



## **My Experience with Health Care Inflation in the ER**



By David J. Gibson, MD

**Physicians need to do something about the high cost of ambulatory care in the hospital setting - because they'll be blamed for the mess in any event.**

MY DAUGHTER developed a viral upper respiratory infection just before she left for college this past summer. Besides being febrile, she demonstrated acute pharyngitis, tonsillar hypertrophy, emesis and malaise.

She was seen by her physician and, following a complete evaluation with diagnostic testing, was found to have borderline positional tachycardia thought due to hypovolemia secondary to inadequate fluid ingestion for 48 hours. My daughter's physician made a presumptive diagnosis of acute viral illness of unknown type after she reviewed the diagnostic testing results. Specifically, Streptococcus, Group A and Mononucleosis were looked for and eliminated from the differential diagnosis.

Her attending physician felt that an elective infusion of one liter of D5NS was warranted. The resources for administering IV fluids were not available in the attending physician's office. Thus, she referred my daughter to the emergency room of a local hospital that was located just across the street with a request for the infusion.

Then the fun began.

By just walking into the ER, my daughter was charged \$1,063.50. I wonder how many people in Sacramento would view this to be a reasonable charge.

My daughter was then evaluated by a physician who is a member of the medical group that has a contract with the hospital's ER. That physician proceeded to order over \$700 in redundant laboratory diagnostic testing (CBC - \$205.85; metabolic panel - \$345.25; and a heterophile (Monospot) test - \$149.35). No effort was made by either the physician or the ER staff to contact my daughter's physician and obtain the results of diagnostic testing that had previously been performed.

The ER physician charged for a Level IV exam that he billed at \$273.00. It should be noted that a Level IV evaluation in the ER setting calls for 60 minutes of time spent with the patient.<sup>1</sup> The actual time spent was less than 15 minutes. Thereafter, he charged an additional \$144.30 for starting a peripheral IV, which he did not perform or attend.

I have serious doubts that the ER physician needed to see my daughter at all: she had just been evaluated by her attending physician and sent across the street for an elective IV infusion. The attending physician did not request a medical consultation by the ER physician.

If an evaluation was warranted, it stretches the limits of credulity to imagine a Level IV exam was warranted on an otherwise healthy young woman. A more realistic view is that

the ER physician inappropriately inserted himself into the case and then opportunistically up-coded his fees.

Pharmaceuticals used in the IV infusion totaled \$387.20. This included Ketorolac, 30 mg for \$104.89; Dexamethasone, 10 mg for \$98.92; and Ceftriaxone, 1 mg for \$183.39.

The Ceftriaxone ordered by the ER physician is particularly troubling. Ceftriaxone (Brand Name - Rocephin) is a third generation cephalosporin. It is generally used in the treatment of nosocomial neonatal sepsis and meningitis caused by susceptible gram-negative organisms (e.g., E. coli, Pseudomonas, Klebsiella, H. influenza). I find it impossible to justify its use in this clinical setting. Perhaps I should be grateful that Ampicillin was not used in that my daughter had a viral illness.

The hospital's charges for the IV solution (\$130.75), IV therapy - whatever that is - (\$81.00) and disposable supplies (\$69.85) came to a total of \$281.60 for infusion disposables.

Based upon my 10 years of experience as a consultant to the pharmaceutical industry both at manufacturing and distribution levels, I estimate that the hospital tripled its charges for the pharmaceuticals, and marked up the IV solution and disposable supplies by a factor of ten. Of course, as Dennis Miller would say, I could be wrong. It is conceivable the hospital could be paying above market rates for the supplies used in its ER.

In summary, we have a previously healthy college student with no history of chronic illness, who has just been evaluated with a full battery of diagnostic testing by her attending physician and is electively referred with a request to perform a rather simple intravenous infusion. The total bill from the hospital and the ER medical group: \$2,840.05.

## Perspective

**The inflationary trend in health care is hurting patients.** Individuals are being exposed to higher personal cost liability as employers seek to contain the rising health care premiums. Small group employers - those with two to 100 employees that make up the vital core of Sacramento's business community - are facing increases in the 20 to 50 percent range. They are taking any reasonable means to hold down these cost increases. Most are increasing cost sharing by passing on 20 percent to 30 percent of the premium cost increases to employees. They are also increasing copayments and giving employees incentives to select high-deductible, major medical coverage. In the future, patients coming into physicians' offices and local ERs will be exposed to the full first dollar cost of the invoices generated.

**Hospitals are now the primary driving force in health care inflation.** This year the Center for Studying Health System Change<sup>2</sup> in Washington, D.C., found that hospital spending on inpatient and outpatient care accounted for nearly half of the 7 percent increase in national health care costs in 2000. Thus, hospitals are now the primary driving force in health care inflation. This increase in hospital spending during 2000 drove the largest health care cost increase in a decade while prescription drug spending began to moderate last year.

**Hospitals should return to their core competency.** During the 1990s, hospitals across the country "vertically integrated" into health care systems. They became regional conglomerates by acquiring community-based not-for-profit hospitals and integrated these institutions into large multi-hospital systems. This trend for vertical growth is exemplified in Sacramento by the growth of both Sutter Health System and Catholic Healthcare West (CHW).

Managed care has produced profound damage to the infrastructure of California's health care system over the past decade. However, one often overlooked trend during this past decade has been particularly detrimental. By leveraging the contract for the most

expensive resource in health care - the hospital bed - health systems like Sutter and CHW conspired with managed care insurance companies to eliminate competition for ambulatory services. Thus, independent diagnostic and therapeutic modalities, other than those owned by the hospital systems, have been essentially eliminated from the Sacramento market.

We now have a monopolistic environment with no competitive alternatives to the services provided by these hospital systems. The result - unjustified markups and service prices that would not be tolerated in any other industry.

Frankly, hospitals know very little about managing an efficient ambulatory care system. By acquiring medical practices and stripping them of diagnostic and therapeutic modalities, these systems channel patients into their ERs - but further weaken the health care system. It is past time for both Sutter and CHW to get out of the ambulatory environment and let the sunshine of competition back into Sacramento.

**Sutter and CHW monopolistic strategies are damaging Sacramento's economy.**

These two systems have eliminated innovative entrepreneurial competition in the ambulatory environment here in Sacramento. As a result, we face inefficiency, lack of innovation, and the retardation of new technology deployment.

It is important to realize that approximately 70 percent to 80 percent of surgical procedures are now performed on an outpatient basis. That compares to only 15 percent in 1980. Within this environment, hospitals in Sacramento are now marking up their charges for diagnostic testing and supplies used in therapy by a factor of ten, or more.

We are now seeing the economic consequences of hospital monopolistic strategies, and they are disastrous for Sacramento's economy. Hospitals are now the dominant driving force in health care inflation. We know few certainties in this life, but monopolies always overcharge.

Clearly, life has not been easy for hospitals in California. More than 82 percent of emergency rooms in the state reported losing money in 2000, and many expect to lose more money this year.<sup>3</sup> However, the opportunistic shifting of costs onto the back of individual families in Sacramento is not the answer to their dilemma.

**Eliminating competition in the ambulatory environment is bad public policy.**

Currently, nearly half the visits to emergency rooms in Sacramento are for non-urgent care because any alternative for therapeutic care has been eliminated. In Sacramento County, 347,022 ER visits in 1999 were non-urgent - approximately 50 percent, compared with 35 percent statewide. Sutter and Mercy's ability to provide critical care here has been compromised by their success in eliminating ambulatory alternatives.

Ambulance diversions in the Sacramento area, a major indicator of capacity in area emergency rooms, reached a record 18,472 hours in the first nine months of 2001. This is an increase from 11,097 hours during the previous year and a total number of 4,101 hours in 1999.

**Experienced medical management is clearly called for in Sacramento.** It appears that the inmates are now running the asylum. Common sense would preclude charging unreasonably high fees for diagnostic services. The above documented markup for injectable fluids and pharmaceuticals are beyond reasonable.

The medical groups covering the ERs clearly need close supervision by the medical staff. A reasonable starting point would involve avoiding unneeded, unrequested, and unskilled intrusion into the clinical environment. Common sense would dictate a phone consultation with the attending physician to obtain results of prior work-ups. Deferring to the therapeutic judgment of a respected colleague would be a reasonable course of action.

If this is too much to ask, then a seasoned medical supervisor needs to review the ordering

of redundant diagnostic studies, and the prescribing pattern for therapeutic intervention by these groups. The use of a third-generation cephalosporin (Ceftriaxone) in a community-acquired upper respiratory infection represents questionable medical judgment. I believe most physicians practicing in this community would agree with that assessment.

One additional point is warranted. For these hospitals' long-term well-being, future investigations had better not reveal an incentive clause with profit sharing for ordering diagnostic tests in the ER medical groups' contracts with the various hospitals.

## **Conclusion**

There is a recurring pattern when ill designed health care financing products and public policies collapse - physicians are blamed.

A major mess is about to develop as managed care exits health care. This ill-conceived health care financing product will soon lose its dominant position in underwriting the private sector's health benefits. Its first dollar coverage is inherently inflationary, its management style is inefficient and the overhead structure costs are unreasonable.

The likely replacement will be defined contribution, which is built upon a high deductible major medical coverage core. Thus, patients will be exposed to a wide corridor of financial risk. In fact, during any given year, 90 percent of individuals under major medical coverage will not meet their deductible limit.

Uninsured and unbudgeted medical debt are an evolving hardship for Sacramento's patients and their families. Medical debt is the leading cause for household bankruptcy in the economy today. It has been demonstrated that an average household with medical debt in excess of 2 percent of income is nine times more likely to file for bankruptcy.

It is, therefore, incumbent upon physicians to proactively take responsibility for both the medical and the financial well-being of their patients in this coming environment. In the process, we cannot ignore the elephant in the room. The primary driver of health inflation is the cost of hospital services.

Physicians should, in my view, purchase high deductible indemnity insurance products for themselves and not accept discounts or professional courtesy (if such still exists) from their peers or hospitals to which they refer. By doing so, they will be exposed to the same financial liability that their patients now face and will avoid an inherent conflict of interest.

Physicians need to be able to provide the full range of medical services, including IV infusion therapy, in their offices at reasonable prices. Third-party payers should reimburse for these services.

Furthermore, physicians need to regain their entrepreneurial roots and open innovative alternatives to the hospitals for diagnostic testing and interventional therapy in the ambulatory environment.

No one in Sacramento knows, or for that matter cares, who is the administrator of a hospital. The business types running our hospitals have shown themselves to be bottom-line oriented, lacking both common sense and decency. Despite their outrageous business practices, the public will inevitably hold their personal physician responsible.

Physicians must monitor the pricing structures at the hospitals to which they refer patients. Any administrator attempting to mark up pharmaceuticals and supplies by a factor of ten should be run out of town by the medical staff.

As an informed consumer and the parent of a former exploited patient, I expect no less.

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1. Health Care Financing Administration (HCFA) guidelines, 2001.
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3. California Medical Association.

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