How hospitals & insurers drive soaring healthcare costs

Richard Master: Is that really what we want in our society? Is that what America's all about, that my child is going to get better care because I have more resources than your child? That's not a country that we're anticipating or comfortable with.

Dispatcher: 911, what's your emergency?

Caller: America's healthcare system is broken and people are dying! (ambulance siren)

Welcome to **Code WACK!**, where we shine a light on America's callous healthcare system, how it hurts us and what we can do about it. I'm your host, **Brenda Gazzar.**

(music)

This time on **Code WACK!** How is it that treating COPD, a respiratory disease, can cost someone $7,000 in the Bronx, New York but nearly $100,000 just 30 miles away in New Jersey? How has the state of Maryland kept its hospital costs in check – and how might other states do the same?

To find out, we spoke with **Richard Master**, CEO of MCS Industries, founder of Business Leaders for Health Care Transformation and executive director of his latest documentary, *American Hospitals.* He's joined by **Wendell Potter**, a former health insurance company executive turned whistleblower, the New York Times bestselling author of Deadly Spin and an associate producer of the film. This is the second episode in a two-part series about the film *American Hospitals*.

Welcome back to **Code WACK!,** Richard and Wendell.

Q: Let's talk about hospitals. Your new film American Hospitals cites a New York Times article that reported the survival of seriously ill COVID patients depended largely on what hospital they were sent to. Why is that?

Master: Brenda, this is Richard. I think you were referring to the New York Times articles on the, you know, where your survival rates for COVID depended on what borough you lived in New York City and what hospital you went to. And what those studies showed and which are really reflected in other studies across the United States was that these safety-net hospitals, hospitals that have a larger percent of Medicare – upwards of 90% of the patients in some of these hospitals are Medicare/Medicaid-insured patients – And, and what it showed was that a sophisticated up-to-date, hospital in Manhattan or a university-related research hospital those hospitals had ... four patients to every nurse. In a hospital in Brooklyn, in a disadvantaged neighborhood, it could be eight, nine to one.

They had less access to technology which we were seeing, you know, in our media, they had less access to the new advances in medications that that university hospitals had. So you had some hospitals which had 41% of COVID patients going in, not coming home – dying and we're seeing that across the country, that these safety net hospitals, that we don't have them in Maryland because of the payment system in Maryland, these hospitals just do not provide the same level of care. And so what we have in our system, we have an inequitable system that the quality of care you get depends on your social and economic class. Is that really what we want in our society? Is that what America's all about, that my child is going to get better care because I have more resources than your child. That's not a country that we're anticipating or comfortable with.

Q: And so many of these safety net hospitals have closed down. They just haven't been able to stay afloat, because of a lack of resources. I remember in the film the nurse who spoke so eloquently about working at a safety net hospital and how they were so strapped for employees that all she could do was give the mothers in the delivery room the bare minimum care.

Nurse: We didn't have enough nurses and it was just running and running and running. I just felt so bad and exhausted. I gave patients the floor of what they need, the minimum but they deserve more than just the minimum. And when you

can only give the minimum, that doesn't feel good. It doesn't feel good at all. My heart hurts.

Q: Can you talk about how hospital corporatization and mergers have changed the industry's economic incentives?

Potter: This is Wendell. What has happened in the insurance business is that over the past several years, there have been almost countless mergers and acquisitions to the point that you have just a really, a very few health insurance companies, including the ones that I worked for, that control the marketplace. And they were beginning to have outsized leverage when they were negotiating with hospitals and as this movie points out, unlike Medicare, which sets rates for hospital care insurance companies and hospitals negotiate one by one. Each insurance company negotiates a contract with each individual hospital. So that's another reason why there's wide variations in what we pay for hospital care. But because of all the mergers on the insurance side, hospitals decided to begin to merge themselves so that they would not lose that competitive advantage at the negotiating table.

So we've seen this arms race, if you will, insurance companies continue to consolidate. They're consolidating now vertically. In other words, they're getting more and more into healthcare delivery. But hospitals have merged as well too. So you have these huge mega-systems in many states, many markets as there usually are just one or two enormous hospital systems. And also, as a movie points out, there has been no evidence, in fact, there has been evidence to the contrary that these mergers do not bring the cost of care down. They result in higher prices. So that's a fact and a feature of U.S. health care, and one more reason why we have out of control healthcare costs and in particular, out of control hospital costs.

Q: Right. Yeah, I was also surprised to hear from the film that hospital mergers led to hospital price increases at 41% from 2007 to 2014. That's shocking.

Potter: Yeah. This is Wendell. Yeah, it is shocking when these companies propose to merge and they have to get, in most cases, regulatory approval, they make the case that those mergers will bring down the cost of care. It is not true. And there's empirical evidence as we point out in the movie, that it's just the opposite. And yes, 41% over a recent time frame of cost increases, price increases from these systems that have merged.

Q: This question is for either Richard or Wendell. How do high hospital expenses affect the cost of health insurance?

Master: Well it's more than a one-to-one relationship. As hospital prices go up, let's say 6% a year on average, 5.5% to 6% a year, that translates into increases in health insurance premiums by a similar amount or more because the insurance companies have to tack on a profit percentage. And there's, of course, administrative complexity related to these increases. So we expect that. So this is a perverse incentive because, you know, insurance companies are supposed to be negotiating on our behalf for better pricing, but they make a percentage of the overall premium. So they're incentivized to raise prices. They want premiums to go up. It's a built-in revenue enhancer. I wish we could have that at MCS Industries, you, know but we can't and we don't expect it. So this is why hospitals and insurance companies sometimes are on … both sides of the bargaining table. But really when it comes to challenges, like the challenges that we're making or the public is making, or the government is making, they're really in the same camp.

Q: Wow, that's so interesting. You've been on the company side, Wendell. What kind of job do you think insurance companies do when it comes to negotiating the costs of covered care?

Potter: Insurance companies are not honest brokers here. They're not really negotiating in good faith. They will say they are. And what you see is that insurance companies and hospitals point the finger of blame at each other, but behind the scenes, they work together to finance front groups and lobby together to protect the status quo because it is profitable for both of them. It's a game that works for them and against the rest of us. So don't believe an insurance company. Don't believe, really, a hospital executive that points a finger of blame somewhere else. They're all culpable and they're in this together because as hospital prices go up, that, as Richard just noted, the insurance companies just tack on some additional amount for the next when premiums are up for renewal, it's in the industry referred to as “medical trend.”

They base their premiums next year on what the bean counters see as where healthcare prices are going, what inflation is, and they set their premiums based on that. And they're just fine as those prices go up because they can and do charge higher premiums, and the more premiums go up, the more revenue they get and the more money they have to convert to profits.

Q: So what kind of revenues are we talking about?

Potter: The seven big insurance companies last year took in $1.25 trillion in revenue. Just those six companies made $69 billion in profits. And it's because they're able to increase premiums the way they are. So it's a game that they want to keep going.

Q: Right. Wow. To all of our detriment, unfortunately. So you mentioned the Maryland all-payer system. Can you tell us a little bit more about that? What is it and how could it help?

Potter: This is Wendell, and it essentially is a system in which every entity that pays for health care pays the same price. In other words, Medicare and Medicaid pay the same price. In most states, the Medicaid rate is lower than Medicare, and almost in every state, what private insurance pays is greater than what either Medicare or Medicaid pays. So in an all-payer system everybody pays the same thing. It eliminates this problem that we've talked about of there being this wide variation in how much a hospital on one side of town will charge for a procedure compared to a hospital on the other side of town. That goes away. And it makes all the sense in the world that you get rid of this, this negotiation, this individual negotiation that is so much a part of how health insurance companies, private insurance companies and hospitals strike a deal. And that eliminates that. And that brings the total cost of care down. And it is also a relief for people who have private insurance because they're not paying this extra amount that is common in other states.

Master: This is Richard. Yeah. That this is something that Maryland has traditionally done. And when during the latter part of the Reagan years when, when regulation was not a good word, not, it didn't have a good reputation, and it continues to not be something that people embrace, but frankly, we need intelligent regulation. What we got is some crazy regulation. You know, I have a pet peeve about privacy. Every time I go to the doctor, I got to sign another release on privacy, you know, and there is all this documentation and concern over privacy. But no one's concerned about the prices that my hospital and my physician is paying, which should be regulated. Twenty-eight states, you know, in 1980, had price regulation. They negotiated prices by procedure with hospitals. Maryland continued to do it. Maryland gets annually, they have a price commission and doctors and other providers and hospitals and insurance companies. Medicare of course has an interest in this.

They all get together and they hash out what is a reasonable price for service. And that price, if it's $10,000 for an appendectomy, is the price that is paid regardless of who is paying the bill. Medicare had to give a waiver. The U.S. Congress had to allow Medicare to pay initially more than its base rate nationally for that appendectomy. But over time, what's happened is that the increase overall in the expense in Maryland was much more modest and here we are in 2023, where Maryland has actually been able, as a result of all-payer, to contain its overall hospital prices, the cost of prices for those procedures, to the point where Maryland had the lowest price or, or among the lowest price to handle a complex COVID patient. So this is something and it is working.

Q: So it seems pretty straightforward and a pretty simple solution. Is it a politically viable solution for other states?

(15:39):

Potter: I'll start with that too. It is viable for other states. It's not going to be necessarily the easiest lift because there is opposition to it. Maryland was the state that kept regulation, and it is why they have an all payer system. Other states will need to, at this point, look to get a waiver from the federal government because it does involve changes in how Medicare and Medicaid pay for care. So there is that, but it also comes down to political will and lawmakers in other states are indeed looking at what Maryland has done.

The global budgeting part of the equation is very important as well, too, arriving at budgets for each individual hospital to make sure that they've got an adequate budget and that they can benefit from savings if they keep people well in their communities. So it's something that I think lawmakers are looking at, including in California. And hopefully there will be some courageous politicians and hospital leaders around the country. There are many hospital CEOs who understand the merit of what Maryland has done but there is opposition as well.

Q: Got it. So do you think the all payer system is more viable than single payer healthcare? Like more politically viable?

Master: Well, I think it's a transition that, you know, ultimately in our society we want universal coverage. We don't want to see 10 or 15%. You know what, what I've just read in my New York Times, I just read that there are 90 million people who are insured through Medicaid. Okay and during COVID, the government ceased to

apply the income standards for Medicaid recipients. Alright. And now that we're past the extreme COVID crisis, the government is now reinstituting income tests for who's eligible for Medicaid. The estimates are that 15 million people will be thrown off of Medicaid. And you know, some of them may go into these Obamacare insurance situations and get subsidized commercial insurance, which that's another really questionable practice.

But ultimately we need universal coverage and we need a simplified way of paying bills in the United States – healthcare bills in the United States. Employers are willing to pay their share, certainly, and taxpayers are, are willing to pay a reasonable amount for this. But, you know, the administrative complexity of our system eats upwards of 25% of the overall healthcare bill in the United States. Yes, we're talking about global budgeting and we're talking about employers having a fiduciary responsibility to get the best price. Now that there's more transparency in pricing, we're talking about all these things, but ultimately we've got to have a simplified payment system in this country. That's the only way,

Potter: This is Wendell. And I might add that I don't predict what would be easier to achieve – a single-payer healthcare system or a system like Maryland has, but I would say that what Maryland has done is an important component and single-payer bills do and should include doing what Maryland has done. It's essential. You've got to get the costs under control. It can be considered a stepping stone, but it is absolutely an important provision of single-payer bills.

Thank you, Richard Master and Wendell Potter. To find out where you can watch the new film American Hospitals go to fixithealthcare.com/events.

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