A Summary of “Bitter Pill: Why Medical Bills Are Killing Us,”
by Steven Brill

Introduction

A first in the history of *Time Magazine*, this single story—36 pages, 24,000 words—filled the feature section of the March 4, 2013 issue. It’s had plenty of press, but I know you won’t read it. I’m retired and it took me a week to read it. Still, it’s crucial stuff, so I’m attempting to summarize this thoroughly researched piece of investigative journalism. If it’s in quotes, those are Brill’s words. Otherwise, I’m paraphrasing and leaving information out like crazy. I’ve boiled it down to 1,665 words. Mr. Brill, my apologies.

“When we debate health care policy, we seem to jump right to the issue of who should pay the bills, blowing past what should be the first question: Why exactly are the bills so high?” That question prompted Brill to begin his research. For seven months, he analyzed bills from hospitals, doctors, drug companies and every other player in the health care system; interviewed doctors, drug, hospital, Medicare and insurance administrators and collected patient stories across the country. The individual stories are gripping: read those, if you can, online. No room for them here.

Findings

“In hundreds of small and midsize cities across the country...the American health care market has transformed tax-exempt ‘nonprofit’ hospitals into the towns’ most profitable businesses and largest employers, often presided over by the regions’ most richly compensated executives.”

Such hospitals dominate our economy—nearly 20% of our GDP goes to health care. Our taxpayer burden is greater than anywhere else on earth. We spend more on health care than the next 10 biggest spenders combined, which include Japan, Germany, France, the U.K and Canada. “*Yet in every measurable way, the results our health care system produces are no better and often worse than the outcomes in those countries.*”

Shocked by the $60 billion cleanup from Hurricane Sandy? “We spent almost that much last week on health care.” McKinsey research identified $750 billion in annual health
care overspending. The health care industry wants to keep it that way, spends more than three times what the military-industrial complex spends lobbying Washington.

**From the charts and graphs (of which there are many)**

- 62% of personal bankruptcy filings each year are related to medical bills
- The *lowest* paid CEO on the list of 10 largest nonprofit hospitals earns $2,080,779
- Of the countries that spend most on health care, we spend by far the highest per person and yet our life expectancy is the lowest in that group.
- Our infant mortality rank is 50th in the world, nine spots below Cuba
- One Nexium pill here costs as much as eight pills in France.

**Surprise! Medicare works.**

Brill’s investigation of Medicare shows an effective organization staffed by more people employed by private contractors (8,500) than government workers (700). Bills are generally processed within 30 days. The system is efficient, and 96% of doctors accept Medicare patients in spite of the discounted rates in part because they pay quickly.

“Medicare collects troves of data on what every type of treatment, test, and other service costs hospitals to deliver. Medicare takes seriously the notion that nonprofit hospitals should be paid for all their costs but actually be nonprofit after their calculation.” Besides direct costs, allocated expenses such as overhead, capital expenses, executive salaries, insurance, regional costs of living and even the education of medical students, are factored in. Even so, Brill finds, in one of many like examples, Medicare would have paid $13.94 for a hospital test billed at $199.50.

The almost poor—those who don’t qualify for Medicaid and don’t have insurance—are most often asked to pay exorbitant prices. Medicare forces discounts, as do insurance companies, so those with such resources are buffered. “If you are confused by the notion that those least able to pay are the ones singled out to pay the highest rates, welcome to the American medical marketplace.”

“The only players in the private sector who seem to operate efficiently are the private contractors working—dare I say it?—under the government’s supervision. They’re the Medicare claims processors...” Medicare’s total management, administrative and
processing expenses amount to two-thirds of 1% of the amount of the claims, less than $3.80 per claim. As a comparison, Aetna spends $30 for each of its claims, about 29% of the amount of claims.

**How Congress handcuffs Medicare**

“Federal law restricts the biggest single buyer—Medicare—from even trying to negotiate drug prices. As a perpetual gift to the pharmaceutical companies...Congress has continually prohibited the Centers for Medicare and Medicaid Services (CMS)...from negotiating prices with drug makers.” A law passed by Congress in 2003 requires Medicare to reimburse for any cancer drug approved by the FDA, plus 6%. Most states require insurance companies to do the same.

This is the “comparative-effectiveness” debate that almost derailed Obamacare in 2009. The critics charged that Washington bureaucrats would dictate which drugs were worth giving to which patients and even which patients deserved to live or die. So comparative effectiveness was dropped. If research shows that Drug A for cancer, at $300 a dose, is just as effective as Drug B, at $3,000 a dose, Medicare can’t do a thing about it. Keeping comparative effectiveness out of Obamacare means we still pay way too much for drugs.

We also spend ridiculous amounts “on durable medical devices like canes and wheelchairs, in part because a heavily lobbied Congress forces Medicare to pay 25% to 75% more for this equipment than it would cost at Walmart.” Tests and equipment are similar cases. CT equipment pays for itself in a year if it does 10 – 15 procedures a day. After a year, every scan means pure profit, less maintenance cost. The U.S. does more CT tests per capita than any other country and pays much more for each test.

**Possible solutions**

Allow competitive bidding. Congress hasn’t allowed Medicare to drive down the price of durable medical equipment through competitive bidding, but *did* allow a competitive bidding pilot program that produced 40% savings. Medicare spends $15 billion a year on durable medical equipment. Competitive bidding could save us $6 billion a year.
Lower the age at which people can join Medicare. Medicare buys health care services at lower rates than any insurance company. The best way both to lower the deficit and help people save money would be to let near seniors join before 65. They could pay premiums based on their incomes and a higher proportion of their bills—say, 25% or 30%—rather than the 20% now required for outpatient bills. Adding younger people would lower the overall cost per beneficiary and reduce the deficit, because younger members tend to be healthier.

Tax hospital profits and place a tax surcharge on all non-doctor hospital salaries over $750,000. “Why shouldn’t those who profit most from a market whose costs victimize everyone else chip in to help?” Brill says it’s unlikely to happen: hospitals are often the most politically powerful institution in a congressional district.

Change the chargemaster, the infamous price list of products and services all hospitals use, which seems to be based in fantasy and results in drastic overpricing like a 10,000% markup on acetaminophen. $199.50 was the chargemaster price for that $14 test mentioned above.

Reduce drug prices to what they get in other developed countries. Save $90 billion a year.

Defenses for doctors. “Embarrass Democrats into stopping their fight against medical-malpractice reform and instead provide safe-harbor defenses for doctors so they don’t have to order a CT scan whenever, as one hospital administrator put it, someone in the emergency room says the word head.” Eliminating unneeded lab tests, CT scans and MRIs could cut more billions.

The core problem

You must have electricity and can’t go elsewhere, are stuck with a sole provider. Your health care situation isn’t much different. You have whatever insurance your employer chooses, can only use certain hospitals or doctors. Most of us “are powerless buyers in a seller’s market where the only sure thing is the profit of the sellers.” But unlike with the electric company, no regulator caps hospital profits. “Unless you have Medicare, the health care market is not a market at all. It’s a crapshoot.”
“The real issue isn’t whether we have a single payer or multiple payers. It’s whether whoever pays has a fair chance in a fair market.” We don’t have to scrap our system and aren’t likely to, but can significantly reduce the $750 billion we overspend. “Put simply, the bills tell us that this is not about interfering in a free market. It’s about facing the reality that our largest consumer product by far— one-fifth of our economy— does not operate in a free market.”

The Affordable Care Act (Obamacare) does good work around the edges of the core problem. It restricts abusive hospital bill collecting, forces insurers to explain policies in plain English, and puts the insurance umbrella over millions more Americans, a historic breakthrough. But nothing in the act addresses health care costs. Republican opposition eliminated comparative effectiveness, remember. Three of the best things about Obamacare, prohibiting exclusions for pre-existing conditions, restrictions on co-pays for preventive care and the end of annual or lifetime payout caps, will cause insurance premiums to rise. Obamacare changed the rules related to who pays for what, but hasn’t done much to change the prices we pay.

Conclusion

“We’ve enriched the labs, drug companies, medical device makers, hospital administrators and purveyors of CT scans, MRIs, canes and wheelchairs. Meanwhile, we’ve squeezed the doctors who don’t own their own clinics, don’t work as drug or device consultants or don’t otherwise game a system that is so gameable. And of course, we’ve squeezed everyone outside the system who gets stuck with the bills.”

Following the money shows that we’ve let the big health care moneymakers control the debate, keeping us from seeing the main issue: all the prices are too damn high.