

# SAN ANTONIO ORTHOPÆDIC SPECIALISTS

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## A Brief History of Medical Billing and Collections

I would first try to point out that in any “explanation” there must be a balance between clarity and accuracy. If something is absolutely accurate, it is often so convoluted as to be absolutely incomprehensible. Conversely, if an explanation is absolutely clear, then it is likely to be inaccurate. In this brief history, I’ve endeavored to strike a balance between these two. To the best of my knowledge, there is nothing here that is absolutely inaccurate; at times perhaps oversimplified, but not inaccurate. Let us begin.

If you’ve taken the time and opportunity to look at a recent “explanation of benefits” it may seem very confusing. The numbers billed and the numbers paid both seem to make no sense. Yet, it is a system with which most physicians live day to day, and most patients ignore. At the same time, it is a system which allows the insurance companies to take money from policyholders, and keep most of it. In my personal opinion, this is legalized thievery.

Please remember at the outset, that without doctors, there is no health care. Hospitals depend on doctors to admit patients. Pharmaceutical and medical device companies depend on doctors to prescribe their products. Therapists, nurses and laboratories all depend upon doctors to request their services. All of these entities however, all compete for the health care dollar. For a typical orthopaedic hospital admission, the physician’s bill now constitutes though, only about 5% to maybe 10% of the total bill. The physician’s reimbursement is a fraction of bill. The commissions paid to salesmen for implant sales can exceed the physician reimbursement for doing the surgery.

How did we get here?

Many decades ago, the business aspects physicians offices worked much like the business aspects of any other service industry. Physicians charged a fee for their services, and the patients received and usually paid the bills. Prices were reasonable, and the physician had

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flexibility to do charity work when he or she felt it necessary or appropriate. Most doctors made a healthy living, and had no problem providing a reasonable amount of charity care.

Then insurance companies got into the picture. They offered to pay for health care, if you, the patient, gave them money upfront. They would then take that money, and invest it. They invested in the stock market, and probably other areas. As needed, they'd liquidate some of those assets to actually pay for medical services provided to their members. They would make money when their investments did well, or if their patients did not need as much in services as they paid in premiums. If their investments did poorly, they'd raise their premiums. To this day, health insurance premiums reflect the stock market more than they reflect medical advances or increases in health care billing. With the collapse of the sub-prime mortgage lending industry, one can expect astronomical increases in the cost of health insurance. The companies, of course, will blame the doctors for their "costs".

It is said that the modern day version of the "Golden Rule" is, "He who has the gold, makes the rules." Thus it is with the insurance companies. The companies started going around to the physician's offices, and offering to send their "covered lives" (ie. patients) to the offices of contracted physicians. To accept the contract, the physician had to accept as payment in full the "usual and customary" bill for the service.

"Usual and customary" was initially intended to be the "average" of the region's charges for the particular service. At least it was advertised to the physicians as such. Subsequently, the companies started paying, say 85% of usual and customary. In response, most physicians raised their rates so that the usual and customary was increased, and the reimbursement did not drop. The insurance companies always seemed to be just ahead of the game by squeezing on both ends of this system. They gained more money by increasing the premiums charged to their covered lives and paying less for the services.

Then the government got involved. Initially, the government paid for services at a reasonable rate, and with few regulations. Over the years though, the regulations have increased, and the reimbursements have dropped. Again, he who has the gold makes the rules. The government though is subject to the influence of lobbyists. Hospitals argued for more money, pharmaceutical companies argued for more money. Implant makers and

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other medical device companies argued for more money. Physicians argued for better care for the patients. Thus, the percentage of the health care dollar that actually goes to physicians has steadily diminished.

In many areas, not only physicians offices, the reimbursements have not kept pace with costs. Hospitals, for example, are required by law to treat anybody who shows up in their emergency room, without regard to their ability to pay. As the stock market goes down, and insurance premiums go up, the number of uninsured increases. To offset the expense associated with treating the uninsured, hospitals increase the bills charged to all of the paying patients. This means that the insurance companies need to pay more to the hospitals. When they get to keep less of the money that they bring in, what do they do? They raise premiums of course, then more people drop their insurance, the hospitals charge more, and the cycle continues without a visible end.

The story is not over however. Insurance companies have found more ways to keep more of the money that you send them. They designate some of their doctors as “premium” doctors. This term implies higher quality. It really means less expensive. Those doctors willing to work for less or who cost them less get the designation as “premium” physicians. These are then marketed to large companies. The large companies get a tax break for providing health insurance to their workers. The employees get a small portion of that break on the cost of the insurance. Of course, they get no choice of insurance companies. That decision has been made, often on a financial basis, rather than quality basis, by the owners of the company. The small business and the individual cannot negotiate with the insurance company for lower rates, nor do they get a break on their taxes for obtaining health care insurance. They get hit from both sides.

Only two more steps here. Now that the government is involved, they set prices. Most insurance companies have now abandoned the “usual and customary” in favor of a fixed percentage of Medicare rates. There is no other industry or service in this country where the government sets the amount that is to be paid for the product or service. As the government decides to spend less on health care, the insurance companies get to keep even more of your premiums.

Lastly, most, if not all insurance company contracts include a clause whereby they will pay the lesser of their contracted rate or the minimum that anybody else pays for the same

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service. This has two effects. First, if company #1 finds out that company #2 pays only 80% of Medicare, then company #1 can request refunds of all amounts paid over 80%. Worse, if a doctor provides discounted service for good will or charity, the company can come back and demand the same “price” for all of their covered lives. Thus, even a \$5 discount to one patient may be extended (by insurance companies) to all patients. As this office sees more than three thousand outpatient visits per year per doctor, a \$5 discount given to one patient can result in a “recall” of more than \$35,000. The insurance company can demand that the physician give this money “back” to them. They are under no obligation however, to give the money back to the patient. Hence, physician’s offices need to be sticklers about deductible amounts and co-pays.

Please remember that 100% of the health care dollar is prescribed by physicians. Without physicians, there is no health care. The hospitals need physicians to admit patients. The pharmaceutical companies need physicians to prescribe their drugs. Implant makers need physicians to implant their components. Therapists need physicians to send patients for exercises. Insurance companies need physicians to care for their “covered lives.”

In most arenas, you get that for which you pay. If you want a good product, you expect to pay a little more for it. In medicine, on the other hand, the government, sets the prices. (They often end up spending more for the care of a lesser quality physician.) Still, the full responsibility for the care of the patient belongs to the physician. So now, the entire system is upside down.

Respectfully submitted,

Adam I. Harris, M.D.