Major hospitals pile up the cash

They are nonprofits by name but not in practice.
How your hospital helps drive up the cost of health care

By Joseph Neff, Ames Alexander and Karen Garloch
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North Carolina’s hospitals are respected community institutions. They save lives, heal the sick, contribute to local charities and provide good jobs.

Most of them are nonprofits. But many of them, especially the big ones, are making a fortune.

During the Great Recession, their profits have stayed strong, and they’ve raised their prices. Top executives enjoy million-dollar compensation packages as they expand, buy expensive technology and build lavish facilities. Their customers buy the services before they know the cost, and they often don’t understand the bills.

And the hospitals enjoy a perk worth millions each year: They pay no income, property or sales taxes.

These institutions were created with charitable mission.
Junius Davis was billed $26,000 for an outpatient procedure at UNC Health Care. He complained, and the hospital reduced the bill by $5,000. “I am beginning to believe that the hospital’s ‘creative accounting’ is too complex for intelligent scrutiny and confirmation,” he said.

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Major hospitals pile up the cash: First of five parts
By Joseph Neff, Ames Alexander and Karen Garloch
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with crippling debt. Some hospitals have sued thousands of patients, while others have turned to collection agencies to pursue debtors.

They’ve plowed their profits into expensive buildings and machines and have rewarded executives with generous salaries. Twenty-five executives of public and non-profit hospitals in North Carolina had total compensation of more than $1 million in 2010 or 2011, the most recent data available.

They’ve solidified their market power by stashing billions of dollars for future purchases. Duke, for example, has reserves of $1.5 billion. In Charlotte, Carolinas HealthCare System has banked more than $2 billion.

All of this is legal. No laws limit hospital profits, charges or executive pay.

Unlike insurance companies, which are easy to dislike, hospitals are easy to love. They save lives every day, while providing care for people who can’t afford it.

In the national debate over health reform, soaring costs and insurance premiums have drawn attention. But one trend driving costs - the growing market power of hospitals - has gone largely unnoticed.

While growth at Wal-Mart and Target has led to lower prices, the opposite is true for hospitals. They compete by offering ever more sophisticated, high-tech and costly services.

Across the country, hospital systems have become so large and dominant that insurance companies can’t afford to exclude them from the plans they offer to employers. These consolidated systems use their clout to negotiate higher reimbursement for privately insured patients.

“What you’re seeing is increasing market power on the part of the hospitals and increasing leverage in negotiation with the payers, “ said Dr. Kevin Schulman, who teaches medicine and business at Duke. “What are they going to do with all the money...? They can’t give it to shareholders.”

Consolidation has contributed to growing hospital bills and insurance premiums. To ease their burden, employers have shifted more of their health care costs to employees, in the form of higher deductibles and co-pays, to the point where a single medical catastrophe can financially devastate even an insured patient.

Hospital officials say they are not overcharging. They must mark up prices for those with private insurance, they say, or lose money from treating patients with Medicare, Medicaid or no insurance.

Junius Davis, a retired UNC Greensboro dean, tussled with UNC Health Care about hospital bills he found inflated and complicated.

“I am beginning to believe that the hospital’s ‘creative accounting’ is too complex for intelligent scrutiny and confirmation, “ Davis said. “There are wondrous ways of modifying charges for those who pay or who are insured to guarantee a life in fat city for the administrators and doctors.”

Soaring prices, profits

It has been a good decade for Triangle hospital systems.

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Duke University Health System and UNC Health Care, which owns Rex Hospital in Raleigh, have seen profits march higher for the past five years, even during a recession.

Duke, which includes three hospitals, reported an operating profit of $190 million, or 8 percent, in 2011. And that does not include the income generated by its health system’s $1.5 billion investment portfolio. Counting investment income, Duke’s profit soars to $542 million.

A recent audit of UNC Hospitals, the flagship of UNC Health Care, showed a total profit of $133 million, or 12.3 percent.

WakeMed’s system is the exception among major Triangle hospitals, with a 4.3 percent total margin in 2011; its operating margin was 3.4 percent. WakeMed officials point to their large amount of charity care.

The riches are not universal. About a third of North Carolina hospitals - most of them small and rural - reported losing money in 2010. Betsy Johnson Hospital in Lillington had an operating loss of $2.5 million in 2010; Person Memorial Hospital in Roxboro posted a $2 million operating loss.

But North Carolina hospitals are more profitable than most, according to the American Hospital Association. In 2010, the overall total profit margin for state hospitals was 9.3 percent. That was about 2 percentage points more than the national average - and higher than it was a decade earlier, when the economy was stronger.

**Revenue exceeds costs**

One reason North Carolina’s major hospitals have grown so profitable: Revenue has risen faster than the cost of treating patients - and much faster than inflation.

Duke Hospital, for instance, saw its total patient revenue rise 100 percent from 2000 to 2010. Its costs rose 83 percent. The average revenue from each inpatient there more than doubled over that time, rising at more than three times the rate of inflation.

Blue Cross and Blue Shield of North Carolina, the state’s largest health insurer, says its cost per hospital admission went up nearly 40 percent from 2007 through 2010 - during the continuing economic downturn.

Hospital executives stress that profits are central to their mission of caring for patients.

UNC Health Care aims for a 4- to 4.5-percent operating margin, according to Chris Ellington, the chief financial officer. The hospital needs reserves to weather a recession, capital to buy equipment and funds to attract the best doctors, he said.

“The whole deal is to keep this going concern going to the extent that it is as beautiful as it is right now,” Ellington said.

**Roots of the problem**

With the 2010 passage of the Affordable Care Act, the Obama administration aims to control health care costs. Some experts, however, fear the law - under review at the U.S. Supreme Court - could wind up doing the opposite.
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The law calls for the creation of networks of hospitals, doctors and other medical providers. But that sort of consolidation, studies have shown, almost always leads to higher prices.

With mergers and acquisitions, some hospital systems have become so large and dominant that they can easily raise their prices.

Increasingly, the Triangle is dominated by three expanding hospital systems: Duke, UNC and WakeMed.

Rex Hospital, part of UNC Health Care, saw its revenues go from $470 million in 2008 to $571 million in 2010. This increase, according to its audit, “is primarily the result of increased reimbursement resulting from renegotiated payer contracts.”

William Roper, CEO of UNC Health Care, told the General Assembly that getting larger allows UNC to buy supplies cheaper and sell services higher:

“The value to us of Rex is, it allows us a larger scale and more sophisticated abilities to purchase in bulk, for example, all of the things that hospitals and organizations like us need,” Roper said. “We are able to get a much better master contract with Blue Cross and the other private insurers than we would if we were a smaller, Chapel Hill-only entity.”

Those higher reimbursements push up the cost of health care.

UNC’s expansion has been at the root of tensions with WakeMed, its biggest competitor in Wake County. UNC Health Care bought Rex in 2000, and since then, it has been expanding services.

It now is taking on WakeMed in heart treatment, planning a new $120 million center and luring a major cardiology practice from WakeMed.

The doctors were interested in joining with UNC-Rex, in part, because UNC can guarantee higher reimbursements from insurers than the doctors could get themselves.

Schulman, director of the Fuqua Health Sector Management Program at Duke, said eight hospital systems make up the majority of the market in North Carolina.

With that concentration of big systems, insurance companies are pretty much “over a barrel,” he said.

Carolinas HealthCare officials disagree with Schulman.

“I can’t imagine anybody who knows anything about the health care industry saying that any health care provider has Blue Cross Blue Shield over the barrel,” said Russ Guerin, executive vice president for business development and strategic planning.

Blue Cross dominates North Carolina, with 75 percent of the health insurance market.

But Schulman said increasing negotiating power is a primary reason for hospital mergers.

Other experts agree. Asked why some hospitals charge so much, Gerard Anderson, director of the Johns Hopkins Center for Hospital Finance and Management,
Major hospitals pile up the cash

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said, “Because they can. It’s not any more sophisticated than that.”

Inflated prices

Hospital officials say their systems are profitable because they operate efficiently. But they’ve also pumped up revenues with big markups on drugs and procedures.

Carl King, head of national contracting for Aetna, said insurance companies typically pay 40 percent over cost as hospitals look for a way to make up for losses on Medicare and Medicaid, the government insurance programs for people who are elderly, poor or have disabilities.

Duke and UNC Hospitals raise charges every year: Duke by 6 percent, UNC by 5 percent. WakeMed does not.

Junius Davis questioned the bills he and his wife received last year from UNC Health Care. In June, Davis wrote a column for The Chapel Hill News questioning the $19,215 bill for an outpatient biopsy. (That bill did not include $7,108 in doctor and anesthesia charges.) Medicare paid the bill.

The next day, UNC Health Care spokeswoman Karen McCall called Davis to say the hospital had erred and overcharged by $5,154. McCall said the hospital had classified the procedure as more complicated than it was, leading to higher Medicare reimbursement.

Junius Davis died in January of this year. He was 86.

Other charges are published in advance, if you know where to look. In its 2007 application for a new cancer center, Duke laid out the figures for a typical CT scan. Average charge: $6,208. Average cost: $498. Duke is paid an average of 19.6 percent of its CT charges, or $1,217. That’s a profit of 144 percent.

In 2010, Presbyterian Hospital in Charlotte billed the state nearly $16,000 for use of its cardiac catheterization lab after treating a prison inmate who had been suffering from chest pains. The average cost to the hospital for using its cath lab: about $1,064. The full bill was covered by taxpayers.

Jim Tobalski, a Novant spokesman, said the hospital does not typically collect such large amounts for services. Insurers and government agencies usually pay hospitals much less than full charges.

Such markups trouble - but no longer surprise - Jason Beans, the CEO of Rising Medical Solutions, a Chicago company that examines hospital bills for payers. At the request of the newspapers, Beans’ firm examined bills from various hospitals - and found markups as high as 500 percent.

“Everyone blames the (insurance) carriers,” he said, “but what the hospitals are doing in these situations is egregious.”

Who pays the price?

The soaring hospital prices come at the expense of taxpayers and business owners, patients who have insurance and those who don’t.

Those price hikes have been a primary driver in premium increases, insurers in North Carolina say. That’s a burden on businesses, which are facing record premiums for insuring their employees.

But employers are also passing the cost on to workers, who are paying more for insurance - and often more for deductibles and co-pays.

“John Q. Citizen is who winds up paying for this. Not big bad insurance companies,” said Martin Gaynor, professor of economics and health policy at Carnegie Mellon University. “It’s actually taking money out of everybody’s paycheck.”

Making enough to save

Cash reserves at local hospitals:

- Duke University Health System: $1.55 billion
- UNC Hospitals: $739 million
- Rex Hospital: $309 million
- WakeMed: $473 million
- Johnston Memorial: $13 million

story continues on next page
Several Triangle hospitals hit upon a way to increase revenue by relabeling a doctor’s office as an outpatient clinic, which gets reimbursed more from Medicare or insurance. Hospitals can charge a facility fee for outpatient services; a doctor’s office cannot.

In April 2010, Tony Auwn, a Cary businessman, paid $50 when he visited his endocrinologist at Duke Health, as he had whenever he saw a doctor at Duke. The endocrinologist recommended that Auwn see a back specialist. Two weeks later, Auwn did, making a $50 co-pay.

Auwn said he was shocked when he received a letter from his insurance company explaining that he owed Duke another $100 for the endocrinologist and $389 for the back specialist, all for facility fees.

“For years, I see the same doctor in the same office for the same 15-minute visit, but all of a sudden I’m charged eight times more,” Auwn said.

According to Auwn, Duke acknowledged many complaints about the shift to higher outpatient fees. Duke denied that the shift was about more revenue and called it a practice common to academic hospitals. Because he complained, Duke reduced the charge to $50 as a one-time goodwill gesture.

“Converting these clinics from private practice to hospital-based gives these providers access to broader health system resources which ultimately improves quality for our patients,” Duke wrote him.

It has also improved the bottom line: According to Duke University’s two most recent audits, the converted doctors’ offices and new primary care clinics increased the number of outpatients by 7 percent in 2009 and 10 percent in 2010.

The dry language common to fiscal audits shrouded the increased revenue from the new fees: “Overall, price and patient care intensity impacted net patient service revenue by $117 million.”

Duke CFO Kenneth Morris acknowledged that the shift to outpatient billing resulted in higher out-of-pocket costs to patients. But the hospital’s expenses rose too, as it started running the clinics.

“It was revenue-neutral for the hospital,” Morris said. These higher reimbursements are increasing the cost of health care, according to MedPAC, the independent commission that advises Congress on Medicare.

Fees paid for visits to hospital-based practices are often more than 50 percent higher than those paid to freestanding practices, MedPAC noted.

“Physician practices and ambulatory surgical centers are being reorganized as hospital outpatient entities in part to receive higher reimbursements,” according to the March 2011 report.

**What hospitals say**

Hospital officials point to other factors behind the price increases.

Increasingly, they say, they’re stuck with the expenses from treating patients who don’t pay their bills. North Carolina hospitals reported $631 million in bad debt in 2010, according to the N.C. Hospital Association. That year, the state’s hospitals generated $1.9 billion in total profits, the American Hospital Association reported.

Added to that, hospital officials say, are the burdens of treating Medicare and Medicaid patients. Those programs don’t cover their costs, so they must increase charges to private-pay patients - a practice known as cost shifting.

No one disputes that hospitals are losing money on Medicaid patients and the uninsured. Federal studies, however, have found that efficient hospitals should be able to break even or make a small profit on Medicare patients.

Officials for Duke and UNC say their profits come from operating efficiently, not overcharging. Duke CFO Morris pointed with pride to a cost-containment program that this year will squeeze $140 million in operat-
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Hospital officials say they invest in needed facilities, staff and equipment, often without regard for profit. Unlike for-profit businesses, nonprofit hospitals don’t pay dividends to stockholders. Instead, they reinvest profits in their organizations.

What’s more, they say, it may help them weather the financial storm they see brewing.

Under health care reform, the federal government plans to cut Medicare reimbursement to hospitals and transfer more responsibility for Medicaid to the states. The states, in turn, will likely push costs to counties and hospitals.

Hospital leaders say they “need the margin to meet the mission.”

But at some systems, Duke’s Schulman said, the high profits lead to excessive spending.

“They have more margin than meets the mission,” he said. “It leads the managers of the hospitals to build an ever more expensive delivery system.

“They want to be more and more attractive to the private payers. That’s why they want marble lobbies. I joke with my students that when you go to Europe, you visit cathedrals. When you come to the United States, you visit hospitals.”

Duke recently opened its new $235 million cancer center, which features a soaring atrium, artwork to conceal oxygen hookups and waiting rooms that rival lobbies at four-star hotels. It also features a “quiet room” with mood lighting and sounds that visitors can program themselves.

Where the money goes

Hospital officials say some factors involved in rising prices - such as the high cost of pharmaceuticals and technology and the aging population - are beyond their control.

North Carolina’s hospitals are investing billions in lifesaving staff and technology. But they’re also buying things that may not improve outcomes for patients, experts say.

Recent studies say that nearly 30 percent of U.S. medical spending is wasted on unnecessary tests and procedures.

That’s partly why nine medical specialty groups this month listed 45 tests and procedures that patients often don’t need, even though doctors routinely order them. They include repeat colonoscopies within 10 years of a first one, CT scans for low back pain, heart imaging stress tests for patients without coronary symptoms, and chest X-rays before surgery.

Another example: About 15 percent of cardiac stenting or angioplasty was found to be unnecessary or of dubious medical benefit in a 2011 study of 500,000 patients who had the procedures.

“We basically don’t see any improvement in patient outcomes from the last 5 to 10 percent of spending by hospitals,” said Anderson, the hospital finance expert from Johns Hopkins. “There’s a lot of unnecessary spending.”

“It’s a competition based on the newest, fanciest, best. The American public doesn’t know if it’s better or not. But it sounds better.”

Database editor David Raynor contributed to this report.

Tomorrow: Little help for the needy

Neff: 919-829-4516
Major hospitals pile up the cash

Major hospitals pile up the cash: First of five parts

By Joseph Neff, Ames Alexander and Karen Garloch
Published April 22, 2012 in The News & Observer

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Source: IRS returns filed by the hospitals. The returns are for calendar and fiscal year 2010, the latest available.

Note: Total compensation includes base pay, bonuses, benefits and deferred compensation. It does not include compensation reported in previous years’ IRS returns. IRS rules require non-profit organizations to report some forms of compensation, such as deferred compensation, in two separate years – the year the company puts aside deferred compensation for the executive, and the year the executive actually collects that compensation.

CAROLINAS HEALTHCARE SYSTEM (CHARLOTTE)

Michael Tarwater
President/COO
Carolinas HealthCare System
$4,236,305

Greg Gombar
President/COO
Carolinas HealthCare System
$2,536,792

Paul Mazza
President/COO
FirstHealth of the Carolinas
$2,215,773

David McRae
CEO
Pitt County Memorial Hospital
$1,534,183

Fred Hargett
President/COO
Novant Health, Winston-Salem
$1,405,451

Lawrence Hendricks
President/COO
FirstHealth of the Carolinas
$1,693,314

Paul Friz
President/COO
FirstHealth of the Carolinas
$1,575,927

Dennis Phillips
President/COO
FirstHealth of the Carolinas
$1,351,138

John Knox
President/COO
FirstHealth of the Carolinas
$1,197,528

Roger Ray
President/COO
FirstHealth of the Carolinas
$1,080,159

Dave Gipson
President/COO
FirstHealth of the Carolinas
$1,060,931

Source: IRS returns filed by the hospitals. The returns are for calendar and fiscal year 2010, the latest available.

Note: Total compensation includes base pay, bonuses, benefits and deferred compensation. It does not include compensation reported in previous years’ IRS returns. IRS rules require non-profit organizations to report some forms of compensation, such as deferred compensation, in two separate years – the year the company puts aside deferred compensation for the executive, and the year the executive actually collects that compensation.)
Major hospitals pile up the cash: First of five parts
By Joseph Neff, Ames Alexander and Karen Garloch
Published April 22, 2012 in The News & Observer
Major hospitals pile up the cash: First of five parts

By Joseph Neff, Ames Alexander and Karen Garloch

Published April 22, 2012  in The News & Observer
Rachael Shehan has no health insurance and virtually no income. But when serious respiratory problems strike, her hospital has never provided financial help, she said.

Instead, the 39-year-old Lenoir resident says, Caldwell Memorial Hospital has sent bill collectors who have hounded her for payment and ruined her credit.

Now, she sometimes bursts into tears when medical problems arise. “I know the hospital isn’t going to help me with my bills, “ says Shehan, who relies on food stamps and the help of friends.

Nonprofit hospitals such as Caldwell Memorial are exempt from property, sales and income taxes. In return, they are expected to give back to their communities, largely by providing care to those who can’t afford it.

Like Caldwell, most North Carolina hospitals are devoting a fraction of their expenses to help the poor and uninsured, an investigation by the Charlotte Observer and The News & Observer of Raleigh found.

In 2010, most of the state’s hospitals spent less than 3 percent of their budgets on charity care - the practice of forgiving all or part of a patient’s bill.

Mecklenburg County’s hospitals perform better than average, with all spending more than 4 percent of their budgets on charity care. They are among the state’s most profitable hospitals.

In North Carolina, no government rules dictate how much charity care a nonprofit hospital must provide. Not even the IRS takes action. The result: A nonprofit hospital can spend virtually nothing on charity care and receive the same tax breaks as a hospital that sets aside as much as 10 percent of its budget to help the poor.

The newspapers’ findings raise questions about whether some hospitals are earning their nonprofit status, experts say.

The investigation found:

About a third of North Carolina hospitals - including Caldwell Memorial - spent less than 2 percent of their budgets on charity care in 2010. Most of these are small hospitals in rural areas, and many report they are losing money.

Some of the hospitals with the lowest percentages serve counties where the needs are high. Vidant Duplin Hospital, for instance, caters to a high-poverty county where one in four people lack health insurance. It spent less than 1 percent of its budget on charity care.

Hospital practices vary widely. While the least gener-story continues on next page
Most N.C. hospitals slim on charity care

story continued from previous page

ous hospitals are giving less than 1 percent to free care, the most charitable hospital - Thomasville Medical Center - spent about 13 percent.

Many uninsured patients are never offered financial assistance. More than a third of hospitals in the state provide no details about their charity care policies on their websites. And more than 20 uninsured patients interviewed say they were never informed about charity care policies when they sought treatment.

Most hospitals appear to be getting more in tax exemptions than they’re giving back in the form of charity care.

No agency or group calculates the value of hospital tax exemptions, so the newspapers derived estimates from publicly available data.

Based on the taxes paid by large for-profit hospital systems, North Carolina’s nonprofit hospitals get tax breaks worth roughly 4.4 percent of their expenses, the newspapers estimated. About two-thirds of those hospitals spend less than that on charity care.

story continues on next page
Most N.C. hospitals slim on charity care

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Adam Searing, director of the N.C. Justice Center’s Health Access Coalition, questions whether many hospitals are doing enough charitable work to earn their tax exemptions.

“I feel like the hospitals are breaking the contract they made, “ he said.

Jessica Curtis, director of Community Catalyst’s Hospital Accountability Project, said the Observer’s findings echo what she sees happening elsewhere in the country. “It’s almost a blatant disregard for the needs of the poor, “ said Curtis, whose Boston-based group works to improve access to care.

To be sure, charity care - medical treatment provided for free or at reduced rates to low-income patients - is just one of many ways that hospitals help their communities.

They absorb millions in losses from treating Medicare and Medicaid patients because government reimbursement doesn’t cover their costs. They also train doctors and nurses, sponsor wellness programs and support community clinics.

But experts say charity care is by far the most important way hospitals can help the needy. It’s particularly crucial in North Carolina, where the unemployment rate is among the nation’s highest - and where roughly one in five residents under 65 lacks health insurance.

While some low-income people receive health care paid for by the government’s Medicaid program, many of the working poor make too much to qualify and don’t get insurance from their employers. Officials with the N.C. Hospital Association, the group that lobbies for the state’s hospital industry, say their members work hard to help the poor. Charity care spending in North Carolina rose to about $853 million in fiscal 2010 - almost twice the amount spent in the pre-recession days of 2006, the NCHA estimates.

But some of the hospitals that spend the least on charity care simply can’t afford to do more, says NCHA spokesman Don Dalton. That’s because they’re among the state’s most financially challenged hospitals. Many are in rural areas.

“The resources available for them to do vastly more charity care are probably not there, “ Dalton says.

But experts say it generally doesn’t hurt a hospital’s finances to become more charitable.

When hospitals sue patients or turn their accounts over to collection agencies, their actions often damage patients’ credit. Hospitals are losing money on those patients anyway and would likely experience little financial harm if they forgave more of the bills, experts say.

A 2005 study by the Center for Studying Health System Change found that bad debt at hospitals declined as charity care policies became more generous. Such changes, the study found, had “little impact on hospital bottom lines.”

Large needs, little help

Some of the least generous hospitals serve counties where numerous residents are poor and uninsured.

North of Wilmington, many families in Duplin County work demanding, low-wage jobs in poultry plants or farm fields. But advocates for Duplin County’s poor say it has been difficult to get financial help for uninsured people with large hospital bills.

Sonia Royes, a social worker for Catholic Charities, said she has tried about six times to get financial assistance for uninsured clients who had bills from Vidant Duplin - and has never succeeded.

She called the hospital in January 2011, asking if there...
was help available for one uninsured client. The official told her the hospital had no charity care policy, she said.

Duplin spent about $245,000 on charity care in 2010 - less than 1 percent of its budget.

Curtis, of Community Catalyst, said it’s “unacceptable” that any nonprofit hospital spend less than 1 percent of its budget on charity care. “A hospital spending that little on charity care in a community with high needs raises questions about that hospital’s commitment to the community,” she said.

According to Vidant Duplin’s policy, uninsured patients who can’t pay their bills can qualify for free care if their income is less than 200 percent of the poverty level and their household net worth is less than $25,000. For an individual, 200 percent is equivalent to making about $22,000 a year.

Officials for Vidant Duplin say many patients simply don’t provide the documentation that the hospital requires to prove that they’re eligible for charity care.

“I do believe our charity care could be a lot higher,” said Lucinda Crawford, the hospital’s vice president of financial services. “It’s sometimes a challenge for folks to bring in financial information and to follow up.”

Hospital CEO Jay Briley said that his hospital outstrips most others when judged by a different measure - the amount of “unreimbursed” care it provides. In 2010, the hospital reported losing about $1.1 million on Medicaid patients and about $4.3 million on patients who never paid their bills.

Duplin, like many other hospitals, routinely sends collection agencies to recover some of that money - a practice that can damage a patient’s credit.

Duplin’s officials say they’ve beefed up efforts to make uninsured patients aware of their charity care policy.

Until recently, Crawford said, patients who came through the emergency department didn’t routinely interact with a counselor who explained the policy. But the hospital changed that last year, so those patients now have a chance to talk with a counselor before they’re discharged.

With so many of its patients poor and uninsured, Duplin has struggled financially in recent years, losing more than $400,000 in 2010.

In North Carolina, as in most other states, hospitals aren’t required to spend even a single dollar on charity
Most N.C. hospitals slim on charity care

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care. Federal rules require nonprofit hospitals to provide some “community benefit,” but they don’t specify what those benefits should be.

In 2007, the U.S. Senate Finance Committee proposed requiring nonprofit hospitals to spend at least 5 percent of their budgets on charity care - a standard that only about a fifth of North Carolina hospitals met in 2010.

That proposal never became law.

In Illinois, the state Department of Revenue last year denied property tax exemptions to three hospitals that were found to be spending less than 2 percent of their patient revenue on charity care. That followed a 2010 ruling by the Illinois Supreme Court, which concluded that Provena Medical Center wasn’t providing enough charity care to qualify for a tax exemption.

No group or agency keeps national statistics on what hospitals spend on charity care. But in some states where charity care reporting is required, the data give some sense of how hospitals stack up.

North Carolina hospitals appear to be providing less charity care than those in Texas, one of the few states that requires hospitals to give a minimum level of financial assistance.

In Texas, most hospitals spend more than 4 percent of their budgets on charity care; in North Carolina, most spend less than 3 percent.

North Carolina hospitals provide more charity care, on average, than those in California, where hospitals operate on significantly smaller profit margins.

Restrictive charity policies

In the Blue Ridge foothills that surround Caldwell Memorial, many patients could use financial help.

The closings of textile plants and furniture factories have left Caldwell County with an unemployment rate of 13 percent, among the state’s highest. Nearly one in five residents lives in poverty.

About 3,500 of the hospital’s patients got free care last year, said Don Gardner, the hospital’s vice president of finance. But many more - about 7,000 to 8,000 - got something else: calls or letters from collection agencies.

Rachael Shehan was among them.

She estimates her hospital bills now total more than $15,000. The 110-bed hospital put her on monthly payment plans that she says she can’t afford.

Now, she says, her credit is so bad she has been turned down for a small loan and has no hope of getting a car.

“I think (the hospital) should offer help,” Shehan said. “There’s an awful lot of people who need it.”

At Caldwell Memorial, only patients who live in Caldwell County, have less than $3,000 in assets and earn less than 125 percent of the poverty level are entitled to free care, according to the hospital’s website.

In 2010, the hospital reported spending about $1.5 million of its $99 million budget on charity care. But Gardner said that represents just a part of its good works.

Caldwell Memorial, for instance, provides about $1.3 million worth of free tests and medical procedures each year to a clinic that provides medical help to needy residents. It also reported losing about $2.3 million treating Medicaid patients in 2010.

“I have no doubts that we’ve done a yeoman’s job of providing service, regardless of ability to pay,” Gardner said.

The foundation that raises money for Caldwell Memorial recently claimed on its website that the hospital gave $18 million to charity care in 2010. In fact, the hospital spent about a tenth that much. The foundation removed that claim last year, soon after an Observer reporter asked a hospital executive about it. Gardner said he believes the error was unintentional.

The hospital operates on a slim profit margin - less than 2 percent in 2010.

Gardner declined to discuss any patients’ accounts with the Observer. But in general, he said, some patients don’t
Most N.C. hospitals slim on charity care

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complete charity care applications or don’t cooperate in providing documents the hospital needs to verify eligibility. Others, he said, are “too proud to take charity care.”

Policies hard to find

At some North Carolina hospitals, it’s not easy for patients to learn what financial help is available.

Many patients told the newspaper that hospital officials never mentioned the availability of charity care.

More than 40 hospitals - including Gaston Memorial Hospital in Gastonia and Lake Norman Regional Medical Center in Mooresville - didn’t put key details about their charity care policies on the Web in late 2011, the newspapers’ review found.

Two-thirds of North Carolina hospitals didn’t list their full financial assistance policies on the Web.

Sampson Regional Medical Center was among them.

The hospital spends less than $250,000 a year on charity care - less than 1 percent of its budget. But many of its patients need all the financial help they can get. The hospital serves Sampson County, a rural community east of Fayetteville where more than one in five residents lives in poverty.

Hospital officials say those earning less than 125 percent of the poverty level can qualify for free care. They say they’ve been working to get more patients qualified.

But many patients have not cooperated by applying, says Chief Financial Officer Jerry Heinzman. Some simply don’t care because they don’t intend to pay and already have poor credit ratings, he said.

Mary Jo Warren has been swamped by hospital bills.

Since she suffered a stroke in 2010, Warren lost her nursing job and her employer-sponsored health insurance. She’s since been to Sampson Regional several times for high blood pressure, congestive heart disease and broken bones from frequent falls.

Until her health worsened, Warren said she was frugal, hardworking and self-reliant. Now she frets about not being able to pay her hospital bills. She gets groceries from a food pantry and two local churches.

She applied for charity care, and Sampson Regional cut 45 percent off the balance that she owed.

Two months later, a lawyer for the hospital wrote Warren two letters demanding payment of more than $1,000 and threatening a lawsuit.

After being contacted by a reporter, Heinzman said he has asked Warren to apply again for financial assistance. He previously knew nothing about her inability to work, he said.

Still, calls from hospitals and collection agencies come almost daily, rattling her nerves.

“They say, ‘Ms. Warren, we expect you to pay us money,’ “ she said. “I say, ‘I ain’t got any.’ And they say, ‘Well, that’s no excuse.’ “

Fearing more bills, she has been reluctant to seek additional medical treatment. So she now waits until she is “really desperate to get some help.”

And that, she knows, can’t be good for her health.

Washington correspondent Franco Ordoñez and News & Observer database editor David Raynor contributed.

Tomorow: Little help for the needy
Most N.C. hospitals slim on charity care: Second of five parts
By Ames Alexander, Joseph Neff and Karen Garloch
Published April 23, 2012 in The Charlotte Observer
Most N.C. hospitals slim on charity care: Second of five parts
By Ames Alexander, Joseph Neff and Karen Garloch
Published April 23, 2012 in The Charlotte Observer
Hospital suits force new pain on patients

Investigation: N.C. hospitals sue 40,000 patients, including many who might have qualified for charity care

By Ames Alexander and David Raynor
aalexander@charlotteobserver.com, 
draynor@newsobserver.com

When serious abdominal pains sent Joyce Jones to the hospital, she hoped the bill would be the least of her problems. She had no job and a bare-bones health insurance policy that she knew would cover only a fraction of her bill. So it helped ease her worries, she said, when a social worker at Carolinas Medical Center-Mercy told her the hospital had a fund to help patients like her.

Jones thought the hospital was taking care of the cost. But soon after her two-week stay, she received a bill for $34,000.

In 2006, the hospital sued her and put a lien on her small west Charlotte home. A widow, Jones would like to leave the house to her disabled daughter some day. But the lien - which will allow the hospital to collect money if Jones dies or sells her home - may make that impossible.

“All that money they’ve got, they should be helping people,” said Jones, now 65.

Like CMC-Mercy, most N.C. hospitals are tax-exempt - a distinction that saves them millions each year. In exchange, these nonprofits are expected to provide financial help to those without the means to pay.

But thousands of times a year, hospitals are suing patients instead, an investigation by the Charlotte Observer and The News & Observer of Raleigh found.

An in-depth look at some of those cases suggests most of the patients were uninsured, and that a significant number of them should have qualified for free hospital care.

Critics contend those hospitals are financially ruining people they could afford to help. Carolinas HealthCare System, the multibillion-dollar public enterprise that owns CMC-Mercy, has generated average annual profits of more than $300 million over the past three years.

During the five years ending in 2010, N.C. hospitals filed more than 40,000 lawsuits to collect on bills.

Most of those suits were filed by just two entities: Carolinas HealthCare and Wilkes Regional Medical Center in North Wilkesboro. Each filed more than 12,000 suits over the five-year period, according to state courts data. Wilkes Regional, which is managed by Carolinas HealthCare, appears to be the state’s most litigious individual hospital.

Most N.C. hospitals rarely, if ever, sue patients to collect on next page
Hospital suits force new pain on patients

By Ames Alexander and David Raynor
Published April 24, 2012 in The Charlotte Observer

But virtually all use collection agencies, which can seriously damage a patient’s credit.

Often, the lawsuits hit people who are among those paying the highest rates for hospital care: the uninsured. Bills for uninsured patients are usually higher because they don’t have insurance companies to negotiate discounts on their behalf.

It’s unclear how many of the patients sued in North Carolina lacked health insurance and substantial income or assets. But in interviews with 25 of those patients, the newspapers found 17 of them were uninsured; 10 said they were never told about the hospitals’ financial assistance programs.

Carolinas HealthCare wins most of the lawsuits it files, allowing it to put liens on the homes of patients.

“We always struggle with, ‘Should we be doing that (filing lawsuits)?’” said Greg Gombar, chief financial officer for the Charlotte-based system. “But it comes back to a message ...: If you have the ability to pay, you need to pay...
hospital suits force new pain on patients: third of five parts
by ames alexander and david raynor
published april 24, 2012 in the charlotte observer

Hospital suits force new pain on patients: Third of five parts
By Ames Alexander and David Raynor
Published April 24, 2012  in The Charlotte Observer

because other people are.

The system never forces people from their homes, but
does collect money after the patients die or sell their
houses, officials say.

System officials say they file suit only when people fail
to answer repeated requests for payment.

That, they say, is what happened in Jones’ case. The hos-
pital said it sent her five statements and left three mes-
sages at her home before filing suit.

Jones says she stayed with her brother for a long period
after she was hospitalized for pancreatitis, and doesn’t re-
member receiving the letters.

She had plenty to worry about at the time. Her hus-
band had recently died, and money was scarce. But she
had one thing - the 1,200-square-foot home that she and
her husband had worked for 30 years to buy.

The home has a tax value of $70,000, but Jones now
worries that the hospital’s lien may cause the family to
lose it.

It wasn’t until 2009 that she discovered the true toll of
her unpaid bills. Lacking money to repair a leaky roof,
she tried to get a reverse mortgage. Lenders turned her
down because of the hospital system’s lien, she said.

Her daughter offered to use the equity in her home to
raise $10,000 so Jones could negotiate a settlement. Jones
said she offered to pay that amount, and to go on an in-
stallment plan to repay the rest. The hospital rejected her
offer.

Adam Searing, director of the N.C. Justice Center’s
Health Access Coalition, said “the hospital was unwill-
ing to be reasonable” in Jones’ case.

“If you have one person who’s being treated like she’s
been treated, I think you’re failing your mission,” he said.

Carolinias HealthCare CEO Michael Tarwater said
the system treats more uninsured and underinsured pa-
tients than any other N.C. system. “We never turn off
somebody’s health (care) because they don’t pay,” he said.

The number of lawsuits filed by Wilkes Regional has
deprecated markedly since 2007, when Carolinas Health-
Care began managing the hospital, system officials note.
Carolinias HealthCare says it has worked with the hospital
to help it become more selective about which cases it
takes to court. The hospital once sued patients with debts
as low as $300, but that threshold has been increased to
$750.

Critics contend it’s inappropriate for hospitals to sue
patients they could afford to help. And they question
why so many lawsuits are filed by tax-exempt hospitals
that are supposed to pursue charitable missions.

“Pure and simple, suing people is not a charitable act,
especially when you’re dealing with people of limited fi-
nancial means,” said Mark Rukavina, who heads the Ac-
cess Project, a Boston-based nonprofit.

‘I almost passed out’

It’s unclear how many of the sued patients could af-
ford to pay their bills. But the newspapers’ investigation
found that many of them are among the working poor.

In a sampling of 100 suits that Carolinas HealthCare
filed against Mecklenburg County residents, the news-
papers found that 43 of them either didn’t own prop-
erty in the county or owned houses assessed at less than
$100,000.

Under its current financial assistance policy, Carolinas
HealthCare says it offers free care to uninsured and un-
derinsured patients who earn less than twice the poverty

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level and have less than $150,000 in home equity. For an individual, that’s equivalent to earning about $22,000 a year.

Interviews with 14 patients who were sued suggest at least five of them should have qualified for the charity care available at the time they were taken to court.

Carolyn Barber is grateful to the doctors at CMC-University, who she believes may have saved her life. She’s less happy with the hospital’s billing office.

Suffering from a respiratory problem that left her gasping for breath, Barber was hospitalized for 15 days in early 2009. She was 63 at the time, with no health insurance, no job and a monthly income of less than $900.

But about a month after leaving the hospital, she got a bill for more than $56,000. Collections agents began calling every other day. Barber told them she couldn’t work and couldn’t afford to pay the bill. Then a lawyer for the hospital sent a sheriff’s deputy to serve her with a lawsuit.

“I almost passed out,” Barber said. “I was scared I was going to be locked up in jail because of that hospital bill.”

The hospital won a judgment for more than $56,000 in principal, plus interest - and about $8,500 in attorney’s fees.

When Barber tried to refinance her home in 2010, the mortgage company told her she couldn’t. The reason: The hospital had obtained a lien on the house. With so little income, she needed the extra money a refinancing would provide.

Barber previously worked at a Charlotte facility that helps people with disabilities. Now she’s on Social Security disability herself.

For half her life, she said, she saved up to buy her home - an immaculate three-bedroom house near University City with a tax value of $144,000.

“It’s something I’ve worked hard for so I can leave something for my three children,” Barber said. “The way it is now, I might not be able to.”

NEW FEDERAL REQUIREMENTS

If it survives review by the U.S. Supreme Court, the new healthcare law will affect how hospitals deal with uninsured patients. Detailed rules have yet to be hammered out by federal agencies, but the Affordable Care Act stipulates that hospitals must:

■ Develop financial assistance policies. Among other things, hospitals must spell out whether they offer free or discounted care - and specify the criteria for receiving financial assistance. The bill doesn’t detail what those policies must require.

■ Limit what they charge. If patients get “medically necessary” care and qualify for the hospital’s financial assistance policy, they can’t be charged more than the “amounts generally billed” to insured patients for the same services. The provision is designed to stop the practice of charging uninsured patients much more than those with insurance.

■ Refrain from unfair billing and debt collection practices. The law bans nonprofit hospitals from engaging in “extraordinary collection actions” before making a “reasonable effort” to determine whether a patient qualifies for the financial assistance policy. The bill doesn’t define the terms “extraordinary” and “reasonable”; that will be up to federal agencies like the IRS.

■ Assess the needs of their communities. Every three years, hospitals must perform a survey to determine health needs – and develop a plan to meet them.

Ames Alexander

Carolinas HealthCare said it unsuccessfully tried to qualify Barber for Medicaid. The system said it also evaluated her to determine whether she qualified for financial assistance, but found she had too much in savings and home equity.

Barber said she deserved help, but the hospital didn’t get an accurate picture of her finances. Hospital officials apparently concluded she had too much in savings, she said, because they confused her savings with her sister’s.

Officials for Carolinas HealthCare say they provide
story continued from previous page
care to anyone who needs it, and work hard to determine whether patients can afford to pay before filing suit.

“Do we miss some people? We probably do, “ Tarwater said. “We have 9 million patient encounters each year. And I’m quite sure once in a while we may miss somebody... If that’s brought to our attention ... we will work with that person.”

Nationally, it’s not uncommon for hospitals to take aggressive collections actions.

But some states discourage the practice. Illinois prohibits hospitals from pursuing legal action against uninsured patients who don’t have sufficient income or assets to pay their bills. California, meanwhile, bans hospitals from putting liens on the primary residences of patients who are eligible for charity care.

North Carolina has no such rules.

Patients are suffering as a result, says Searing, of the Health Access Coalition. Nonprofit hospitals shouldn’t be in the business of putting liens on patient’s houses, he contends.

“That’s not strengthening the community, “ he said. “That’s tearing it down.”

To sue or not to sue

Most N.C. hospitals don’t regularly sue patients. Novant Health, the nonprofit chain that owns Presbyterian Hospital and 12 other hospitals, has a policy against doing so.

“In health care, where you have people battling for their lives ..., we just decided this is not what a not-for-profit health-care organization should do, “ says Novant spokesman Jim Tobalski.

Novant’s hospitals are among a growing number that run credit profiles on uninsured patients to help determine whether they qualify for financial assistance. The process doesn’t affect patients’ credit.

Suing patients is “very old school, “ says Cecilia Moore, chief operating officer for Duke University Medical Center. “It is not a good use of resources any more.”

But like most hospitals, Duke and Novant do use commission-driven collections agencies.

Jen Algire, former director of Care Ring, a Charlotte nonprofit that tries to improve access to health care, said she has seen hospitals grow more aggressive on collections.

“People are declaring bankruptcy when they have less than $10,000 in debt, partly because they’re being harassed so heavily, “ Algire said.

Former patients say the bill collectors working on behalf of many N.C. hospitals call repeatedly, sometimes with threats and misleading claims.

In complaints to state agencies, dozens of former patients contend that collections agencies harassed them, sometimes reporting inaccurate information to credit bureaus or continuing to pursue them long after they paid their bills.

In 2008, Elaine Brauninger received notice from a collections agency that she owed about $275 to Lake Norman Regional Medical Center in Mooresville for medical services she had received eight years earlier.

The agency didn’t explain what medical services had been provided in 2000, Brauninger said. She had health insurance, she said, and didn’t recall any unpaid bills.

“I opened the bill and I said, ‘You’ve got to be kidding me,’ “ the Mooresville resident said.

She said she spoke by phone with a bill collector, who hung up when she asked for documentation.

The collections agency put the account on her credit report - a fact she and her husband later discovered when they sought a loan to buy a condominium.

After Brauninger complained to the N.C. insurance department, the collections agency contacted the hospital, which agreed to take the account off her credit report.

A spokeswoman for Lake Norman says the hospital story continues on next page
Hospital suits force new pain on patients

story continued from previous page

“takes seriously any patient complaints” and is pleased that Brauninger’s complaint was “resolved to her satisfaction.”

U.S. Rep. Heath Shuler, a Waynesville Democrat, has pushed a bill to ease the damage that medical debt can do to a person’s credit rating. Medical bills can remain on a credit report for up to seven years, even if the bill has been paid and the balance is zero.

Shuler wants to change the law so that medical debts of less than $2,500 are removed from credit reports 45 days after the balance goes to zero.

Saying goodbye to good credit

Experts say many collections agencies have an incentive to pursue debtors aggressively. They often negotiate deals with hospitals that allow them to keep between 5 and 25 percent of the money they collect.

Charlotte lawyer David Badger speaks of the pitch that a collection agent made to one elderly woman: “You have the right to remain silent.”

Many patients complain that such agencies have destroyed their credit, making it harder to buy a home or car.

The stories have become familiar to Care Ring’s managers. In a 2010 survey by the nonprofit, about a third of the 327 clients polled said their credit had been harmed.

Tony Chris Davis knows all too well about such worries.

When serious respiratory problems sent the Yadkin County resident to Carolinas Medical Center in October 2008, he had no health insurance and just $1,400 a month in income from Social Security disability. He told hospital officials he was deeply concerned about the cost of care, he said.

But following his discharge from the hospital, CMC sent him a bill. The total: about $40,000.

Alarmed, Davis called the hospitals and spoke with an official who, he said, told him that he wasn’t eligible for charity care because he owned a home and other assets.

Carolinas HealthCare said Davis had too much in savings to qualify for charity care, and that he declined to “spend down” those savings in order to qualify for Medicaid, which would have paid his bills.

Davis’ two-bedroom house has a tax value of about $63,000. He had about $20,000 in savings, he said, but needed the money to supplement his disability payments.

While he was hospitalized, Davis said, an official in the business office told him that CMC had decided to treat his case as charity care. Had he known the system would reverse its decision, he would have left CMC and gone to his local hospital, which had previously given him charity care, he said.

The hospital sued him and won a judgment. “I had perfect credit before this happened to me,” Davis said. “It has ruined me.”

Alexander: 704-358-5060
Observer staff writer Karen Garloch, researcher Maria David and News and Observer staff writer Joseph Neff contributed.
Hospital suits force new pain on patients: Third of five parts
By Ames Alexander and David Raynor
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Hospitals’ clout in capital built with money, contact

The N.C. Hospital Association rarely loses, but says credit belongs elsewhere

By Joseph Neff, David Raynor and Ames Alexander
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Last year, state Rep. Dale Folwell took aim at a substantial tax benefit for North Carolina’s nonprofit hospitals - their refund on sales taxes, which averages about $200 million yearly.

Folwell proposed limiting refunds to nonprofits to 100 percent of the first $1 million and 25 percent of tax paid above $1 million. The cap would have affected 28 nonprofit hospitals, many of them very profitable, and six colleges and universities.

Folwell’s bill would have allowed state and local governments to keep more than $100 million. It was never even discussed in committee.

“The reason this bill never got a hearing is because big money bottled it up,” said Folwell, a Winston-Salem Republican who’s running for lieutenant governor. The hospitals “came after me with cleats high.”

North Carolina hospitals are one of the most powerful and effective interest groups in state politics, deploying a squad of lobbyists at the General Assembly and giving generously to elected officials.

Their clout grows from many roots. Hospitals are the state’s third-biggest employer. They are economic engines for their communities, providing livelihoods for the families of doctors, nurses, janitors and executives. They give substantial amounts to charities.

Hospitals are run by boards of directors, invariably the movers and shakers in each community: legislators, developers, business owners, newspaper publishers.

The N.C. Hospital Association leverages these connections. The association’s political action committee has handed out more than $1 million to state candidates over the past decade, ranking in the top 10 PACs for political donations. The hospitals have given the most to those with the most power: former senators Tony Rand and Marc Basnight, Attorney General Roy Cooper and former House Speaker Jim Black, all Democrats.

Now, with Republicans in charge of the legislature, more money is going to the GOP: Sen. Pete Brunstetter, co-chair of the appropriations committee, Senate Republican leader Phil Berger and former speaker Harold Brubaker, for example.

The checks don’t come in the mail: A local hospital executive or board member hand-delivers the contributions to the politicians.

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The lobbying goes on all year, not just in Raleigh, but in every community with a hospital. Hospital association staffers try to visit all hospitals every year.

“One of the questions ... to ask every time you are in a CEO’s office is, ‘When was the last time you visited with your legislator?’” said Don Dalton, a hospital association spokesman. “ ‘How is your relationship with your legislator? How can we facilitate building this relationship?’”

**Politics of fear**

Former Sen. David Hoyle knows that relationship from both sides. In the 1980s, he chaired the board at Gaston Memorial Hospital.

In 2009, as the state faced a $3.4 billion budget shortfall, Hoyle proposed capping sales tax refunds for nonprofits at $5 million. This was much more favorable to hospitals than the cap that Folwell would propose in 2011.

Hoyle’s proposal would have affected only a handful of the state’s biggest and most profitable hospitals. It would have raised about $15 million for the state.

Hoyle’s idea went nowhere. He said he believes hospital representatives talked to every member of the Senate Finance Committee, arguing that health insurance premiums would rise if the bill passed. It was an effective argument from persuasive people.

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“They are the folks back home; they’re the people we go to church with and golf with,” he said. “It puts the fear in you. You don’t want to be the one blamed for health care costs being so high.”

According to Folwell, hospitals are among the largest users of tax-funded services such as ambulance, police and fire protection. Most of them pay no property taxes, so other taxpayers have to shoulder the burden.

Cash-strapped public schools do not get a sales tax refund, while wealthy hospitals do, and that’s not fair, Folwell said.

Hugh Tilson, lead lobbyist among the 10 who registered in 2011 for the N.C. Hospital Association, made no apologies for killing the sales tax bills.

“As nonprofits, any revenues that we forgo would diminish our ability to care for the public,” Tilson said.

Tilson agreed with Hoyle and Folwell that his members are the key to his success lobbying the General Assembly.

“Our success has little to do with what I do,” Tilson said. “It’s that local relationship between the community and its legislators. Most legislators want their hospitals to succeed.”

Many wins, few losses

Those local relationships are strong.

State Sen. Dan Blue of Raleigh, a former House speaker, sits on the board of Duke University Health System, as does Jim Goodmon, president and CEO of Capitol Broadcasting in Raleigh. At WakeMed, there’s a former Raleigh mayor, a Wells Fargo executive, the former head of Wake County Schools and a former state auditor. Orange Quailles III, president and publisher of The News & Observer, is a member of the board of Rex Hospital in Raleigh.

In Charlotte, the board of trustees of Presbyterian Healthcare includes Larry Stone, retired president of Lowe’s Home Improvement, and Jim Palermo, a retired Bank of America executive. Carolinas HealthCare System’s board members include NASCAR team owner and businessman Felix Sabates, former Wachovia CEO Ken Thompson, retired Wachovia executive Mac Everett and Ed Brown, a former Bank of America executive who’s now CEO of Hendrick Automotive.

The hospitals perpetuate their power by staying in the good graces of legislators. The hospital political action committee raises small amounts from thousands of donors across the state: Doctors, board members, lawyers, administrators, pharmacists and nurses give in amounts ranging from $15 to $2,800, with the majority of contributions $100 or less, records show.

The hospital association is well-funded, with $4.6 million in revenue during 2010, the most recent year available. It paid $3.2 million in salaries and benefits, including $869,169 to its president, Bill Pully.

The association has been so successful over the years that Dalton, the spokesman, struggled to name any setbacks suffered at the General Assembly. After a pause, he came up with one: The hospitals pushed a bill to cap

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damages in lawsuits, which foundered and didn’t become law at the time.

That was in 2003.

Tilson, the hospital lobbyist, pointed to a long-term frustration: The hospitals have long pushed for better care for the mentally ill, including more inpatient mental health care. The conditions for the mentally ill are no better than they were 10 years ago, Tilson said.

But such setbacks have been rare. More often, the hospitals get exactly what they want.

In 2011, they got the damage cap they’ve been seeking, though the big push came from doctors and the N.C. Chamber of Commerce. The law limits medical malpractice awards for non-economic damage - pain and suffering, emotional distress and less tangible injuries - to $500,000.

Reversing a loss

For years, the state Department of Correction has been trying to rein in skyrocketing costs for hospital care for inmates, which rose from $17.5 million in 1999 to $63.8 million in 2011.

Prison officials had a problem: Unlike insurance companies that represent regular patients and can negotiate hospital charges downward, they had no bargaining power and generally paid whatever the hospital demanded. Paying the list price is expensive, since North Carolina hospitals generally set their charges at three times their costs; an inmate hospital stay that cost the hospital $10,000, for example, could be billed at $30,000.

Paying the list price means a 200 percent profit for the hospital at the expense of taxpayers.

Many hospitals don’t like treating inmates.

“Inmates?” asked Kenneth Morris, chief financial officer at Duke University Health System. “We don’t want their business. It’s disruptive.”

So the Department of Correction turned to the General Assembly. Last year, prison officials thought they had finally fixed the problem. The state budget mandated that prisons would pay the lesser of 70 percent of charges or twice the rate that Medicaid will pay. Either would guarantee a profit for the hospital and a significant savings for taxpayers.

Under federal law, all hospitals must see anyone who shows up in the emergency room. The state budget law would have required hospitals to admit inmates, not just treat emergencies.

But the day after the budget passed, a senator slipped a bland sentence into a “technical corrections” bill at the request of the hospitals; the requirement that hospitals treat inmates for non-emergencies was quietly deleted. Those hospitals include big institutions such as WakeMed, Duke and Carolinas Medical Center.

Tilson, the hospital lobbyist, said he urged hospitals to call lawmakers if they didn’t want to be forced to admit murderers, rapists and child molesters.

Sen. Richard Stevens, a Cary Republican, submit-
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ted the amendment. Stevens had heard from officials at WakeMed, who complained that they have provided a disproportionate share of inmate care over the years.

Stevens also said legislative staff was troubled by the language of the law, which could revoke a hospital’s license if it didn’t treat inmates.

In the fall, the Department of Correction opened a new $155 million hospital at Central Prison in Raleigh that will diminish, but not eliminate, the need for inmates to be seen in outside hospitals.

Frank Rogers has been in charge of the prison’s push on inmate health care at the legislature, and he has seen the hospitals’ clout.

“I was disappointed, “ Rogers said of the last-minute change. “But I was not surprised.”

A governor’s help

The hospitals’ influence extends beyond the legislature. They know how to get the ear of the governor.

As the General Assembly struggled with the state budget in 2010, lawmakers tentatively cut $519 million in case expected federal stimulus funds were not continued. If the federal funds did not come through, the state budget director was to make cuts from a prioritized list of the disaster relief fund, the state lottery, Medicaid, retirement system contributions, and other funds.

The Department of Health and Human Services planned to cut $26 million in Medicaid reimbursements, a 1.35 percent reduction for doctors, hospitals and other providers. Secretary Lanier Cansler announced the rate cuts would take effect Sept. 1.

The hospital association geared up. Pully wrote Gov. Bev Perdue, reminding her that hospitals and doctors lose money on Medicaid patients and that further cuts would strain the system.

A letter-writing campaign followed. Hospital CEOs copied Pully’s letter to their letterhead and sent it to Perdue. Doctors, clinics and other practices also wrote Perdue, urging her not to cut provider fees. They sent 104 letters in all, including 36 from hospitals.

The governor asked her staff to set up a meeting with Pully as well as leaders of the groups that lobby for doctors and long-term care facilities.

Perdue met with them at 10 a.m. Aug. 27 at her office in the Capitol.

At 12:30 p.m. that day, the chief financial officer for the state’s Medicaid office sent an email to staff: “Per Lanier’s direction from the Governor, she has reversed the rate reductions proposed for 9/1/10.”

Some stimulus funds had come in, so Perdue had to cut only $222 million. But the other programs did not fare

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LIMITING COSTS BY IMPROVING QUALITY

Ask hospital leaders what they do to keep health care affordable, and you get a common answer: Improve quality of care.


“Higher quality leads to lower costs, “ said David Strong, president of Rex Hospital.


While higher quality may not lower the list price of an appendectomy or an X-ray, it can prevent costly additional charges. Higher-quality procedures lead to less time in the hospital, fewer infections and a faster recovery.

The N.C. Hospital Association has been pushing efforts to improve quality, according to president Bill Pully.

It’s important to eliminate unneeded tests or procedures, he said.

“Forty percent in health care is waste,” Pully said. “We spend too much on health care.”

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Hospitals’ clout in capital built with money, contact: Fourth of five parts
By Joseph Neff, David Raynor and Ames Alexander
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so well; money was taken from the Disaster Relief Reserve, unclaimed lottery money, the state’s rainy day fund and others. In effect, Perdue’s budget director skipped over Medicaid, the fifth item on the list, and made cuts from the rainy day fund and another management fund.

Tilson said the governor recognized the dangers of cutting Medicaid.

“She understood the cuts would be detrimental to the state’s most vulnerable populations,” he said.

Perdue said she didn’t need any convincing. Keeping Medicaid funded as much as possible was her top priority for hospitals.

Before she ran for the state House in 1986, Perdue was an administrator at Craven Memorial Hospital. When she ran for office, she followed a campaign plan drafted by a lawyer for the hospital association: Bill Pully.

She won. They have been allies ever since.

Workers’ comp charges

North Carolina hospitals long have received some of the most generous payments in the country for treating patients covered by workers’ compensation. That’s a charge absorbed by businesses that pay workers’ comp premiums.

It’s not a huge business for hospitals - about 1 percent, according to the hospital association. But it was very profitable: The policies paid hospitals 95 percent of charges for outpatients (an average markup of roughly three times costs), and 77 percent on inpatients (more than double the costs).

According to a study of 16 states by the Workers Compensation Research Institute, North Carolina had the highest payments to hospitals. Among non-hospital providers, such as doctors and physical therapists, North Carolina ranked among the lowest.

The N.C. Industrial Commission set up a committee to find ways to reduce the payments.

Hank Patterson, a Chapel Hill labor lawyer who led the committee, said the insurance companies wanted to tie reimbursement rates to Medicare. Insurance companies generally use Medicare rates as the starting point when negotiating with hospitals.

The hospital association objected, Patterson said, and the hospitals prevailed. Reimbursement remained tied to hospital charges, which is in the hospital’s financial interest.

Patterson said the reductions, to 79 percent for outpatients and 75 percent for inpatients, were progress. But he acknowledged that the hospitals could erase the cuts simply by raising their charges. Many hospitals raise their charges 5 percent or more each year.

“The hospitals are very politically powerful,” Patterson said. “If you are pragmatic, you tread carefully to make progress.”

Tomorrow: What can be done?

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Hospitals’ clout in capital built with money, contact: Fourth of five parts
By Joseph Neff, David Raynor and Ames Alexander
Published April 25, 2012 in The News & Observer
Prices soar as hospitals dominate cancer market

By Ames Alexander, Karen Garloch and Joseph Neff
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Large nonprofit hospitals in North Carolina are dramatically inflating prices on chemotherapy drugs at a time when they are cornering more of the market on cancer care, an investigation by the Observer and The News & Observer of Raleigh has found.

The newspapers found hospitals are routinely marking up prices on cancer drugs by two to 10 times over cost. Some markups are far higher.

It’s happening as hospitals increasingly buy the practices of independent oncologists, then charge more - sometimes much more - for the same chemotherapy in the same office.

Asked about the findings, hospital officials said they are relying on a longtime practice of charging more for some services to make up for losses in others. Hospitals have a name for this: cost-shifting.

“The drug itself may just be the vehicle for charging for the services that are provided (elsewhere), “ said Joe Piemont, president of Carolinas HealthCare System, the $7 billion chain that owns many of the region’s hospitals. “We make literally thousands of trades to have it balance.”

The rising price of cancer treatment has financially devastated many families, while driving up insurance costs and causing some patients to put off needed treatments.

“If you have enough money or good enough insurance, it may not be an issue for you,” said Donna Hopkins, CEO of Dynamic Medical Solutions, a company that audits medical bills. “If you’re somebody who doesn’t have that, it can be a death sentence.”

After examining some chemotherapy bills collected by the Observer, Hopkins called the markups “outrageous.”

Some of the largest markups are made by nonprofit hospital chains that generate millions of dollars of profit each year and have billions in reserves.

It’s a mystery to the public how hospitals set their charges. But the newspapers obtained and analyzed a private database with information on more than 5,000 chemotherapy claims to get insight into pricing for cancer patients, a group that faces some of the nation’s highest medical bills.

The drug data, along with scores of interviews, help explain why hospitals have become so expensive - and why health care spending now makes up 18 percent of the national economy.

Among the markups found:
Levine Cancer Institute, owned by Charlotte-based Carolinas HealthCare, this year collected nearly $4,500 for a 240-milligram dose of irinotecan, a drug used to treat people with colon or rectal cancer. The average sales
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By Ames Alexander, Karen Garloch and Joseph Neff
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price for that amount of the drug: less than $60.

Carolinas Medical Center-NorthEast in Concord was paid about $19,000 for a one-gram dose of rituximab, used to treat lymphoma and leukemia. That was roughly three times the average sales price.

Forsyth Medical Center in Winston-Salem, owned by Novant Health, collected about $680 for 50 milligrams of cisplatin. The markup: more than 50 times the average sales price.

Such markups are hidden from patients.

Charlotte native Chuck Moore, the patient in the Forsyth case, got nine weeks of chemotherapy for cancer at the base of his tongue in 2008 and 2009. Though he had good health insurance, he still paid about $15,000.

When a reporter told him the average sales price of the drugs he’d received, he questioned the hospital’s charges.

“I’ve never had a business where I could get a markup like that,” said Moore, an assembly plant supervisor now living near Atlanta. “It seems almost predatory.”

Costlier, not better?

Until recently, those who needed chemotherapy had more alternatives. They could go to the offices of oncologists who weren’t employed by hospitals.

Increasingly, however, private oncologists are under financial pressure to sell their businesses to hospitals. When they do, hospitals often charge more.

In a review of claims for seven cancer drugs, the newspapers found that charges for all but one drug were significantly higher at hospitals and hospital-owned clinics - usually more than 45 percent higher.

Levine Cancer Institute, for instance, charges about $106 for each unit of Aloxi, the anti-nausea drug. But at Carolina Oncology Specialists, an independent clinic in Hickory, the charge is just $50.

Insurers have found similar patterns.

At the newspapers’ request, Blue Cross and Blue Shield of North Carolina, the state’s largest health insurer, examined data from thousands of 2011 chemotherapy claims and found that hospital-owned facilities in the state tend to be paid 50 to 150 percent more for cancer drugs than independent oncologists.

A recent study by Avalere Health, a consulting firm, found similar disparities nationally. Chemotherapy costs 24 percent more in an outpatient hospital setting than in a doctor’s office, the study concluded.

Dr. Ira Klein, assistant to the chief medical officer at Aetna insurance company, said he believes the acquisitions of oncology practices by hospitals have increased costs without improving the quality of care.

“We’re essentially enriching people and getting nothing for it,” he said. “And there are higher premiums every year.”

Shifting the costs

Hospital officials defend their pricing.

Unlike many independent clinics, they say, hospitals suffer losses from treating patients without insurance and patients covered by Medicaid, the government pro-

Same drug, different prices

Here’s a look at what several North Carolina hospitals were paid this year for a typical dose of a common cancer drug under one private health plan.

AVASTIN: Used to extend life in patients with lung, breast, colon, kidney and ovarian cancer.

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<th>Drug</th>
<th>Average sales price for 100-unit dose</th>
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<td>AVASTIN</td>
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<td>Carolinas HealthCare System, Charlotte</td>
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<td>Catawba Valley Medical Center, Hickory</td>
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<td>Duke University Hospital, Durham</td>
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Prices soar as hospitals dominate cancer market

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gram for the poor and disabled. Some independent oncologists acknowledge that they often refer such patients to hospitals.

Hospital officials say they provide counseling and many other cancer services that insurers don’t cover.

Officials for Carolinas HealthCare and Novant, which runs four Mecklenburg County hospitals, emphasize that they provide free care to many financially needy cancer patients.

Carolinas Medical Center spent about 5.5 percent of its budget on charity care in 2010. Presbyterian Hospital spent about 5 percent.

Piemont, of Carolinas HealthCare, said charges for chemotherapy drugs may be used to cover costs of other money-losing services, such as the emergency department, which treats a high number of uninsured patients.

“We cannot be compared to (an independent doctor) who can just overtly select who they see, “ Piemont said. “We take everybody. That requires cost-shifting that is so emblematic of this industry.”

Novant spokeswoman Kati Everett pointed to shortcomings in the Avalere study, noting that hospital patients tend to be sicker than those treated in doctors’ offices. Comparing prices at hospitals versus doctor’s offices doesn’t provide an accurate picture, she argued.

Like most hospitals, those owned by Carolinas HealthCare and Novant are nonprofits, a designation that provides them substantial tax breaks. In exchange, they are expected to provide charity care and other benefits to their communities.

Hospitals will likely face fewer unpaid bills under the federal Affordable Care Act. That’s because the law, scheduled to become fully effective in 2014, requires millions of people to buy health insurance. At the same time, hospitals will likely face cuts in government reimbursement for care.

Neither hospital system answered questions about how much they’ve spent on chemotherapy drugs in recent years, and how much revenue those drugs generated. But Everett said Novant lost money on outpatient chemotherapy infusion last year.

Vulnerable patients

It’s understandable why many cancer drugs don’t come cheap, according to those who make and administer them. Drug companies must cover research and development costs. Hospitals have to cover overhead.

The N.C. Hospital Association said the costs of handling and preparing cancer drugs “far exceed those re-

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quired for most other medications.”

“Medicines that treat cancer are toxic, dangerous chemicals that demand the highest levels of trained personnel, specialized equipment and facilities, “ the association said.

But community oncologists say they use the same toxic drugs in their practices at a much lower price.

And some experts contend that hospitals don’t need to inflate prices so dramatically.

Gerard Anderson, who heads the Johns Hopkins Center for Hospital Finance, thinks hospitals mark up charges on cancer drugs more than most other drugs and supplies. One reason, he suspects, is that patients are “not inclined to do comparison shopping in a life-or-death situation.”

In at least two ways, size has given hospitals a financial edge.

An Observer investigation in April showed how hospital consolidation has led to higher prices. When hospitals merge into large systems, they gain leverage to negotiate higher payments from private insurers.

While insurers might be willing to exclude a small clinic from their networks, they are loath to lose the hospital chains that have come to dominate many markets.

That has helped some North Carolina hospital chains evolve into profitable, fast-growing giants. At Carolinas HealthCare, the nation’s second-largest public hospital system, the average annual profit has exceeded $300 million over the past three years. The chain has built up more than $2 billion in investments and owns more than $1 billion in property.

Novant had about $1.6 billion in cash and investments in 2010 - a threefold increase over the decade.

A positive for patients is that such profits have improved access to quality health care. With the creation of Levine Cancer Institute in 2010, Carolinas HealthCare has recruited specialists from respected institutions such as the Cleveland Clinic and M.D. Anderson Cancer Center in Houston.

Size gives hospitals another advantage, allowing them to save money when they purchase drugs in bulk.

And more than 40 North Carolina hospitals - including Carolinas Medical Center and Presbyterian Hospital - are able to obtain deep discounts on outpatient drugs under the federal 340B program, which requires drug manufacturers to provide price breaks to hospitals that treat large numbers of financially needy patients.

Although Congress set up the program to offset the cost of treating Medicaid patients, hospitals can buy discounted drugs for all outpatients, including those with private insurance.

“There is no requirement to pass the savings on to patients, and they don’t,” said Dr. John Peterson, who practiced as a private oncologist in Sanford for 18 years before moving to Dartmouth College last year. “These hospitals are driving out the private practices, and they’re becoming the Wal-Mart of health care, squashing the competition, but without the low prices.”

Costs can jeopardize lives

Cancer costs more per patient, on average, than any other medical condition.

In North Carolina, Blue Cross and Blue Shield said the cost of cancer drugs for members younger than 65 rose from $178 million in 2009 to $211 million last year.

New drugs have given hope to many cancer patients. But some of those drugs come with annual price tags that rival those of a small home.

Treating a cancer patient with Avastin, for instance, costs about $90,000 a year, doctors say.

Much of the bill is picked up by employers and their

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prices soar as hospitals dominate cancer market

workers, who pay ever-increasing sums for insurance and other costs.

But no one feels the financial pain more than patients. In a 2010 survey commissioned by the American Cancer Society, 21 percent of people younger than 65 undergoing cancer treatment said they had used up all or most of their savings. And 19 percent said they or their family members had put off getting a recommended cancer test or treatment because of cost.

Dr. Otis Brawley, the society’s chief medical officer, has seen the consequences.

When Brawley headed the cancer center at Emory University in Atlanta from 2001 to 2007, he regularly treated patients who waited too long to get treatment - often because of financial concerns.

“Many folks put off managing their problems until it’s so, so bad, they have to come into the emergency room, “ he said.

Too often, Brawley said, such delays cost patients their lives. Patients who initially suffered from treatable colon cancer, for instance, sometimes delayed seeking treatment until the malignancy spread to the liver and became incurable.

Doctors in North Carolina see some patients making similar choices.

“A lot of patients are forgoing care, “ said Dr. David Eagle, of Huntersville, who is president of the Community Oncology Alliance, a national nonprofit group dedicated to community cancer care.

Marge Beazley, who manages an oncology practice in Western North Carolina, said some underinsured patients wind up with more than $50,000 in annual out-of-pocket expenses. Others, she said, choose not to be treated because of the cost.

“Those are the ones that break your heart, “ she said.

‘Oh my God’

When Carol Fleming of Huntersville was diagnosed with breast cancer in 2008, her husband’s job in Saudi Arabia provided health insurance.

But he died of leukemia in 2010. Ten days later, her insurance was canceled. Within a month, the bills for her

CHS, DUKE CHEMO PRICES HIGHER THAN MOST

Chemotherapy prices vary wildly, even among hospitals. Under one health plan, Catawba Valley Medical Center in Hickory received $1,035 this year for a typical single-session dose of Aloxi, a drug used to prevent the nausea that often results from chemotherapy. N.C. Baptist Hospital, in Winston-Salem, received just $290.

Officials with Catawba Valley Medical say market data indicate their chemotherapy charges are in line with those of several other area hospitals.

Two of the state’s largest hospital systems - Carolinas HealthCare System and Duke University Health System - appear to charge more than most hospitals for some common cancer drugs, the newspapers found.

Carolinas HealthCare said its pricing for chemotherapy is “comparable to healthcare providers across the country.”

Officials said large systems see higher volumes of uninsured patients and provide more sophisticated services, such as clinical trials.

HOW WE REPORTED THE STORY

To research chemotherapy costs, reporters for the Observer and The News & Observer of Raleigh obtained and analyzed a database of more than 5,000 chemotherapy claims.

The database includes records from more than 200 North Carolina practices and hospitals that treat cancer patients.

Reporters also examined several dozen itemized bills and explanations of benefits from insurance companies, and asked hospital billing experts to review some of them as well.

In addition, reporters interviewed more than 25 cancer patients, along with many hospital officials, oncologists, practice managers, national experts and insurance executives.

When calculating the number of cancer specialists employed by hospitals, the newspapers focused on medical oncologists, who oversee infusion of cancer drugs. Surgeons and radiologists who specialize in oncology were not counted.

Arabia provided health insurance.

But he died of leukemia in 2010. Ten days later, her insurance was canceled. Within a month, the bills for her

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Patient’s chemotherapy charges top $145,000

Carolinas Medical Center-Northeast, in Concord, billed one patient a total of more than $145,000 for six cycles of rituximab, a drug used to treat lymphoma and leukemia. The patient and his employer, a N.C. university, paid more than $130,000. The average sales price for that amount of the drug: less than $40,000. Following is an excerpt from one of the six bills.

A hefty markup

The hospital billed the patient more than $24,000 for ten units of rituximab. The patient and his health plan wound up paying most of that amount. The average sales price for that quantity of the drug: less than $6,500.

Fee for injecting drugs

On this visit, the hospital billed a total of more than $1,800 for the work that went into injecting cancer drugs. The patient and his health plan paid most of that. Medicare would have paid less than $550 for those injection services. National studies say that efficient hospitals are able to cover costs with Medicare reimbursement.

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chemotherapy and related services had topped $65,000. She recalls opening her first bill and saying: “Oh my God. Oh my God.”

“I remember thinking, ‘I’m in the middle of my battle. How many more treatments am I going to need?’ I was petrified.”

Presbyterian Huntersville provided excellent care, along with help with some of her bills, said Fleming, a former CIA agent. She exhausted her savings paying some of the rest.

Now she’s living in a small apartment, dependent on government assistance. It’s a far cry from her life in Saudi Arabia, when she lived in a six-bedroom house with marble floors.

“This has happened to me,” she said. “It can happen to anybody.”

Database editor David Raynor contributed.

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Prices soar as hospitals dominate cancer market

By Ames Alexander, Karen Garloch and Joseph Neff
Published September 23, 2012 in The Charlotte Observer

Patient information from the Southern Strategy Specialists in Huntersville, one of the few remaining independent oncology clinics in the Charlotte area. Hospitals are increasingly buying doctor groups and hospital networks in cancer care as whole entities.

FALL PREVIEW HELPS YOU FIND A WINNER

THE LEVINE

WHAT'S ON TV?
FALL PREVIEW HELPS YOU FIND A WINNER

CBS: 'Made in Jersey'

PUBLIC'S SENTIMENT that lower taxes benefit the economy.

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Prices soar as hospitals dominate cancer market
By Ames Alexander, Karen Garloch and Joseph Neff
Published September 23, 2012 in The Charlotte Observer
Doctors join hospitals, and prices soar

Patients and insurers pay vastly more for routine services

By Joseph Neff, Ames Alexander, Karen Garloch and David Raynor
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draynor@newsobserver.com,

North Carolina patients pay more for many tests and procedures if their physician is employed by a hospital, an investigation by The News & Observer and The Charlotte Observer has found.

It’s true whether the health care offered is a heart stress test or a routine visit to a doctor’s office. And it’s part of a national shift that experts say is raising costs but not quality: Hospitals are increasingly buying doctors’ practices, then sending bills for routine services that are significantly higher than those charged by independent doctors.

By one count, the percentage of doctors nationally who are employed by hospitals has doubled over the past decade. No similar statistics are available in North Carolina, but it’s clear that more and more doctors are affiliating with hospitals.

For example, in the Triangle, about 90 percent of cardiologists work for hospitals, which can charge more for procedures than private practices.

As a result, the cost of many routine medical tests and services has soared, according to Medicare data and insurance claims reviewed by the newspapers.

The same service performed in the same location by the same doctor can cost more than double what it did just a few years ago.

“Prices are increasing, often for no other reason than the sign on the door changed,” said Robert Zirkelbach, spokesman for America’s Health Insurance Plans, a trade group representing the insurance industry.

Same test, different price

Some routine cardiac tests, including echocardiograms, cost more than twice as much in hospital-owned clinics as in independent cardiology offices. The following figures show the current Medicare payments to free-standing physicians’ offices and hospital-owned outpatient facilities in the Raleigh area.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Free-standing physicians’ offices</th>
<th>Hospital outpatient facilities</th>
<th>Stress test with echocardiogram**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Echocardiogram*</td>
<td>$200.35</td>
<td>$442.15</td>
<td>$645.31</td>
</tr>
<tr>
<td>Stress test with echocardiogram**</td>
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Notes: Echocardiograms are tests that use ultrasound to create a moving picture of the heart. The figures above include both the professional fee to the doctor and the technical fee for the test itself.

*Reflects figures for CPT code 93306, the most common type of echocardiogram.

**Reflects figures for CPT code 93351, an echocardiogram performed during a stress test to determine the effects of stress on the heart.

Source: Medicare payment schedules

Here’s why: Medicare and private insurers pay more for outpatient care - which includes an allowed facility fee for hospital infrastructure - than for the same procedure in a doctor’s office, which cannot charge a facility fee. A hospital can increase revenue by acquiring a practice and changing the billing to outpatient. Or the hospital can simply convert its doctors’ offices to hospital facilities.

In the Triangle, Duke University Health System has been most aggressive in converting its doctor practices to outpatient entities.

“Outpatient visits (in 2010) increased 12.1 percent over 2009, which was due entirely to converted clinics,” according to a 2011 Duke bond document.

One example: For a common echocardiogram procedure, Duke Hospital submitted 4,879 claims to Medicare in 2010, up 68 percent from the year before. Medi-

story continues on next page
Doctors join hospitals, and prices soar

The percentage of U.S. doctors employed by hospitals has doubled over the past decade.

Percent of U.S. doctors

0 10 20 30 40 50%

'02 '04 '06 '08 '10 '11

23% 47%

Source: Medical Group Management Association survey

AMES ALEXANDER – RESEARCH
DAVID PUCKETT – STAFF CHART

Doctors flock to hospitals

story continued from previous page

care allows $471 for outpatient echocardiograms, more than twice the $200 allowed for those performed in physician offices.

Hospital officials contend they deserve to be paid more because they have expenses and obligations not shared by independent physicians. They must comply with more regulations, keep many departments staffed at all times and treat all patients, regardless of ability to pay.

Experts agree that hospitals should be reimbursed for the extra services they provide.

But there’s a limit, said Robert Berenson, an analyst at the Urban Institute’s Health Policy Center. For many routine services, Medicare pays hospitals about 80 percent more than it pays independent doctors, he said. But he said the additional expenses for a hospital don’t justify that kind of payment difference.

The newspapers’ latest findings underscore the lessons of the newspapers’ previous investigations, which found that the growing market power of nonprofit hospital systems is one of the factors in the rising cost of health care.

Now some public officials are questioning whether hospital systems have grown too big for the public good. Among them is state Attorney General Roy Cooper, who is examining whether to use antitrust laws or push for new legislation to reduce health care costs.

In the meantime, experts say, it’s likely that hospitals will continue to buy doctors’ practices at a rapid clip.

“It’s only going to grow, and it’s going to grow substantially,” said Paul Ginsburg, president of the Center for Studying Health System Change. “It raises the amount people pay. And I don’t think there’s a redeeming benefit to it.”

Jenny Palmer of Durham had been seeing a Duke neurologist for years for her epilepsy. She was furious when her $50 copay turned into a $425 payment applied to her deductible.

“IT makes no financial sense for me to see Duke doctors now,” Palmer wrote to her neighborhood Listserv. “BUT there aren’t many non-Duke doctors in Durham. ARGH!”

Palmer, 41, an administrator of a nonprofit, eventually found a neurologist in Raleigh.

Duke would not comment on Palmer’s case. It has acknowledged the fees in the past but said they were legitimate because of the increased costs of running the doctors’ practices.

“I was just shocked”

Gay Miller thought she knew what to expect when she received a heart test earlier this year - until she got the bill.

After a heart valve replacement eight years ago, she has

story continues on next page
been getting periodic echocardiograms at her cardiologist's office in Shelby to ensure the valves still work properly. Under her insurance plan, the tests used to cost her a $60 copay.

Not this year. During Miller's annual checkup at the Sanger Heart & Vascular Institute in February, her doctor told her she would need to go to nearby Cleveland Regional Medical Center for her echocardiogram.

At the hospital, Miller received the usual 30-minute test. And the usual technician conducted it.

But there was nothing typical about the bill: Miller wound up owing $952.

"I was just shocked," said Miller, 64, who lives in Lincoln County west of Charlotte. "I feel like I got taken advantage of."

Across North Carolina and the U.S., hospitals are increasingly billing for heart tests like these. Experts say the higher bills for those tests are a telling illustration of a structural shift that is leaving patients with higher bills for identical procedures.

In 2005, doctors with Sanger - Charlotte's oldest and largest group of cardiologists and heart surgeons - became employees of Carolinas HealthCare System, the hospital system that runs Cleveland Regional.

At the time of the merger, officials said Sanger patients wouldn't notice any difference. Now, however, some Sanger patients who need echocardiograms are diverted to higher-charging hospitals.

Officials for Carolinas HealthCare did not address questions about the case. But in general, the system said, Sanger has been nationally recognized "for cost effectiveness and delivering the most appropriate care to each patient."

Flocking to hospitals

Until recently, the large majority of physicians worked in doctor-owned practices. But that's swiftly changing.

Last year, 47 percent of physicians in the U.S. were employed by hospitals - roughly twice the percentage in 2002, according to surveys by the Medical Group Management Association.

That trend is expected to continue, with one health care recruiting company predicting that hospitals could employ as many as 75 percent of all doctors within two years.

About 35 percent of North Carolina cardiologists work for hospitals - almost three times the percentage who did so five years ago, according to a recent survey by

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Bruce Stanley got some routine lab work done at WakeMed Brier Creek that cost him $240, versus less than $14 two months earlier at LabCorp. Stanley had thought the facility "was a satellite clinic."

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Published December 16, 2012 in The News & Observer

the American College of Cardiology.

The irony, some doctors say, is that federal efforts to reduce health care costs have helped drive the trend.

In 2010, Medicare reduced payments to physicians for various cardiology tests while raising payments to hospitals. That prompted many independent doctors to sell to hospitals, which could collect significantly more for the same tests.

Many doctors, however, have been unhappy about the trend. In a recent Physicians Foundation survey, 75 percent of North Carolina doctors said they disagreed “somewhat” or “mostly” with the premise that hospital employment of physicians is a “positive trend likely to enhance quality of care and decrease cost.”

While money helps explain why many doctors have opted to join hospitals, other factors also play a role. By joining hospital systems, many overworked physicians have been able to shorten their workweeks and share on-call duty. Hospitals also take over the complicated back office functions such as billing, negotiating with insurance companies and managing the expensive transition to electronic medical records.

Hospital systems have plenty to gain as well. Purchasing doctors’ offices helps hospitals enlarge their referral networks and boost profitability. It will also help them become Accountable Care Organizations, networks of doctors and hospitals that the architects of President Barack Obama’s health care plan believe will improve quality and efficiency.

Many experts predict that hospital acquisitions of doctors’ offices will boost prices still higher.

“This is really a historic change in the practice of medicine in the U.S.,” said Dr. William Zoghbi, president of the American College of Cardiology. “It’s more costly to the whole health care system, including patients.”

Dr. Daniel Wise has been on both sides. He was an independent cardiologist, then an employee of Presbyterian Hospital in Charlotte, and now he’s independent again. He left the hospital because he didn’t agree with its priorities.

But the reduced Medicare reimbursements make him wish he had stayed.

Wise said cardiologists’ incomes have declined by 30 percent to 40 percent in the past three years. “It doesn’t make economic sense anymore to try and do it in the office,“ he said.

Two labs, two prices

In late 2011, Bruce Stanley was invited to an open house at WakeMed’s new Brier Creek facility. He nibbled cookies and toured the facility. He liked the convenient location and pleasant staff.

In January, he had two routine blood tests done there. He did them in advance of a physical and wanted to be able to discuss the tests with his doctor.

The results pleased Stanley. The bill did not.

Stanley owed WakeMed $240.82 for two routine blood panels. Three months earlier, he had paid $13.73 for the same tests done at the LabCorp office near Rex Hospital. Stanley didn’t know he would be charged full hospital prices.

Jenny Palmer of Durham saw her $50 copay turn into $425.

story continues on next page
“I thought it was a satellite clinic,” said Stanley, 58, a Raleigh businessman.

Debbie Laughery, a WakeMed spokeswoman, said the hospital can’t compete with LabCorp, partly because hospitals have more expensive facilities. Laughery also pointed to the practice of “cost-shifting,” where hospitals pay for charity care for the poor by collecting more from insured patients.

“We have to pay for all of our indigent care somehow,” Laughery said.

Is cost bump justifiable?

For many tests and services, the difference between what hospitals and independent physicians can collect is vast.

Hospitals, for instance, can get about 80 percent more from Medicare than independent physicians for a 15-minute office visit - and more than twice as much for many cardiac tests.

The payments to hospitals are also higher from private insurers. For a common outpatient echocardiogram in 2012, Duke was paid an average of about $1,800 by a private health plan. WakeMed was paid about $1,500; UNC, about $900, according to thousands of private insurance claims reviewed by the newspapers.

The same data showed the average payment to an independent cardiologist for the same test was $480.

Experts say private insurers have little choice but to pay hospitals more. When negotiating contracts with health care providers, insurers can survive without a single doctor’s office in their networks. But they must be able to offer customers access to major hospitals. That gives hospitals power to negotiate higher payment rates.

The employers and workers who share costs for health insurance wind up footing much of the bill. Patients, meanwhile, are left with higher out-of-pocket costs.

Hospital officials say there are valid reasons they can collect more. They say they’re obligated to serve all patients, regardless of ability to pay, while independent doctors can be more selective about which patients they treat.

“Provider-based services are also under state and federal regulatory oversight, while free-standing physicians and clinics are not,” the N.C. Hospital Association said in a written statement.

The association stresses that its members are merely following Medicare rules. Doctors’ offices owned by hospitals are generally allowed to bill Medicare at the higher outpatient rates if they are within 35 miles of the hospital campus and integrate their operations with the hospital.

But some experts and insurers question whether that’s reason enough for patients and taxpayers to pay dramatically higher prices.

Margie Maxwell, president of Aetna’s Southeast market, said: “There is no logic and there is no reason to allow a higher payment because it has now become a hospital billing... It should not be happening.”

‘Harming consumers’

In a review of Medicare and private health plan data, the newspapers found that North Carolina hospitals are increasingly billing for routine office visits and for echocardiograms.

The number of office visits that North Carolina hospitals billed to Medicare climbed by more than 40 percent from 2007 to 2010, according to data compiled by the American Hospital Directory. And at Duke University Hospital, the number more than tripled.

During the same period, the number of echocardiography claims that North Carolina hospitals billed to Medicare increased more than 20 percent. At Carolinas Medical Center in Charlotte, the number more than quadrupled.

Berenson, of the Urban Institute, sees nothing redeeming in the trend.

“That’s taking advantage of the payers and really harming consumers,” said Berenson, who previously served as a commissioner of MedPAC, which advises Congress on Medicare policy. “It is not promoting more efficient care.”

Neff: 919-829-4516
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