industrialized countries for those same exact pieces of care.

It isn't just Canada who pays less than we do for each piece of care. Every other industrialized pays less to buy each piece of care. The charts in this chapter show the prices that are paid for care in several other industrialized countries.

The comparative prices for pieces of care in this book come from countries that use the same basic care delivery models and the same basic care delivery equipment and the same basic procedures that we use in our country to deliver care. CT scans are a universal commodity. Scans are scans. We all use the same equipment from the same manufacturers and we all basically do the same scans. The price comparisons for scans in this chapter are, as the saying goes, apples to apples. The data shows that prices for those identical CT scans vary hugely from country to country. We pay two to ten times more for our scans than other countries pay for their scans.¹¹⁴ Prices for surgeries also differ by a significant amount -- and the prices paid for a day in the hospital vary by an amazing amount from country to country. Even drug prices for the exact same drugs made by the exact same drug companies differ quite a bit from country to country. We need to understand what those price differences are and we need to understand why those differences exist if we want to make care more affordable in this country.

Our Prices Are Often Double Or Triple The Prices Paid In Other Countries

So what are the actual price differences between us and the rest of the world? Let's start with appendectomies.



Appendectomies are a good example of price variations that happen between countries. Look at the price chart above. The total cost for an appendectomy in Spain last year was \$2,615. The cost for that same procedure in Germany was \$3,093. France was slightly higher -- at \$3,164. Canada actually had higher prices than any of those counties -- running \$5,606 per appendectomy,¹¹⁵ and the Swiss paid \$5,408 for each appendectomy patient.

How much did those surgeries cost here? The average price for an appendectomy in the U.S. was \$13,003.¹¹⁶

That is the exact same procedure being done in each and every country.

Appendectomy techniques are about the same from country to country. The human body is the same in each country. The quality of care is pretty consistent, site to site. We definitely do not get higher quality appendectomies for our higher prices. Other countries have appendectomy success rates that are as good as or better than ours and patients in some of our hospitals are actually more likely to get post-surgical infections and be damaged than hospital patients in other countries.¹¹⁷ People don't fly to our country from Europe or Canada to

have their appendix removed. An appendectomy is an appendectomy everywhere. But the prices paid for appendectomies are far higher in the U.S. than in any other country.

We Don't Pay Just One Price In The U.S.

It's useful to take a close look at each of the bars on that appendectomy price chart. There truly is a lot to learn from that array of data. The variation of prices for that surgery that is shown on the U.S. data bar is a particularly good data point for us all to study and understand.

The U.S. prices shown on that chart are actually a wide range of prices. That is important to know. We don't pay just one price in the U.S. for that procedure. We pay a wide range of prices. Every care site in the country sets its own prices -- and those prices vary a lot. Prices vary from site to site and prices in this country can even vary significantly from patient to patient at the exact same care site.

Other countries tend to have a single price for most procedures. That same standard price for each procedure is usually paid at every care site in each geography in those countries and that same exact price is typically charged by each caregiver to every payer in that geography. Many other countries achieve that level of multi-site and multi-payer price uniformity by literally mandating prices. The pricing mandate that they use in other countries can be pretty rigid. A doctor in Canada can actually lose their license to be paid for care by their national health service for any of their government paid patients if the doctor charges any patient even one dollar more than the government approved fee for any of the services on their approved fee list.¹¹⁸

So prices for pieces of care are very rigid in that lovely part of the world that sits just north of our borders.

Prices Vary A Lot In The U.S.

By contrast, prices in the U.S. vary. A lot.

In the U.S., the \$13,003 price mentioned above was the average fee that was actually paid in the U.S. in 2011 by health plans or health insurers for an appendectomy.¹¹⁹ There was actually a very wide range of fees charged that year for that procedure in this country, however. The American bar on that appendectomy chart shows the range of fees that were used in the U.S. for that surgery.

Twenty-five percent of the time, U.S. care sites that year charged less than \$7,756 for the procedure. Five percent of the time, U.S. care sites charged more than \$27,797.¹²⁰ Those are huge price differences. It is particularly important and useful to know, understand and remember that those major price differences that are charged in our country don't just vary between care sites. Some people who have heard that caregiver prices vary in this country think -- in error -- that the price variations that exist in U.S. are actually based on price and cost differences that occur between different sites of care. That seems logical -- but it is actually is a wrong belief. Prices charged to patients often vary hugely in this country for the exact same procedure done at the exact same site of care -- with the care delivered at that site by the exact same caregiver. Because of the business model we use to buy care, any given American care site might actually have dozens of different prices for each specific procedure. What causes the fees to vary from patient to patient? The answer to that question also surprises some people. The actual fee that is used by each American care site to deliver a particular service to any single patient usually depends directly and entirely on who the official payer is for each patient receiving care. The fees charged for each patient are based on the patient's health plan. Each health plan payer in this country tends to negotiate their own fee schedule with individual providers of care. Because of those negotiations, the fee that is charged in this country to any given patient usually is based on whoever the actual specific insurer or payer is for that patient. A care site that has contracts with a dozen local insurers could charge a dozen different fees for the same procedure for insured people.

Medicare And Medicaid Have Their Own Fee Schedules

To complicate the situation a bit more, each care site is also very likely to have a separate Medicare fee and a separate Medicaid fee for that same procedure.

And for the patients who do not have Medicaid coverage, Medicare coverage, or private insurance coverage of any kind, the providers tend to use a master fee schedule often called a “chargemaster.” That chargemaster fee schedule basically sets the fees that are charged to uninsured patients.

The chargemaster fees tend to be the very highest fees of all. Those fees are high, in part, because the care sites often negotiate their contracted payment levels with health plans using a payment formula that is based on a fixed percentage of discounts from the provider’s chargemaster. A health plan might negotiate a 30 percent discount off the chargemaster fees for a care site, for example.

Obviously, the care providers who use that negotiation approach to set their fees are strongly incented to have the highest possible chargemaster fee levels. It is better for the care site to have a high fee when the chargemasters serve that mathematical purpose as the key determiner of the actual revenue they receive from their contracted and discount paying health insurers.

The actual chargemaster fees can be so high as to be almost unbelievable. Several are listed later in this chapter. The prices on these charts, however, are based on the actual fees that were paid last year by the health insurers.

Are Any Prices Inherently Legitimate?

So what does that wide variation in fees paid in this country tell us about the inherent legitimacy and appropriateness of any given fee?

People who receive care often believe that there must be an inherent legitimacy of some kind to each price that is being charged to them by their caregiver for their personal care. People who get care and then receive bills from their caregivers often believe that the pure price

on the bill that is being charged to them by their care site must be “right” in some important way or it wouldn’t be used by a caregiver they trust as the fee that is being charged to them as a patient for that piece of care.

That sense that there is actually a “right” price for any given piece of care is clearly not an accurate way of thinking about prices. There really is no such thing as a “right” price for pieces of care in this country. In the real world of health care cash flow, all prices tend to be functionally situational and all prices tend to be linked to payment mechanisms and tied to negotiated price levels. To the extent that the price variations happen at the care sites, those variations are not patient based, functionality based, or resource based in any way. That is an important reality to understand. Variation happens. The business model we use to buy care has created an amazing range and array of prices for most pieces of care and every provider who sells care in this country lives with that pricing reality every day.

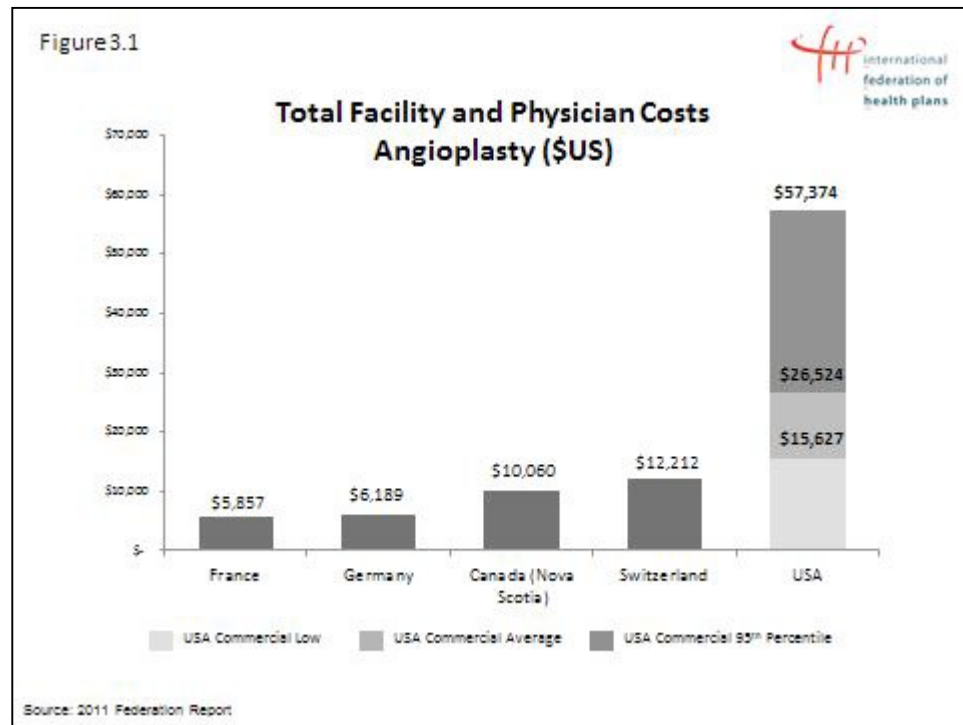
[Angioplasties Fees Are A Lot Higher Here](#)

The U.S. price ranges for each procedure are fascinating. As noted earlier, all American health insurers tend to negotiate fees with their care sites -- and most of the negotiated fees are discounts of one kind or another from the full “chargemaster” fee schedule that is set up by each care site. Some of the negotiated fees are actually based on the Medicare fee schedule -- with insurers using Medicare fees as the base and then negotiating a private insurer fee that might be, for example, 120 percent of Medicare.

But even with both sets of those negotiated discounts -- either basing discounts on the chargemaster or basing payments on percentages of the Medicare base fee for that service -- we clearly pay a lot for each piece of care in this country than any other country in the world.

The next chart shows the angioplasty cost in the same countries that were cited above. Again, the U.S. clearly pays more for that care. Various payers in the U.S. range from paying under \$15,000 for that

procedure to paying more than \$57,000 to have an angioplasty done. The average cost here is \$26,000. No other country spends more than \$12,000 for that procedure. You can buy a very nice angioplasty in Paris for \$5,857.¹²¹



All of those price charts in this book with the data from the other countries were compiled by the International Federation of Health Plans. The Federation is an interesting confederation of roughly 100 private health plans from 25 countries.¹²² The prices on these charts from those other countries were usually the amount that was paid by the private health plans in those countries to buy each piece of care. The Canadian prices came from a government fee schedule. The prices on this set of charts for the United States were calculated from a massive American claims payment database that included actual payment data for over 100 million covered people.

As noted earlier, the U.S. price ranges shown on these charts were based on the actual amounts that were paid by U.S. payers...and do not include or show the inflated chargemaster prices that have been set up at

the care sites. The numbers on those charts are what we actually paid in this country to buy that care. The prices are real.

In some cases, the prices are also stunning.

We Spend Ten Times As Much To Deliver A Baby

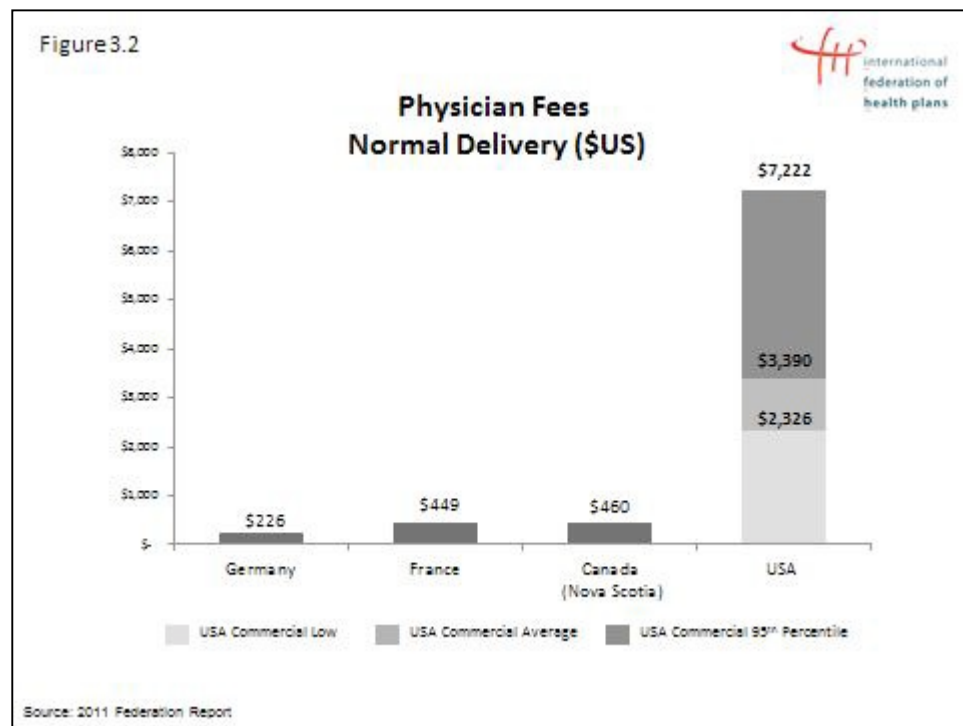
Delivering a baby is another area where the U.S. has a clear lead on prices. Look at the next chart. A doctor in Germany gets paid \$226 to deliver a baby. A doctor in Canada gets paid \$460. The average price paid in the U.S. to deliver a baby is \$3,390. The lower end of the baby delivery price range in the U.S. runs down to \$2,326. At the top of the range, 5 percent of babies delivered in this country triggered a fee in excess of \$7,222.¹²³ Some care sites in this country now charge \$15,000 to \$20,000 to deliver a baby.¹²⁴

Again -- when anyone wonders why Germany spends 11.6 percent of their GDP¹²⁵ on health care when the U.S. spends nearly 18 percent,¹²⁶ -- a quick look at the fees charged to buy care in Germany and the prices used to buy that same care the U.S. makes the explanation of that GDP percentage difference pretty simple.

Medicare And Medicaid Prices Tend to Be Lower

Most of the charts in this chapter do not include the amounts that are paid by either Medicare or Medicaid to buy each piece of care. The prices paid by those programs are discussed below. Both Medicare and Medicaid tend to spend significantly less money than the private payers in this country to buy pieces of care. Why do the Medicare and Medicaid programs pay less for care? They pay less because they can. Both of those government programs have the legal right to simply impose prices rather than having to negotiate prices with various providers of care. As a result of that authority, both of those programs tend to pay prices that are significantly below the average price levels shown on those charts for private payers.

Medicaid generally is the lowest payer for any piece of care in the U.S. The amount paid by Medicaid in California to deliver a baby for example, is \$544.¹²⁷ That number looks very similar to European prices for delivering a baby and it is far below the private market prices that are paid in this country for doing that same procedure. Those relatively low Medicaid price levels obviously help to explain why it has been increasingly difficult to get many U.S. doctors to accept high numbers of Medicaid patients in significant areas of the country.



Delivering a baby tends to be fairly similar from country to country. Cultural differences do exist relative to the way people approach giving birth, but those cultural differences should not be sufficient enough to cause a procedure that costs under \$500 in France or Canada to generate an average fee of \$3,390 in the U.S.

[Heart Surgery Prices Vary A Lot](#)

Heart surgery follows that same pricing pattern.

One of the more common heart procedures that is done here and elsewhere is coronary artery by-pass surgery. That is a lovely surgical procedure. It saves and prolongs lives. It can be transformational for patients' lives. It is very much a high value procedure.

It is also a high cost procedure. Every country charges significant amounts of money to do that procedure. In France and Germany, as you can see below, that surgery costs over \$16,000 per heart. That is a lot of money. In Switzerland, doing that same procedure costs the payer \$25,486 per heart.¹²⁸

Canada is even more expensive -- currently averaging about \$40,954 per heart.¹²⁹ That is even more money than Switzerland.

What about the U.S.?

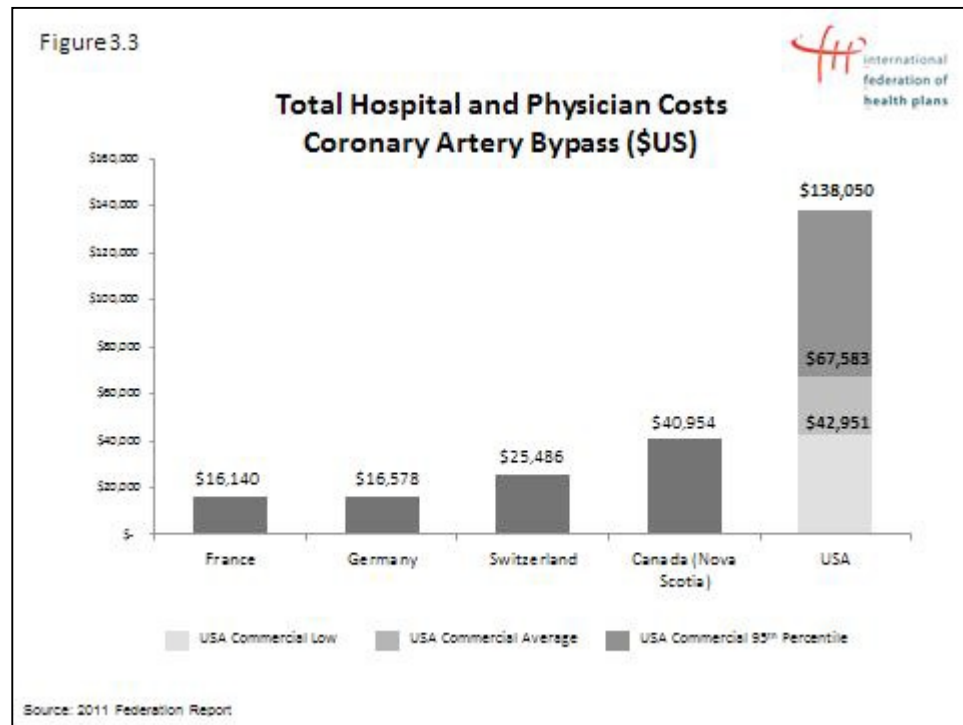
We win again. The average price paid in this country to do that basic heart surgery procedure was \$67,583 per heart in 2011.¹³⁰

Twenty-five percent of the fees to do those by-pass surgeries in the U.S. actually ran below \$42,951...very near the Canadian numbers. At the other extreme, five percent of the fees in this country to do that bypass surgery exceeded \$138,050¹³¹... with no improvement in safety levels and no guarantee of better outcomes for the higher priced surgery sites.

People Have The Illusion That Prices Reflect Quality

As the first two chapters of this book pointed out clearly, there is actually no mechanism linking high fees to higher quality care in this country. Many people do have the illusion that prices must reflect quality in some way, but the heart surgery sites that are charging over \$100,000 to do those surgeries can actually have much worse outcomes and higher death rates than the care sites that are charging \$20,000 or \$40,000 for that same procedure. In fact, a number of studies have shown that the care can be less safe and less consistent in some of the higher priced care sites.¹³²

So for that very basic heart procedure, we currently have care sites in the U.S. charging ten times as much as the average fee in Germany or France.¹³³ The outcomes in Germany and France are generally the same or better than the outcomes in U.S. care sites that charge a lot more.¹³⁴



This is actually a surgery where some of the best care in the world now is coming from some extremely low cost surgery sites in the Middle East and India.

In a couple of developing countries, a few hospitals have recently built world-class heart surgery care sites that do that particular procedure with great effectiveness and skill. The very best sites in India have better outcomes and lower infection rates than the typical American hospital. The American hospitals do that work for an average piece of \$67,000 -- and those very best Indian surgery sites now charge between \$3,000 and \$10,000 per heart for the same procedure.¹³⁵ The Indian prices and the surgical results in those Indian hospitals prove again that prices and quality have no inherent linkage in health care delivery. Best care is not inherently more expensive and the worst care sites sometimes have the highest price tags.

The Highest Cost Sepsis Sites Had The Highest Death Rate

One fascinating recent study of sepsis patients showed that the hospitals who charged the most for sepsis care actually also had the highest death rates from sepsis.¹³⁶ That inverse relationship between cost and quality can shock people who think that paying more for care means that higher priced care is better. For the sepsis patients in the hospitals that were included in that study, the higher prices meant bad care was happening. Those higher prices actually resulted from the bad care to a significant degree. Significantly more patients died of sepsis in the higher cost hospitals that were involved in that study.

That fact -- about prices and quality not being somehow linked for care delivery -- really does confuse a lot of people. The confusion is understandable. That linkage is how things usually work. Prices and quality are usually linked in other areas of the economy. "Spend more; get more," is the economic norm. We tend to believe that a \$20,000 car is better than a \$10,000 car -- and we tend to believe that a five thousand dollar computer will be better than a one thousand dollar computer. We have come to expect and believe in that direct relationship between value and price in many other things that we buy. So it is hard for people to understand that the current business model we use to buy care in this country does not have that linkage built into either the purchase process or the pricing process for care. Value does not drive prices in our business model for care delivery. Prices are created and driven by each business unit's financial goals, by each business unit's revenue strategies and by the various circumstances and historical charge patterns that exist at each care site.

Medicaid Tends To Be The Lowest Payer Everywhere

There is some pricing pattern consistency for some parts of the health care ecosystem. As noted earlier, our government programs do tend to have some price consistency for the care they buy. The

government creates that pricing consistency for Medicare and Medicaid by imposing prices rather than by negotiating prices for Medicare and Medicaid patients. Those government imposed prices are usually not very high... relative to the “retail” prices charged to other payers.

Medicaid, in fact, tends to be the lowest payer everywhere in the country. Hardly anyone in any care setting in this country pays providers less than the local state-imposed Medicaid fee schedule. Many care providers argue that the Medicaid prices are so low that almost all caregivers lose money on every Medicaid patient and most caregivers have to make up for those losses by charging more money to their non-government patients. Some caregivers state that their Medicare prices are also below their cost of actually providing care -- and they often say that they make up for Medicare losses as well by shifting the care costs to their insured patients through higher fees for those patients. Some care sites argue that the “cost shift” from their Medicare and Medicaid patients actually are a “hidden tax” -- and argue that their fees are higher in large part because of that “hidden tax” and “cost shift” to other payers.

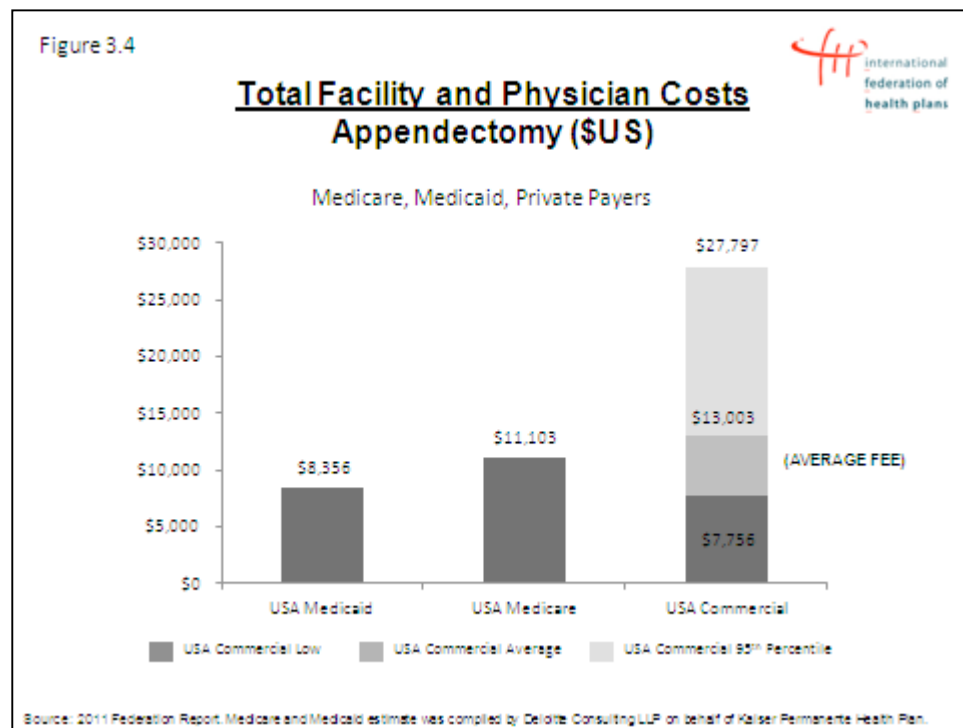
Is that a true set of assumptions? It probably is true for some care sites -- particularly the sites who serve a lot of Medicaid patients. The cost shift argument is probably less true for the care sites that have both very high fees and very few Medicaid patients. The cost shift argument is often not supported with any volume numbers that justify the high prices being charged in a number of care sites. That situation is very care-site specific in its relevance.

Medicare Pays More than Medicaid But Less Than Everyone Else

In any case, Medicare clearly also imposes a fee schedule on caregivers that runs significantly below the usual amounts that are paid to buy care for insured people. Anytime we use taxpayer money to buy care, the government tends to set the prices that are paid for each piece of care. Medicare simply sets fees that are fixed, non-negotiable, and significantly lower than the usual private market fees for the same procedure. Some Medicare payment levels are show below.

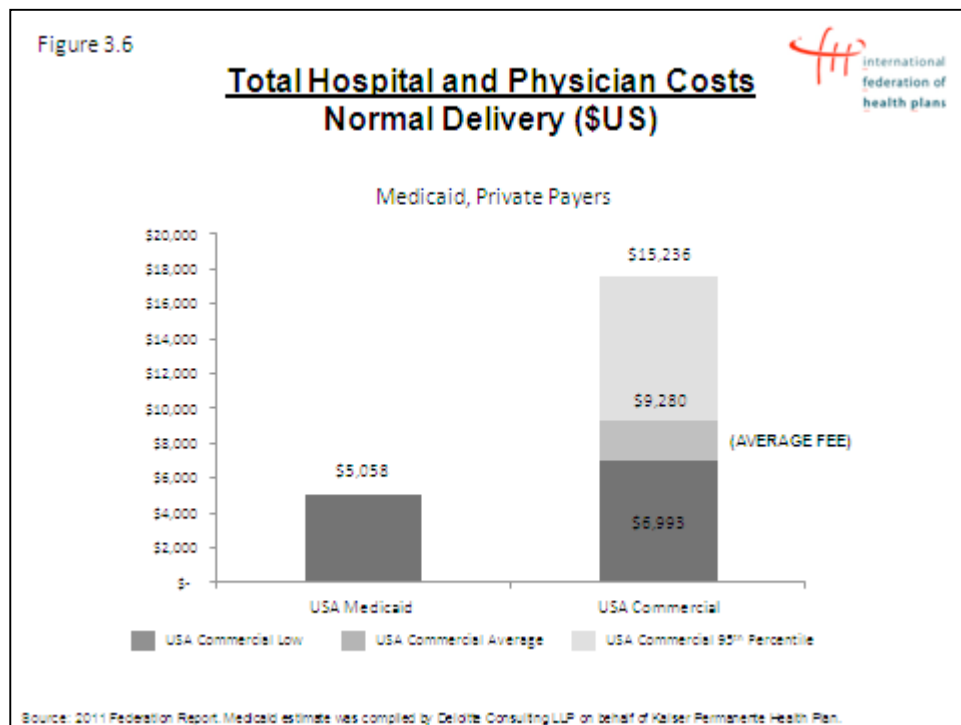
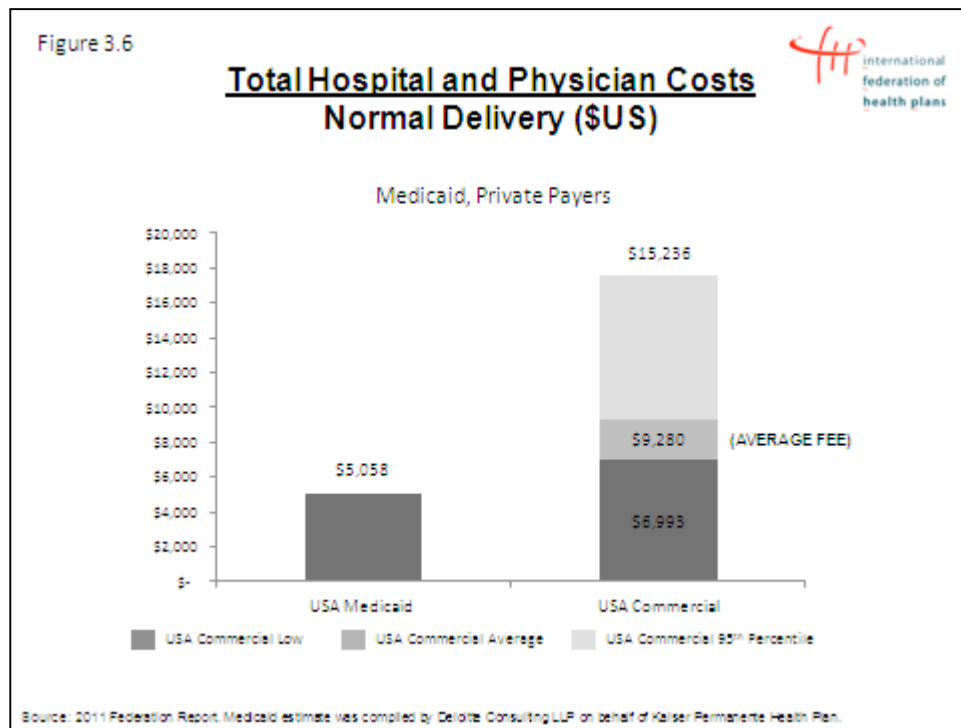
The next chart includes the U.S. average fee and the Californian Medicare and Californian Medicaid fees for the three procedures that were outlined earlier in this chapter -- appendectomies, delivering a baby and coronary artery bypass surgery.

As you can see, the payments made by those two major government programs fall well below the average payment for private health plans for each of the procedures.



What we can see from each of those charts is that both Medicare and Medicaid pay significantly less than the commercial average payment. It is also true that some patients in the U.S. who have commercial insurance are charged fees that resemble the Medicare and Medicaid fee schedules.

The patients who are not shown on these payment charts are not the people who are the most damaged and abused by the overall spectrum of fee levels used in this country.



The Uninsured May Pay the Most for Each Piece of Care

As noted earlier, the prices shown on those charts basically represent either negotiated fees or mandated fees. People who have Medicare or Medicaid coverage or who have private insurance all have someone either negotiating fee on their behalf or imposing fees on their behalf. The uninsured people in this country, however, have no one helping mitigate the fees charged to them for care. They tend to have the pure top level chargemaster retail fees imposed on them when they seek care.

So the people who are charged the most for each piece of care in this country are almost always the uninsured people who are paying for their own care. Those uninsured people, unfortunately, not only do not have either a health plan negotiating their prices or a government agency mandating prices on their behalf.

They also have no legal protection today against abusive fees. There are no laws that limit the chargemaster top fees or address their use for low income people. There are no laws that limit these fees to a level that might, for example, be a multiple of Medicare fees -- or an average of all negotiated fees in that care setting, plus 10 percent -- or some other formula-based regulatorily defined fee cap.

As a result, the chargemaster prices that are used to create bills for the uninsured consumers who get care in this country can run quite high.

A recent article in Time Magazine looked at a number of those charges that are being used today as the fees that are charged to uninsured people. Time Magazine showed chargemaster fees for an emergency room visit by an uninsured person for \$21,000 and Time showed a stress test that was billed to the uninsured person by the care site at a chargemaster fee of \$7,997. Then the Time article showed that Medicare would have paid \$554 for the same stress test and less for the emergency room use. The Time article also showed chargemaster fees to an uninsured patient of \$157.61 for a CBC (complete blood count). That was the fee when that service was billed to an uninsured person. Medicare, Time pointed out, would have paid the doctor \$11.02 for that same exact CBC test in Connecticut if it had been done for a Medicare patient.¹³⁷

The Chicago Tribune wrote an article about the chargemaster fees based on the Medicare data report. The Tribune article showed a variation on local fees for a major hip replacement ranging from \$36,141 at one care site to \$117,102 at another care site -- for the same exact procedure.¹³⁸

Medicare payments for that procedure were \$21,072, according to the Tribune.¹³⁹

The Los Angeles Times wrote a similar article showing price variations based on the Medicare report. The Times reported that the price range for an artificial joint replacement varied from a top price of \$220,881, to a low price of \$35,524.¹⁴⁰

That same Los Angeles Times article cited prices for the treatment of simple pneumonia that varied from \$19,852 at the bottom of the range, to \$54,400 at the top of the price range.¹⁴¹

The Denver Post wrote an article on that same set of issues showing price variation for joint replacement, ranging from \$32,000 at the bottom of the local price list, to \$84,000 at the top.¹⁴²

Medicare pays \$13,000 to \$20,000 for that procedure in that geographic area according to The Post.¹⁴³

So the patterns are widespread. Price variation in those chargemaster prices is massive and has no relationship to care quality or even care availability.

There is clearly no rational expense-based reason or resource-linked reason that can be used to justify either of those horrific chargemaster fee levels being charged for those services. The truth is, of course, that many of the uninsured people end up being charged those very high fees by the care sites simply don't pay those very high fees. Many uninsured people have very little money and absolutely cannot afford to pay those extraordinary fees. So they often don't pay them.

Those people can be damaged twice in the process. Look back to the Los Angeles Times magazine article cited above.

The impact on an uninsured person for not paying that \$7,997 fee for what was actually a \$500 stress test¹⁴⁴ is that the credit status of that uninsured patient can be impaired or ruined. The future debt capacity of that uninsured person can be destroyed by having that particular bad

debt. And -- to add insult to injury -- the hospitals that created those exorbitant and entirely artificial fees might actually get to write off the unpaid fees by the low income patients as "bad debt" for their tax-related issues.

Many hospitals and medical care sites do not fully enforce those kinds of abusive pricing approaches and consequences for their patients. Many care sites also do not wreck the credit rating of the lower income uninsured people who cannot pay their medical bill. But too many care sites do manage to bankrupt patients with those kinds of financially abusive bills -- or ruin the patient's credit ratings -- and then get public credit for charity care in the process.

Many people work very hard to pay off the debts incurred by those high bills. Look back again at the Los Angeles Times article.¹⁴⁵ It is painful to think of the basic injustice of a minimum wage worker having to take \$50 out of every paycheck for years to pay off an incident-based health care bill -- shelling out cash every month for two years to pay for a care service that would have generated that particular care site only a single \$50 paid-in-full fee if Medicare had been the payer. Too many uninsured people have been ruined financially and even bankrupted by those prices.

Low Income Uninsured People Will Still Face Abusive Prices

The new health care reform legislation will significantly reduce the number of uninsured people in America. It is a good thing that our very-low-income people in this country will now qualify for Medicaid coverage. These kinds of pricing dilemmas will no longer be relevant for those very low income people who join Medicaid next year because Medicaid will now buy their care.

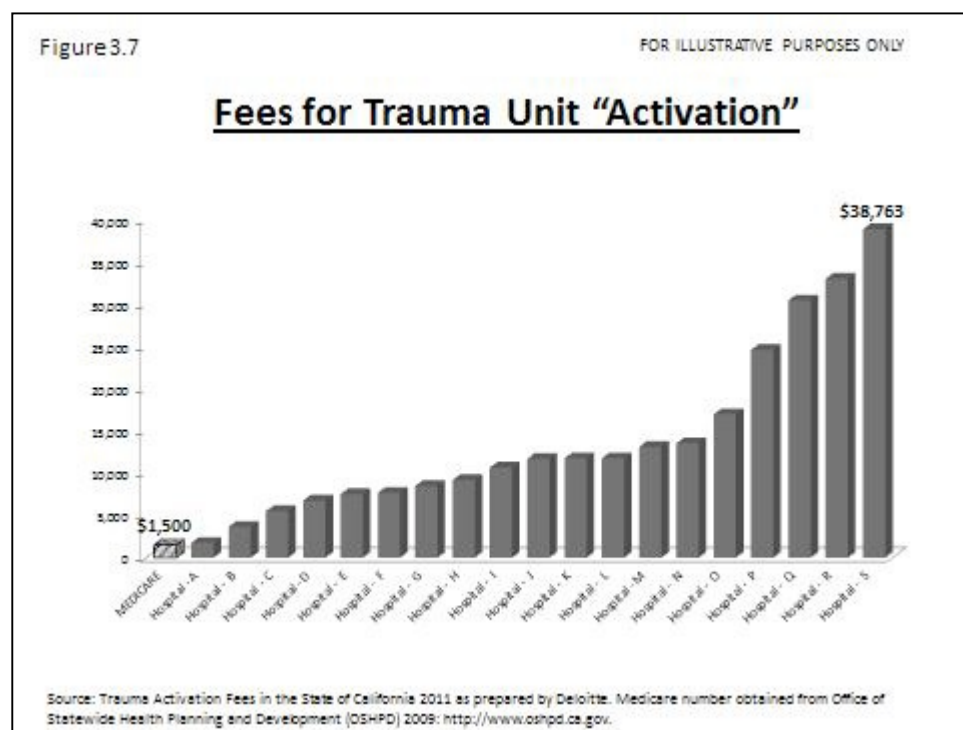
Other low income people who are currently uninsured will now also be able to buy subsidized coverage through the new insurance exchanges. These horrendous and crippling chargemaster prices will be completely irrelevant to all of those people once they have insurance coverage of

some kind and they have either insurers or the government mitigating prices on their behalf.

So those abusive prices will damage fewer people a year from now.

But even after many people move to Medicaid and even after millions of others move to subsidized private coverage, we will still have over ten million uninsured people in this country.¹⁴⁶ Those ten million people with no insurance will all still be at the mercy of the abusive chargemaster prices that will continue to be charged to uninsured people.

Those high chargemaster fees, of course, are often charged to an uninsured person at the worst possible time in a person's need for care – an emergency situation. The next chart shows emergency room activation fees at several Californian hospitals. Some of the prices charged by some care sites are reasonable, and some can only be labeled as abusive.



Again -- the variation in fees from site to site is almost mindboggling. The fee that is paid by Medicare for that service is shown at the bottom of the chart. Health plans pay more than Medicare and more than Medicaid, but less than full chargemaster prices.

Prescription Drug Prices Are Also Higher Here

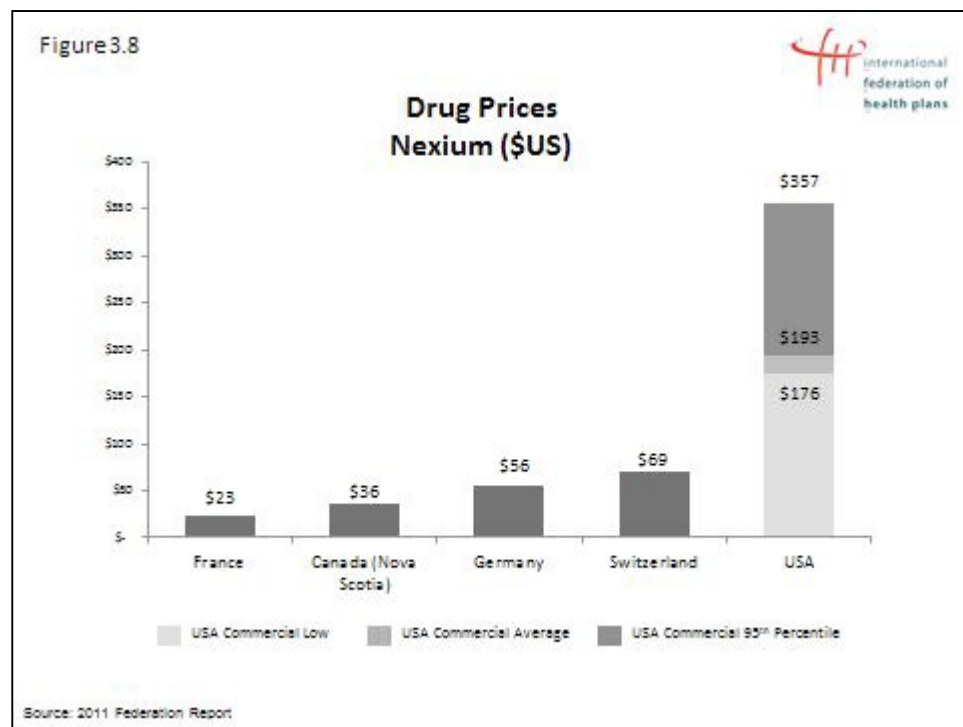
Overall -- when you look at the average amount we spend for each piece of care -- our prices are the highest in the world.

We pay more for just about everything. We see very significant price differences between us and other countries for medical technology and for prescription drugs. Medical technology prices in other countries tend to be significantly lower for the same exact pieces of equipment. Implants also definitely cost a lot more here. Prosthetics cost more here. We pay a lot more in this country for most pieces of medical technology.

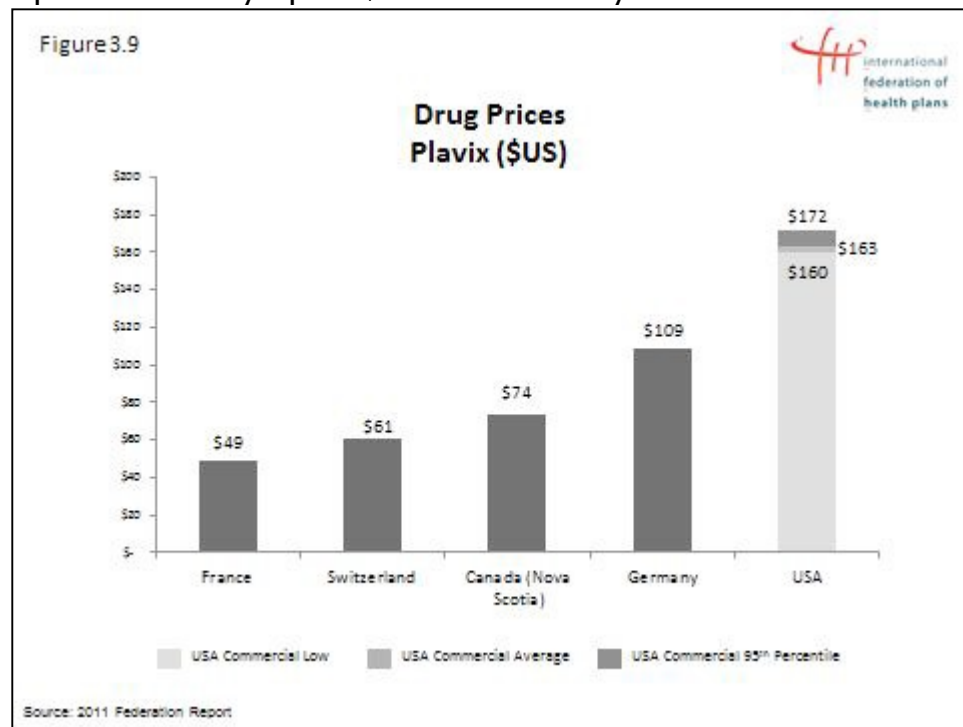
Drug prices also tend to be much higher in the U.S. Nexium, for example, costs \$23 in France. That same drug costs \$36 in Canada and the price jumps to \$56 for Germany.¹⁴⁷

In the U.S., the average price paid for Nexium is \$193 -- and five percent of American patients pay more than \$357 for the drug.¹⁴⁸

The chart below shows the Nexium prices.



Likewise, Plavix prices run from \$49 in France to \$74 in Canada and those prices run way up to \$109 in Germany.¹⁴⁹



The U.S., of course, beats Germany. We pay an average price of \$163 for that drug.¹⁵⁰ Is that a fair price for us? That question has been asked many times. It isn't easy to answer. What exactly constitutes a fair price for a prescription drug? That really is an interesting and important question. Other countries clearly pay less. We can safely assume that the drug companies are not taking financial losses for each sale they voluntarily make in each of those other countries.

We know from sheer common sense that the costs of providing those drugs must be below the prices they currently charge to sell those drugs to patients in those other industrialized countries.

Our prices are higher -- but higher for no functional, operational, or logistical reason. There is no higher cost factor here for drugs that is created by some expense-related issue that is unique in the U.S. What we can obviously conclude from the evidence in front of us is that all of the prices shown on those charts for all of those drugs in each country are simply invented by those drug companies for each market.

Drug prices here and in those other countries clearly have no inherent unit price relationship in any country that ties each price directly to the actual cost of producing those drugs, storing those drugs, or delivering those drugs in those countries. The prices are obviously set in each case and in each country based on what each local market will pay. The U.S. clearly will pay a lot. So prices here are very high.

An example of countries paying what the markets allow to be paid is the price range for the breast cancer drug, Herceptin. Herceptin extends life for some breast cancer patients.¹⁵¹ It doesn't technically save lives but it clearly extends some lives. It is a very expensive drug.

One of the recent ongoing debates in the health policy world in this country has focused on whether insurance companies in this country should pay for Herceptin. An ancillary debate that has also occurred in this country has focused on whether the insured patients who have cancer who want that drug should pay a larger share of the Herceptin price. It is a very expensive drug. Herceptin currently costs about a \$100,000 per patient in the U.S.¹⁵² A hundred thousand dollars per patient is a significant amount of money. That price makes it extremely expensive for any people who need to use their own money to pay for that drug. That high price also increases the premiums that are charged by health plans when that drug is a covered benefit and the health plans pay for the drug. That payment for that drug by health plans arithmetically increases the average cost of care for all of the insured people in each health plan that pays for the drug.

So how do actual U.S. prices paid for that drug compare to the prices paid for that same drug in other countries? The answer, of course, is the same one we saw for other fees. We pay more. That same exact drug with the same exact dose runs about \$40,000 per patient in Great Britain.¹⁵³ We pay \$100,000. British patients pay less than half that amount.

Much of the ethical debate, the political debate, and economic concern about whether any level of constraint or limitation on the use of that drug is needed or appropriate in the U.S. could be ended fairly immediately if the drug company that is selling that drug simply stopped charging American patients two or three times as much for that drug in

the U.S. as that same company charges breast cancer patients for that same drug in other countries. The ethical debate would not be needed if the economic reality was that our patients were charged the same prices charged to patients in other countries.

The Drug Has Been Assigned An Unaffordable Price

This is a basic truth we ought to understand. That drug is only unaffordable in the United States because it has been assigned an unaffordable price in the United States. That debate about rationing that particular drug is a little like having a debate about rationing food in a setting where the only baker in town is charging a thousand dollars per loaf for bread and people are starving because they can't afford bread. The debate in that town about how to respond to that thousand dollar loaf of bread should not be about how many people should starve. The debate in that town should be about repricing bread.

Insurance premiums could clearly be lower in the U.S. if this country paid British or Canadian prices for that drug and then also paid the same prices that those other countries pay for all other prescription drugs as well.

Paying Canadian Drug Prices Could Cut Insurance Premiums By 7 Percent

At a more macro level, we need to understand the basic economic fact that prescription drugs currently consume about 14 percent of the average premium costs for U.S. health insurance companies.¹⁵⁴ The basic economic reality is that 14 percent of the premiums collected by the insurers are used by the insurers in this country to buy prescription drugs. If American patients -- and American insurers -- could suddenly buy all drugs at Canadian prices, the total premium levels that are charged to their customers by American health insurers could drop by 7 percent over night just to reflect the lower prices that would be paid for drugs.¹⁵⁵

Seven percent is real money.

[We Have Never Had The Political Courage To Address Those Issues](#)

We have never had either the political courage or the political momentum in this country to address those issues. We don't ever link those prices for pieces of care to the premiums we charge. We have never publically looked at how much less our insurance premiums would be in this country if we paid either Dutch or Swiss or Canadian prices for our prescription drugs.

The new loss ratio laws in the Affordable Care Act now very clearly mandate that the premium levels that can be charged by each health insurer must be based directly on the actual cost of care that is paid by each insurer. It's probably time to have a meaningful discussion about the impact of prescription drug prices on insurance premiums because the relationship is pretty clear at this point.

[The Extreme Price Variation for a CT Scan Has To Be Seen To Be Believed](#)

Drug manufacturers are actually not the worst unit-pricing offenders. Scans win that award.

Perhaps the most extreme level of price variation in American health care currently relates to CT scans and MRIs. CT scans and MRIs are wonderful technology. Done well, those scans can unveil important information about patients that can save lives, improve diagnosis and then help guide and monitor care plans for individual patients in very important ways. No one doubts the value and the benefits of those lovely scanning technologies.

What is a little less clear as a value and a benefit is the relative array of prices that are being paid today for those particular imaging procedures and the number of times that those scans are done. This book does not address or discuss the scan frequency appropriateness issues. Work done at the Virginia Mason Medical Center in Seattle can

shed huge light on that topic.¹⁵⁶ That care team did some excellent quality redesign work relative to the need for scans. They have published their results. Take a look at what they have concluded. It is a well-done study. We do more scans, overall, than we need to do. We do more scans than any other country -- other than Japan -- by a wide margin -- so we win on both volume and price when it comes to scans.

We pay more per scan than anyone in the world.

The next chart shows the price range for a CT scan of the abdomen. In Canada, the price paid for that scan is \$122. France pays a price of \$141. Germany and Switzerland pay much higher amounts, with the Germans paying \$354 per scan and the Swiss paying \$425 per scan.¹⁵⁷

In the U.S., the average scan price was \$584 -- nearly five times higher than the prices paid in Canada or Spain. The range of prices paid in the U.S. was amazing -- with five percent of the scans in this country running over \$1,657 and a number of scans running under \$200.¹⁵⁸ The Medicare prices for those scans is now \$316.¹⁵⁹ In California, the Medicaid price paid for those scans is \$311.¹⁶⁰

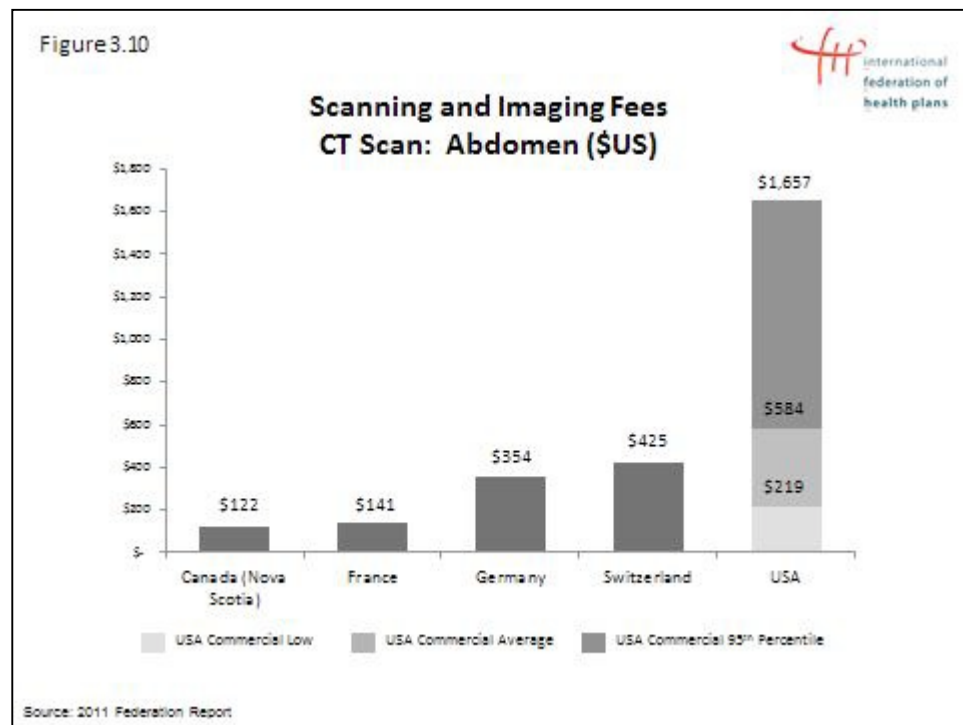
Some care sites have charged over \$10,000 for a scan.¹⁶¹ Other care sites in the U.S. have publically advertised the availability of \$49 scans.¹⁶² That is an amazing range of prices. What is even more amazing is the fact that it is actually possible to charge \$40 for a scan and not lose money.

How can that be true?

Once a piece of scanning equipment is in place and once it has been paid for by other customers, the incremental real cost of doing the very next scan is close to zero. The production cost of doing an additional CT scan is actually less than the cost of doing an additional traditional x-ray, because doing a traditional x-ray involves the care site having to buy a piece of actual film and then use a mixture of expensive chemicals to process the film. Film based X-rays create real incremental costs and they create both supply and purchasing expenses that do not exist when you do a purely electronic scan. A CT scan may have the radiation exposure for each patients of a thousand x-rays¹⁶³, but that scan can cost less than a single x-ray in pure per scan production costs.

The variation on scan prices is huge.

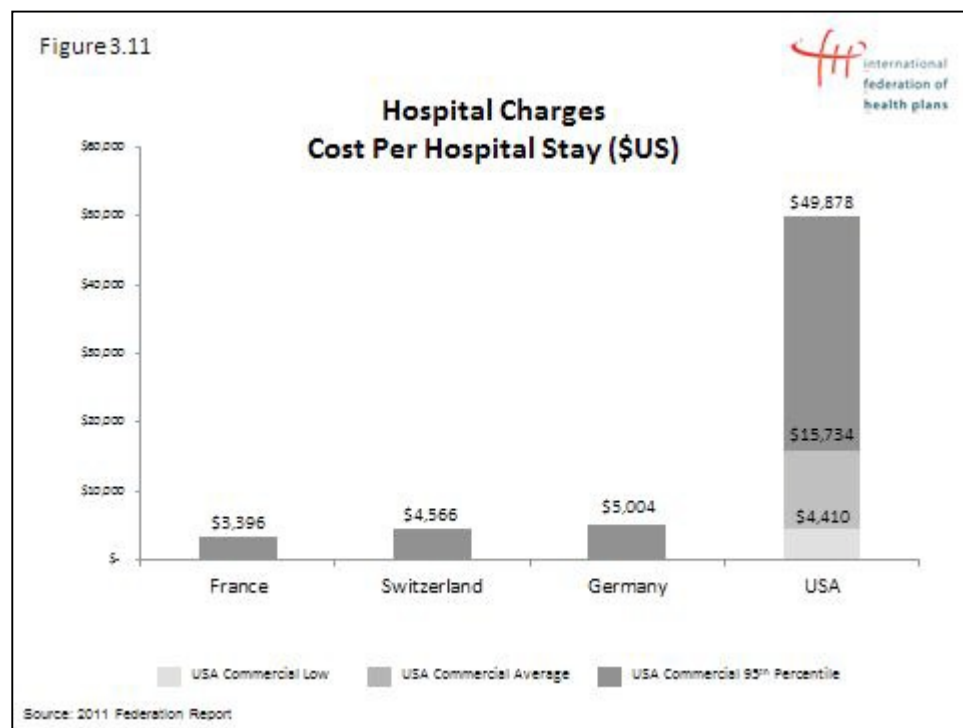
So a market based purchasing model of some kind that is focused on bringing scan prices down in this country obviously has a high likelihood of success. There is already a range of more than ten to one for American care site scan prices. When we are trying to keep health care costs flat in this country, it's clear that if we simply -- on average -- brought our scans a little further down the existing price continuum for scans in this country, we could meet and exceed a very aggressive cost reduction goal for scanning costs and we could achieve those savings within the range of prices that already exist today in this country for scans. Take a good look at the next chart. We pay more than the other countries and we have an amazing range of prices here.



We Also Have The Highest Hospital Costs In The World

When you look at prices charged in this country for pieces of care, some of the most interesting information relates to hospital prices. Hospital prices in this country -- not surprisingly -- tend to be the highest in the world by a large margin. The chart below shows that every

single country in Europe spent less than a thousand dollars per day for hospital care in 2011. Our average cost per day in this country exceeded three thousand dollars in 2011.¹⁶⁴ We spend a lot more money for each day in the hospital than any country in the world by a wide margin. Our daily hospital costs usually run three to five times higher than the daily hospitalized costs in other industrialized countries. We pay more per day and we pay more stay. The next chart shows average cost per stay in the hospital. We clearly win on both charts. The average cost per stay in Germany -- the second highest priced country -- is \$5,000. We spend on average, more than \$15,000 per stay -- and ten percent of our hospital stays exceed \$50,000.¹⁶⁵



[Why Isn't Our GDP Percentage Triple Other Countries?](#)

So when we look at hospital care, medical care, many tests, scans, medical equipment and prescription drugs, we see prices in this country for each piece of care that tends to be two to five times higher than any other country. Those extreme ratios raise a very interesting and important question.

If our unit prices for all of those pieces of care are also that much higher than the European prices and if our prices are so much higher than the Canadian hospital, medical, procedural and pharmaceutical unit prices, why aren't we spending even more of our GDP on care compared to their percentages? We spend roughly 18 percent of our GDP on care. Those other countries now spend seven to twelve percent of their GDP on care.¹⁶⁶ If our unit prices are more than triple their prices, why isn't our total GDP percentage difference also triple their GDP percentage? Why are the GDP amounts spent for care in each of those European countries actually running at about half of our percentage instead of running at a third of our expense? That is actually an important question that we need to answer in order to understand the reality of our health care delivery expenses.

People In Other Countries Get More Care Than We Do

Why aren't we spending three times as much money in total for care in this country instead of spending -- in total -- roughly twice as much?

The answer to that question surprises most Americans. Some people who have read this book chapter were shocked. It is a very important point to examine, understand and discuss. The truth is, by most measurements of care delivery, the people in those other industrialized countries actually get more care than we do. We spend more money -- but we get less care. The urban legend that we hear very often in American health care debates is that all of those countries in Europe spend less money than we do on care because they ration care. Again -- facts can often be useful when dealing with health care policy thinking. That particular urban legend is not true. Look at the numbers. In just about every major category of care delivery, the Europeans have both higher volumes of care and faster access to care.

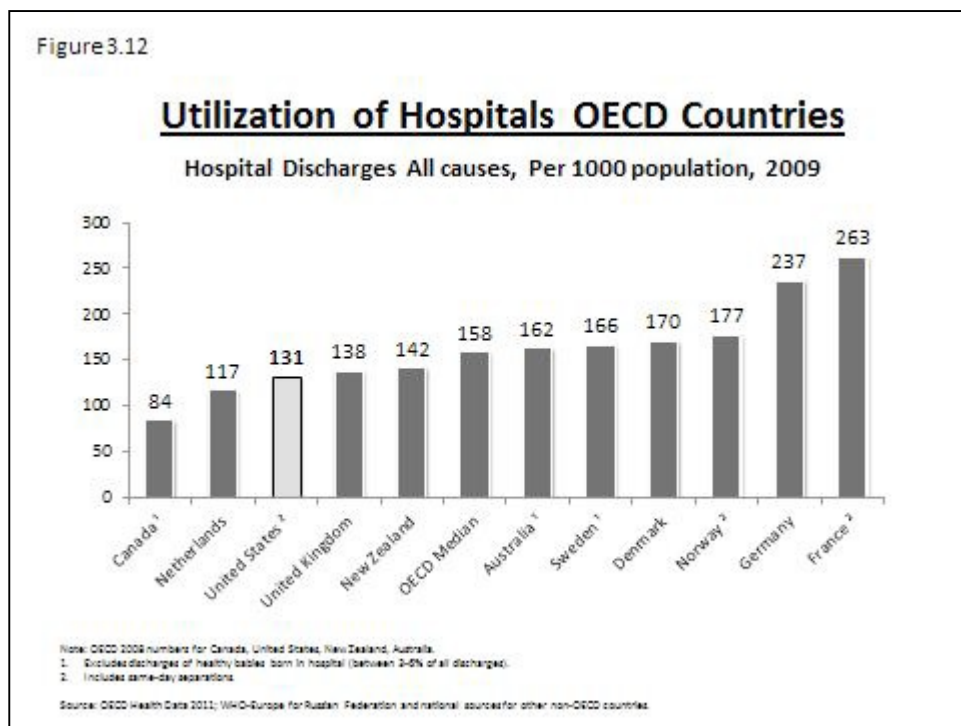
Let's start by looking at hospital days. A popular urban legend in this country is that we, Americans, have too many hospital beds and that

we, in fact, significantly over use hospital care compared to all other countries in the industrialized world.

That is not true.

We Have Nearly The Lowest Hospital Use In The Industrialized World

We Americans actually have among the lowest hospital admission rates of any country. Our hospital admission rates are lower than almost every other country in the industrialized world.¹⁶⁷ The next chart shows the relative number of hospital admissions per capita in half a dozen countries. We clearly admit patients to our hospitals far less often than those countries admit patients to their hospitals. We Americans are, in fact, significantly less likely to be admitted to the hospital for care than folks from almost every other industrialized country.



Only Canada and the Netherlands have lower hospital admission rates than we do. The average length of stay for delivering a baby in the Netherlands is less than one day.¹⁶⁸ It is very low because the Dutch

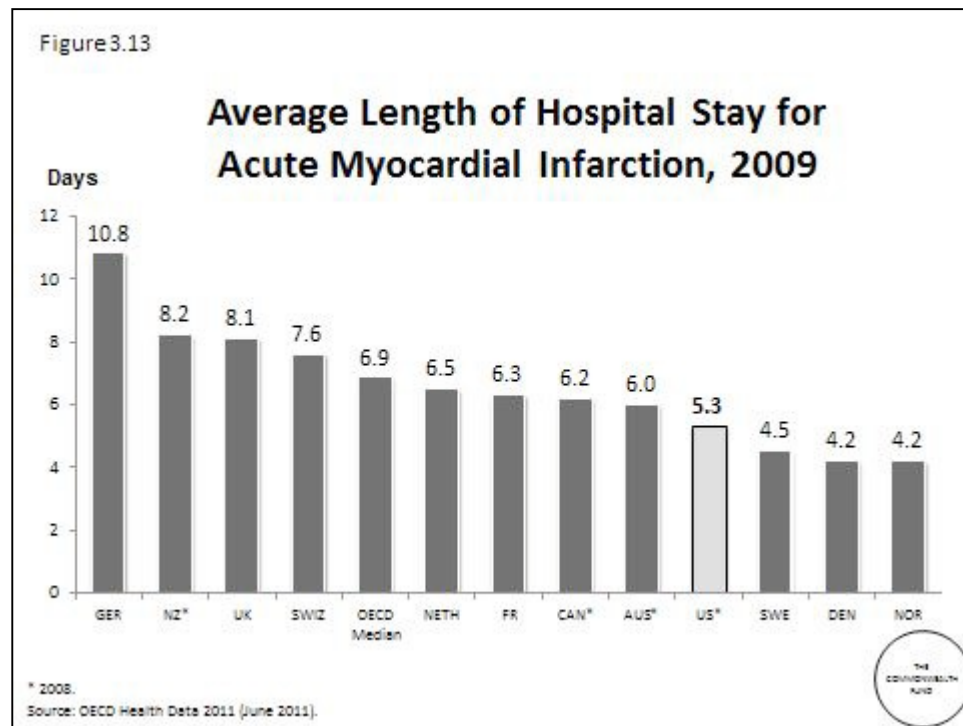
prefer to deliver babies at home. Just about every other industrialized country is much more likely to admit a patient to a hospital than we are. Germany and France are roughly twice as likely as our country to admit patients for hospital care. Admitting patients to hospital care twice as often as we do clearly isn't hospital care rationing by those other countries. That urban legend is wrong. Even Great Britain is slightly more likely to hospitalize a patient than we are.

[They Also Have Longer Lengths of Stay](#)

So if we admit fewer patients to the hospitals, do the people we admit to the hospital stay there longer than the people in those other countries who admit more patients?

Again -- the answer is no. Look at the next chart.

We also have one of the shortest lengths of stay in hospitals of any industrialized country.¹⁶⁹ The chart below show the actual numbers. Only the Scandinavian countries that use government hospitals and tend to employ their own physicians tend to have their patients leave the hospital faster than we do.



Other countries -- as you can see from these charts -- currently keep their patients in the hospital for significantly longer lengths of stays than our average stay in this country. This next chart shows the length of stays for a basic heart attack. The average length of stay in hospitals for a heart attack in Germany is about ten days. In Great Britain, the patients who have heart attacks stay in the hospital for over eight days. Our average length of stay in this country for a heart attack is slightly over five days.¹⁷⁰

So the urban legend about our care costs being so much higher than European care costs because we have too many hospital beds and because we use our hospitals a lot more than Europeans use their hospitals is simply not true.

[Do Other Countries Ration Medical Care?](#)

What about medical care? If these countries don't ration hospital care, do they ration medical care? Another commonly held belief in this country is that our overall health care costs are so much higher because

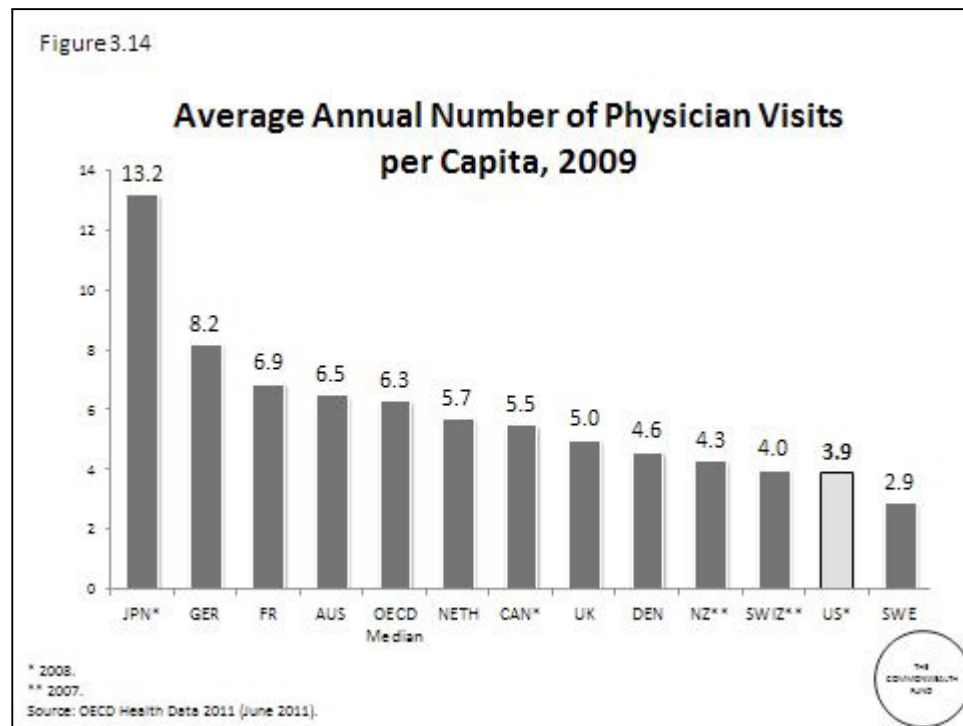
we Americans have much better access to physician care. Many people in our country believe that urban legend that those other countries who spend less money overall on care spend less money and keep their costs down primarily by rationing access to physician care. The urban legend is that we Americans use medical care far more extensively than people in those other industrialized countries use medical care. Is that belief about higher levels of physician care for patients in this country true?

No. That belief is also wrong. Again -- looking at real data on a given issue is often useful in figuring out what is true about that topic. Look at the actual numbers. We Americans actually see our doctors less often than the people in most other industrialized countries see their doctors.¹⁷¹

We Americans see our doctors -- on average -- slightly less than four times a year. Canadians, in contrast, see their doctors five point five times a year. The French see their doctors almost seven times a year.

The Germans and the Japanese see their doctors the most -- with Germans going to the doctor over eight times a year and the Japanese seeing their doctors -- on average -- an amazingly high level of 13 doctor visits per year. Our four visits per year are significantly lower than their 13 visits. So the basic data about how often we see our doctors tells us that those countries are not rationing access to their doctors.

Anyone who believes that we see doctors more often and that is the reason why we spend more money on care should look carefully at the next chart.



The other countries on this physician visit chart are clearly not rationing access to medical care. Again, only the Swedes -- with their government owned and government operated care system -- see their doctors less often than we Americans see our doctors.

So if we look at the actual data, we can see that patients in other industrialized countries see their doctors more often than we see our doctors. They are also more likely to be hospitalized than Americans and when they are actually hospitalized, the patients in those countries tend to spend more time in the hospital.

So where do we Americans get real value for all of that additional money that we spend on health care? Do we at least get faster access to our doctors when we need faster access to our doctors?

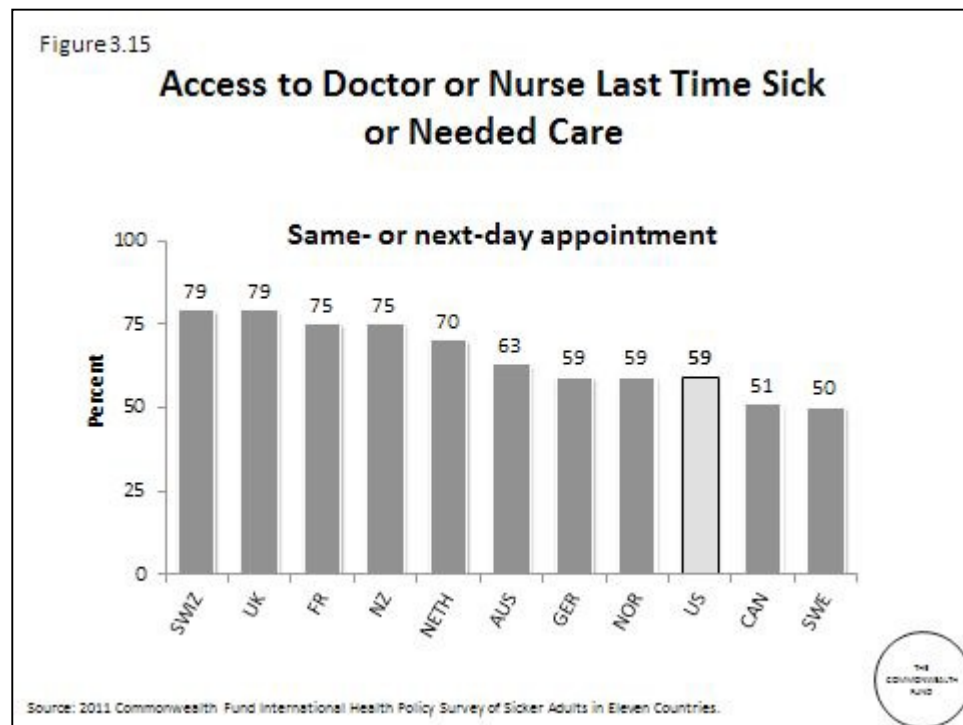
The answer to that questions is the same answer.

No.

We also do not get faster access to basic medical care than the other industrialized countries.

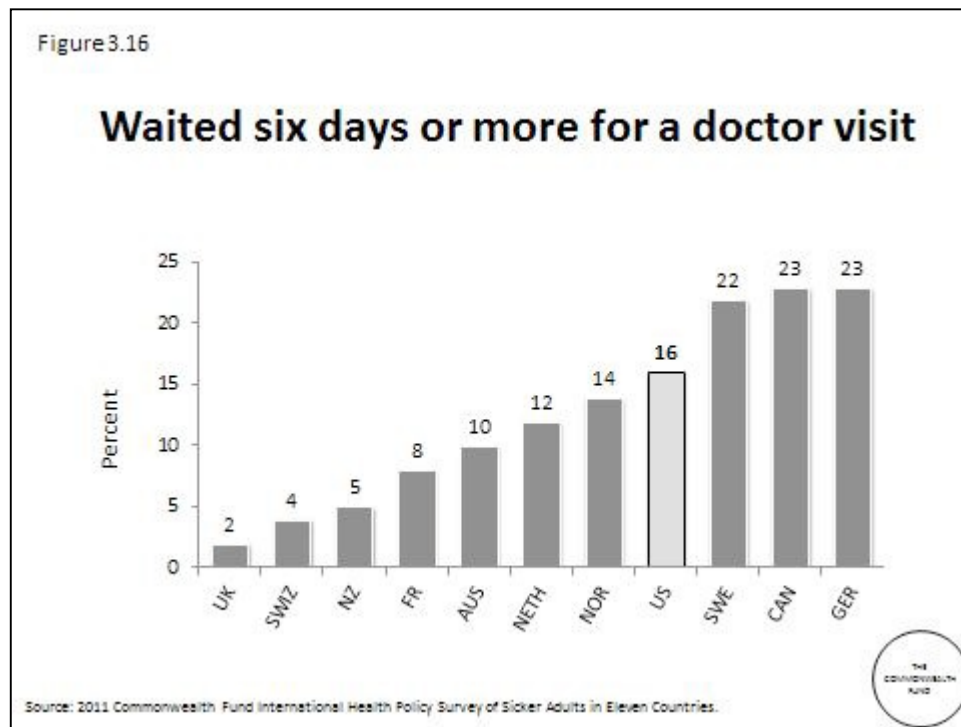
Other Countries Get Better Same Day Access

Several other countries that spend half as much money as we spend on care actually tend to have significantly better access than we do to same day care. Again -- look at the numbers on the next chart. Our numbers are over on the right hand side of the chart. The lower side. Just over half of American patients who want same day care can get it. By contrast, the Dutch patients currently have their same day care needs met almost 70 percent of the time.¹⁷² We do get faster access to doctors than patients in Canada and Sweden. We lose to all the other industrialized countries on that basic measurement of care access. All of these countries have more doctors per capita than we do. We do tend to have more nurses per capita than those other countries, but we have fewer physicians.



When you measure how long people actually waited in each country for primary care, we were in the middle range -- with 16 percent of Americans waiting 6 days or more for basic care. The French had half as

many people waiting 6 days for care—with only 8 percent of the French population not getting that level of care within a week.



The clear winners on getting fast access to primary care doctors are the British. They use a different care financing model. They don't buy care by the piece. They buy care as a package -- with primary care doctors paid a lump sum each month to meet the total primary care needs of their patients. People in Great Britain chose a primary care doctor and each doctor is then paid a flat amount per month per patient. Every primary care doctor has a known panel of patients. That approach somewhat resembles the patient-centered medical home model we are learning to use in the United States. Using their primary care model -- where their doctors sell packages of care rather than pieces of care -- the Brits only had two percent of their people who were not seen by their doctor within six days. Our 16 percent six-day access to care performance was not the worse in the world but our performance was far from the best.

Access To Specialty Care

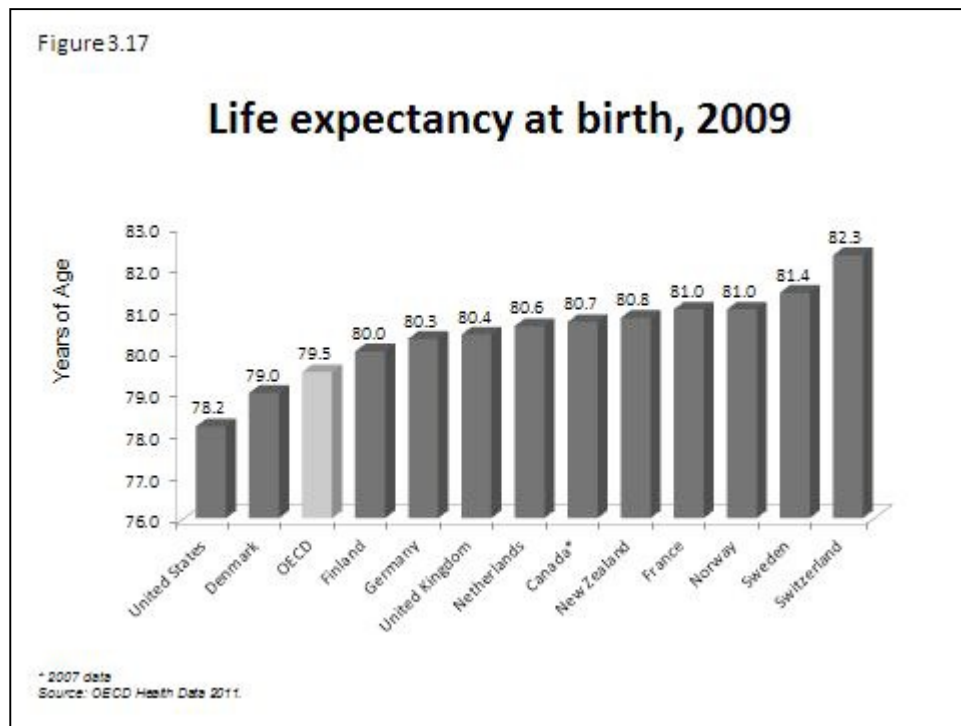
The one area where we are not at or near the bottom of the care access performance charts is in access to specialty care. On the specialty care access chart shown below, we do fairly well. We don't do as well on access to specialty care as the Swiss -- but we do slightly better than the Dutch and the Germans and we do quite a bit better than Canada, Sweden or Norway. We spend significantly more money on specialty care than any of those other countries. We spend over than twice as much money on specialty care compared to most other countries. Our access to specialty care numbers aren't twice as good -- but they are roughly tied with the best performance in Europe.

The Business Model Affects Availability

So what is the impact of all of those accesses to care performance levels for care delivery on our total health and on relative outcomes of our care?

The next chart shows life expectancy levels for people in each of the countries listed on these charts. We do not win on the scale of life expectancy. The U.S. currently rates 51st in life expectancy in the world.¹⁷³ On this next chart -- comparing just the industrialized countries -- we rank in last place. We pay the most money for care and we get less access to most categories of care. We rank dead last in our survival statistics. Primary care access seems to help prolong lives. Timely access to specialists doesn't seem to have the same life extension impact.

That is, of course, due in part to the simple biological fact that by the time you need a specialist, your health has probably already deteriorated. Having access to heart transplant surgeons twice as fast as another country is a good thing until you recognize that patients in those other countries are less than half as likely to actually need a transplant surgeon. As this book keeps saying -- we get what we pay for.



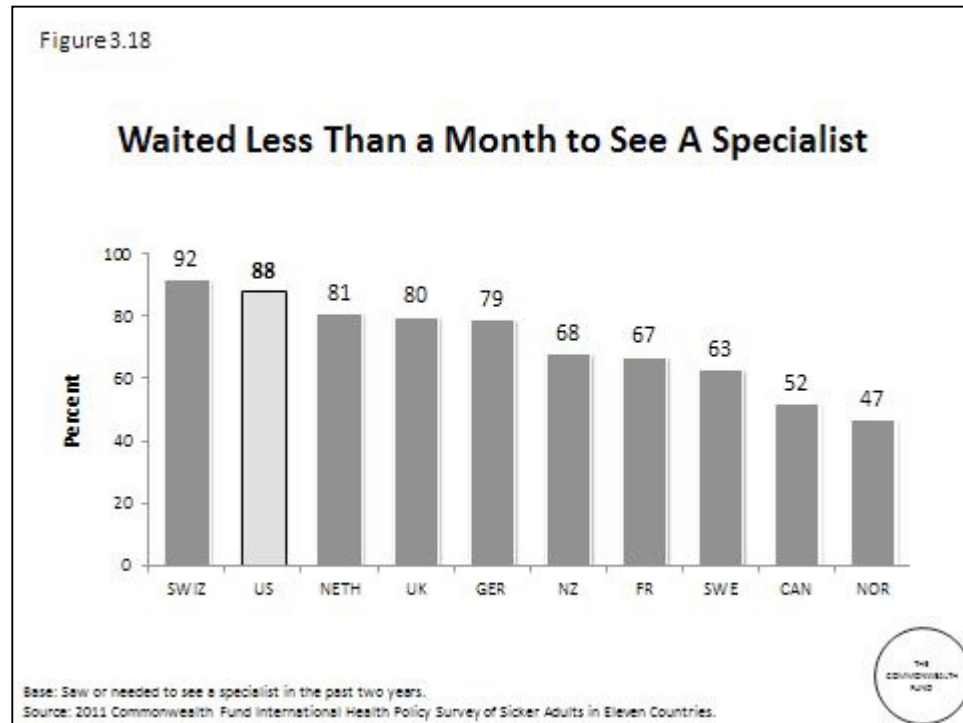
Care Financing Sculpts Care Delivery

One of the interesting points to discuss is the fact that care delivery seems to be influenced quite a bit by the financing approaches used by each country.

There seems to be a fairly strong correlation across countries between easy or delayed access to specialty care and the type of business model that is used by each country to buy and sell care. Countries that use private insurance plans to pay for the care of their citizens tend to have faster access to specialty care than countries that use only government payers. Switzerland, The Netherlands and Germany all use both private health insurers and private care sites to deliver and finance care. Those countries do well on access to both specialists and primary care.

By contrast, the countries that deliver and fund their care entirely using either a single payer approach or a government run and government owned care system tend to have measurably slower access than other countries to specialty care and slightly slower access to primary care. Sweden, Norway and Canada all fit that model. It's an

interesting and fairly obvious pattern and correlation. The care systems in the countries with the most government control over financing and care delivery operations clearly have the slowest access to specialty care.



[We Pay Primary Care Doctors Half As Much Money](#)

Most of the other industrialized countries place a very strong emphasis on primary care. Most other countries do not encourage as many of their doctors to be specialists. We do the exact opposite. We encourage specialty care. We generally pay our primary care doctors only about half as much as we pay most of our specialists. Lower paid primary care doctors in the U.S. can take a decade to repay medical school debts that higher paid specialists and subspecialists can repay in a couple of years -- sometimes a couple of months. Other countries tend to have their primary doctors graduate from medical school with little or no debt -- and usually only specialists in those countries end up with educational debt.¹⁷⁴ We set up very different financial realities for our medical students.

Other countries tend, -- as a matter of policy -- to have two thirds or more of their doctors in the primary care specialties and a much lower percentage of their doctors in the specialty and subspecialties care areas.¹⁷⁵ The people who do health planning in those countries believe that patients will get better care overall and will live longer if patients have quick and easy access to primary care. The charts above that show both relative access to care and the better life expectancy levels that exist in those countries might indicate that those could be good and valid theories and strategies. Their goal and their key strategies are to prevent medical disasters. Our model and care strategy is to let a large number of disasters happen and then throw large numbers of specialists and subspecialists into the intensive care units of our hospitals to provide an avalanche of purely reactive and very expensive care for those patients who are in dire need. Patients in other countries live longer than we do. Our specialists make a lot more money. Those are not unrelated facts.

Rationing Is Not The Winning Strategy

So what does all of this data about access to multiple levels of care tell us relative to the prices we spend to buy care? It tells us that other countries do not spend significantly less of their GDP on care delivery because they ration care. Switzerland spends a lot less money than we do on care. We know that to be true. It is also true that no one in Switzerland rations care. When we compare ourselves to other industrialized countries, the people in those countries actually tend to have more doctor visits, faster access to doctors, more hospital admissions and longer stays in the hospital than we do.

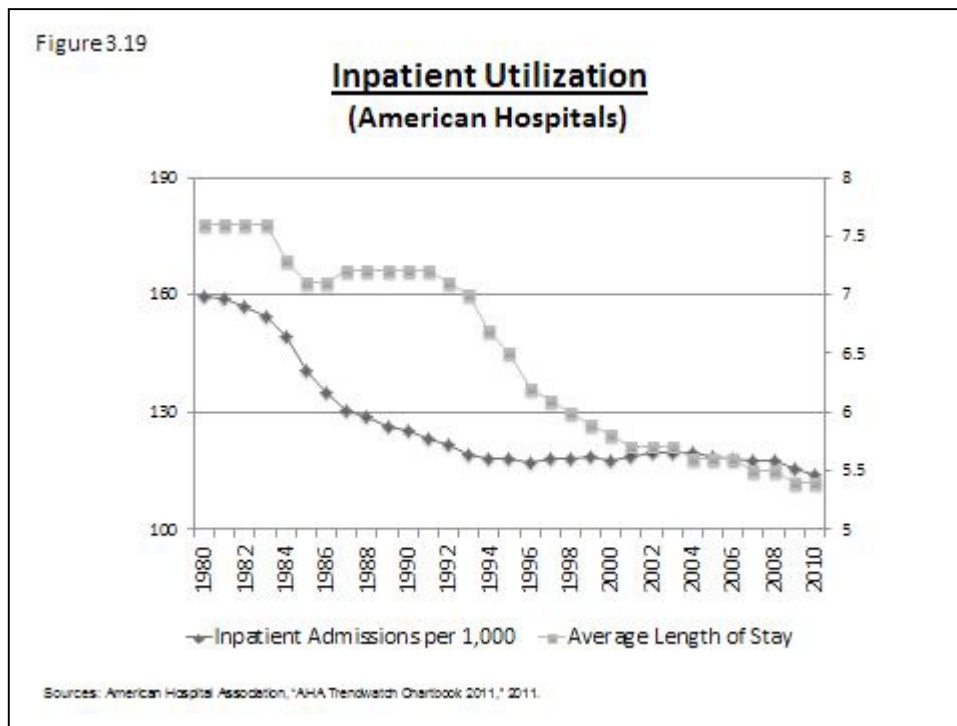
So why are overall care costs so much higher here? This chapter also answers that question. Prices are the key difference between us and them. We get less care but we spend a lot more for each piece of care. As the opening of this chapter stated very directly, prices for pieces of care are clearly the key cost driver that is the difference between us and them on the total cost of care in each of our countries.

How Did Prices Get So High Here?

Our world record prices for care obviously raise another key question that it is useful to answer. How did we manage to end up with all of those prices for pieces of care that are so much higher than the prices that are charged in all other countries?

The next two charts are fascinating. They outline an extremely important piece of data that we need to understand. The first chart shows the decrease in hospital lengths of stay and in hospital admissions that has occurred in the U.S. for the past couple of decades.

We obviously don't have our current very low levels of hospital use numbers by accident. We have been reducing both hospital admission rates and the length of stay for hospital patients in our country steadily over the entire time frame shown on this chart. This chart shows that we now have the lowest hospital admission rates in the world. We made that happen. Those very low hospital utilization levels did not happen serendipitously. Market forces and the business model we use to buy hospital care created that hospital use outcome. We made important changes in the way we buy care and those changes helped point us irreversibly and irrevocably toward that overall reduced hospital use performance level.



DRGs And HMOs Reduced Length of Stay

We changed the business model we used to buy hospital care roughly thirty years ago. Hospital use was going up. We were buying hospital care in those days entirely by the piece -- with every day in the hospital generating a new avalanche of fees. Medicare believed they were facing a hospital cost explosion and they had a mild panic attack. Medicare decided to change the way they bought hospital care to keep those costs from exploding. Medicare is a huge purchaser of care. When Medicare changes the way it buys care, care changes. So what did Medicare do?

Medicare decided to stop buying hospital care by the piece. Medicare decided to pay for hospital care using package prices for each patient. The new package prices were based on the hospital admission diagnosis for each patient. Medicare based their new payment approach on what they called "DRGs" -- Diagnosis Related Groups.

The DRG's had a huge impact on the business model and cash flow reality for the hospitals. It no longer made sense for a hospital to do an entry level, cost-generating x-ray for every patient because the new

DRG-payment approach did not pay for each separate x-ray. Those hospital admission x-rays actually used to be done routinely for just about every hospital patient. They were done in the days when hospitals were paid by the piece and when those x-rays were a very profitable thing to do.

Then the payment approach changed. Hospitals could no longer send a separate bill to Medicare for each of those pre-admission x-rays. Hospitals looked very differently at the actual biological and medical need for that particular piece of film when the payment approach changed. That piece of film turned out not to be an important piece of medical data for new patients when those x-rays stopped generating revenue. That was just one example. DRGs changed the way hospitals thought about many areas of care. Many areas of care changed. Lengths of stay were high on the list of changes.

Then -- at about the same time Medical implemented DRGs -- "managed care" plans began growing in the private insurance market in this country. Employers who were unhappy with exploding insurance premiums turned away from the old simple insurance model and began hiring health plans to reduce their costs. The new health plans began replacing the old health insurance companies. The old pure health insurers had been simply functional conduits for cash. Those original health insurers generally made no attempt to influence the delivery of care in any significant way. They simply received a bill from a caregiver -- checked to see if the service on the bill was listed on the approved list of services -- and if it was on that list, they paid the bill. No questions asked. They didn't even negotiate the prices. Quite a few employers who were paying the premiums for those pure insurance plans found that the premium prices were increasing at unacceptable levels, so the employers began to move their purchasing decisions. The employers began using managed care plans -- HMOs -- instead of traditional health insurers instead to pay their claims.

The new health plans, by contrast with the old insurers, started looking at ways care could be made better and cheaper. The insurers who became health plans stopped functioning purely as a conduit for cash

and began to try to manage the cash flow and care costs to reduce their premium levels.

The new health plan approach that began replacing the old insurance company conduit for cash approach began to functionally do a number of new things to actually “manage” care. The health plans decided to look for ways to eliminate wasteful and unnecessary care expenses. The new health plans immediately stopped paying for those preadmission x-rays on every patient. They also stopped paying for pieces of care like Friday hospital admissions for Monday surgery. Those Friday admissions actually were fairly common in some settings. Big bills were being incurred over the weekend for those Friday admissions but more often than not, there was no real care being delivered to those patients because the purpose of the admission was generally just for the patient to “rest.” A hospital can be an expensive place to “rest” -- when there are no medical care needs for the patient to be in that bed.

Health plans found many opportunities of that sort to affect the costs of hospital care. Changing a number of elements of care delivery became a major goal of some plans. In the process, the new health plans started looking at lengths of stay for patients in the hospital, and they did that work initially by diagnosis. They worked to cut maternity stays, for example, from five days to three days and then to two days. Other lengths of stay were reduced as well. Health plans also started to figure out which inpatient surgeries could have been done just as well and much less expensively in an outpatient setting.

This book isn't a history book about those changes in care delivery that resulted from “managed care” -- other than to note that they happened...but it is important to recognize that some aspects of the business model for care changed in the process. Hospital days were affected.

When Medicare stopped buying hospital care by the piece and when the new health plans began to “manage” hospital care with one of their key goals being to reduce unnecessary hospital use whenever possible, then the number of days in the hospital went down at the levels shown on that last chart.

There was a lot of tension in some care settings as those health plan triggered changes in practice and payments were implemented. Some of those changes were really needed and well done and some of the changes were clumsy, insensitive and more focused on cost reduction than care improvement. Revisiting all of that history in a lot of detail isn't particularly productive at this point in this book -- other than to say that the full scope of changes in the hospital business model that were triggered by both sets of payers clearly changed the delivery of hospital care in the U.S. You can clearly see the results on the hospital utilization chart above.

Changing some basic business realities for hospitals changed the way the hospital product in this country was both structured and produced. That chart tells a very powerful story about the impact of those changes over time.

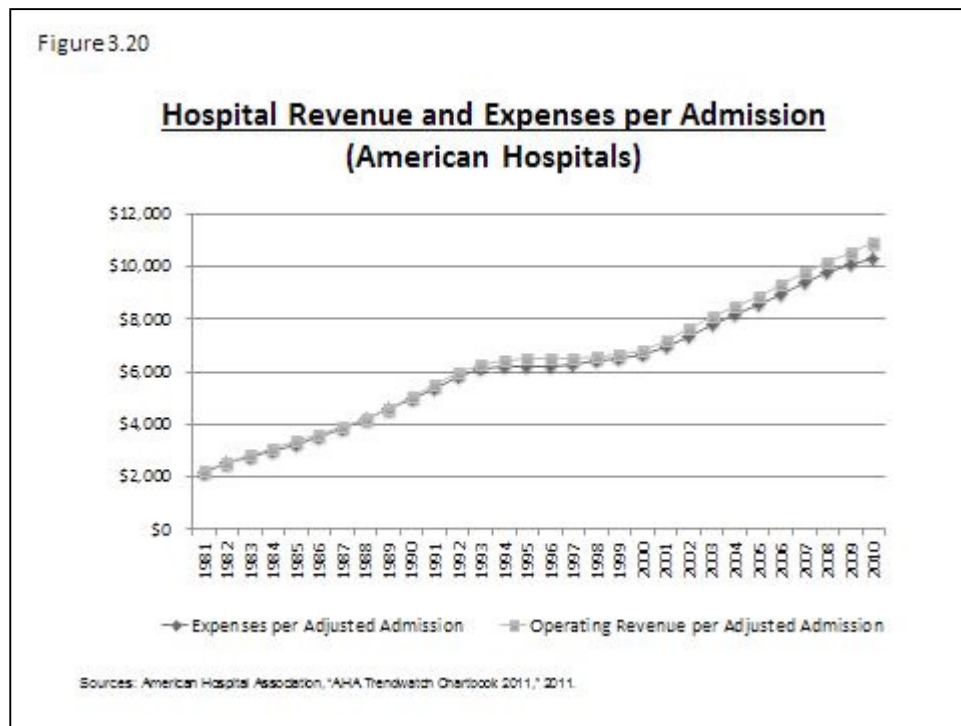
If that chart is accurate and if that very impressive reduction in hospital use happened, why don't we now spend less money on hospital care than anyone in the world?

Again, the answer is simple.

Prices.

Hospital days went down. Unit prices went up.

The next chart shows the increase in hospital prices that happened over that same time frame.



Clearly, hospital prices have gone up -- year after year. Operating revenue increased for the hospitals even when their utilization levels decreased.

Prices Offset Utilization Drops

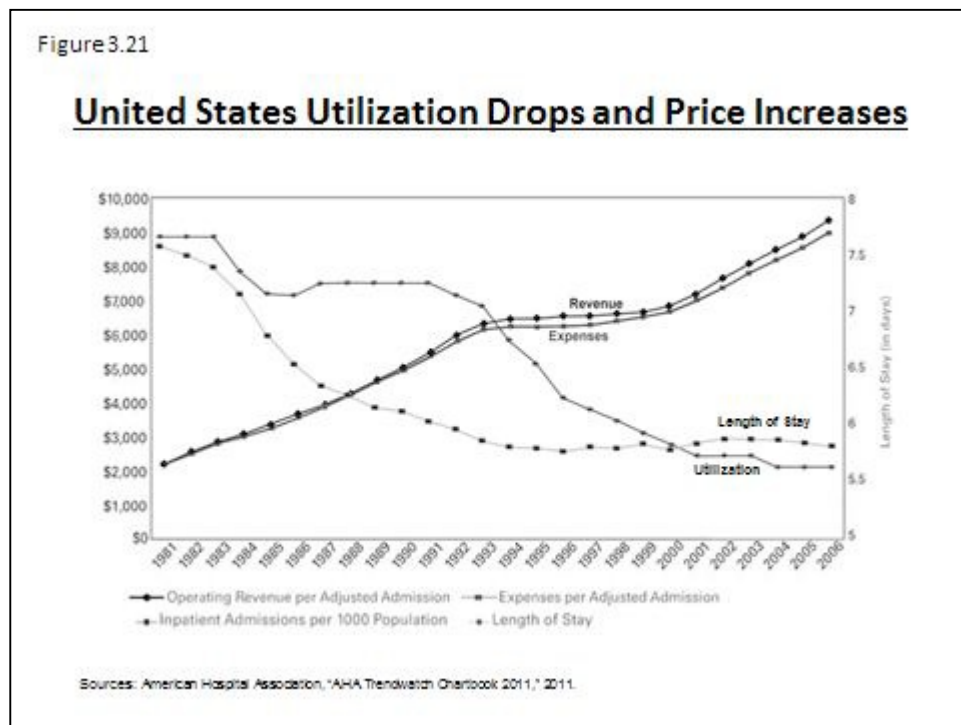
The next chart blends the last two charts. The story of those two intercepting trends is pretty clear. Price went up. A lot. Some of the price increases charged by the hospitals made obvious operational sense. The cost to produce a day of care should go up a bit when there are fewer people being hospitalized because the people who are still being hospitalized are -- on average -- sicker people, and sicker people do need more care. The Friday admissions for Monday surgery that were happening in 1982 and then eliminated -- and the final three days of a five-day maternity stay -- had not involved patients who actually needed a lot of care. Those patients were functionally resting in the hospital. Resting is a good thing, but those patients were not being actively treated in the hospital.

Don't Let Health Care Bankrupt America: Strategies for Financial Survival

So some price increases for a day of hospital care made some sense when the hospital admissions went down and the length of stay diminished because the average intensity levels of the care for the patients in the hospital did increase.

The actual increase in prices, however, more than offset the reduction in hospital utilization and exceeded the increase in the care intensity levels. The net impact of all of those prices going up in hospitals has been to give America the highest per capita hospital costs in the world by a factor of two.

We now spend more than \$15,000 per stay for hospital care. No other country in the western world spends more than \$5,000 per stay.¹⁷⁶



That is the economic reality about hospital costs we all need to understand.

Why Weren't Consumers Upset About Higher Hospital Prices?

Why weren't consumers outraged -- or at least upset and alarmed -- by all of those increases in hospital prices? Consumers were not upset because the increases were invisible. Consumers had absolutely no idea that those price increases were happening. Our insurance benefits very effectively hid those price increases from us as consumers. As those prices were increasing, we Americans either had full insurance coverage for our hospital care -- and that full coverage payment approach obviously concealed prices from patients really well -- or we had deductible plans with relatively low deductibles. The deductible plans showed us the deductible amount charged to each patient for care, but that deductible payment approach completely hid the full price that was being charged by each hospital for each patient and then paid by the insurers.

That's why consumers did not object to the price increases. They were invisible. Both types of insurance payment hospital benefit plans very effectively concealed all of those hospital price increases from all insured consumers. Those full coverage and low deductible benefit plans also concealed all of those hospital price increases year after year from our policy makers, our legislators, and our news media. The overall premium increases that were being charged by the health plans were sometimes somewhat visible to the public and the media. But the actual price increases that were created each year by American hospitals were totally invisible. Those prices increase were out of sight, out of mind. But they were obviously not out of the health care economy.

Why Didn't Health Insurers Blow The Whistle On Price Increases?

Health insurers, of course, knew exactly what was driving their premium increases. They paid the bills. They cut the checks. So why didn't health insurers blow the whistle and expose all of those price increases to the rest of the world? Health insurers choose -- for years -- not to draw any attention to those prices. Health plans had business reasons not to make a fuss about those prices increases. Many health

insurers did not want the public or the government drilling down into any of the specifics of their cost structures, so insurers generally kept their mouths shut about the hospital price increases. The insurers also did not highlight or spotlight all of the other fee increases that have been set up over time by the various medical practitioners, drug companies, or technology companies. Why were insurers generally silent about the prices that were causing their premiums to go up?

For starters, insurers often compete with each other based on their relative level of negotiated discounts. So perversely, if a provider price goes up by a lot but the insurer can say to their client, “We have a thirty percent discount on that fee,” -- then the perceived value of the discount is greater when the prices are higher.

Insurers also tell their employer clients -- “We have a 30 percent discount and the other insurers only have a 20 percent discount. Thirty is better than twenty.”

Any public reaction that might have been triggered relative to the per unit price increases by included consumers or well-informed news media could have resulted in some kind of legislation that might have made that relatively comfortable competition that was based on relative price discounts irrelevant.

In that time frame, insurers also were not particularly interested in having their entire financial infrastructure exposed to the public eye. Once people started looking at the role that unit price increase actually played in creating premium costs increases, that set of discussions might have opened the door to looking more closely at other pieces of the total premium cost package. Those numbers used to be invisible to the outside world. So the old business model worked just fine for most insurers and there was no reason for insurers to highlight all of the hospital price increases that created that particular chart. It was easier to pay the higher prices and pass the costs on to self-insured employers and in premium increases.

That meant that silence prevailed about prices from the best and most relevant source of knowledge in this country about prices.

Journalists and health care economists have also both been singularly uninterested in prices as a topic for either reporting or study.

The public media has done many stories about care developments, medical science improvements, and treatment innovations and have written some highly informative pieces -- those stories almost never reflect, touch on, or even mention the price that will be charged for the new treatment. Those stories never mention or even hint at the inevitable impact of that new price and new service on insurance premiums. Most journalists actually do not know that linkage between costs and premiums exists -- and health insurers have not explained it to them.

In addition, health care economists seldom mention either prices or price increases in their own analysis of health care costs. Professor Uwe E. Reinhardt of Princeton did a brilliant piece two decades ago for the *Journal of Health Affairs* where he explained the issue clearly. The piece was called, "It's the Prices, Stupid." ¹⁷⁷ The piece was clear, concise, well-reasoned, well-structured, and amazingly accurate, and it was basically ignored literally for decades. The primary reason that it was ignored is that the paper made the intellectual and the academic points brilliantly -- but the author did not include one single actual price number in the article. If any of the price charts that are included in this chapter of this book had been in that article by Dr. Reinhardt, it would have been game/set/match for the health policy world for the argument and debate about the impact of prices on overall costs of care in this country. Because there were no actual unit price numbers in the article, the argument was regarded as pure theory.

Influential people who very much did not want this country to look at pricing issues were able to categorize it as an interesting but unsubstantiated theory instead of having to treat it as a deadly accurate statement of facts and reality about the actual key issue for health care costs in America.

We probably would have taken health care purchasing in this country down some very innovative and productive paths had that article been accepted as absolute fact at the time it was published.

In any case, even the health insurers who know exactly what was driving their costs up every month were silent about the impact of prices on premiums. The public had no idea of that impact and most people had

no clue that prices were going up or that those prices increases had any impact on insurance premiums.

That legacy of silence about the actual causes of premium increases has recently not been good for the overall creditability of insurance companies. Some insurers are now paying a significant credibility price for that particular transparency deficiency. The credibility issues exist for insurers because surveys show that most people in this country now believe that premium increases are driven almost entirely by the health plan profits and even by health plan greed.

That transparency level is in the process of changing. It isn't voluntary. Insurers today are far more likely to point out the impact of prices on their premiums because the Affordable Care Act has now mandated that premiums are to be created by care costs, and that is creating significant insurance company transparency relative to their cost factors in the new premium-setting process. Hiding the expense factors is no longer allowed by the new rating rules for insurance premiums. One result of that change is that an increasing number of insurers are now beginning to tell the unit price story, and some are even pointing out some price abuses. The public will be well served by that new flow of data from insurers to the world. No one has better data about prices than the organizations that pay those prices.

We Should Not Make That Mistake Again

In any case, the chart that shows us both sets of lines for hospitals utilization and hospital prices tells us a really important story. We did not get the cost benefit from the utilization changes. We clearly made a mistake. We need to make very sure we don't make that same mistake again. It is actually possible for us to make that mistake again as we go forward with the approaches outlined in this book and as we make care better and more efficient.

As we create team care, and as we bring computer-supported, continuously improving care to levels where we can reduce in-hospital utilization in this country even more, we need to be very sure that we

don't once again lose the financial benefits of all of our care improvements and have those gains in better care destroyed and erased by another generation of simple, per-unit price surges for hospital care. If we lose the next generation of that particular price war, we could make the next set of care delivery performance gains disappear entirely as financial wins for the country.

We need to achieve and hold price gains at this point in time and not simply face and pay for another round of price surges.

The Urban Myth of Fee Legitimacy

To deal with prices, we do need to have more people understand exactly how the price setting approach usually works for care prices in this country. We need the public to better understand care prices.

One of the urban myths of American health care economics is that the prices that are being charged by a caregiver to any given patient somehow have a basic fundamental validity and an inherent legitimacy. People who get care generally feel like each fee that is charged to them by their care site or their caregiver must be legitimate or their caregiver would not make them pay that amount of money for their care. We tend to grant the prices that are charged in this country an amazing level of legitimacy, and we tend to assume in our future thinking that prices for care will always be either stable or perpetually increasing. That is a bad way to think. Instead, we obviously should be looking at price flexibility and price variability as a key and easy to use cost mitigation factor.

We have not traditionally looked at prices as being an opportunity to bring down costs. We don't think like that as individuals. Amazingly, even health care economists and policy "experts" who look long and hard at health care cost issues far too often don't think of prices as a possible tool for making care more affordable.

It's a bit easier to understand the public thinking on that issue than it is to understand why very intelligent health care economists and policy gurus think that way.

It is really fascinating that so many health care economists who are deeply immersed in the economic issues of care don't even look at price or think of price as a potential cost variable when they are doing future financial projections about health care costs.

Even very intelligent economists who should know better often assume in their own thinking that all current prices are somehow collectively "right" and inherently legitimate. Those economists who believe in the inherent rightness of overall prices then tend to base their own future cost projections and their strategic thinking for health care expenses on the aggregate set of today's prices, with the assumption that prices for all pieces of care will perpetually and inevitably rise -- like some kind of inexorable economic tide.

Economic projections and policy strategists both tend to be anchored for too often intellectually in the inevitability of perpetual price increases. That is a highly simplistic and singularly unproductive way to think about prices.

Prices Are All Invented

What is true is that the private market prices for each piece of care are all invented for the business purposes of the health care business units that are charging the prices. The business units generally set overall revenue goals for themselves, and they each then create an array of prices that will -- in the aggregate -- achieve those total revenue goals. In that context, the truth is that individual prices are extremely variable in multiple directions almost all of the time. We really should not assume that any of those prices for any piece of care ever has an inherent legitimacy on its own merit as being a pure and accurate and direct reflection of the actual cost of producing care for that particular service in that place and that time. Private market prices are all invented by the business units of care to meet their business goals. As noted earlier, government prices for each piece of care are simply set arbitrarily by the government and then those prices are imposed on each caregiver to meet the government's budget goals.

Those non-negotiated Medicare and Medicaid prices do not pretend to reflect the actual cost of care for care sites. Both of those government run programs simply impose their prices on the caregivers. Those imposed prices reflect how much money the government is willing to pay for each piece of care for the people they insure.

As noted earlier, many other countries also use that government imposed price approach for their patients. Those government mandated prices are also used to set payment levels for the patients who are covered by private health insurers in most counties. Some countries do allow some levels of market forces or competitive factors to be involved in setting some of their care prices. Others governments just mandate all prices that are paid for each piece of care.

All Other Countries Have Lower Prices Than We Do

Regardless of which approach each country uses, however, the other countries all end up paying a lot less than we do for each piece of care.

The appendectomy, angioplasty and coronary artery bypass surgery fee schedules examples that were shown above each gives us some sense of the price variation that exists between countries and also gives us some sense of the individual price variation that exists today within our U.S. health care ecosystem.

One Role of Health Plans Is to Negotiate Prices

As noted earlier, one of the major roles played by health plans and health insurers in this country has been to negotiate prices on behalf of the people who buy their insurance. The first Blue Cross plans began that tradition during the Great Depression.¹⁷⁸ To have an affordable premium level, those early Blue Cross plans all negotiated significant hospital discounts for the people who bought health insurance through the plan. Those price discount negotiations and volume purchasing processes have always been a major role that health plans play for their customers.

Health plans in this country are allowed by law to negotiate the purchasing of care. Most plans use their purchasing volume and their market leverage to negotiate lower than list prices with most of their caregivers. Since insurance premiums that are incurred by any health insurer are always based on the average cost of care for any set of insured people, each of the negotiated discounts for those individual pieces of care helps to reduce the premium levels that are needed by the health plans to buy care for the people they insure.

Plans that have strong market leverage tend to negotiate prices based on the Medicare fee schedule -- with the actual payment being "Medicare, plus a defined percentage." Health plans that have less market power and who deal with local care businesses units that have some levels of local market control or market dominance tend to pay based on a discount from the care provider's chargemaster fee schedule that were described earlier in this chapter.

That is almost always weaker price leverage. Those prices that originate with the chargemaster fee tend to be higher than the ones that are based on the local Medicare fee level.

Other plans have their own payment level -- and negotiate a whole array of fees based on local market realities. Approaches vary from buyer to buyer.

Providers Don't Like Price Negotiations

For all of those approaches, providers often complain to media, patients, and politicians about those health plans' price negotiations. Many providers of care express both public and private unhappiness about the fee discounts or the pricing arrangements that result from their contracting process with health insurers.

One of the almost humorous ironies of the American health insurance marketplace and the health care policy world has been that some of the same consumers who have been most unhappy with the high premiums that are being charged to them by their insurers sometimes both publically and privately criticize those same health plans for

negotiating any fee discounts with their caregivers. That actually does makes emotional sense -- because patients everywhere tend to like their personal caregivers. Fee negotiations by health insurers can make providers of care unhappy and patients generally don't like it when their personal caregivers are unhappy. But the basic arithmetic of health care coverage and unit prices is pretty clear. Higher fees for prices of care that are charged by providers to insurers directly result in higher premiums for those insurers.

Price Transparency or Price Relevancy?

One of the strategies that some people have proposed to reduce health care spending levels in the U.S. is to require price transparency of some kind. Creating transparency relative to prices has been a goal and preferred strategy for some health care policy strategists and for some segments of the purchasing community. Some people believe strongly that if patients in this country somehow could come to know what the actual and relative prices are for various care sites and various care procedures, people who would have that transparent set of price data in hand about pieces of care would see the actual price differences between the various caregivers and between various sites of care and those patients would then move their own care to the lower cost care sites.

Price transparency, those people believe, will -- all by itself -- bring down prices and reduce health care spending levels. Is that true? Is pure transparency a good price reduction strategy?

Will we save money on the purchase of care if we somehow make all key care prices transparent to patients?

Probably not. Transparency is not enough.

Prices need to be both transparent and relevant before people will make decisions to use lower priced care sites.

Transparency Can Have Unintended Consequences

That hoped-for movement of patients to lower priced care sites when the actual prices of all relevant care sites become transparent to the patient tends not to happen unless the prices for individual pieces of care are both transparent and financially relevant to each patient. Relevant is the key word. Relevant is essential. Transparent is not enough. In fact, transparency, all by itself, can have serious unintended consequences.

When prices are merely transparent, the patient who chooses between a hospital that charges \$2,000 to deliver a baby versus picking a hospital that charges for their care \$8,000 to deliver a baby generally tends to believe that the \$8,000 care site must somehow be better. Pure and naked transparency about the relative prices that are charged by caregivers can actually cause many patients who know both sets of prices to migrate to the higher cost site in the mistaken -- but entirely understandable -- belief that prices and quality are somehow linked.

That set of decisions by patients to pick the higher priced site instead of selecting the lower priced site is highly likely to happen when prices are transparent because the benefit design for insurance we generally use to buy care in the U.S. makes the price difference between those care sites financially irrelevant to the patient.

Our standard insurance benefit package designs very clearly make most caregiver prices differences for significant caregiver completely irrelevant to the patient.

Deductibles Hide Price Differences for High Cost Procedures

Deductibles create a real problem for that particular set of care site choices.

When the insurance benefit plan for a patient is a flat \$1,000 annual deductible, then the consumer only pays -- at most -- the deductible cost of one thousand dollars -- regardless of the care site that the consumer chooses. The obvious arithmetic truth is that both the \$2,000 fee charged by Hospital A and the \$8,000 fee charged by Hospital B to deliver a baby both blow right past the flat \$1,000 deductible. So the actual out of pocket cost difference that would be charged directly to the

consumer for choosing and using either hospital is zero -- even though the pure price to deliver a baby charged by Hospital B is actually \$6,000 higher than the fee charged by Hospital A.

In that cash flow reality, patients often decide to use the high priced care site in the simple, unsubstantiated but entirely understandable belief that the higher priced site must somehow offer better care because it charges a lot more. That's why pure stand alone price transparency can actually sometimes be both dangerous and counterproductive.

When prices are simply transparent but when the price differences are not financially relevant to the individual patient, then the patients have a tendency to prefer the higher priced site in the belief it must be better or it wouldn't cost more. The standard insurance benefit designs that we use in this country make those price differences on most significant care purchases irrelevant to the patient.

Prices for pieces of care that happens before the deductible is met each year can be relevant -- but we know for a fact that 80 percent of the cost of care in this country actually comes from the patients who have exceeded their deductibles. A few people incur most care costs, and those people easily exceed their deductibles.

The French Model Makes Prices Visible and Relevant

Is there any other way to buy care? Yes.

The French, for example, use a very different payment model. The French model does make price differences between caregivers relevant to the patient. The French have made some very intelligent decisions about both benefit plans and prices. Instead of using a front-end deductible and then having the insurer pay all of the price differences between the care sites, the French set up a fixed fee for each procedure and they pay that predetermined fixed amount to the provider when that care is delivered to a patient.

The French also, however, allow each provider to charge the patient more for doing the procedure than that predetermined base-level fee. If

the provider wants to charge more than that base fee, the French require the consumer to pay the cash difference between the base government fees and the higher fee that is charged by the care sites. That two-tier payment approach makes prices both visible to the patient and directly relevant to both the patient and the caregiver.

If we used the French approach for the care decision example that was listed above -- where there is a choice between two maternity care sites with very different prices -- there would have been a very different consumer choice dynamic for the patient.

The French predetermined base line fee for that service might be to have a \$2,000 flat fee basic insurance benefit for maternity care. In that case, the patient who went to the care site that charged \$2,000 for the care would pay nothing from their own pocket to have their baby delivered. Those patients would, functionally, have full coverage for that service. Their \$2,000 base payment insurance benefit would pay the full \$2,000 fee for the delivery.

Using the American price examples that were mentioned earlier -- if that same French patient decided to go to the eight thousand dollar site, however and if the patient had her baby there, then the patient would have to pay the \$6,000 difference between \$2,000 flat insurance benefit payment level and the actual \$8,000 provider fee. Just like caregiver prices in the U.S., the second French care site would still be allowed to charge \$8,000 to deliver the baby. But that higher fee would not be invisible or irrelevant to the patient in France. That price difference between the two sites is made moot and irrelevant by the American deductible based insurance plan payment approach -- but any higher prices are very relevant in France. Any care site in France that decides to charge a lot more money to deliver the baby than the baseline fee would need to convince the patient that their care was so good that the care at their site is worth the patient paying the extra money. Suddenly, with that payment approach, market forces actually became very relevant and very real. Prices in France are more than just transparent -- they are relevant. Prices become relevant decision factors both for patients and for caregivers when they occur.

That is a very different market reality. Price transparency helps keep prices down in that French model instead of price transparency driving costs up.

Market forces become very relevant when price based decisions must be made by both patients and caregivers.

Interestingly, that approach and that base payment insurance plan benefit design also gives consumers in France the first dollar insurance coverage that consumers everywhere love. Consumers in France receive immediate benefits from their insurance coverage every time they need care -- rather than having to pay their full deductible first before getting any insurance benefits for the care they use.

The Choice of A More Expensive Care Site Doesn't Increase Insurance Premiums

Any time higher prices are charged in our country, someone has to be the source of cash for the higher prices.

In this country -- because insurance is the mechanism we usually use to allow each of us to pay for the costs of our care using other people's money -- the higher prices that are charged when we pick Hospital A instead of Hospital B are paid by the insurer. When an insured consumer chooses to use Hospital A, the higher expenses from hospital A are simply added to the average cost of care for that group of insured people. That choice to use higher priced Hospital A by any insured patient simply increases the premiums that are charged to all patients who have that same insurance plan. Premiums paid by all insured people in that risk pool pay for that high cost provider choice by any patient who chooses the higher cost site. In France, people use their own money to buy the higher priced care. That is a very different cash flow, a very different cost sharing reality and a very different market model.

Our cash flow model actually encourages, supports, enables, funds and rewards high prices. So we get what that model creates -- high prices that exceed the prices paid for prices of care anywhere else in the world.

Why Don't We Use The Approach Other Countries Use To Keep Prices Low?

So why don't we just change the way we pay for care and use one or more of the approaches that the other countries use who spend a lot less than we do on care? That question is worth answering. To do that, it makes sense to look quickly at the approaches that the other countries actually use.

The opening pages of this book pointed out that the high cost of care in America is both a blessing and a curse. Health care creates great jobs. It anchors a number of communities. Health care is a thriving part of our national and local economies. That's why we don't simply decide to use the Canadian approach or simply adopt Canadian fee schedules. Setting up mandatory price levels here and moving to the current Canadian fee schedule would cripple our care infrastructure. It would badly damage our local economies. That strategy of using Canadian fee levels in the U.S. would be dead on arrival as a political agenda -- for very good reasons. We clearly do not want to cripple the care industry and damage local economies in this country by paying Canadian fees.

The Canadian model does have its obvious charm as a much simpler way to buy care. Canada uses a single payer system, with one government payer for each province. Each province in Canada sets all prices for all insured medical procedures that are done in that province.

Most Canadian Provinces Don't Cover Prescription Drugs

Canada also sets prices for all prescription drugs sold in each province. What a great many otherwise well informed people in this country do not know is that most provinces in Canada actually don't cover prescription drugs as an insured benefit in their government insurance plan. That coverage decision is a useful point to understand in a book chapter on care prices. Drugs are actually not a covered benefit

for most of Canada for their single payer system. Patients in most Canadian provinces actually pay for their own drugs.

Why do Canadians accept that benefit plan gap? Prices help. Canadians pay prices for each of those prescription drugs that have been set by their local government. The provinces that don't cover drugs simply set the actual drug prices that are paid by consumers in the province to buy drugs.

The basic benefit design strategy is to set those prices low enough for each drug so that people in Canada who use prescription drugs for their care can afford to buy their own drugs. In other words, they use mandated drug prices -- not mandated drug benefits -- in most provinces of Canada to create consumer and patient affordability for drugs.

The number of health care policy people or political leaders in this country who know that six of eight Canadian provinces actually do not cover prescription drugs for their own citizens is tiny. The Canadians very cleverly use prices as a major tool to help people with their drug expenses instead of using government insurance and tax money to buy these drugs for people. Those Canadian provinces have chosen mandating low drug prices over offering prescription drug coverage in their tax-funded single payer system as their basic drug strategy. They have successfully kept that drug purchase expense away from the single payer taxpayer funded part of health care costs in Canada by simply having each patient in those six Canadian provinces buy their own drugs.

They do allow people who want to buy private health insurance to pay for their drugs to buy that insurance. Some people do buy that insurance.

Several Countries Set Prices

The Canadian government also sets very specific prices for every other piece of care delivered in Canada.

In Canada, the government is the single payer. The government, as the single payer, simply sets the prices for each and every piece of care.

Most people believe that all countries in Europe use that Canadian model for their coverage. That isn't true. European countries actually do not use the Canadian single payer model. No country in Europe uses the Canadian approach.

In most European countries, private health plans are the preferred insurance approach. Most people actually have private insurance -- not Canadian-style government insurance -- in Europe. The government is absolutely neither the primary payer nor the insurance administrator in most European countries. The Netherlands, Switzerland and Germany all use competing health insurance plans to provide coverage to their populations.

There are both for-profit insurers and not-for-profit health insurers in those countries. The private insurers in those countries compete in multiple ways for customers. They tend to have very competitive private insurer markets in those countries -- with competition and television ads that look a lot like the private insurers' plans and ads in the U.S.

But the private insurance plans in those countries generally all use the same exact local fee schedule that has been set up, created and mandated by the government when those insurers buy care from the caregivers in those countries for their insured people. Those countries use private insurers, private doctors, mostly private hospitals and they all compete for patients and customers -- but they all tend to pay the same amount for each piece of care in each geographic area.

As noted earlier, the French government also sets a basic fee schedule for each piece of care as well. The French model is different than the Swiss or Dutch models because the French Government allows caregivers in France to charge more than the government set amount if the providers want to charge more. That model was explained earlier in this chapter. Quite a few French patients currently buy private insurance plans to pay for the difference between the government set fee and the actual price charged by the care sites.

We are not very likely as a country to transplant the approach used by any of those countries to the U.S. because we are highly unlikely to

allow the government in our country to set all fees for all American caregivers.

They Don't Use Fees in Sweden and Norway

We are even less likely to use the payment approach they use in the Scandinavian countries. The Scandinavian countries technically do not provide health insurance to their citizens. They provide care -- not insurance -- to their citizens.

The Scandinavian countries actually don't regulate fees for their caregivers because they actually do not use fees in any way for pay for most care. They do not buy care by the piece in the Nordic countries. They don't use fees in other care settings because they deliver almost all of their health care in those countries from care sites that are owned by the government.

People in each of those countries are legally entitled to have care from those care sites, not insurance coverage. The Scandinavians only have insurance-like "coverage" with actual insurance functionality if they leave their country and then need to buy care elsewhere. In that case, their national system will accept the bill and pay for that foreign care. Inside each country, fee schedules are completely irrelevant to the functional cash flow of care delivery.

Physicians in those Scandinavian countries tend to work for the local health authorities. The doctors in those countries are paid by the month -- not by the piece. So formal government budgets directly control the total costs of care in those countries and controlling specific fee levels is not relevant for most care in Scandinavian countries. Even though the Scandinavian approach has its obvious merits, the likelihood of converting all of American health care to a model of integrated hospitals and salaried physicians -- with no fees used to pay for any care -- is so challenging that the problems of full system to that model conversion are fundamentally insurmountable.

Great Britain Skips Fees by Using Capitation

They use a different model in Great Britain.

Great Britain, as noted earlier, has its own unique model where all of the primary care doctors have an enrolled list of patients and each doctor receives a flat lump sum payment per month for every patient on their panel. The doctors receive that monthly fee from the National Health Service.

The British in effect, “capitate” their primary care doctors. Each doctors’ revenue is based on the size of each doctors’ patient pool -- or “panel.” As in the Scandinavian model, there are no fees charged, paid or recorded for any care that is delivered by those doctors to their own panel of patients. The cash flow for those doctors is a little more complicated than just the flat fee.

The British National Health Service has actually also set up a few performance-based bonus plans for their primary care doctors. The bonus plan payments are based on the doctors achieving some process based performance goals -- with a focus on their patient who have chronic conditions. So some bonuses are paid to those doctors but there are no actual fees collected by or for any patients by those NIH reimbursed doctors.

Most hospitals in Great Britain are owned by the government. The government owned hospitals in Great Britain tend to operate very much like the Scandinavian hospitals, the government-covered Canadian hospitals and the Veterans Administration Hospitals in the U.S. -- with annual macro budgets set by the government for each hospital and no individual fees for pieces of care inside the hospital. The budgets for the hospitals are usually modified somewhat based on volumes of patients -- but not in a way that creates any fees for any explicit services.

The British are constantly experimenting with their payment approaches for specialist care. Each new government in Great Britain tends to have its own variation on specialty care management. These efforts seem to be a perpetual work in progress everywhere.

So those are the basic ways that the other countries that are shown on the price charts in this chapter fund the delivery of care. Would any of

those approaches that are used in Europe or Canada work in the U.S.? Probably not very well.

It Would Be Hard for Us to Use Any of Those Payment Models Here

We are not likely to transplant any of those care delivery or care financing approaches in their current form into the U.S.

It's pretty hard to imagine the U.S. turning all American hospitals over to the government. It's also pretty hard to imagine our government directly hiring all of the doctors in the country. Having the government own our entire care delivery infrastructure isn't likely to happen. Our government does own some care sites now -- so we Americans will probably continue to get our care from a mixture of both private and government owned care sites for the foreseeable future.

The truth is we are highly unlikely to disrupt our current infrastructure of care and business model for care to move to an entirely government owned care system for either hospital care or medical care.

We Probably Will Not Set Up Primary Care Panels For All Patients

We are also highly unlikely to set our primary care doctors up with panels of patients and then pay the doctors a flat sum of money every month for every patient. That model works well for primary care in Great Britain, and it creates the fastest access to primary care in the industrialized world, but the potential and the sheer logistical complexity of transplanting that approach here as the way we pay our physicians is unfathomable.

Moving to that model would be extraordinarily disruptive. It is also unnecessary. We will, however, as the next chapter of this book points out, probably get some of the key care coordination benefits that are achieved by that British model as we begin to move some patients in this country to receiving some basic levels of care from well-designed patient-centered medical homes and Accountable Care Organizations. The team care that can result from that patient-centered medical home

care delivery approach can achieve some of the care coordination and care access successes of British primary care. But we are highly unlikely to assign all people to patient centered medical homes in this country. We are far more likely to incent our patients and our caregivers to use team based care than we are to mandate the use of team based care or move to anything resembling a primary care capitation model for our patients.

So we are not likely to convert as a nation to any of the care delivery or financing model used by any other country. We will not bring down the prices for care by moving to a different funding model for our overall care.

Growing Interest in Simply Dictating Fees

A growing number of people who look at all of our cost and price issues are beginning to believe that we should and probably will evolve over time more to a system where we will control key costs by mandating fees. An increasing number of people are beginning to suggest that we Americans should follow the lead of many other countries and begin to pay for all care using some level of standardized fees -- with the government setting the exact prices and determining the fee levels that are charged here for each piece of care. It's easy to see why that strategy has its fans.

The Germans, Swiss, and Dutch all use that model. We actually do know now to do that payment model here. We already do exactly that now for both Medicaid and Medicare fees. The infrastructure to use a mandated set of fees to buy all care is in place in this country today.

So why not have our government follow the Canadian or Dutch model and control care costs by simply setting fees for every single piece of care?

Fee Schedules Cripple Care Improvement

The most fundamental problem with simply using a government imposed fee schedule to pay for all care for this country is that fee schedules are a really bad way to buy care. The last two chapters of this book have tried to make that point. The next couple of chapters will make that same point again -- with some vigor and several examples. Fee schedules are very limiting. Buying care by the piece is flawed at multiple levels. Fee schedules cripple innovation. Fee schedules cripple process redesign. Fee schedules and buying care entirely by the piece dictate particular approaches to care delivery and then lock those dictated care approaches firmly in place.

We very much need care in this country to continuously improve. Continuous improvement should be our top strategic care priority for the country. Fee schedules as a business model stifle continuous improvement. Fee schedules are both rigid and limiting by their very nature. When the only care that is paid for in a health care delivery infrastructure is just the specific pieces of care that are explicitly included on the list of approved care procedures that is embedded in an authorized fee schedule, then that all-powerful fee schedule literally defines and dictates the delivery of care.

When you buy care entirely by the piece and when you then try to reengineer any care processes, that reengineering process has a high potential to streamline care delivery, but it will not be done if it reduces cash flow for the caregiver for any pieces of care.

Streamlining care delivery can eliminate -- for example -- duplicate processes. Duplicate tests exist. They add no value for care delivery. Duplicate tests are a source of revenue, however, that is now rewarded totally and well by the piecework purchase model of care. Those duplications are rarely eliminated in any care setting as long as care in that setting is paid for by each billable piece. That piecework payment model really does dictate care. Care redesign and care innovations are almost impossible to do when the cash flow for care is defined, channelled, and controlled by an authorized and regulatory enforced piece-work based fee schedule.

We Need Care to Continuously Improve

Why is that a problem? The next two chapters of this book explain why that is a problem. We need care to continuously improve. When care continuously improves, care will be higher quality, safer, and more affordable. Continuous improvement -- as a culture, a skill set, and an operational reality -- will give us much better care outcomes than status quo care. We need a business model for care that triggers and rewards continuous improvement -- not a business model and cash flow approach that stifles improvement. That's why pure discounts are bad. That's why a government fee schedule is not a good thing to do. Using government imposed fee levels as our cost control tool would simply reinforce and solidify the fee-based approach to care delivery. The fee-based payment model restricts care innovation and strongly worse incents higher volume of pieces instead of helping use figure out optimal care. There is not viable fee-based path to optimal care.

Continuously Improving Care Cut the HIV Death Rate by Half

Instead of buying care by the piece, we need to buy care by the package. Fees become financially and functionally irrelevant when care is purchased as a package. The fees for those old pre-admission x-rays for all patients become entirely irrelevant immediately when Medicare started using DRGs to buy hospital care and stopped paying for pieces of hospital care. No fee control was needed for those x-rays because x-rays were included in the overall purchase package for hospital care. Once that x-rays status happened, only the patients who needed those x-rays continued to get them.

Buying a full set of care for a fixed packaged price instead of paying for each item of care by the piece is very empowering for the people who delivery care because the care site can eliminate that unnecessary x-ray without losing needed revenue generated by that piece of film.

Selling and buying full packages of care is a much better payment approach that can improve care and bring down the costs of care. That approach is very familiar to the author of this book for obvious reasons. Kaiser Permanente -- the author's employer -- sells care by the package...not by the piece. Kaiser Permanente receives a fixed payment per month for each patient -- not a revenue stream based on each piece of billable care.

Kaiser Permanente has cut the death rate for HIV patients to half of the national average.¹⁷⁹

How did that happen and why is that relevant to a chapter on fees and prices? Care at Kaiser Permanente has been reengineered around those HIV patients. Care in other care settings for those patients would be based entirely on the fees authorized by payers like Medicare, Medicaid, and insurance companies for specific services delivered to those patients. Only services with an authorized CPT code would create revenue under that model.

Those successes in dropping the death rate for HIV patients hugely have happened because the Kaiser Permanente care teams are not bound to only doing pieces of care that are defined by that pay schedule of fees. Kaiser Permanente sells packages of care. Kaiser Permanente also engineers entire packages of care. Kaiser Permanente is paid a lump sum paid every month for all care needed by each patient, and that lump sum for each patient buys a full package of care for each patient. Kaiser Permanente is not paid piecework fees -- so Kaiser Permanente is not limited by any list of authorized services or by any insurance based fee schedule to define its care.

Why is that freedom from services defined on an "approved" fee schedule relevant to price issues? Fourteen of the things that are done now to cut the HIV death rate to half of the national average at Kaiser Permanente do not show up on a Medicare, Medicaid or typical Blue Cross fee schedule.¹⁸⁰ If care in the Kaiser Permanente care settings was limited to doing only the pieces of care included on those fee schedules, twice as many HIV patients would be dead.

Likewise, Kaiser Permanente had cut the number of broken bones in the oldest seniors by over a third.¹⁸¹ Nine things are done to achieve

those success levels. Six of those nine things that are done to achieve that care success do not show up on a Medicare fee schedule.¹⁸² So again, if the only care delivered to those high risk patients relative to broken bones was the approved and authorized pieces of care that are listed on the current Medicare fee schedule, fifty percent more very elderly seniors at Kaiser Permanente would have broken bones.

Likewise, the number of stroke deaths has been dropped by forty percent at Kaiser Permanente.¹⁸³ Those successes were achieved by doing multiple proactive things that don't show up on a fee schedule. The number of highly convenient e-visits between doctors and patients at Kaiser Permanente now exceeds 12,000,000 visits a year.¹⁸⁴ Those millions of e-visits between patients and doctors happen because Kaiser Permanente is prepaid and doesn't need to collect a separate fee for every visit with a patient in order to survive financially.

Pressure ulcers were mentioned earlier in this book. Most hospitals have seven to ten percent of their patients with pressure ulcers.¹⁸⁵ Many of those pressure ulcer patients are damaged for life. Kaiser Permanente has less than one percent of their patients with pressure ulcers.¹⁸⁶ Some Kaiser Permanente hospitals have not had one single pressure ulcer for more than a year.

Why is that data point relevant to a chapter on prices and to the issue of selling care by the package and not selling care by the piece? It takes incredible nursing care that is focused on every single patient to get the pressure ulcers that occur in a hospital down to zero. Some patients have to be turned every hour to avoid those ulcers. There is no fee on a standard approved standard piecework fee schedule that would pay Kaiser Permanente to turn those patients every hour. There is also no fee to have the highest risk patients in beds that have special liners. There is no fee for monitoring the care results continuously at each micro care site to deliver that great care for those patients.

So great care that saves lives actually generates literally no money in coded fees from a standard fee schedule. But if that great care was not there, if the care for those patients failed and if pressure ulcers rebounded, those ulcers would each generate an abundance of fees.

If the Kaiser Permanente hospitals were paid by the piece instead of being prepaid for all hospital care, those patients would generate significant revenue when ulcers happened. The average revenue increase that would happen for each pressure ulcer payment is literally over \$40,000 per patient.¹⁸⁷

In the rest of the country -- where hospitals are paid by the piece -- seven percent of patients get those ulcers.¹⁸⁸ Those piecework-paid hospitals average over \$43,000¹⁸⁹ in piecework fees for each damaged patient. Other hospitals who are not prepaid do not usually have those care success levels for pressure ulcers -- and if they did, the revenue for those piecework paid hospitals would drop significantly.

Which set of care outcomes do we want? Fee schedules can never reward zero ulcers. Fee schedules do, however, create care settings all over this country where 10 percent¹⁹⁰ or more of the patients have those horrible wounds...each triggering a rich flood of fees for the piecework care site.

So the point here is that the right answer to prices for pressure ulcers is not to negotiate steeper discounts on fees charged for pressure ulcer care. The answer is not to pay lower or discounted fees for each piece of that care. The answer is to transform care. The answer is to transform care so those levels of care are not needed. Care transformation solves the unit price problem much more effectively than using a Canadian fee schedule.

We Need Care to Be Continuously Improving

The point made earlier is that we need care in this country to get continuously better. Continuous improvement should be a goal.

The pressure ulcer work at Kaiser Permanente has gotten continuously better. The care model of being paid by the package rewards continuous improvement. With that payment model, the ulcer level has dropped from 3 percent to 2 percent of patients and now it averages less than 1 percent. Very smart people did things in systematic data supported ways to continuously improve that care.

We need all care in this country to continuously improve. We should be obsessively focused as a country throughout our infrastructure of care by the goal of continuous improvement. We need to set targets for care outcomes -- like having less than 1 percent of your patients with pressure ulcers or less than ten percent of sepsis patients dying of sepsis -- and then we need to engineer and reengineer care to achieve those goals everywhere in a context of continuous improvement.

You really can't redesign care well in a piecework payment business model where care delivery is made entirely rigid by a fee schedule.

We very much need care in this country to be continuously improving. We need care delivery models to be redesigned and continuously reengineered to be more patient focused and more affordable. That work will not happen while the cash flow for care in this country is generated by a piecework payment model and restricted to doing the things that are listed on an approved fee schedule.

That's why following the lead of those other countries who set fees and then simply setting up a discounted government fee schedule for all care in this country that arbitrarily pays a lower amount for each piece of care could obviously reduce the immediate cost of care for America -- but that pure fee-based approach would impair the ultimate care improvement we need for the future. We can't achieve optimal care while we are paid for care by the piece. We need great care. We can't get great care in the context of a piecework payment model. We really do want care in this country to get continuously better -- not just get temporarily cheaper.

Paying entirely by the piece for care also creates a wide range of opportunistic gamesmanship and levels of fraud and abuse relative to defining and reporting the pieces of care. The growing and painfully expensive issues of Medicare and Medicaid fraud are largely driven by the fact that both of those programs buy care by the piece and that piecework payment approach is highly vulnerable to fraudulent billing. It is very hard for a care team to achieve fraudulent billing when you sell a package of care. It is very easy for a care team to achieve fraudulent billing when you sell care by the piece.

We Need To Sell Care By The Package And Not By The Piece

We clearly need to bring down the cost of care and we need to make both care and coverage affordable. We need to make unit prices either meaningfully relevant to the patients or we need to make those prices irrelevant to the caregiver because the caregiver is selling care by the package and not by the piece. If we sell care by the piece, we need to stop paying a lot of money for care that damages patients and undermines patient safety and health.

If we do need to pay for care by the piece, then using some version of the French model is a far better way to introduce real market forces and price relevance to the purchase of care...with prices probably going down for many pieces of care when they become relevant to the business model in a better way.

The next chapter deals with those purchasing and cash flow issues very directly. The next chapter talks about business models that can help refocus care on better outcomes, continuous improvement and lower costs...buying packages of care rather than just pieces of care. The next two chapters discuss various ways caregivers and health plans can connect and collaborate to create better and more affordable care.

If We Can't Reengineer Care, We May Need To Reprice Care

We need to take all of those issues on as a country and we need to make market based payment reform very real.

The truth is, however, that if we can't achieve those repackaging and reengineering goals, and if we can't create affordable care with those approaches, then we may need to surrender to that cold reality and we may very need to simply set macro fees for all care. Repricing care is clearly a better model to use than borrowing money to pay for care and transferring the debt created by the overpriced care being received by us today to our children and our grandchildren. Repricing is also clearly a much better path going forward than rationing. Rationing is a very bad cost-containment strategy. The pure repricing model -- if it is ultimately needed --- actually works better than either rationing care or deferring

care costs to our kids. As this chapter has shown, other countries who deliver more care than we do for their citizens at multiple levels have lower costs because they clearly understand their local care pricing model, and they use it to keep costs lower than their costs would be if they didn't use that approach.

Let's not go down either the path of rationing or the path of borrowing if we can use reengineering, refocusing and process redesigning to make care better and more affordable instead.

The next chapter deals with those issues.