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As doctors flock to hospitals, bills spike for patients

By Ames Alexander, Karen Garloch and David Raynor
PUBLISHED IN: LOCAL NEWS

North Carolina patients are likely to pay more for routine health care if their doctors are employed by a hospital, an investigation by the Observer and the News & Observer of Raleigh has found.

It's true for services ranging from heart tests to routine office visits. 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 U.S. doctors employed by hospitals has doubled over the past decade. In Mecklenburg County, more than half of all physicians are employed by hospitals.

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

The same service performed in the same location by the same doctor can cost more than double what it did before the hospital acquired the practice.

"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.

Here's why: For many routine services, insurers pay hospitals more than independent doctors.

- EARLIER STORIES IN PROGNOSIS: PROFITS

In April, the Observer and The News & Observer of Raleigh published a five-part investigation showing how nonprofit hospitals in North Carolina cities have become hugely profitable.

It showed that Charlotte-area hospitals have:

• Generated some of the nation's largest profit margins and amassed billions of dollars in reserves.

• Consolidated into two large systems – Carolinas HealthCare System and Novant Health – that have leverage to negotiate higher payments from insurance companies.

• Paid top executives millions. At least 25 North Carolina hospital executives have received total annual compensation exceeding $1 million.

• Sued thousands of needy patients, frequently putting liens on their homes and damaging their credit.

In September, a follow-up investigation showed that large nonprofit hospitals are dramatically inflating prices on chemotherapy drugs at a time when they are cornering more of the market on cancer care.

To read the stories, visit **charlotteobserver.com/hospitals**.

Under Medicare rules, hospitals are allowed to collect more than doctors – and that means the out-of-pocket share for Medicare patients also is larger.

The shift also has affected those covered by private insurance. That's because hospitals wield far more market power than independent doctors, which allows them to negotiate higher payments from insurance companies.

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. Hospitals get about 80 percent more Medicare revenue than independent doctors for many routine services, he said. But the additional expenses for a hospital don't justify that kind of payment difference, he said.

The latest findings underscore the lessons of a previous Observer investigation, which found that hospital consolidation is contributing to the rising cost of health care.

Many large North Carolina hospitals are quite profitable, despite their status as nonprofits, the newspapers reported in April. Those hospitals pay top executives millions and have amassed billions in reserves, even as they have pursued some poor and uninsured patients with lawsuits and collection agencies.

Now some officials are questioning whether hospital systems have grown too big. Among them is N.C. 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.

- Cost of routine care rising as hospitals dominate market

Independent doctors, who usually provide less expensive care, are becoming harder to find.

In a review of Medicare and private health plan data, the Observer and the News & Observer of Raleigh found that more of the state's routine office visits and echocardiograms are being done by hospitals and hospital-owned physicians' practices, which typically collect much more than independent physicians do.

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.

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, the number increased more than 300 percent.

Blue Cross and Blue Shield of North Carolina, the state's largest insurer, reports that an increasing percentage of echocardiograms are performed by hospitals and the practices they own. That has led to a 28 percent increase in the average payment for echocardiograms – more than twice the rate of inflation.

Robert Berenson, an analyst at the Urban Institute's Health Policy Center, says the trend is harming consumers.

"That's taking advantage of the payers," he said. "… It is not promoting more efficient care."

Ames Alexander

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"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."

'Fell into their web'

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

Following a heart valve replacement eight years ago, she has 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 co-pay.

This year, during Miller's 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.

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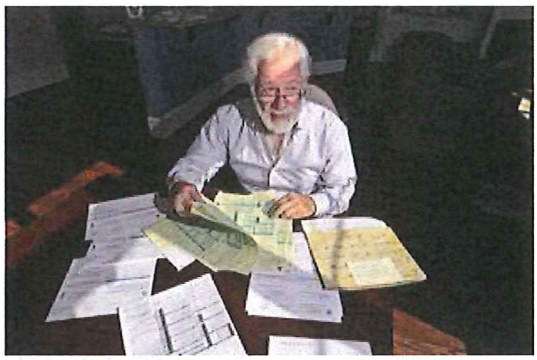

Same test, different price

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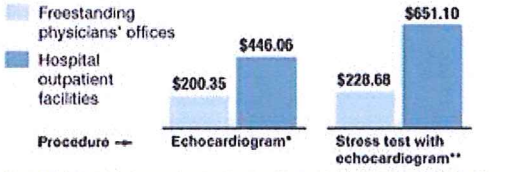

Notes: Echocardiograms are tests that use ultrasound to create a moving picture of the heart. The figures above include both the professional fee to the doctor and the technical fee for the test itself.
*Reflects figures for CPT code 93306, the most common type of echocardiogram
**Reflects figures for CPT code 93351, an echocardiogram performed during a stress test to determine the effects of stress on the heart.
Source: Medicare payment schedules

AMES ALEXANDER - RESEARCH DAVID PUCKETT - STAFF GRAPHIC

"I was just shocked," Miller said. "… I feel like I got taken advantage of."

Across North Carolina and the U.S., hospitals are increasingly billing for heart tests. Experts say the higher bills illustrate the structural shift that has left patients paying more 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 massive hospital system that runs Cleveland Regional.

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

Miller's insurance plan won't cover hospital outpatient tests and procedures until she pays her $3,500 annual deductible.

"It's like we were hoodwinked and fell into their web," said Miller's husband, John, who owns a trucking company. "…Something is not right."

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

A former Sanger cardiologist, however, said he felt moving such tests to hospitals would not improve the quality.

"It has everything to do with money," said the doctor, who asked not to be named. " … It's a constant game you play with insurance companies."

A similar change happened in 2010, when Asheville Cardiology Associates, the largest cardiology practice in Western North Carolina, merged with Mission Hospital. Subsequently, Mission began billing at the higher hospital outpatient rates for echocardiograms and MRIs done at those offices.

Charlotte's second-largest cardiology group, Mid Carolina Cardiology, is also hospital owned. In 2007, its doctors became employees of Novant Health, which owns four Presbyterian hospitals in Mecklenburg County.

Mid Carolina continues to provide echocardiograms and other diagnostic tests in its offices, at the physician rate, not the hospital rate, Novant spokeswoman Kati Everett said. All but about three percent of the physician practices owned by Novant charge at the lower rate, she said.

Trend brings higher prices

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

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

One health care recruiting company predicts that hospitals could employ as many as 75 percent of U.S. doctors within two years.

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.

In Mecklenburg, about 90 percent of the more than 100 cardiologists are employed by hospital systems.

Dr. Daniel Wise, a former Novant cardiologist who now has a Charlotte private practice, said cuts in reimbursement have gone too far, especially for doctors trying to remain independent. He said cardiologists' incomes have declined by 30 percent to 40 percent in the past three years.

Wise left Novant in 2008, but said, "If I had foreseen where things were going, I would not have done it."

When hospitals try to increase reimbursement by moving tests from the office to the hospital, it's not about improving quality, Wise said. "It's a volume-driven thing. If you stuff more people into the hospital system, and you try to do it with less (technicians) to keep your costs down, … it's got the potential of driving it in the other direction."

Many doctors have been unhappy about the trend. In a recent 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 compensation helps explain why many doctors have opted to join hospitals, other factors play a role. By joining hospital systems, many overworked physicians get shorter work weeks and share on-call duties. Hospitals also take over complicated back-office functions such as billing, negotiating with insurance companies and managing the expensive transition to electronic medical records.

Hospitals have plenty to gain as well. Buying doctors' practices helps hospitals enlarge their referral networks and boost profitability. Now, however, many experts say the trend is boosting the already high price of health care.

"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."

Bill changes; service doesn't

Gary Ziomek can vouch for that. The Waxhaw resident began getting physical therapy in 2011, after undergoing an unsuccessful spinal fusion surgery. He went to a therapist at Carolinas Rehabilitation on the campus of Carolinas Medical Center-Pineville hospital.

Early this year, his bill was $148 for 30 minutes of massage. But starting in May, the charge for a 30-minute massage rose sharply, to $249.30 – even though he got the same therapy from the same therapist in the same building.

Ziomek said an employee told him the higher charge came about because the office, which is owned by Carolinas HealthCare, began billing as a hospital-based setting. He said he was told that patients could go to the Ballantyne office and pay the lower amount.

Ziomek's Aetna insurance reimburses differently based on where a service is rendered. For an office visit, Ziomek was responsible for a $20 co-pay, no matter if he had met his $250 deductible. For a hospital visit, he pays 10 percent of the bill after paying the $250 deductible.

In this case, Ziomek's out-of-pocket expense dropped, because he had already met his deductible for the year. But he's concerned that the overall cost went up, with no change in service or quality.

"Somewhere along the line, they realized, 'We can charge more to the insurance company even though the patient is getting exactly the same service,' " said Ziomek, 70, a retired investment banker. "They could have kept the lower rate, but they chose not to. Why? Because of greed."

Margie Maxwell, president of Aetna's Southeast market, which includes the Carolinas, agreed to review Ziomek's bills at the Observer's request. She said company officials have seen more bills for services at the higher hospital rate.

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Hospitals fight closing costly loophole

By Ames Alexander
PUBLISHED IN: PROGNOSIS: PROFITS

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In the convoluted world of Medicare billing, hospital-owned clinics can collect far more than independent physicians for routine office visits.

A federal panel that helps set Medicare policy is pushing to change that.

As hospitals buy more physicians' practices, they're increasingly billing for office visits. Typically, they collect about 80 percent more from Medicare for those visits than independent doctors can.

That trend could increase annual Medicare spending by $2 billion by the year 2020, according to the Medicare Payment Advisory Commission. Because Medicare patients are responsible for paying 20 percent of their doctor bills, patients also stand to see substantial increases in their medical costs.

MedPAC, an independent panel which advises Congress on Medicare policy, has proposed what some experts see as a common-sense solution. It wants to equalize payments to hospitals and doctor's practices for office visits.

But hospitals have vigorously fought the proposal. In a letter to Congress, the American Hospital Association contends the MedPAC proposal would reduce access to care and prove "significantly damaging to beneficiaries and the providers on which they rely."

Medicare already pays hospitals too little to cover costs, the association said.

"America's hospitals have greater responsibilities and requirements than physician offices: requirements to treat all comers (regardless of ability to pay), 24-7 staffing requirements, and seemingly endless regulations from nearly a dozen different … agencies," the hospital association wrote.

Hospital-based clinics also tend to treat sicker patients, the association said.

Others, however, argue that the physicians' practices bought by hospitals aren't usually staffed around the clock. And if they treat sicker patients, they can use the appropriate billing codes to collect more money, says Robert Berenson, an analyst at the Urban Institute's Health Policy Center.

Treating Medicare patients doesn't have to be a money-losing proposition for hospitals, some experts say. They point to studies by MedPAC, which have found that efficient hospitals are able to make a profit treating Medicare patients.

Congress has not acted on MedPAC's recommendation.

It's clear that hospitals have obligations to treat all-comers at all hours, said Berenson, a former MedPAC commissioner. But that, he said, doesn't mean the suburban physicians' offices that they own should be able to collect far more than independent practices for the same services.

"We have to close this loophole," he said. "This has been known about for years. … It's time to bite the bullet and do something about it."

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Reponse from Carolinas HealthCare System

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Questions from The Charlotte Observer

On Nov. 2, the Observer sent Carolinas HealthCare System the following questions:

• After CHS buys a physicians' practice, how does the billing for routine office visits and echocardiograms at those offices typically work? Does the billing automatically switch to the hospital system's higher outpatient rate? Do some of the doctors continue to bill at the existing physicians' office rate? Is there a policy about how this is routinely handled?

• Why do hospitals sometimes charge significantly higher amounts than physicians' offices for routine tests and services, such as echocardiograms, office visits, physical therapy and sleep studies?

• We understand that after the Sanger Clinic joined CHS, some patients have been sent to hospitals for echocardiograms and other cardiac tests that used to be done in the doctors' offices. Were doctors instructed not to do those tests in the office anymore? If so, why was that change made and when was it made?

• Related to that, we have spoken to the husband of a patient who had been getting echocardiograms at the Sanger office in Shelby and is now being directed to get her echocardiograms at Cleveland Regional Medical Center. As a result, the patient's out-of-pocket expenses increased substantially. She used to pay a $35 co-pay each time she had her annual echocardiogram. But this year, Sanger told her to get her echo test at Cleveland Regional Medical Center. It was the same test she'd received in previous years, but this time it was billed as an outpatient procedure, and her out-of-pocket expense was nearly $1,000.

What are your thoughts about that? Could the hospital system keep such tests at the lower price point? Is it fair to patients to pay so much more money for the same test?

We also asked Presbyterian about this and learned that, even after Mid Carolina Cardiology doctors became employees of the hospital system, they continued charging the same office rate for echocardiograms.

• Another example is physical therapy.

A patient who has been getting physical therapy at Carolinas Rehabilitation Pineville was told that his charge would increase last spring. The amount of his bill doubled for the same therapy, with the same

therapist, in the same office on the CMC-Pineville campus. The patient was told the change came about because the office began billing for its services as a hospital-based setting instead of an outpatient setting. Can you explain why that change made?

• We notice from Medicare data on claims for echocardiograms and routine office visits that N.C. hospitals are submitting significantly more bills for those services than they have in the recent past.

The number of echocardiography claims that CHS hospitals billed for increased by nearly 50 percent from 2007 to 2010. At CMC alone, the number more than quadrupled over that time period.

And the number of office visits that CHS hospitals billed to Medicare climbed by more than 40 percent from 2007 to 2010. Can you explain what accounts for these increases?

• A former member of the MedPAC board and other health care experts suggest that, in general, this is a national problem and that these increases in prices -- after hospitals absorb doctors offices -- are not accompanied by an improvement in quality. Would you disagree with that?

• How many doctors does CHS now employ?

We read in one CHS bond disclosure document that the system employed 1,228 primary and specialty physicians in 2011. Is that the best measure? If not, please tell us what figure you think is most accurate? And can you tell us what the figure was 10 years ago?

We also read a separate figure showing 2,765 physicians for the CHS combined group staff. What's the difference between these two figures?

• Can you tell us what percentage of doctors employed by CHS now work in offices that are considered outpatient facilities or departments of CHS?

Carolinas HealthCare System statement

On Dec. 6, CHS sent this response:

"As the region's largest safety net provider, Carolinas HealthCare System is committed to providing the highest quality healthcare to everyone who needs it, regardless of ability to pay. CHS's Sanger Heart & Vascular Institute is one example of how we are building on that commitment, being nationally recognized by the American College of Cardiology for cost effectiveness and delivering the most appropriate care to each patient.

"Throughout the entire network of hundreds of CHS physician practices, only about 20 percent are hospital-based. Those that are hospital-based are clinically integrated with a CHS hospital which allows for improved access, quality and coordination of care for our patients. Furthermore, hospital-based practices are held to higher regulatory and quality standards than private practices which therefore may result in higher costs.

CHS does not take a one size fits all approach to providing care or to the charges applied to services, and we work hard to achieve greater value and better care for our patients if these higher charges do occur. Our mission at Carolinas HealthCare System is to provide every patient in every community we serve with the healthcare they need. We know our patients have a choice in where they receive

care, and we remain vigilant in innovating to create higher quality, better outcomes and an improved experience; ultimately creating true value for all patients."

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Posted: Friday, Dec. 14, 2012

Graphic: Doctors, procedures, costs compared

PUBLISHED IN: NEWS

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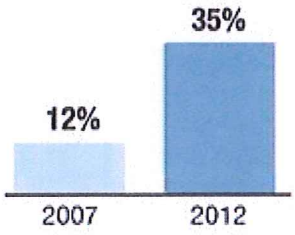
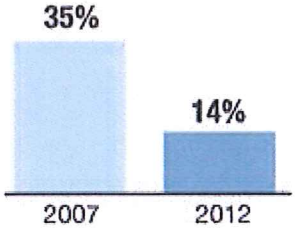
N.C cardiologists join hospitals

In North Carolina, the percentage of cardiologists employed by hospitals has soared in recent years...



...while the percentage employed by freestanding physicians' offices has plummeted.



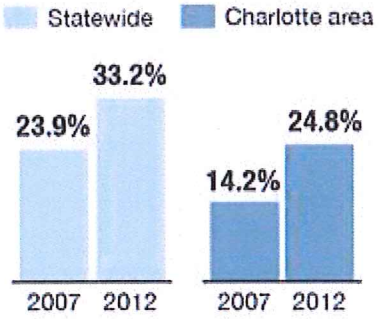
NOTE: The remaining cardiologists are employed by medical schools, universities and government agencies.

SOURCE: Surveys conducted by the American College of Cardiology.

AMES ALEXANDER – RESEARCH
DAVID PUCKETT – STAFF GRAPHIC

N.C. hospitals do more heart tests

When patients get echocardiograms these days, they're more likely to get a hospital bill. That's because hospitals are buying more cardiology practices. And because hospitals are able to collect more than independent physicians, that trend is costing patients and insurance policy holders more. The following figures, from Blue Cross and Blue Shield of North Carolina claims data, show how the percentage of echocardiograms billed as hospital procedures has risen over the past five years.



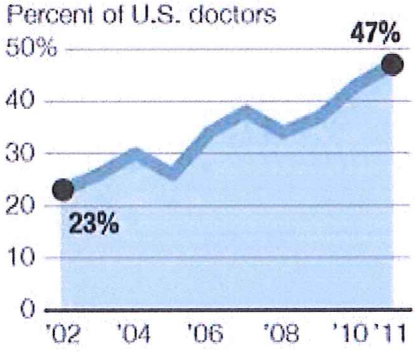
Note: Data excludes echocardiograms conducted on an inpatient basis

Source: Blue Cross and Blue Shield of North Carolina, the state's largest health insurer.

AMES ALEXANDER – RESEARCH
DAVID PUCKETT – STAFF GRAPHIC

Doctors flock to hospitals

The percentage of U.S. doctors employed by hospitals has doubled over the past decade. In Mecklenburg County, more than half of doctors are employed by hospitals.



Source: Medical Group Management Association survey

AMES ALEXANDER – RESEARCH
DAVID PUCKETT – STAFF CHART

DAVID PUCKETT – STAFF GRAPHIC

Same test, different price

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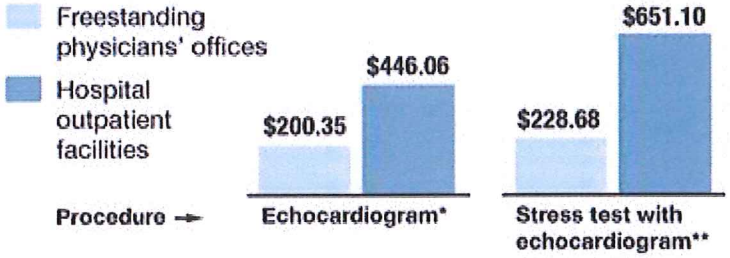

Notes: Echocardiograms are tests that use ultrasound to create a moving picture of the heart. The figures above include both the professional fee to the doctor and the technical fee for the test itself.

*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

AMES ALEXANDER – RESEARCH DAVID PUCKETT – STAFF GRAPHIC

North Carolina Hospital Association
Serving North Carolina's Hospitals & Health Systems

Provider-Based Services

North Carolina hospitals and the physician practices that are owned by hospitals are following Medicare regulations when filing both a professional claim and an institutional or technical claim for procedures done in physicians' offices or clinics. The professional claim is for the actual procedure provided by the physician and the institutional claim is to cover overhead expenses for the provider-based service.

To qualify as a provider-based service, a hospital-owned physician's practice location must be within a specific distance from the hospital and must have integrated its operations with the hospital. The integration required involves the physician's practice combining its governance, medical records, employee payment system, registration and revenue generation with the hospital. These rules apply to every Medicare certified hospital, healthcare system and fully owned physician's practice or clinic in the country and have been in place for cost reporting periods since January 10, 2001.

Medicare pays free-standing (not hospital owned) physician offices and clinics a global fee to cover medical records, employee and other office costs. This global fee may be higher or lower than the professional fees paid to hospital-owned physicians practices and clinics. In recent years many physicians have argued that these Medicare rates are inadequate to cover their costs, and in some cases have closed their practices to new Medicare patients. Through the filing of an "institutional" claim, the physicians' office or clinic is able to receive reimbursement to offset expenses for office personnel, medical records and other expenses necessary for operation of the practice, as well as some additional costs incumbent in aligning itself with a hospital.

Medicare recognizes that provider-based settings take on the same mission as hospitals: to serve everyone in the community regardless of their ability to pay. This creates a difference between provider-based services and free-standing physicians' practices that can be more selective in the patients they serve. Medicare compensates provider-based services differently to compensate for those who cannot pay. Provider-based services are also under state and federal regulatory oversight, while free-standing physicians and clinics are not, another factor than increases provider-based services' costs and their compensation from Medicare.

By allowing hospital-owned physicians' practices and clinics to become provider-based services, Medicare is encouraging system integration. Medicare's encouragement of system integration can create coinsurance issues for patients. Because Medicare requires two claims for service in a provider-based setting, patients often encounter two co-pays and two deductibles. Patients covered by commercial insurance — which must be billed identical to Medicare — may also be affected by having copays and deductibles that are based on percentages of charges rather than set amounts.

The Medicare regulations governing provider-based designation are available online at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/a03030.pdf

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N.C. Attorney General eyes 'artificial' hospital pricing

By Ames Alexander and Joseph Neff
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Calling the state's health care costs artificially high, N.C. Attorney General Roy Cooper says he will examine whether to use antitrust laws or new legislation to reduce them.

"I'm concerned about this issue," Cooper told the Observer. "Health care costs are high enough without artificial boosts that could come from lack of competition."

Cooper's announcement comes in the wake of antitrust investigations into hospitals in other states. It also follows an Observer story showing large nonprofit hospitals are dramatically inflating prices on chemotherapy drugs at a time when they are cornering more of the market on cancer care.

In a joint investigation published last month, the Observer and The News & Observer of Raleigh found hospitals are routinely marking up prices on cancer drugs two to 10 times over cost. At the same time, hospitals are increasingly buying the practices of independent oncologists, then charging more for the same chemotherapy in the same office.

A previous investigation by the two newspapers, published in April, showed consolidation has given hospitals leverage to demand higher payments from insurance companies. That investigation also found North Carolina hospitals are among the most powerful interest groups in state politics, a fact that could neutralize any push for legislative reform.

Cooper said there's little question health care costs too much. The issue, he says, is whether a

- U.S. hospital mergers under scrutiny over pricing

As the number of hospital mergers across the country climbs, regulators are giving those deals closer looks.

In California, the state attorney general is investigating whether mergers have given hospitals power to increase prices in a way that violates antitrust law, the Wall Street Journal reported recently. The office has sent subpoenas to several large hospital chains, including Dignity Health in San Francisco and Scripps Health in San Diego.

Earlier this year, the Pennsylvania attorney general stepped in as Geisinger Health System acquired a nearby hospital. Authorities negotiated an agreement, requiring the two merging hospitals to contract separately with insurers for eight years, thereby reducing their power to demand higher payments.

The Federal Trade Commission also has fought some proposed hospital mergers, including one between OSF HealthCare and Rockford Health System in Illinois. OSF abandoned its plans to buy Rockford following the FTC's lawsuit.

Ames Alexander

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recent increase in consolidation has contributed to that problem. His staff will study whether antitrust laws – which are designed to prohibit monopolies and other anticompetitive arrangements – are the right tool for reducing costs.

Cooper said his lawyers will talk with officials from the Federal Trade Commission and with attorneys general in other states who have used antitrust laws to investigate consolidation.

A number of hospital systems in North Carolina have grown into profitable, fast-growing giants. Carolinas HealthCare System, a $7 billion chain that runs more than 30 hospitals, has built more than $2 billion in investments and owns more than $1 billion in property. Now the nation's second-largest public hospital system, it has posted average annual profits of more than $300 million in the past three years.

Novant Health, which owns 13 hospitals, generates more than $3 billion in annual revenue. The two systems own all hospitals in Mecklenburg.

The newspapers' April investigation found Charlotte-area hospitals generate some of the nation's largest profit margins. The region's hospital prices are about 5 percent higher than the national average, and comparable to those of larger cities, according to Aetna insurance company.

Meanwhile, a number of small, rural hospitals in North Carolina are struggling financially and feeling pressure to join with larger hospital systems.

The N.C. Hospital Association says the state's hospitals are committed to complying with antitrust laws. Consolidation hasn't driven up prices inordinately, the association says.

The group pointed to data showing hospital costs across North Carolina are, on average, below those in most other states. By one measure – hospital expenses per inpatient day – North Carolina was 15 percent below the national

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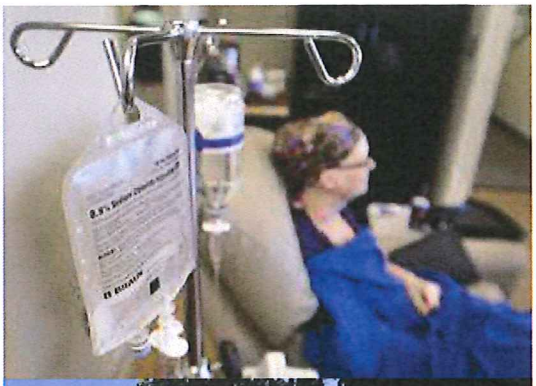
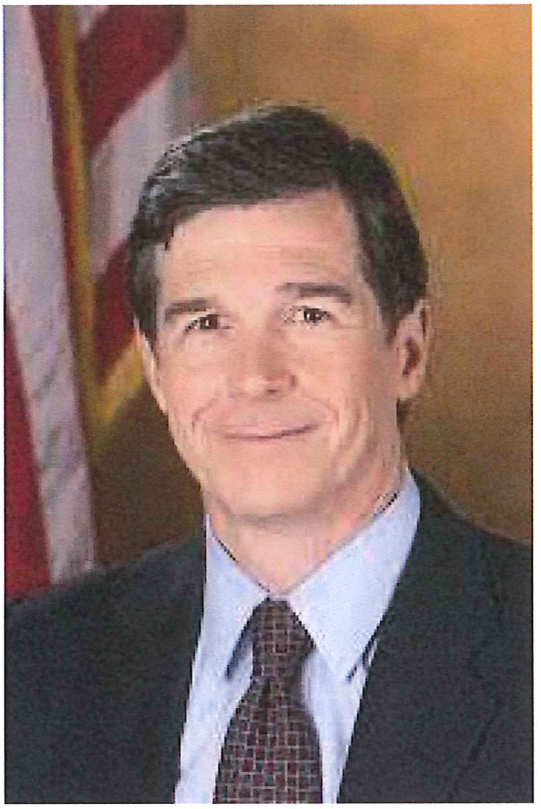


average in 2010, according to American Hospital Association figures.

"Consolidation in North Carolina health care is being driven by an evolving regulatory and market environment, one that demands higher quality and lower costs," the hospital association said in a statement. "These two goals can be achieved only through economies of scale and greater efficiency among providers."

Cooper's staff likely will meet with insurance company officials who complain they're in a bind, unable to do without the hospitals in large systems and forced to pay them too much. The staff also plans to meet with hospital industry representatives, who argue that consolidation has led to fewer administrative costs, lower prices and better service. A meeting with hospital association lawyers should happen in the next two weeks, Cooper said.



AG: New laws could be best fix

Antitrust laws are "difficult to enforce," Cooper said. For that reason, he said, his office also will examine whether new legislation would be a better remedy.

"You may be able to accomplish with a piece of legislation much more than you could accomplish with a protracted antitrust lawsuit," he said.

Cooper said it's premature to speculate about what such legislation might look like. But he suggested new rules could be aimed at structuring hospital mergers so they're less likely to drive up prices.

The hospital association said new legislation isn't needed and "could be harmful to advancing the goals of health care reform."

If lawmakers attempt to change the system, they may face an uphill fight. The newspapers' April investigation found the hospital association rarely loses when it comes to protecting the financial interests of its members. Last year, for example, a senior state legislator proposed limiting sales tax refunds to the state's largest hospitals. The hospital association ensured that the bill was never even discussed in committee.

"The hospitals constitute one of the strongest political forces in the state," said Adam Searing, director of the N.C. Health Access Coalition. "Unless legislation is structured so that most hospitals think it's a pretty good idea, it's going to be difficult to get that legislation passed."

The hospital association has been generous to people in power. Since 2000, it has contributed $21,000 to Cooper's election campaigns. The association has handed out more than $1 million to state candidates over the past decade, ranking in the top 10 state PACs for political donations.

The hospital industry's checks often don't come in the mail. Instead, a hospital executive or board member hand-delivers the contributions. The hospital association encourages hospital officials to forge relationships with local lawmakers.

High costs imperil lives

Hospitals in North Carolina are increasingly buying physician offices, Cooper said.

Most oncologists in the Charlotte area work for hospitals, the newspapers' most recent investigation found. And in the Raleigh-Durham area, nearly 90 percent of oncologists are employed by hospitals.

The newspapers also found two of the state's largest hospital systems – Carolinas HealthCare and Duke University Health System – appear to charge more than most hospitals for common cancer drugs.

Carolinas HealthCare said its pricing for chemotherapy is "comparable to health care providers across the country."

U.S. Sen. Chuck Grassley, R-Iowa, Congress' leading critic of nonprofit abuses, last month asked three of North Carolina's largest hospitals to share information about their use of a rapidly growing discount drug program, saying they don't appear to be passing along the "massive" savings to patients.

Cooper said he is troubled by apparent inequities in billing practices, with some North Carolina patients being charged "significantly more than others based upon their insurance or lack thereof, or whether their insurance company has been able to negotiate a better deal than someone else's."

"I'm concerned about the consumer who … may have an insurance company that has not negotiated as good a rate with a provider – and who cannot afford a particular treatment to save their life," said Cooper, a former state lawmaker who is serving his 12th year as attorney general. "We've seen those instances."

Hospital officials acknowledge they must charge higher prices on some patients and services to cover losses on others. They have a name for the practice: cost-shifting.

The attorney general said the current system also makes it hard for many prospective patients to determine what procedures will cost them. That, in turn, makes it hard for patients to shop around, he said.

"Consumers should have more information about the ultimate cost of potential procedures," he said.

Some top state lawmakers – including House Speaker Thom Tillis and Senate President Pro Tem Phil Berger, both Republicans – have agreed that patients need an easier way to find key information about hospital pricing. Tillis said previously that lawmakers will likely work with the hospital industry to make more data available.

But in May, a House subcommittee rejected a plan by Gov. Bev Perdue to make hospital bills more transparent and understandable. News and Observer database editor David Raynor contributed.