The $2.7 Trillion Medical Bill

Colonoscopies Explain Why U.S. Leads the World in Health Expenditures

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Matthew Ryan Williams for The New York Times

A colonoscopy scope at a Veterans Affairs center in Seattle.

MERRICK, N.Y. — Deirdre Yapalater’s recent [colonoscopy](http://health.nytimes.com/health/guides/test/colonoscopy/overview.html?inline=nyt-classifier) at a surgical center near her home here on Long Island went smoothly: she was whisked from pre-op to an operating room where a gastroenterologist, assisted by an anesthesiologist and a nurse, performed the routine [cancer](http://health.nytimes.com/health/guides/disease/cancer/overview.html?inline=nyt-classifier) screening procedure in less than an hour. The test, which found nothing worrisome, racked up what is likely her most expensive medical bill of the year: $6,385.

That is fairly typical: in Keene, N.H., Matt Meyer’s colonoscopy was billed at $7,563.56. Maggie Christ of Chappaqua, N.Y., received $9,142.84 in bills for the procedure. In Durham, N.C., the charges for Curtiss Devereux came to $19,438, which included a polyp removal. While their insurers negotiated down the price, the final tab for each test was more than $3,500.

“Could that be right?” said Ms. Yapalater, stunned by charges on the statement on her dining room table. Although her insurer covered the procedure and she paid nothing, her health care costs still bite: Her premium payments jumped 10 percent last year, and rising co-payments and deductibles are straining the finances of her middle-class family, with its mission-style house in the suburbs and two S.U.V.’s parked outside. “You keep thinking it’s free,” she said. “We call it free, but of course it’s not.”

In many other developed countries, a basic colonoscopy costs just a few hundred dollars and certainly well under $1,000. That chasm in price helps explain why the United States is far and away the world leader in medical spending, even though numerous studies have concluded that Americans do not get better care.

Whether directly from their wallets or through insurance policies, Americans pay more for almost every interaction with the medical system. They are typically prescribed more expensive procedures and tests than people in other countries, no matter if those nations operate a private or national health system. A list of drug, scan and procedure prices compiled by the International Federation of Health Plans, a global network of health insurers, found that the United States came out the most costly in all 21 categories — and often by a huge margin.

Americans pay, on average, about four times as much for a hip replacement as patients in Switzerland or France and more than three times as much for a [Caesarean section](http://health.nytimes.com/health/guides/surgery/c-section/overview.html?inline=nyt-classifier) as those in New Zealand or Britain. The average price for Nasonex, a common nasal spray for [allergies](http://health.nytimes.com/health/guides/disease/allergies/overview.html?inline=nyt-classifier), is $108 in the United States [compared with $21 in Spain](http://www.ifhp.com/news153.htmlIF). The costs of hospital stays here are about triple those in other developed countries, even though they last no longer, according to a recent [report by the Commonwealth Fund](http://www.commonwealthfund.org/Publications/Issue-Briefs/2012/May/High-Health-Care-Spending.aspx), a foundation that studies health policy.



Matthew Ryan Williams for The New York Times

A poster illustrating diseases of the digestive system at a doctor's office.

While the United States medical system is famous for drugs costing hundreds of thousands of dollars and heroic care at the end of life, it turns out that a more significant factor in the nation’s $2.7 trillion annual health care bill may not be the use of extraordinary services, but the high price tag of ordinary ones. “The U.S. just pays providers of health care much more for everything,” said Tom Sackville, chief executive of the health plans federation and a former British health minister.

Colonoscopies offer a compelling case study. They are the most expensive screening test that healthy Americans routinely undergo — and often cost more than childbirth or an [appendectomy](http://health.nytimes.com/health/guides/surgery/appendectomy/overview.html?inline=nyt-classifier) in most other developed countries. Their numbers have increased manyfold over the last 15 years, with data from the Centers for Disease Control and Prevention suggesting that more than 10 million people get them each year, adding up to more than $10 billion in annual costs.

Largely an office procedure when widespread screening was first recommended, colonoscopies have moved into surgery centers — which were created as a step down from costly hospital care but are now often a lucrative step up from doctors’ examining rooms — where they are billed like a quasi operation. They are often prescribed and performed more frequently than medical guidelines recommend.

The high price paid for colonoscopies mostly results not from top-notch patient care, according to interviews with health care experts and economists, but from business plans seeking to maximize revenue; haggling between hospitals and insurers that have no relation to the actual costs of performing the procedure; and lobbying, marketing and turf battles among specialists that increase patient fees.

While several cheaper and less invasive tests to screen for [colon cancer](http://health.nytimes.com/health/guides/disease/colon-cancer/overview.html?inline=nyt-classifier) are recommended as equally effective by the federal government’s expert [panel on preventive care](http://www.uspreventiveservicestaskforce.org/uspstf08/colocancer/colors.htm) — and are commonly used in other countries — colonoscopy has become the go-to procedure in the United States. “We’ve defaulted to by far the most expensive option, without much if any data to support it,” said Dr. H. Gilbert Welch, a professor of medicine at the Dartmouth Institute for Health Policy and Clinical Practice.

In coming months, The New York Times will look at common procedures, drugs and medical encounters to examine how the economic incentives underlying the fragmented health care market in the United States have driven up costs, putting deep economic strains on consumers and the country.

Hospitals, drug companies, device makers, physicians and other providers can benefit by charging inflated prices, favoring the most costly treatment options and curbing competition that could give patients more, and cheaper, choices. And almost every interaction can be an opportunity to send multiple, often opaque bills with long lists of charges: $100 for the ice pack applied for 10 minutes after a [physical therapy](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/physicaltherapy/index.html?inline=nyt-classifier) session, or $30,000 for the artificial joint implanted in surgery.

The United States spends about 18 percent of its [gross domestic product](http://topics.nytimes.com/top/reference/timestopics/subjects/u/united_states_economy/gross_domestic_product/index.html?inline=nyt-classifier) on health care, nearly twice as much as most other developed countries. The Congressional Budget Office has said that if medical costs continue to grow unabated, “total spending on health care would eventually account for all of the country’s economic output.” And it identified federal spending on government health programs as [a primary cause of long-term budget deficits](http://www.cbo.gov/sites/default/files/cbofiles/attachments/06-05-Long-Term_Budget_Outlook_2.pdf).

While the rise in health care spending in the United States has slowed in the past four years — to about 4 percent annually from about 8 percent — it is still expected to rise faster than the gross domestic product. Aging baby boomers and tens of millions of patients newly insured under the Affordable Care Act are likely to add to the burden.

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With [health insurance](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/health_insurance_and_managed_care/index.html?inline=nyt-classifier) premiums eating up ever more of her flat paycheck, Ms. Yapalater, a customer relations specialist for a small Long Island company, recently decided to forgo physical therapy for an injury sustained during [Hurricane Sandy](http://topics.nytimes.com/top/reference/timestopics/subjects/h/hurricanes_and_tropical_storms/index.html?inline=nyt-classifier) because of high out-of-pocket expenses. She refused a dermatology medication prescribed for her daughter when the pharmacist said the co-payment was $130. “I said, ‘That’s impossible, I have insurance,’ ” Ms. Yapalater recalled. “I called the dermatologist and asked for something cheaper, even if it’s not as good.”

The more than $35,000 annually that Ms. Yapalater and her employer collectively pay in premiums — her share is $15,000 — for her family’s Oxford Freedom Plan would be more than sufficient to cover their medical needs in most other countries. She and her husband, Jeff, 63, a sales and marketing consultant, have three children in their 20s with good jobs. Everyone in the family exercises, and none has had a serious illness.

Like the Yapalaters, many other Americans have habits or traits that arguably could put the nation at the low end of the medical cost spectrum. Patients in the United States make fewer doctors’ visits and have fewer hospital stays than citizens of many other developed countries, according to the Commonwealth Fund report. People in Japan get more CT scans. People in Germany, Switzerland and Britain have more frequent hip replacements. The American population is younger and has fewer smokers than those in most other developed countries. Pushing costs in the other direction, though, is that the United States has relatively high rates of [obesity](http://health.nytimes.com/health/guides/symptoms/morbid-obesity/overview.html?inline=nyt-classifier) and limited access to routine care for the poor.

A major factor behind the high costs is that the United States, unique among industrialized nations, does not generally regulate or intervene in medical pricing, aside from setting payment rates for [Medicare](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/medicare/index.html?inline=nyt-classifier) and [Medicaid](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/medicaid/index.html?inline=nyt-classifier), the government programs for older people and the poor. Many other countries deliver health care on a private fee-for-service basis, as does much of the American health care system, but they set rates as if health care were a public utility or negotiate fees with providers and insurers nationwide, for example.

“In the U.S., we like to consider health care a free market,” said Dr. David Blumenthal, president of the Commonwealth Fund and a former adviser to President Obama. ”But it is a very weird market, riddled with market failures.”

Consider this:

Consumers, the patients, do not see prices until after a service is provided, if they see them at all. And there is little quality data on hospitals and doctors to help determine good value, aside from surveys conducted by popular Web sites and magazines. Patients with insurance pay a tiny fraction of the bill, providing scant disincentive for spending.

Even doctors often do not know the costs of the tests and procedures they prescribe. When Dr. Michael Collins, an internist in East Hartford, Conn., called the hospital that he is affiliated with to price lab tests and a colonoscopy, he could not get an answer. “It’s impossible for me to think about cost,” he said. “If you go to the supermarket and there are no prices, how can you make intelligent decisions?”

Instead, payments are often determined in countless negotiations between a doctor, hospital or pharmacy, and an insurer, with the result often depending on their relative negotiating power. Insurers have limited incentive to bargain forcefully, since they can raise premiums to cover costs.

“It all comes down to market share, and very rarely is anyone looking out for the patient,” said Dr. Jeffrey Rice, the chief executive of [Healthcare Blue Book](https://www.healthcarebluebook.com), which tracks commercial insurance payments. “People think it’s like other purchases: that if you pay more you get a better car. But in medicine, it’s not like that.”

A Market Is Born

As the cases of bottled water and energy drinks stacked in the corner of the Yapalaters’ dining room attest, the family is cost conscious — especially since a photography business long owned by the family succumbed eight years ago in the shift to digital imaging. They moved out of Manhattan. They rent out their summer home on Fire Island. They have put off restoring the wallpaper in their dining room.

And yet, Ms. Yapalater recalled, she did not ask her doctors about the cost of her colonoscopy because it was covered by insurance and because “if a doctor says you need it, you don’t ask.” In many other countries, price lists of common procedures are publicly available in every clinic and office. Here, it can be nearly impossible to find out.

The cost of a colonoscopy in the United States varies widely, from place to place,  
and even within a city.

Until the last decade or so, colonoscopies were mostly performed in doctors’ office suites and only on patients at high risk for colon cancer, or to seek a diagnosis for intestinal bleeding. But several highly publicized studies by gastroenterologists in 2000 and 2001 found that a colonoscopy detected early cancers and precancerous growths in healthy people.

They did not directly compare screening colonoscopies with far less invasive and cheaper screening methods, including annual tests for blood in the stool or a sigmoidoscopy, which looks at the lower colon where most cancers occur, every five years.

“The idea wasn’t to say these growths would have been missed by the other methods, but people extrapolated to that,” said Dr. Douglas Robertson, of the Department of Veterans Affairs, which is beginning a large trial to compare the tests.

Experts agree that [screening for colon cancer](http://health.nytimes.com/health/guides/specialtopic/colon-cancer-screening/overview.html?inline=nyt-classifier) is crucial, and a colonoscopy is intuitively appealing because it looks directly at the entire colon and doctors can remove potentially precancerous lesions that might not yet be prone to bleeding. But studies have not clearly shown that a colonoscopy prevents colon cancer or death better than the other screening methods. Indeed, some recent papers suggest that it does not, in part because early lesions may be hard to see in some parts of the colon.

But in 2000, the American College of Gastroenterology anointed colonoscopy as “the preferred strategy” for colon cancer prevention — and America followed.

Katie Couric, who lost her husband to [colorectal cancer](http://health.nytimes.com/health/guides/disease/colon-cancer/overview.html?inline=nyt-classifier), had a colonoscopy on television that year, giving rise to what medical journals called the “Katie Couric effect”: prompting patients to demand the test. Gastroenterology groups successfully lobbied Congress to have the procedure covered by Medicare for cancer screening every 10 years, effectively meaning that commercial insurance plans would also have to provide coverage.

Though Medicare negotiates for what are considered frugal prices, its database shows that it paid an average of $531 to gastroenterologists for a colonoscopy in 2011. But that does not include the payments for associated facility fees and to anesthesiologists, which could double the cost or more. “As long as it’s deemed medically necessary,” said Jonathan Blum, the deputy administrator at the Centers for Medicare and Medicaid Services, “we have to pay for it.”

If the American health care system were a true market, the increased volume of colonoscopies — numbers rose 50 percent from 2003 to 2009 for those with commercial insurance — might have brought down the costs because of economies of scale and more competition. Instead, it became a new business opportunity.

Profits Climb

Just as with real estate, location matters in medicine. Although many procedures can be performed in either a doctor’s office or a separate surgery center, prices generally skyrocket at the special centers, as do profits. That is because insurers will pay an additional “facility fee” to ambulatory surgery centers and hospitals that is intended to cover their higher costs. And [anesthesia](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/anesthesiaandanesthetics/index.html?inline=nyt-classifier), more monitoring, a wristband and sometimes preoperative testing, along with their extra costs, are more likely to be added on.

In Mount Kisco, N.Y., Maggie Christ had two colonoscopies two months apart, after her doctor decided it was best to remove a growth that had been discovered during the first procedure. They were performed by the same doctor, with the same sedation. The first, in an outpatient surgery department, was billed at $9,142.84 (insurance paid $5,742.67). The second, in the doctor’s office, was billed at $5,322.76 (insurance eventually paid $2,922.63) because there was no facility fee. “The location was about accommodating the doctor’s schedule,” Ms. Christ said. “Why would an insurance company approve this?”

Ms. Yapalater, a trim woman who looks far younger than her 64 years, had two prior colonoscopies in doctor’s offices (one turned up a polyp that required a five-year follow-up instead of the usual 10 years). But for her routine colonoscopy this January, Ms. Yapalater was referred to Dr. Felice Mirsky of Gastroenterology Associates, a group practice in Garden City, N.Y., that performs the procedures at an ambulatory surgery center called the Long Island Center for Digestive Health. The doctors in the gastroenterology practice, which is just down the hall, are owners of the center.

“It was very fancy, with nurses and ORs,” Ms. Yapalater said. “It felt like you were in a hospital.”

That explains the fees. “If you work as a ‘facility,’ you can charge a lot more for the same procedure,” said Dr. Soeren Mattke, a senior scientist at the RAND Corporation. The bills to Ms. Yapalater’s insurer reflected these charges: $1,075 for the gastroenterologist, $2,400 for the anesthesia — and $2,910 for the facility fee.

When popularized in the 1980s, outpatient surgical centers were hailed as a cost-saving innovation because they cut down on expensive hospital stays for minor operations like [knee arthroscopy](http://health.nytimes.com/health/guides/surgery/knee-arthroscopy/overview.html?inline=nyt-classifier). But the cost savings have been offset as procedures once done in a doctor's office have filled up the centers, and bills have multiplied.

It is a lucrative migration. The Long Island center was set up with the help of a company based in Pennsylvania called Physicians Endoscopy. On its Web site, the business tells prospective physician partners that they can look forward to “distributions averaging over $1.4 million a year to all owners,” “typically 100 percent return on capital investment within 18 months” and “a return on investment of 500 percent to 2,000 percent over the initial seven years.”

Dr. Leonard Stein, the senior partner in Gastroenterology Associates and medical director of the surgery center, declined to discuss patient fees or the center’s profits, citing privacy issues. But he said the center contracted with insurance companies in the area to minimize patients' out-of-pocket costs.

In 2009, the last year for which such statistics are available, gastroenterologists performed more procedures in ambulatory surgery centers than specialists in any other field. Once they bought into a center, studies show, [the number of procedures they performed rose 27 percent](http://www.wcrinet.org/studies/public/books/wcri_why_surgeon_owners_do_more_surgery.pdf). The specialists earn an average of $433,000 a year, among the highest paid doctors, according to Merritt Hawkins & Associates, a medical staffing firm.

Hospitals and doctors say that critics should not take the high “rack rates” in bills as reflective of the cost of health care because insurers usually pay less. But those rates are the starting point for negotiations with Medicare and private insurers. Those without insurance or with high-deductible plans have little weight to reduce the charges and often face the highest bills. Nassau Anesthesia Associates — the group practice that handled Ms. Yapalater’s sedation — has sued dozens of patients for nonpayment, including Larry Chin, a businessman from Hicksville, N.Y., who said in court that he was then unemployed and uninsured. He was billed $8,675 for anesthesia during cardiac surgery.

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For the same service, the anesthesia group accepted $6,970 from United Healthcare, $5,208.01 from Blue Cross and Blue Shield, $1,605.29 from Medicare and $797.50 from Medicaid. A judge ruled that Mr. Chin should pay $4,252.11.

Ms. Yapalater’s insurer paid $1,568 of the $2,400 anesthesiologist’s charge for her colonoscopy, but many medical experts question why anesthesiologists are involved at all. Colonoscopies do not require general anesthesia — a deep sleep that suppresses breathing and often requires a breathing tube. Instead, they require only “moderate sedation,” generally with a Valium-like drug or a low dose of propofol, an intravenous medicine that takes effect quickly and wears off within minutes. In other countries, such [sedative](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/sedatives/index.html?inline=nyt-classifier) mixes are administered in offices and hospitals by a wide range of doctors and nurses for countless minor procedures, including colonoscopies.

Nonetheless, between 2003 and 2009, the use of an anesthesiologist for colonoscopies in the United States doubled, according to a [RAND Corporation study](http://www.rand.org/pubs/research_briefs/RB9648.html) published last year. Payments to anesthesiologists for colonoscopies per patient quadrupled during that period, the researchers found, estimating that ending the practice for healthy patients could save $1.1 billion a year because “studies have shown no benefit” for them, Dr. Mattke said.

But turf battles and lobbying have helped keep anesthesiologists in the room. When propofol won the approval of the Food and Drug Administration in 1989 as an anesthesia drug, it carried a label advising that it “should be administered only by those who are trained in the administration of general anesthesia” because of concerns that too high a dose could depress breathing and [blood pressure](http://health.nytimes.com/health/guides/test/blood-pressure/overview.html?inline=nyt-classifier) to a point requiring resuscitation.

Since 2005, the American College of Gastroenterology has repeatedly pressed the F.D.A. to remove or amend the restriction, arguing that gastroenterologists and their nurses are able to safely administer the drug in lower doses as a sedative. But the American Society of Anesthesiologists has aggressively lobbied for keeping the advisory, which so far the F.D.A. has done.

A Food and Drug Administration spokeswoman said that the label did not necessarily require an anesthesiologist and that it was safe for the others to administer propofol if they had appropriate training. But many gastroenterologists fear lawsuits if something goes wrong. If anything, that concern has grown since Michael Jackson died in 2010 after being given propofol, along with at least two other sedatives, without close monitoring.

‘Too Much for Too Little’

The Department of Veterans Affairs, which performs about a quarter-million colonoscopies annually, does not routinely use an anesthesiologist for screening colonoscopies. In Austria, where colonoscopies are also used widely for cancer screening, the procedure is performed, with sedation, in the office by a doctor and a nurse and “is very safe that way,” said Dr. Monika Ferlitsch, a gastroenterologist and professor at the Medical University of Vienna, who directs the national program on quality assurance.

But she noted that gastroenterologists in Austria do have their financial concerns. They are complaining to the government and insurers that they cannot afford to do the 30-minute procedure, with prep time, maintenance of equipment and anesthesia, for the current approved rate — between $200 and $300, all included. “I think the cheapest colonoscopy in the U.S. is about $950,” Dr. Ferlitsch said. “We’d love to get half of that.”

Dr. Cesare Hassan, an Italian gastroenterologist who is the chairman of the Guidelines Committee of the European Society of Gastrointestinal Endoscopy, noted that studies in Europe had estimated that the procedure cost about $400 to $800 to perform, including biopsies and sedation. “The U.S. is paying way too much for too little — it leads to opportunistic colonoscopies,” done for profit rather than health, he said.

Some doctors in the United States are campaigning against the overuse of the procedure, like Dr. James Goodwin, a geriatrician at the University of Texas. He estimates that about a quarter of Medicare patients undergo the screening test [more often than recommended](http://archinte.jamanetwork.com/article.aspx?articleid=1106083), even though the risks of complications, like long recovery times and poor tolerance of sedation, increase for older people. Routine screening is not recommended for all people over 75.

And some large employers have begun fighting back on costs. Three years ago, Safeway realized that it was paying between $848 and $5,984 for a colonoscopy in California and could find no link to the quality of service at those extremes. So the company established an all-inclusive “reference price” it was willing to pay, which it said was set at a level high enough to give employees access to a range of high-quality options. Above that price, employees would have to pay the difference. Safeway chose $1,250, one-third the amount paid for Ms. Yapalater’s procedure — and found plenty of doctors willing to accept the price.

Still, the United States health care industry is nimble at protecting profits. When Aetna tried in 2007 to disallow payment for anesthesiologists delivering propofol during colonoscopies, the insurer backed down after a barrage of attacks from anesthesiologists and endoscopy groups. With Medicare contemplating lowering facility fees for ambulatory surgery centers, experts worry that physician-owners will sell the centers to hospitals, where fees remain higher.

And then there is aggressive marketing. People who do not have insurance or who are covered by Medicaid typically get far less colon cancer screening than they need. But those with insurance are appealing targets.

Nineteen months after Matt Meyer, who owns a saddle-fitting company near Keene, N.H., had his first colonoscopy, he received a certified letter from his gastroenterologist. It began, “Our records show that you are due for a repeat colonoscopy,” and it advised him to schedule an appointment or “allow us to note your reason for not scheduling.” Although his prior test had found a polyp, medical guidelines do not recommend such frequent screening.

“I have great doctors, but the economics is daunting,” Mr. Meyer said in an interview. “A computer-generated letter telling me to come in for a procedure that costs more than $5,000? It was the weirdest thing.”