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NONPROFIT HOSPITALS THRIVE ON PROFITS

First of five parts

BY AMES ALEXANDER, KAREN GARLOCH AND JOSEPH NEFF
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Hospitals in the Charlotte region are among the most profitable in the U.S. They have billions in investments and real estate. Experts say they should do more to lower patients' rising costs.

Nonprofit hospitals in the Charlotte region are respected community institutions. They save lives, heal the sick and provide good jobs.

At the same time, most of them are stockpiling a fortune.

Their profits have risen along with their prices. Top executives are paid millions as their hospitals expand, buy expensive technology and build aggressively.

And they benefit each year from a perk worth millions: They pay no income, property or sales taxes.

These institutions were created with charitable missions. But many don't act like nonprofits anymore. In their quest for growth and financial strength, they have contributed to the rising cost of health care, leaving thousands of patients with bills they struggle to pay.

An investigation by The Charlotte Observer and The News & Observer of Raleigh found that many Charlotte-area hospitals:

■ Generate some of the nation's largest profit margins. Despite the Great Recession, they have amassed billions of dollars in reserves.

■ Inflate prices on drugs and procedures, sometimes as much as 10 times over costs. Hospital prices in the region are about 5 percent higher than the national average and comparable to those of larger cities, such as Chicago, Dallas and New York City, according to Aetna insurance company.

■ Hike prices almost every year. Blue Cross and Blue Shield of North Carolina, the state's largest health insurer, says its total cost per hospital admission went up nearly 40 percent from 2007 through 2010.

■ Pay their top executives millions. Nineteen officials at Carolinas HealthCare System and Novant Health got total compensation exceeding $1 million in 2010 or 2011.

All of this is entirely legal. No laws limit profits, charges or executive pay for nonprofit hospitals.

Hospital officials say they're simply acting as they must to survive. They point to a U.S. health care system that rewards hospitals for providing more sophisticated services to meet consumer demands.

"The trajectory that we are on in health care spending is not sustainable," said Michael Tarwater, CEO of Carolinas HealthCare.

He said patient expectations are: "I want the best. I want it now. I want it close. And I

SEE **HOSPITALS,** 8A

PHOTOS BY ROBERT LAHSER - rlahser@charlotteobserver.com

Note: Figures for Carolinas HealthCare are for the total enterprise, including facilities managed and leased by the system.

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don't care what it costs. Those are the demands in which this system grew up."

Hospital leaders say profits support their mission of caring for all patients, wealthy or poor. They say they need to pay competitive salaries to attract talented leaders. And they say they need to operate like businesses to survive in turbulent times.

But in many important ways, nonprofit hospitals differ from private businesses. They don't answer to stockholders. They don't compete on price. They don't even tell customers what they charge.

Critics say many hospitals aren't just surviving, they're thriving – and could afford to make medical care less expensive for everyone.

Nonprofit hospitals have become part of the problem, critics say. By consolidating into large systems, hospitals gain leverage to negotiate ever higher payments from insurance companies.

That means patients and employers pay more for treatment and insurance – to the point where a single medical catastrophe can be financially devastating.

As hospitals grow, critics contend they are straying from their charitable missions.

"There's no accountability anymore," said Adam Searing, project director for the N.C. Health Access Coalition. "They started as these social welfare experiments, with all this commitment. ... What they should work for is that no person has to go bankrupt or lose their house to pay their hospital bills. ... That's not a very high standard."

Birth of a giant

To understand what's happening nationally, one need look no farther than Charlotte's Dilworth neighborhood, where North Carolina's largest hospital system got its start.

Carolinas HealthCare System began in 1943 with a 325-bed hospital called Charlotte Memorial, which struggled financially for decades.

Its leaders decided they needed to grow to survive. They built a system that could attract paying patients while continuing to care for the uninsured. It worked.

Over the past 30 years, they have transformed it into a juggernaut. It's now the country's second-largest public hospital system, behind only the nationwide system of Veterans Affairs hospitals.

One of the benefits of that growth is access to quality medical care. Carolinas HealthCare offers one of five organ transplant programs in the state and operates the region's most comprehensive trauma center, where accident victims frequently arrive via medical helicopter. Five-year-old Levine Children's Hospital has brought new pediatric specialties to Charlotte, and Levine Cancer Institute has recruited specialists from such respected institutions as the Cleveland Clinic.

With nearly $7 billion in annual revenue, Carolinas HealthCare runs about 30 hospitals. It owns more than $1 billion worth of property in Mecklenburg County alone, and it has more than $2 billion in investments.

In the five-year period ending in 2011, it spent $1.8 billion on capital projects.

Growth at Novant Health, the region's other major hospital system, has been almost as dramatic.

Novant owns 13 hospitals, including the three Presbyterian hospitals, and has total annual revenue of more than $3 billion. The system had about $1.6 billion in cash and investments in 2010 – a three-fold increase over the decade.

The two chains own all eight hospitals in Mecklenburg.

As hospital systems have grown, experts say, they've been able to use their market power to demand higher payments from insurance companies. And that has allowed them to grow even more.

While volume business at Wal-Mart and Target has led to lower prices, the opposite is true in the hospital industry. Hospitals don't compete on price. They compete by offering more high-tech and costly services.

"John Q. Citizen is who winds up paying for this. Not big bad insurance companies ...," said Martin Gaynor, professor of health policy at Carnegie Mellon University. "It's actually taking money out of everybody's paycheck."

Hospital profit center

Hospitals in the Charlotte region are more profitable than all but one of the nation's largest metropolitan areas, according to one report. Here are the five most profitable metropolitan areas for hospitals.

Region/ City	Median total profit margin
1) Salt Lake City	13.7%
2) Charlotte-Gastonia-Rock Hill	12.4%
3) Indianapolis	7.5%
4) Houston-Galveston-Brazoria	7.0%
5) Orlando, Fla.	7.0%

— SOURCE: 2011 "STATE OF THE HOSPITAL INDUSTRY" REPORT BY CLEVERLEY AND ASSOCIATES

Inflated prices

Across North Carolina, hospital prices have surged.

They are more than 10 percent higher than the national average for Aetna, said Jarvis Leigh, a network vice president in the Carolinas.

According to the 2011 "State of the Hospital Industry" report published by Cleverley and Associates, an Ohio-based consulting firm, Charlotte-area hospitals receive more money for treating each patient, on average, than those in most other large urban areas. This despite the fact that their average cost of treating those patients is lower.

Like others around the U.S., hospitals here boost their revenue with substantially marked-up prices on drugs and procedures.

Carl King, head of national contracting for Aetna, said insurance companies usually pay 40 percent over a hospital's cost as hospitals seek to make up for losses on government insurance programs.

While it's unclear how markups in the Charlotte area compare with those elsewhere, the Observer found inflated prices on more than a dozen local hospital bills, including:

■ Lake Norman Regional Medical Center, a for-profit hospital in Mooresville, billed one patient about $3,000 for two CT scans in 2010. That was more than four times the hospital's average cost, according to American Hospital Directory, a service that uses federal Medicare cost reports to examine hospital finances.

■ Presbyterian Hospital billed the state $15,840 in 2010 for use of its cardiac catheterization lab after treating a prison inmate. The average cost for using its cath lab: about $1,064. The bill was covered in full by taxpayers.

One patient, Robert Talford, was so outraged by his 2007 bill from Carolinas Medical Center that he has taken the issue to the N.C. Supreme Court.

Talford refused to pay the bill after discovering the hospital charges on some drugs were up to 24 times higher than what those medications cost him at the pharmacy. He has asked the court to determine whether those charges are reasonable.

Such markups trouble Jason Beans, the CEO of Rising Medical Solutions, which examines medical bills for payers.

At the newspapers' request, Beans' firm examined bills from various North Carolina hospitals and found possible markups as high as 500 percent.

"Everyone blames the (insurance) carriers, but what the hospitals are doing in these situations is egregious," Beans said. "No other industry can justify charging markups of 500 percent. Health care is often a need, not a want. The system is so broken."

Hospital officials defend their prices, saying their charges for drugs and tests must cover overhead. They say they must mark up prices for those with private insurance or they'd be ru-

SEE **MARKUPS,** 9A

MARKUPS

■ *from 8A*

ined by losses from treating patients who are covered by Medicare and Medicaid or who are uninsured.

Jim Tobalski, a spokesman for Novant, said Presbyterian does not typically collect such large amounts for services such as the cardiac catheterization lab. That's because insurers and government agencies usually pay hospitals much less than full charges.

Tarwater, the Carolinas HealthCare CEO, said it's unfair to compare what retailers and hospitals charge for a pill because hospitals pay to have the drug shipped, repackaged, checked and administered.

Hospital officials say they've worked to reduce costs for patients.

Carolinas HealthCare has saved $120 million in the last 10 years by consolidating, reducing duplication, rebidding contracts and "finding better ways to do things," Tarwater said.

A profitable time

It has been a good decade for Mecklenburg's hospitals.

Despite the recession, all were more profitable in 2010 than a decade earlier.

Hospitals in the Charlotte region are more profitable than those in all but one of the nation's 40 largest urban areas, according to the Cleverley report.

Data from the N.C. Hospital Association show that hospitals in the multi-county Charlotte area had an average total margin of 12 percent in 2010 – far higher than those in other parts of the state.

Novant-owned Presbyterian Matthews was the state's most profitable general hospital in 2010, with a 35 percent total profit margin, according to the American Hospital Directory, a service that examines hospital finances using Medicare cost reports.

CMC-University, part of Carolinas HealthCare, had a total margin of 26 percent in 2010.

Gerard Anderson, director of the Johns Hopkins Center for Hospital Finance and Management, said margins in Mecklenburg suggest hospitals here "are charging a whole lot for health care services."

"Anyone with insurance is paying prices substantially higher than they should be paying," Anderson said. "That's outrageous."

Officials at Carolinas HealthCare argue that the figures for their individual hospitals are misleading. They contend that it's inaccurate to use Medicare cost reports to calculate profit figures for hospitals within a large, multi-hospital system. Instead, they say, it's more accurate to look at the margin of the entire system.

Anderson

Federal officials say the figures for individual hospitals should be reliable if hospitals report accurately.

Carolinas HealthCare's core operation in Mecklenburg, Cabarrus and Lincoln counties – which also includes doctors' offices, clinics and other facilities – had an average total margin of about 7 percent over the past three years. Novant had an average total margin of about 3.5 percent over that period.

Across North Carolina, healthy profits aren't universal. About a third of hospitals – most of them small and rural – reported losing money in 2010. CMC-Lincoln, which is run by Carolinas HealthCare, posted a $3.3 million loss that year.

But on the whole, North Carolina hospitals are more profitable than most, according to data from the American Hospital Association. In 2010, the total profit margin for North Carolina hospitals was 9.3 percent. That's about 2 percentage points more than the national average – and higher than it was a decade earlier, when the economy was stronger.

Officials at Carolinas HealthCare and Presbyterian say they're profitable because the Charlotte region is the most populous in the state and because their hospitals operate efficiently.

Presbyterian Matthews, for instance, operates at near capacity, says Paul Wiles, the recently retired CEO of Novant.

But Wiles acknowledged that North Carolina is a good place to run hospitals, largely because of low labor costs and insurers that are "pretty good to work with."

Margin and mission

Just because a hospital is a nonprofit doesn't mean it makes no profit. Unlike for-profit companies, which use their profits to pay dividends to stockholders, nonprofit hospitals must plow extra revenue back into their organizations.

Hospital officials say they invest in facilities, staff and equipment that the community needs – and demands – often without regard for profit.

Carolinas HealthCare, for example, has proposed building a psychiatric hospital in Huntersville, which is expected to lose money. But they say they're doing it because the area needs more services.

Also, the system's four primary-care clinics in Charlotte serve more than 70,000 low-income patients a year who might otherwise have relied on more expensive emergency rooms for basic care.

"Because we run our health care system like a business, because we try to do things to make sure we're fiscally sound, we're able to do those things," said CEO Tarwater. "If your mission was solely to take care of the indigent, you wouldn't stay in business very long. ... Without margin, you can't have mission."

Even after spending more than $260 million on financial assistance and discounts to uninsured patients, Carolinas HealthCare made a profit of $428 million in 2010.

Kevin Schulman, director of Duke University's Center for the Study of Health Management, says large systems with high profits are spending excessively on new buildings, new services and high salaries.

Schulman

"They have *more* margin than meets the mission," Schulman said. "What are they going to do with all the money they made? They can't give it to shareholders. They put it all into infrastructure. ... It leads the managers of the hospitals to build an ever more expensive delivery system."

Schulman said that hospitals make choices about how they "deploy their capital against their mission" and that they could choose to make health care more affordable.

"Do we want to tax every employer by having them pay higher health care costs? Or should we make the employers more profitable and the hospitals less profitable?"

Consistent profits have allowed Carolinas HealthCare and Novant to amass large cash reserves – more than $2 billion and $1.6 billion, respectively.

Officials say this allows the systems to maintain good credit ratings and borrow money at favorable rates. It lets them build new facilities, add technology and maintain existing buildings and equipment.

What's more, they say, it may help them weather the coming financial storm.

The coming 'horse race'

Under health-care reform, scheduled to become fully effective in 2014, the federal government plans to cut Medicare reimbursement to hospitals and transfer more responsibility for Medicaid to the states. In turn, states will likely push costs to counties and hospitals.

"We have looked at the impending future and tried to be prepared for it," said Jim Hynes, chairman of the board at Carolinas HealthCare. "We're going to have to have strong finances ... to sustain ourselves through the onslaught that is coming."

While hospital growth and consolidation have been occurring for years, the federal Affordable Care Act is spurring more of it, experts say.

The law calls for creation of networks of hospitals, doctors and other medical providers. But that sort of consolidation almost always leads to higher prices, studies have shown.

"It's a horse race right now," said Dr. Donald Berwick, former administrator of the Centers for Medicare and Medicaid Services. "(Hospitals) are trying to gain more and more market power (to prepare for) the changes that are coming."

With those changes, many experts predict hospitals will continue to raise prices.

Asked why, Johns Hopkins' professor Anderson said the answer is simple: "Because they can."

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PROGNOSIS: PROFITS SECOND OF FIVE PARTS

Most N.C. hospitals slim on charity care

JEFF WILLHELM - jwillhelm@charlotteobserver.com

Rachael Shehan, with 5-year-old nephew Dallen, has no health insurance and no job but has been unable to get financial help from Caldwell Memorial Hospital in Lenoir. Her bills total $15,000, and she feels hounded by collections agencies, she said.

In some of poorest counties, it's hard to get forgiveness on bills

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DO YOU QUALIFY FOR FINANCIAL HELP?
Proving eligibility at hospitals isn't always simple. **5A**

CAROLINAS HEALTHCARE
Issues statement in response to hospital series. **5A**

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New policies that could help

By Ames Alexander, Joseph Neff and Karen Garloch
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Rachael Shehan has no health insurance and virtually no income. But when serious respiratory problems strike, her hospital has never provided financial help, she said.

Instead, the 39-year-old Lenoir resident says, Caldwell Memorial Hospital has sent bill collectors who have hounded her for payment and ruined her credit.

Now, she sometimes bursts into tears when medical problems arise. "I know the hospital isn't going to help me with my bills," says Shehan, who relies on food stamps and the help of friends.

Nonprofit hospitals such as Caldwell Memorial are exempt from property, sales and income taxes. In return, they are expected to give back to their communities, largely by providing care to those who can't afford it.

Like Caldwell, most North Carolina hospitals are devoting a fraction of their expenses to help the poor and uninsured, an investigation by the Charlotte Observer and The News & Observer of Raleigh found.

In 2010, most of the state's hospitals spent less than 3 percent of their budgets on charity care – the practice of forgiving all or part of a patient's bill.

Mecklenburg County's hospitals perform better than average, with all spending more than 4 percent of their budgets on charity care. They are among the state's most profitable hospitals.

In North Carolina, no government rules dictate how much charity care a nonprofit hospital must provide. Not even the IRS takes action. The result: A nonprofit hospital can spend virtually nothing on charity care and receive the same tax breaks as a hospital that sets aside as much as 10 percent of its budget to help the poor.

The newspapers' findings raise questions about whether some hospitals are earning their nonprofit status, experts say.

The investigation found:

■ About a third of North Carolina hospitals – including Caldwell Memorial – spent less than 2 percent of their budgets on charity care in 2010. Most of these are small hospitals in rural areas, and many report they are losing money.

■ Some of the hospitals with the lowest percentages serve counties where the needs are high. Vidant Duplin Hospital, for instance, caters to a high-poverty county where one in four people lack health insurance. It spent less than 1 percent of its budget on charity care.

■ Hospital practices vary widely. While the least generous hospitals are giving less than

SEE **CHARITY CARE,** 4A

CHARITY CARE

■ *from 1A*

1 percent to free care, the most charitable hospital – Thomasville Medical Center – spent about 13 percent.

■ Many uninsured patients are never offered financial assistance. More than a third of hospitals in the state provide no details about their charity care policies on their websites. And more than 20 uninsured patients interviewed say they were never informed about charity care policies when they sought treatment.

■ Most hospitals appear to be getting more in tax exemptions than they're giving back in the form of charity care.

No agency or group calculates the value of hospital tax exemptions, so the newspapers derived estimates from publicly available data.

Based on the taxes paid by large for-profit hospital systems, North Carolina's nonprofit hospitals get tax breaks worth roughly 4.4 percent of their expenses, the newspapers estimated. About two-thirds of those hospitals spend less than that on charity care.

Adam Searing, director of the N.C. Justice Center's Health Access Coalition, questions whether many hospitals are doing enough charitable work to earn their tax exemptions.

"I feel like the hospitals are breaking the contract they made," he said.

Jessica Curtis, director of Community Catalyst's Hospital Accountability Project, said the Observer's findings echo what she sees happening elsewhere in the country. "It's almost a blatant disregard for the needs of the poor," said Curtis, whose Boston-based group works to improve access to care.

To be sure, charity care – medical treatment provided for free or at reduced rates to low-income patients – is just one of many ways that hospitals help their communities.

They absorb millions in losses from treating Medicare and Medicaid patients because government reimbursement doesn't cover their costs. They also train doctors and nurses, sponsor wellness programs and support community clinics.

But experts say charity care is by far the most important way hospitals can help the needy. It's particularly crucial in North Carolina, where the unemployment rate is among the nation's highest – and where roughly one in five residents under 65 lacks health insurance.

Searing

While some low-income people receive health care paid for by the government's Medicaid program, many of the working poor make too much to qualify and don't get insurance from their employers. Officials with the N.C. Hospital Association, the group that lobbies for the state's hospital industry, say their members work hard to help the poor. Charity care spending in North Carolina rose to about $853 million in fiscal 2010 – almost twice the amount spent in the pre-recession days of 2006, the NCHA estimates.

Curtis

But some of the hospitals that spend the least on charity care simply can't afford to do more, says NCHA spokesman Don Dalton. That's because they're among the state's most financially challenged hospitals. Many are in rural areas.

"The resources available for them to do vastly more charity care are probably not there," Dalton says.

But experts say it generally doesn't hurt a hospital's finances to become more charitable.

When hospitals sue patients or turn their accounts over to collection agencies, their actions often damage patients' credit. Hospitals are losing money on those patients anyway and would likely experience little financial harm if they forgave more of the bills, experts say.

A 2005 study by the Center for Studying Health System Change found that bad debt at hospitals declined as charity care policies became more generous. Such changes, the study found, had "little impact on hospital bottom lines."

Large needs, little help

Some of the least generous hospitals serve counties where numerous residents are poor and uninsured.

North of Wilmington, many families in Duplin County work demanding, low-wage jobs in poultry plants or farm fields. But advocates for Duplin County's poor say it has been difficult to get financial help for uninsured people with large hospital bills.

Sonia Royes, a social worker for Catholic Charities, said she has tried about six times to get financial assistance for uninsured clients who had bills from Vidant Duplin – and has never succeeded.

She called the hospital in January 2011, asking if there was help available for one uninsured client. The official told her the hospital had no charity care policy, she said.

Duplin spent about $245,000 on charity care in 2010 – less than 1 percent of its budget.

Curtis, of Community Catalyst, said it's "unacceptable" that any nonprofit hospital spend less than 1 percent of its budget on charity care. "A hospital spending that little on charity care in a community with high needs raises questions about that hospital's commitment to the community," she said.

According to Vidant Duplin's policy, uninsured patients who can't pay their bills can qualify for free care if their income is less than 200 percent of the poverty level and their household net worth is less than $25,000. For an individual, 200 percent is equivalent to making about $22,000 a year.

Officials for Vidant Duplin say many patients simply don't provide the documentation that the hospital requires to prove that they're eligible for charity care.

"I do believe our charity care could be a lot higher," said Lucinda Crawford, the hospital's vice president of financial services. "It's sometimes a challenge for folks to bring in financial information and to follow up."

Hospital CEO Jay Briley said that his hospital outstrips most others when judged by a different measure – the amount of "unreimbursed" care it provides. In 2010, the hospital reported losing about $1.1 million on Medicaid patients and about $4.3 million on patients who never paid their bills.

Duplin, like many other hospitals, routinely sends collection agencies to recover some of that money – a practice that can damage a patient's credit.

Duplin's officials say they've beefed up efforts to make uninsured patients aware of their charity care policy.

Until recently, Crawford said, patients who came through the emergency department didn't routinely interact with a counselor who explained the policy. But the hospital changed that last year, so those patients now have a chance to talk with a counselor before they're discharged.

With so many of its patients poor and uninsured, Duplin has struggled financially in recent years, losing more than $400,000 in 2010.

No rules

In North Carolina, as in most other states, hospitals aren't required to spend even a single dollar on charity care. Federal rules require nonprofit hospitals to provide some "community benefit," but they don't specify what those benefits should be.

In 2007, the U.S. Senate Finance Committee proposed requiring nonprofit hospitals to spend at least 5 percent of their budgets on charity care – a standard that only about a fifth of North Carolina hospitals met in 2010.

That proposal never became law.

In Illinois, the state Department of Revenue last year denied property tax exemptions to three hospitals that were found to be spending less than 2 percent of their patient revenue on charity care. That followed a 2010 ruling by the Illinois Supreme Court, which concluded that Provena Medical Center wasn't providing enough charity care to qualify for a tax exemption.

No group or agency keeps national statistics on what hospitals spend on charity care. But in some states where charity care reporting is required, the data give some sense of how hospitals stack up.

North Carolina hospitals appear to be providing less charity care than those in Texas, one of the few states that requires hospitals to give a minimum level of financial assistance.

In Texas, most hospitals spend more than 4 percent of their budgets on charity care; in North Carolina, most spend less than 3 percent.

North Carolina hospitals provide more charity care, on average, than those in California, where hospitals operate on significantly smaller profit margins.

Restrictive charity policies

In the Blue Ridge foothills that surround Caldwell Memorial, many patients could use financial help.

SEE **CHARITY,** 5A

CHARITY

■ *from 4A*

The closings of textile plants and furniture factories have left Caldwell County with an unemployment rate of 13 percent, among the state's highest. Nearly one in five residents lives in poverty.

About 3,500 of the hospital's patients got free care last year, said Don Gardner, the hospital's vice president of finance. But many more – about 7,000 to 8,000 – got something else: calls or letters from collection agencies.

Rachael Shehan was among them.

She estimates her hospital bills now total more than $15,000. The 110-bed hospital put her on monthly payment plans that she says she can't afford.

Now, she says, her credit is so bad she has been turned down for a small loan and has no hope of getting a car.

"I think (the hospital) should offer help," Shehan said. "There's an awful lot of people who need it."

At Caldwell Memorial, only patients who live in Caldwell County, have less than $3,000 in assets and earn less than 125 percent of the poverty level are entitled to free care, according to the hospital's website.

In 2010, the hospital reported spending about $1.5 million of its $99 million budget on charity care. But Gardner said that represents just a part of its good works.

Caldwell Memorial, for instance, provides about $1.3 million worth of free tests and medical procedures each year to a clinic that provides medical help to needy residents. It also reported losing about $2.3 million treating Medicaid patients in 2010.

"I have no doubts that we've done a yeoman's job of providing service, regardless of ability to pay," Gardner said.

The foundation that raises money for Caldwell Memorial recently claimed on its website that the hospital gave $18 million to charity care in 2010. In fact, the hospital spent about a tenth that much. The foundation removed that claim last year, soon after an Observer reporter asked a hospital executive about it. Gardner said he believes the error was unintentional.

The hospital operates on a slim profit margin – less than 2 percent in 2010.

Gardner declined to discuss any patients' accounts with the Observer. But in general, he said, some patients don't complete charity care applications or don't cooperate in providing documents the hospital needs to verify eligibility. Others, he said, are "too proud to take charity care."

ROBERT WILLETT - rwillett@newsobserver.com

Mary Jo Warren sings during Bible study. Since she suffered a stroke she hasn't worked, and she can't pay hospital bills from Sampson Regional Medical Center. The hospital spends less than 1 percent of its budget on charity care.

> "They say, "Ms. Warren, we expect you to pay us money." I say, "I ain't got any." And they say, "Well, that's no excuse." '
>
> **MARY JO WARREN,** ON CALLS FROM COLLECTION AGENCIES

Policies hard to find

At some North Carolina hospitals, it's not easy for patients to learn what financial help is available.

Many patients told the newspaper that hospital officials never mentioned the availability of charity care.

More than 40 hospitals – including Gaston Memorial Hospital in Gastonia and Lake Norman Regional Medical Center in Mooresville – didn't put key details about their charity care policies on the Web in late 2011, the newspapers' review found.

Two-thirds of North Carolina hospitals didn't list their full financial assistance policies on the Web.

Sampson Regional Medical Center was among them.

The hospital spends less than $250,000 a year on charity care – less than 1 percent of its budget. But many of its patients need all the financial help they can get. The hospital serves Sampson County, a rural community east of Fayetteville where more than one in five residents lives in poverty.

Hospital officials say those earning less than 125 percent of the poverty level can qualify for free care. They say they've been working to get more patients qualified.

But many patients have not cooperated by applying, says Chief Financial Officer Jerry Heinzman. Some simply don't care because they don't intend to pay and already have poor credit ratings, he said.

Mary Jo Warren has been swamped by hospital bills.

Since suffering a stroke in 2010, Warren lost her nursing job and her employer-sponsored health insurance. She's since been to Sampson Regional several times for high blood pressure, congestive heart disease and broken bones from frequent falls.

Until her health worsened, Warren said she was frugal, hardworking and self-reliant. Now she frets about not being able to pay her hospital bills. She gets groceries from a food pantry and two local churches.

She applied for charity care, and Sampson Regional cut 45 percent off the balance that she owed.

Two months later, a lawyer for the hospital wrote Warren two letters demanding payment of more than $1,000 and threatening a lawsuit.

After being contacted by a reporter, Heinzman said he has asked Warren to apply again for financial assistance. He previously knew nothing about her inability to work, he said.

Still, calls from hospitals and collection agencies come almost daily, rattling her nerves.

"They say, 'Ms. Warren, we expect you to pay us money,' " she said. "I say, 'I ain't got any.' And they say, 'Well, that's no excuse.' "

Fearing more bills, she has been reluctant to seek additional medical treatment. So she now waits until she is "really desperate to get some help."

And that, she knows, can't be good for her health.

— WASHINGTON CORRESPONDENT FRANCO ORDOÑEZ AND NEWS & OBSERVER DATABASE EDITOR DAVID RAYNOR CONTRIBUTED.

Who pays for the patients?

North Carolina hospitals say they lost $425 million in 2010 treating patients on Medicaid, the government health program for the poor and disabled. Hospitals also say they lost money on uninsured patients and those with Medicare, the government program for those 65 and older or disabled. Therefore, hospitals say they have to charge more to those who have private insurance. Here's a look at each group's share of billed care, according to the N.C. Hospital Association:

Medicare, 45%
Private insurance, 27%
Medicaid, 16%
Uninsured, 9%
Other groups, 3%

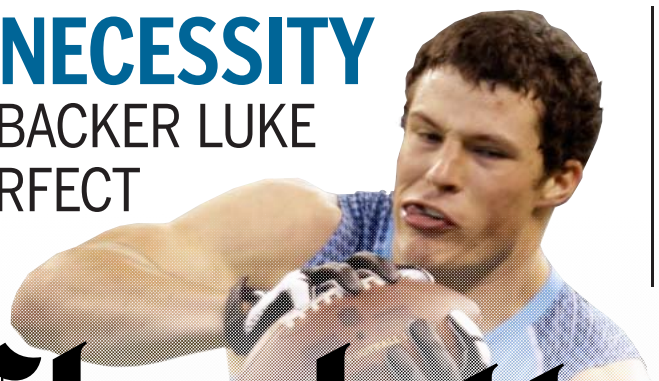
Carolinas HealthCare System statement

Carolinas HealthCare System on Sunday night issued a statement responding to the Observer's series on hospitals. Following is the full statement:

"Carolinas HealthCare System is reading with interest the Charlotte Observer's series examining a wide range of operations at healthcare facilities in our region.

"We are, however, disappointed with the lack of understanding of the complexities of the healthcare industry. The rising cost of healthcare is an important subject that impacts virtually every segment of our communities, and we are committed to working with clinicians, payers, patients and others to find and implement solutions to this issue and the many challenges facing today's healthcare environment.

"We hope that the full content of this series more fairly represents the dedication and commitment of our caregivers to treating all patients while navigating the complexities of the healthcare industry. Our goal is and always will be to increase access to the highest quality healthcare for every community we serve and improve on its delivery for all."



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PROGNOSIS: PROFITS THIRD OF FIVE PARTS

Hospital suits force new pain on patients

T. ORTEGA GAINES - ogaines@charlotteobserver.com

Joyce Jones had little money and bare-bones insurance when she was hospitalized. Carolinas HealthCare System sued her to collect $34,000. "I was willing to pay if they set me up on a payment plan," she said, "but they just want it all."

Investigation: N.C. hospitals sue 40,000 patients, including many who might have qualified for charity care

By Ames Alexander and David Raynor
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When serious abdominal pains sent Joyce Jones to the hospital, she hoped the bill would be the least of her problems. She had no job and a bare-bones health insurance policy that she knew would cover only a fraction of her bill. So it helped ease her worries, she said, when a social worker at Carolinas Medical Center-Mercy told her the hospital had a fund to help patients like her.

Jones thought the hospital was taking care of the cost. But soon after her two-week stay, she received a bill for $34,000.

In 2006, the hospital sued her and put a lien on her small west Charlotte home. A widow, Jones would like to leave the house to her disabled daughter some day. But the lien – which will allow the hospital to collect money if Jones dies or sells her home – may make that impossible.

"All that money they've got, they should be helping people," said Jones, now 65.

Like CMC-Mercy, most N.C. hospitals are tax-exempt – a distinction that saves them millions each year. In exchange, these nonprofits are expected to provide financial help to those without the means to pay.

But thousands of times a year, hospitals are suing patients instead, an investigation by the Charlotte Observer and The News & Observer of Raleigh found.

An in-depth look at some of those cases suggests most of the patients were uninsured, and that a significant number of them should have qualified for free hospital care.

Critics contend those hospitals are financially ruining people they could afford to help. Carolinas HealthCare System, the multibillion-dollar public enterprise that owns CMC-Mercy, has generated average annual profits of more than $300 million over the past three years.

During the five years ending in 2010, N.C. hospitals filed more than 40,000 lawsuits to collect on bills.

Most of those suits were filed by just two entities: Carolinas HealthCare and Wilkes Regional Medical

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HOSPITALS

■ *from 1A*

Center in North Wilkesboro. Each filed more than 12,000 suits over the five-year period, according to state courts data. Wilkes Regional, which is managed by Carolinas HealthCare, appears to be the state's most litigious individual hospital.

Most N.C. hospitals rarely, if ever, sue patients to collect on bills. But virtually all use collection agencies, which can seriously damage a patient's credit.

Often, the lawsuits hit people who are among those paying the highest rates for hospital care: the uninsured. Bills for uninsured patients are usually higher because they don't have insurance companies to negotiate discounts on their behalf.

It's unclear how many of the patients sued in North Carolina lacked health insurance and substantial income or assets. But in interviews with 25 of those patients, the newspapers found 17 of them were uninsured; 10 said they were never told about the hospitals' financial assistance programs.

Carolinas HealthCare wins most of the lawsuits it files, allowing it to put liens on the homes of patients.

"We always struggle with, 'Should we be doing that (filing lawsuits)?' " said Greg Gombar, chief financial officer for the Charlotte-based system. "But it comes back to a message ...: If you have the ability to pay, you need to pay because other people are."

The system never forces people from their homes, but does collect money after the patients die or sell their houses, officials say.

System officials say they file suit only when people fail to answer repeated requests for payment.

That, they say, is what happened in Jones' case. The hospital said it sent her five statements and left three messages at her home before filing suit.

Jones says she stayed with her brother for a long period after she was hospitalized for pancreatitis, and doesn't remember receiving the letters.

She had plenty to worry about at the time. Her husband had recently died, and money was scarce. But she had one thing – the 1,200-square-foot home that she and her husband had worked for 30 years to buy.

The home has a tax value of $70,000, but Jones now worries that the hospital's lien may cause the family to lose it.

It wasn't until 2009 that she discovered the true toll of her unpaid bills. Lacking money to repair a leaky roof, she tried to get a reverse mortgage. Lenders turned her down because of the hospital system's lien, she said.

Her daughter offered to use the equity in her home to raise $10,000 so Jones could negotiate a settlement. Jones said she offered to pay that amount, and to go on an installment plan to repay the rest. The hospital rejected her offer.

Adam Searing, director of the N.C. Justice Center's Health Access Coalition, said "the hospital was unwilling to be reasonable" in Jones' case.

"If you have one person who's being treated like she's been treated, I think you're failing your mission," he said.

Searing

Carolinas HealthCare CEO Michael Tarwater said the system treats more uninsured and underinsured patients than any other N.C. system. "We never turn off somebody's health (care) because they don't pay," he said.

The number of lawsuits filed by Wilkes Regional has declined markedly since 2007, when Carolinas HealthCare began managing the hospital, system officials note. Carolinas HealthCare says it has worked with the hospital to help it become more selective about which cases it takes to court. The hospital once sued patients with debts as low as $300, but that threshold has been increased to $750.

Critics contend it's inappropriate for hospitals to sue patients they could afford to help. And they question why so many lawsuits are filed by tax-exempt hospitals that are supposed to pursue charitable missions.

"Pure and simple, suing people is not a charitable act, especially when you're dealing with people of limited financial means," said Mark Rukavina, who heads the Access Project, a Boston-based nonprofit.

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Tony Chris Davis said Carolinas Medical Center officials told him they'd provide financial help. Instead, the hospital sued to collect on its $40,000 bill. "If I'd known this would happen, I would have packed my bags and left," he said.

'I almost passed out'

It's unclear how many of the sued patients could afford to pay their bills. But the newspapers' investigation found that many of them are among the working poor.

In a sampling of 100 suits that Carolinas HealthCare filed against Mecklenburg County residents, the newspapers found that 43 of them either didn't own property in the county or owned houses assessed at less than $100,000.

Under its current financial assistance policy, Carolinas HealthCare says it offers free care to uninsured and underinsured patients who earn less than twice the poverty level and have less than $150,000 in home equity. For an individual, that's equivalent to earning about $22,000 a year.

Interviews with 14 patients who were sued suggest at least five of them should have qualified for the charity care available at the time they were taken to court.

Barber

Carolyn Barber is grateful to the doctors at CMC-University, who she believes may have saved her life. She's less happy with the hospital's billing office.

Suffering from a respiratory problem that left her gasping for breath, Barber was hospitalized for 15 days in early 2009. She was 63 at the time, with no health insurance, no job and a monthly income of less than $900.

But about a month after leaving the hospital, she got a bill for more than $56,000. Collections agents began calling every other day. Barber told them she couldn't work and couldn't afford to pay the bill. Then a lawyer for the hospital sent a sheriff's deputy to serve her with a lawsuit.

"I almost passed out," Barber said. "I was scared I was going to be locked up in jail because of that hospital bill."

The hospital won a judgment for more than $56,000 in principal, plus interest – and about $8,500 in attorney's fees.

When Barber tried to refinance her home in 2010, the mortgage company told her she couldn't. The reason: The hospital had obtained a lien on the house. With so little income, she needed the extra money a refinancing would provide.

Barber previously worked at a Charlotte facility that helps people with disabilities. Now she's on Social Security disability herself.

For half her life, she said, she saved up to buy her home – an immaculate three-bedroom house near University City with a tax value of $144,000.

"It's something I've worked hard for so I can leave something for my three children," Barber said. "The way it is now, I might not be able to."

Carolinas HealthCare said it unsuccessfully tried to qualify Barber for Medicaid. The system said it also evaluated her to determine whether she qualified for financial assistance, but found she had too much in savings and home equity.

Barber said she deserved help, but the hospital didn't get an accurate picture of her finances. Hospital officials apparently concluded she had too much in savings, she said, because they confused her savings with her sister's.

Officials for Carolinas HealthCare say they provide care to anyone who needs it, and work hard to determine whether patients can afford to pay before filing suit.

"Do we miss some people? We probably do," Tarwater said. "We have 9 million patient encounters each year. And I'm quite sure once in a while we may miss somebody. ... If that's brought to our attention ... we will work with that person."

Nationally, it's not uncommon for hospitals to take aggressive collections actions.

But some states discourage the practice. Illinois prohibits hospitals from pursuing legal action against uninsured patients who don't have sufficient income or assets to pay their bills. California, meanwhile, bans hospitals from putting liens on the primary residences of patients who are eligible for charity care.

North Carolina has no such rules.

Patients are suffering as a result, says Searing, of the Health Access Coalition. Nonprofit hospitals shouldn't be in the business of putting liens on patient's houses, he contends.

"That's not strengthening the community," he said. "That's tearing it down."

To sue or not to sue

Most N.C. hospitals don't regularly sue patients. Novant Health, the nonprofit chain that owns Presbyterian Hospital and 12 other hospitals, has a policy against doing so.

"In health care, where you have people battling for their lives ..., we just decided this is not what a not-for-profit health-care organization should do," says Novant spokesman Jim Tobalski.

Novant's hospitals are among a growing number that run credit profiles on uninsured patients to help determine whether they qualify for financial assistance. The process doesn't affect patients' credit.

Suing patients is "very old school," says Cecilia Moore, chief operating officer for Duke University Medical Center. "It is not a good use of resources any more."

But like most hospitals, Duke and Novant do use commission-driven collections agencies.

Jen Algire, former director of Care Ring, a Charlotte nonprofit that tries to improve access to health care, said she has seen hospitals grow more aggressive on collections.

"People are declaring bankruptcy when they have less than $10,000 in debt, partly because they're being harassed so heavily," Algire said.

Former patients say the bill collectors working on behalf of many N.C. hospitals call repeatedly, sometimes with threats and misleading claims.

In complaints to state agencies, dozens of former patients contend that collections agencies harassed them, sometimes reporting inaccurate information to credit bureaus or continuing to pursue them long after they paid their bills.

In 2008, Elaine Brauninger received notice from a collections agency that she owed about $275 to Lake Norman Regional Medical Center in Mooresville for medical services she had received eight years earlier.

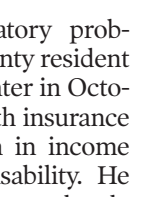
The agency didn't explain what medical services had been provided in 2000, Brauninger said. She had health insurance, she said, and didn't recall any unpaid bills.

"I opened the bill and I said, 'You've got to be kidding me,' " the Mooresville resident said.

She said she spoke by phone with a bill collector, who hung up when she asked for documentation. The collections agency put the account on her credit report – a fact she and her husband later discovered when they sought a loan to buy a condominium.

After Brauninger complained to the N.C. insurance department, the collections agency contacted the hospital, which agreed to take the account off her credit report.

A spokeswoman for Lake Norman says the hospital "takes seriously any patient complaints" and is pleased that Brauninger's complaint was "resolved to her satisfaction."



Shuler

U.S. Rep. Heath Shuler, a Waynesville Democrat, has pushed a bill to ease the damage that medical debt can do to a person's credit rating. Medical bills can remain on a credit report for up to seven years, even if the bill has been paid and the balance is zero.

Shuler wants to change the law so that medical debts of less than $2,500 are removed from credit reports 45 days after the balance goes to zero.

Saying goodbye to good credit

Experts say many collections agencies have an incentive to pursue debtors aggressively. They often negotiate deals with hospitals that allow them to keep between 5 and 25 percent of the money they collect.

Charlotte lawyer David Badger speaks of the pitch that a collection agent made to one elderly woman: "You have the right to remain silent."

Many patients complain that such agencies have destroyed their credit, making it harder to buy a home or car.

The stories have become familiar to Care Ring's managers. In a 2010 survey by the nonprofit, about a third of the 327 clients polled said their credit had been harmed.

Tony Chris Davis knows all too well about such worries.

When serious respiratory problems sent the Yadkin County resident to Carolinas Medical Center in October 2008, he had no health insurance and just $1,400 a month in income from Social Security disability. He told hospital officials he was deeply concerned about the cost of care, he said.

But following his discharge from the hospital, CMC sent him a bill. The total: about $40,000.

Alarmed, Davis called the hospitals and spoke with an official who, he said, told him that he wasn't eligible for charity care because he owned a home and other assets.

Carolinas HealthCare said Davis had too much in savings to qualify for charity care, and that he declined to "spend down" those savings in order to qualify for Medicaid, which would have paid his bills.

Davis' two-bedroom house has a tax value of about $63,000. He had about $20,000 in savings, he said, but needed the money to supplement his disability payments.

While he was hospitalized, Davis said, an official in the business office told him that CMC had decided to treat his case as charity care. Had he known the system would reverse its decision, he would have left CMC and gone to his local hospital, which had previously given him charity care, he said.

The hospital sued him and won a judgment. "I had perfect credit before this happened to me," Davis said. "It has ruined me."

Alexander: 704-358-5060

— OBSERVER STAFF WRITER KAREN GARLOCH, RESEARCHER MARIA DAVID AND NEWS AND OBSERVER STAFF WRITER JOSEPH NEFF CONTRIBUTED.

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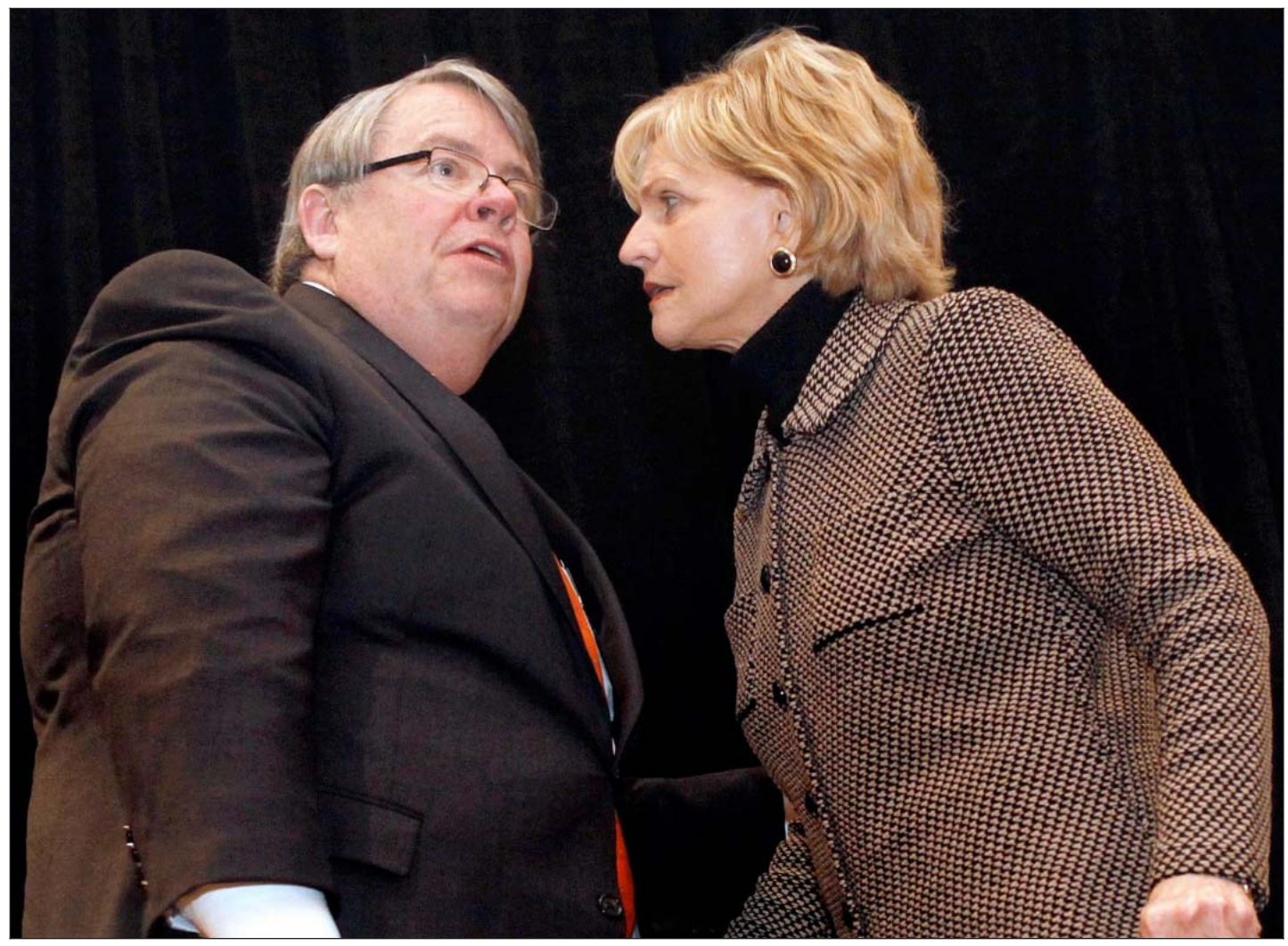
PROGNOSIS: PROFITS FOURTH OF FIVE PARTS

Hospitals' clout in capital built with money, contacts



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Bill Pully talks with Gov. Bev Perdue on Feb. 16 during the annual N.C. Hospital Association winter membership meeting in Cary. A former hospital gerontologist, Perdue has protected hospitals from financial cuts.

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The N.C. Hospital Association rarely loses when it comes to protecting the financial interests of its members

By Joseph Neff, Ames Alexander and David Raynor
jneff@newsobserver.com, aalexander@charlotteobserver.com, draynor@newsobserver.com

Last year, state Rep. Dale Folwell took aim at a substantial tax benefit for North Carolina's nonprofit hospitals: their refund on sales taxes, which averages about $200 million yearly.

Folwell proposed limiting refunds given to some of the state's largest and most profitable hospitals, a move that would have provided state and local governments millions in additional tax revenue. It was never even discussed in committee.

"The reason this bill never got a hearing is because big money bottled it up," said Folwell, a Winston-Salem Republican. The hospitals "came after me with cleats high."

Folwell

N.C. hospitals are one of the most powerful and effective interest groups in state politics, deploying a squad of lobbyists at the General Assembly and contributing generously to elected officials.

Their clout grows from many roots. Hospitals are the state's third-biggest employer. They are economic engines for their communities, providing livelihoods for the families of doctors, nurses, janitors and executives. They are run by boards of directors, invariably the movers and shakers in each community: legislators, developers and business owners.

The N.C. Hospital Association leverages these connections. Its political action committee has handed out more than $1 million to state candidates over the past decade, ranking in the top 10 PACs for political donations. The hospitals have given the most to those with the most power: former senators Tony Rand and Marc Basnight, Attorney General Roy Cooper and former House Speaker Jim Black, all Democrats.

Now, with Republicans in charge of the legislature, more money is going to the GOP than Democrats: Sen. Pete Brunstetter, co-chair of the appropriations committee, Senate Republican leader Phil Berger and former speaker Harold Brubaker, for example.

The checks don't come in the mail; a local hospital executive or board member hand-delivers the contributions to

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the politicians.

The lobbying goes on all year, not just in Raleigh, but in every community with a hospital. The association expects and encourages hospital officials to forge relationships with local lawmakers.

Association spokesman Don Dalton says staffers visit regularly with hospital CEOs, and are expected to ask, "When was the last time you visited with your legislator?"

Politics of fear

Former Sen. David Hoyle knows that relationship from both sides. In the 1980s, he chaired the board at Gaston Memorial Hospital.

In 2009, as the state faced a $3.4 billion shortfall, Hoyle proposed capping sales tax refunds for nonprofits at $5 million.

Hoyle

Hoyle's proposal would have affected only a handful of the state's biggest and most profitable hospitals. It would have raised about $15 million for the state.

Hoyle's idea went nowhere. He said he believes hospital representatives talked to every member of the Senate Finance Committee, arguing that health insurance premiums would rise if the bill passed. It was an effective argument from persuasive people.

"They are the folks back home, they're the people we go to church with and golf with," he said. "It puts the fear in you. You don't want to be the one blamed for health care costs being so high."

Folwell's bill went further: He proposed limiting sales tax refunds to nonprofits to 100 percent of the first $1 million and 25 percent of tax paid above $1 million. The cap would have affected 28 nonprofit hospitals, many of them very profitable, and six colleges and universities.

According to Folwell, hospitals are among the largest users of tax-funded services such as police and fire protection. Most of them pay no property taxes, so other taxpayers have to shoulder the burden.

Cash-strapped public schools do not get a sales tax refund, while wealthy hospitals do, and that's not fair, Folwell said.

Hugh Tilson, lead lobbyist among the 10 who registered in 2011 for the N.C. Hospital Association, made no apologies for killing the sales tax bills.

"As nonprofits, any revenues that we forgo would diminish our ability to care for the public," Tilson said.

Tilson agreed with Hoyle and Folwell that his members are the key to his success lobbying the General Assembly.

"Our success has little to do with what I do," Tilson said. "It's that local relationship between the community and its legislators. Most legislators want their hospitals to succeed."

In Charlotte, Carolinas HealthCare System makes local lawmakers aware of its needs and challenges at an annual breakfast meeting, said Sen. Charlie Dannelly, a Mecklenburg Democrat who's not running for re-election.

"I personally come away with the feeling that they're saying they're struggling. 'Don't do anything to hurt us,' " Dannelly said.

"You're not struggling when your CEO's salary goes up every year, in my opinion," Dannelly said, referring to Michael Tarwater, the system CEO who had total compensation of $4.2 million in 2011.

Many wins, few losses

Ties between hospitals and community leaders are strong.

In Charlotte, the Board of Trustees of Presbyterian Healthcare includes Larry Stone, retired president of Lowe's, and Jim Palermo, a retired Bank of America executive.

Carolinas HealthCare System's board members include NASCAR team owner and businessman Felix Sabates, former Wachovia CEO Ken Thompson, retired Wachovia executive Mac Everett, and Ed Brown, a former Bank of America executive who's now CEO of Hendrick Automotive.

State Sen. Dan Blue of Raleigh, a former House speaker, sits on the board of Duke University Health System. At WakeMed, there's a former Raleigh mayor, a Wells Fargo executive, the former head of Wake County Schools and a former state auditor. Orage Quarles III, president and publisher of The News & Observer, is a member of the board of Rex Hospital in Raleigh.

The hospitals perpetuate their power by staying in the good graces of legislators. The hospital political action committee raises small amounts from thousands of donors: doctors, hospital board members, lawyers, administrators, pharmacists and nurses give in amounts ranging from $15 to $2,800, with the majority of contributions $100 or less, records show.

The organization itself is well-funded, with $4.6 million in revenue during 2010, the most recent year available. It paid out $3.2 million in salaries and benefits, including $869,169 to its president, Bill Pully.

The hospital association has been so successful over the years that Dalton, the spokesman, struggled to name any setbacks suffered at the General Assembly. After a pause, he came up with one: The hospitals pushed a bill to cap damages in lawsuits, which foundered and didn't become law at the time.

That was in 2003.

Tilson, the hospital lobbyist, pointed to a long-term frustration: The hospitals have long pushed for more state money for the mentally ill, including more for inpatient mental health care. The conditions for the mentally ill are no better than they were 10 years ago, Tilson said.

But such setbacks have been rare. More often, the hospitals get exactly what they want.

In 2011, they got the damage cap they'd been seeking, though the big push came from doctors and the N.C. Chamber of Commerce. The law limits medical malpractice awards for noneconomic damage – pain and suffering, emotional distress and less tangible injuries – to $500,000.

Big workers' comp charges

North Carolina hospitals long have received some of the most generous payments in the country for treating patients covered by workers' compensation insurance. That's a charge absorbed by businesses that pay the workers' comp premiums.

It's not a huge business for hospitals – about 1 percent. But it was very profitable: The policies paid hospitals 95 percent of charges for outpatients (an average markup of roughly three times costs), and 77 percent for inpatients (more than double the costs).

According to a study of 16 states by the Workers Compensation Research Institute, North Carolina had the highest payments to hospitals.

The N.C. Industrial Commission set up a committee to find ways to reduce the payments.

Hank Patterson, a Chapel Hill labor lawyer who chaired the committee, said the insurance companies wanted to tie reimbursement rates to Medicare. Insurance companies generally use Medicare rates as the starting point when negotiating with hospitals.

The hospital association objected, Patterson said, and the hospitals prevailed. Reimbursement was cut but remained tied to hospital charges, which is in the hospital's financial interest.

Patterson said the reductions were progress, but he acknowledged that the hospitals could erase the cuts simply by raising their charges. Many hospitals raise their charges 5 percent or more each year.

"The hospitals are very politically powerful," Patterson said. "If you are pragmatic, you tread carefully to make progress."

A governor's help

The hospitals' influence extends beyond the legislature. They also know how to get the ear of the governor.

As the General Assembly struggled with the state budget in 2010, lawmakers made a tentative cut of $519 million to take effect if expected federal stimulus funds were not continued. If the federal funds did not come through, the state budget director was to make cuts from a prioritized list of the disaster relief fund, the state lottery, Medicaid, retirement system contributions, and other funds.

The Department of Health and Human Services planned to cut $26 million in Medicaid reimbursements, a 1.35 percent reduction for doctors, hospitals and other providers. Former Secretary Lanier Cansler announced the rate cuts would take place Sept. 1.

The hospital association geared up. Bill Pully wrote Gov. Bev Perdue, reminding her that hospitals and doctors lose money treating Medicaid patients, and that further cuts would strain an overburdened system.

Pully

A letter-writing campaign followed. Hospital CEOs copied Pully's letter to their letterhead and sent it to Perdue. Doctors, clinics and other practices also wrote Perdue, urging her to not cut provider fees. They sent 104 letters in all, including 36 from hospitals.

The governor asked her staff to set up a meeting with Pully as well as leaders of the groups that lobby for doctors and long-term care facilities.

Perdue met with them at 10 a.m. Aug. 27 at her office in the Capitol.

At 12:30 p.m. that day, the chief financial officer for the state's Medicaid office sent an email to staff: "Per Lanier's direction from the Governor, she has reversed the rate reductions proposed for 9/1/10."

Some stimulus funds had come in, so Perdue had to cut only $222 million. But the other programs did not fare so well; money was taken from the Disaster Relief Reserve, unclaimed lottery money, the state's rainy day fund and others. In effect, Perdue's budget director skipped over Medicaid, the fifth item on the list, and made cuts from the rainy day fund and another management fund.

Tilson said the governor recognized the dangers of cutting Medicaid.

"She understood the cuts would be detrimental to the state's most vulnerable populations," he said.

Perdue said she didn't need any convincing. Keeping Medicaid funded as much as possible was her top priority for hospitals.

Before she ran for the state House in 1986, Perdue was a gerontologist at Craven Memorial Hospital. When she ran for office, she followed a campaign plan drafted by a lawyer for the hospital association: Bill Pully.

She won. They have been allies ever since.

Alexander: 704-358-5060

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PROGNOSIS: PROFITS

Prices soar as hospitals dominate cancer market

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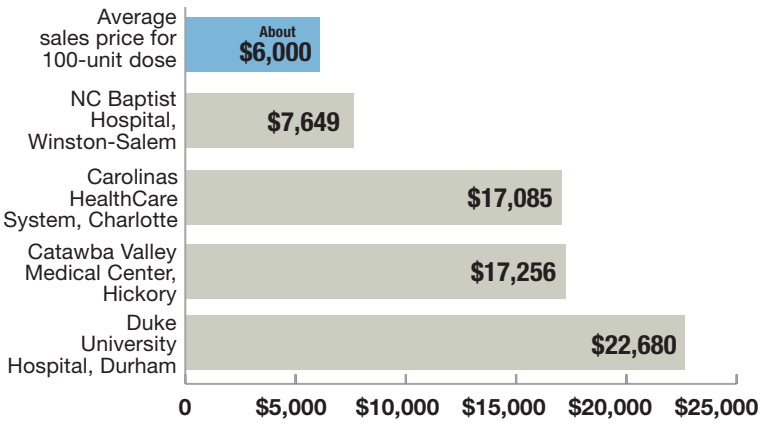
Patients receive chemotherapy at Southern Oncology Specialists in Huntersville, one of the dwindling number of independent oncology clinics in the Charlotte area. Hospitals are increasingly buying doctor groups, and hospital markups on cancer drugs are often higher.

Same drug, different prices

Here's a look at what several North Carolina hospitals were paid this year for a typical dose of a common cancer drug under one private health plan.

AVASTIN: Used to extend life in patients with lung, breast, colon, kidney and ovarian cancer.



SOURCES: Analysis of claims data obtained by The Charlotte Observer and The News & Observer, U. S. Centers for Medicare and Medicaid Services.

STAFF CHART

BY AMES ALEXANDER, KAREN GARLOCH AND JOSEPH NEFF

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Large nonprofit hospitals in North Carolina are dramatically inflating prices on chemotherapy drugs at a time when they are cornering more of the market on cancer care, an investigation by the Observer and The News & Observer of Raleigh has found.

The newspapers found hospitals are routinely marking up prices on cancer drugs by two to 10 times over cost. Some markups are far higher.

It's happening as hospitals increasingly buy the practices of independent oncologists, then charge more – sometimes much more – for the same chemotherapy in the same office.

Asked about the findings, hospital officials said they are relying on a longtime practice of charging more for some services to make up for losses in others. Hospitals have a name for this: cost-shifting.

"The drug itself may just be the vehicle for charging for the services that are provided (elsewhere)," said Joe Piemont, president of Carolinas HealthCare System, the $7 billion chain that owns many of the region's hospitals. "We make literally thousands of trades to have it balance."

The rising price of cancer treatment has financially devastated many families, while driving up insurance costs and causing some patients to put off needed treatments.

"If you have enough money or good enough insurance, it may not be an issue for you," said Donna Hopkins, CEO of Dynamic Medical Solutions, a company that audits medical bills. "If you're somebody who

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INSIDE

One patient's chemo bill tops $145,000. **7A**

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CHEMO

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doesn't have that, it can be a death sentence."

After examining some chemotherapy bills collected by the Observer, Hopkins called the markups "outrageous."

Some of the largest markups are made by nonprofit hospital chains that generate millions of dollars of profit each year and have billions in reserves.

It's a mystery to the public how hospitals set their charges. But the newspapers obtained and analyzed a private database with information on more than 5,000 chemotherapy claims to get insight into pricing for cancer patients, a group that faces some of the nation's highest medical bills.

The drug data, along with scores of interviews, help explain why hospitals have become so expensive – and why health care spending now makes up 18 percent of the national economy.

Among the markups found:

■ Levine Cancer Institute, owned by Charlotte-based Carolinas HealthCare, this year collected nearly $4,500 for a 240-milligram dose of irinotecan, a drug used to treat people with colon or rectal cancer. The average sales price for that amount of the drug: less than $60.

■ Carolinas Medical Center-NorthEast in Concord was paid about $19,000 for a one-gram dose of rituximab, used to treat lymphoma and leukemia. That was roughly three times the average sales price.

■ Forsyth Medical Center in Winston-Salem, owned by Novant Health, collected about $680 for 50 milligrams of cisplatin. The markup: more than 50 times the average sales price.

Such markups are hidden from patients.

Charlotte native Chuck Moore, the patient in the Forsyth case, got nine weeks of chemotherapy for cancer at the base of his tongue in 2008 and 2009. Though he had good health insurance, he still paid about $15,000.

When a reporter told him the average sales price of the drugs he'd received, he questioned the hospital's charges.

Moore

"I've never had a business where I could get a markup like that," said Moore, an assembly plant supervisor now living near Atlanta. "It seems almost predatory."

Costlier, not better?

Until recently, those who needed chemotherapy had more alternatives. They could go to the offices of oncologists who weren't employed by hospitals.

Increasingly, however, private oncologists are under financial pressure to sell their businesses to hospitals. When they do, hospitals often charge more.

In a review of claims for seven cancer drugs, the newspapers found that charges for all but one drug were significantly higher at hospitals and hospital-owned clinics – usually more than 45 percent higher.

Levine Cancer Institute, for instance, charges about $106 for each unit of Aloxi, the anti-nausea drug. But at Carolina Oncology Specialists, an independent clinic in Hickory, the charge is just $50.

Insurers have found similar patterns.

At the newspapers' request, Blue Cross and Blue Shield of North Carolina, the state's largest health insurer, examined data from thousands of 2011 chemotherapy claims and found that hospital-owned facilities in the state tend to be paid 50 to 150 percent more for cancer drugs than independent oncologists.

A recent study by Avalere Health, a consulting firm, found similar disparities nationally. Chemotherapy costs 24 percent more in an outpatient hospital setting than in a doctor's office, the study concluded.

Dr. Ira Klein, assistant to the chief medical officer at Aetna insurance company, said he believes the acquisitions of oncology practices by hospitals have increased costs without improving the quality of care.

"We're essentially enriching people and getting nothing for it," he said. "And there are higher premiums every year."

Shifting the costs

Hospital officials defend their pricing.

Unlike many independent clinics, they say, hospitals suffer losses from treating patients without insurance and patients covered by Medicaid, the government program for the poor and disabled. Some independent oncologists acknowledge that they often refer such patients to hospitals.

Hospital officials say they provide counseling and many other cancer services that insurers don't cover.

Officials for Carolinas HealthCare and Novant, which runs four Mecklenburg County hospitals, emphasize that they provide free care to many financially needy cancer patients.

Carolinas Medical Center spent about 5.5 percent of its budget on charity care in 2010. Presbyterian Hospital spent about 5 percent.

Piemont, of Carolinas HealthCare, said charges for chemotherapy drugs may be used to cover costs of other money-losing services, such as the emergency department, which treats a high number of uninsured patients.

Piemont

"We cannot be compared to (an independent doctor) who can just overtly select who they see," Piemont said. "We take everybody. That requires cost-shifting that is so emblematic of this industry."

Novant spokeswoman Kati Everett pointed to shortcomings in the Avalere study, noting that hospital patients tend to be sicker than those treated in doctors' offices. Comparing prices at hospitals versus doctor's offices doesn't provide an accurate picture, she argued.

Like most hospitals, those owned by Carolinas HealthCare and Novant are nonprofits, a designation that provides them substantial tax breaks. In exchange, they are expected to provide charity care and other benefits to their communities.

Hospitals will likely face fewer unpaid bills under the federal Affordable Care Act. That's because the law, scheduled to become fully effective in 2014, requires millions of people to buy health insurance. At the same time, hospitals will likely face cuts in government reimbursement for care.

Neither hospital system answered questions about how much they've spent on chemotherapy drugs in recent years, and how much revenue those drugs generated.

But Everett said Novant lost money on outpatient chemotherapy infusion last year.

Vulnerable patients

It's understandable why many cancer drugs don't come cheap, according to those who make and administer them. Drug companies must cover research and development costs. Hospitals have to cover overhead.

The N.C. Hospital Association said the costs of handling and preparing cancer drugs "far exceed those required for most other medications."

"Medicines that treat cancer are toxic, dangerous chemicals that demand the highest levels of trained personnel, specialized equipment and facilities," the association said.

But community oncologists say they use the same toxic drugs in their practices at a much lower price.

And some experts contend that hospitals don't need to inflate prices so dramatically.

Gerard Anderson, who heads the Johns Hopkins Center for Hospital Finance, thinks hospitals mark up charges on cancer drugs more than most other drugs and supplies. One reason, he suspects, is that patients are "not inclined to do comparison shopping in a life-or-death situation."

SEE **CANCER,** 7A

In at least two ways, size has given hospitals a financial edge.

An Observer investigation in April showed how hospital consolidation has led to higher prices. When hospitals merge into large systems, they gain leverage to negotiate higher payments from private insurers.

While insurers might be willing to exclude a small clinic from their networks, they are loath to lose the hospital chains that have come to dominate many markets.

That has helped some North Carolina hospital chains evolve into profitable, fast-growing giants. At Carolinas HealthCare, the nation's second-largest public hospital system, the average annual profit has exceeded $300 million over the past three years. The chain has built up more than $2 billion in investments and owns more than $1 billion in property.

Novant had about $1.6 billion in cash and investments in 2010 – a threefold increase over the decade.

A positive for patients is that such profits have improved access to quality health care. With the creation of Levine Cancer Institute in 2010, Carolinas HealthCare has recruited specialists from respected institutions such as the Cleveland Clinic and M.D. Anderson Cancer Center in Houston.

Size gives hospitals another advantage, allowing them to save money when they purchase drugs in bulk.

And more than 40 North Carolina hospitals – including Carolinas Medical Center and Presbyterian Hospital – are able to obtain deep discounts on outpatient drugs under the federal 340B program, which requires drug manufacturers to provide price breaks to hospitals that treat large numbers of financially needy patients.

Although Congress set up the program to offset the cost of treating Medicaid patients, hospitals can buy discounted drugs for all outpatients, including those with private insurance.

"There is no requirement to pass the savings on to patients, and they don't," said Dr. John Peterson, who practiced as a private oncologist in Sanford for 18 years before moving to Dartmouth College last year. "These hospitals are driving out the private practices, and they're becoming the Wal-Mart of health care, squashing the competition, but without the low prices."

Costs can jeopardize lives

Cancer costs more per patient, on average, than any other medical condition.

In North Carolina, Blue Cross and Blue Shield said the cost of cancer drugs for members younger than 65 rose from $178 million in 2009 to $211 million last year.

New drugs have given hope to many cancer patients. But some of those drugs come with annual price tags that rival those of a small home.

Treating a cancer patient with Avastin, for instance, costs about $90,000 a year, doctors say.

Much of the bill is picked up by employers and their workers, who pay ever-increasing sums for insurance and other costs.

But no one feels the financial pain more than patients. In a 2010 survey commissioned by the American Cancer Society, 21 percent of people younger than 65 undergoing cancer treatment said they had used up all or most of their savings. And 19 percent said they or their family members had put off getting a recommended cancer test or treatment because of cost.

Dr. Otis Brawley, the society's chief medical officer, has seen the consequences.

When Brawley headed the cancer center at Emory University in Atlanta from 2001 to 2007, he regularly treated patients who waited too long to get treatment – often because of financial concerns.

"Many folks put off managing their problems until it's so, so bad, they have to come into the emergency room," he said.

Too often, Brawley said, such delays cost patients their lives. Patients who initially suffered from treatable colon cancer, for instance, sometimes delayed seeking treatment until the malignancy spread to the liver and became incurable.

Doctors in North Carolina see some patients making similar choices.

"A lot of patients are forgoing care," said Dr. David Eagle, of Huntersville, who is president of the Community Oncology Alliance, a national nonprofit group dedicated to community cancer care.

Marge Beazley, who manages an oncology practice in Western North Carolina, said some underinsured patients wind up with more than $50,000 in annual out-of-pocket expenses. Others, she said, choose not to be treated because of the cost.

"Those are the ones that break your heart," she said.

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Carol Fleming of Huntersville was "petrified" when she saw her first bill. She exhausted her savings to pay for treatment.

> 'These hospitals are ... becoming the Wal-Mart of health care, squashing the competition, but without the low prices.'
>
> **DR. JOHN PETERSON,** WHO FOR YEARS PRACTICED AS A PRIVATE ONCOLOGIST IN NORTH CAROLINA

'Oh my God'

When Carol Fleming of Huntersville was diagnosed with breast cancer in 2008, her husband's job in Saudi Arabia provided health insurance.

But he died of leukemia in 2010. Ten days later, her insurance was canceled. Within a month, the bills for her chemotherapy and related services had topped $65,000.

She recalls opening her first bill and saying: "Oh my God. Oh my God."

"I remember thinking, 'I'm in the middle of my battle. How many more treatments am I going to need?' I was petrified."

Presbyterian Huntersville provided excellent care, along with help with some of her bills, said Fleming, a former CIA agent. She exhausted her savings paying some of the rest.

Now she's living in a small apartment, dependent on government assistance. It's a far cry from her life in Saudi Arabia, when she lived in a six-bedroom house with marble floors.

"This has happened to me," she said. "It can happen to anybody."

— DATABASE EDITOR DAVID RAYNOR CONTRIBUTED.

How we reported the story

To research chemotherapy costs, reporters for the Observer and The News & Observer of Raleigh obtained and analyzed a database of more than 5,000 chemotherapy claims.

The database includes records from more than 200 North Carolina practices and hospitals that treat cancer patients.

Reporters also examined several dozen itemized bills and explanations of benefits from insurance companies, and asked hospital billing experts to review some of them as well.

In addition, reporters interviewed more than 25 cancer patients, along with many hospital officials, oncologists, practice managers, national experts and insurance executives.

When calculating the number of cancer specialists employed by hospitals, the newspapers focused on medical oncologists, who oversee infusion of cancer drugs. Surgeons and radiologists who specialize in oncology were not counted.