Navigating America's bewildering healthcare maze

Like so many other aspects of life in these here United States, our healthcare delivery system and our healthcare insurance system are broken and on life support.

Medicare is confusing. Co-pays are confusing. Deductibles are confusing and now, if those things weren't enough to raise your blood pressure, some healthcare providers are levying 'facilitation fees' (user fees) in addition to exorbitant charges for routine medical visits and co-pays. Mergers and buyouts of healthcare providers are happening with increasing frequency and are severely compounding our healthcare problem. The new owners are, obviously, dedicated to generating profit and are proving it from the outset with their new user fees and an unwillingness to reveal the actual costs for patient services TO their patients.

Here's an example. A close friend of mine who had a single heart bypass a few years ago wanted to establish a new relationship with a cardiologist (her old one had retired). Happily, she was able to get an appointment without waiting too long and was excited about the prospect of getting a new diagnosis about her heart. The day arrived for the appointment. She registered with the receptionist who made her sign some forms and explained, that in addition to a co-pay, she would be charged a 'facilitation fee'. When queried about the size of the fee, the receptionist said she didn't know and couldn't enlighten the woman because the clinic had just been taken over by a new company.

A surprised look crossed the woman patient's face. She then asked what the charges would be for the office visit with the cardiologist. Again, the receptionist said that she could not tell her "because the cost is different for each patient." The woman was perplexed. How could that be? A routine office visit is a routine office visit, isn't it? Doctors or their clinic bosses don't charge on the basis of their patients' ability to pay or do they? The answer is, unfortunately, yes. They do. The woman was ushered into the examination room and her vitals were taken by a technician. Then an EKG was administered after which the cardiologist entered and chatted with the woman, looked at her chart and the results of the recently-administered EKG.

He then suggested she wear a heart monitor for a couple of weeks and then, later, submit to a stress test which would be scheduled for the following month along with a follow-up visit to his office to discuss the results and chart a path for future treatment. Then, after 15 minutes, he left and the woman's appointment was over. She was shown out and told to talk with the receptionist to schedule the upcoming tests. All in all, it was a good visit and the woman was pleased with the efficiency of the technician and doctor and was looking forward to getting a diagnosis and a plan for future treatment.

Then, a week later, she received a bill from the clinic. The charge for the routine 15-minute office visit was $431 and the EKG was $105. (Two months earlier the woman had an in-office EKG in the clinic when it was under different ownership and the charge was $34.) Every procedure has a CPT/E&M code, but on this bill there were none for the clinic visit which was listed as "Clinic - General" so no justification for the charge could be accurately explained because there were no background criteria for it. Neither did the woman receive a bill for the 'facilitation fee' which she was told would come later. Her insurance covered about half of the charges, leaving a little over $300 owed.

Thousands of patients have probably had similar experiences, but it is worth noting that these situations are rapidly becoming the norm rather than the exception. The 'patient's right to know' about charges before they're incurred has been replaced by the 'provider's right to obfuscate' vital information regarding procedural charges. This situation has, essentially, thrown a shroud over transparency and enabled the providers to charge whatever they feel they can get away with using a complex set of elaborate charging models based on the patients' (or their insurance companies') ability to pay.

Further exacerbating the problem are many states 'hands-off' approach to questioning or regulating healthcare providers' practices and charging models. They need to be more involved if things are to improve for patients.

America's healthcare delivery system is neither transparent nor patient-driven. THAT is the problem. Unless the healthcare industry is forced to change, things will only get worse for the consumer of healthcare services. With that in mind, is single-payer government-managed healthcare the answer? The answer is both yes and no. Yes in theory, but no in practice. Our insurance industry and our healthcare service providers are too big and too powerful to be pretzel-twisted into a government-mandated single-payer system that would effectively be the largest socialist experiment in our history. Accounting for about a fifth of our GDP, the healthcare industry (and the jobs it provides) needs to be both protected AND challenged, simultaneously.

After having lived in five foreign countries, all with some form of socialized (read: government sponsored or managed) medical care, I think the answer to our American problem is really a very simple - albeit massive - one. We need to create the single largest public-private partnership we've ever attempted in order to give people affordable, accessible and professional healthcare otherwise we will continue to see our costs skyrocket, mergers accelerate, services decline and transparency disappear.

Seeing those words in print even I am tempted to call myself naïve about the size of the task. However true that might be, that doesn't change the urgency of finding a solution that won't precipitate mass firings in the insurance industry or create a chaotic situation during a transition to a public-private solution. Before we move to opposite sides of the issue and put on our ideological blinders to possible changes let us remember our overarching goal: to cover all Americans with insurance, to provide adequate health services and remove the specter of potential personal bankruptcy that could result from catastrophic illnesses that are not covered by most insurance policies.

We need all-hands cooperation to find the answers.

If we are serious about moving ahead, we will need to give all stakeholders a seat at the solutions table. That includes government, the general public, patients' rights organizations, the insurance industry, healthcare service providers like hospitals and out-patient clinics and, of course, doctors and nurses. As I see it, this is THE one area where we are ALL involved and will all benefit from constructing a true 21st century healthcare system where the patients' rights aren't eclipsed by the profit motive.

Finally, in case you're wondering about the female cardiac patient, she is petitioning for relief from the excessive charges levied by the healthcare services provider and redress from them for not honoring their obligation to provide adequate patient information - in advance - about their charges. She's also canceled all future visits with the cardiologist. Hardly a heart-healthy solution.

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