Patients’ Costs Skyrocket; Specialists’ Incomes Soar

By ELISABETH ROSENTHAL  JAN. 18, 2014

CONWAY, Ark.
— Kim Little had not thought much about the tiny white spot on the side of her cheek until a physician’s assistant at her dermatologist’s office warned that it might be cancerous. He took a biopsy, returning 15 minutes later to confirm the diagnosis and schedule her for an outpatient procedure at the Arkansas Skin Cancer Center in Little Rock, 30 miles away.

That was the prelude to a daylong medical odyssey several weeks later, through different private offices on the manicured campus at the Baptist Health Medical Center that involved a dermatologist, an anesthesiologist and an ophthalmologist who practices plastic surgery. It generated bills of more than $25,000.

“I felt like I was a hostage,” said Ms. Little, a professor of history at the University of Central Arkansas, who had been told beforehand that she would need just a couple of stitches. “I didn’t have any clue how much they were going to bill. I had no idea it would be so much.”

Ms. Little’s seemingly minor medical problem
she had the least dangerous form of skin cancer — racked up big bills because it involved three doctors from specialties that are among the highest compensated in medicine, and it was done on the grounds of a hospital. Many specialists have become particularly adept at the business of medicine by becoming more entrepreneurial, protecting their turf through aggressive lobbying by their medical societies, and most of all, increasing revenues by offering new procedures — or doing more of lucrative ones.

It does not matter if the procedure is big or small, learned in a decade of training or a weeklong course. In fact, minor procedures typically offer the best return on investment: A cardiac surgeon can perform only a couple of bypass operations a day, but other specialists can perform a dozen procedures in that time span.

That math explains why the incomes of dermatologists, gastroenterologists and oncologists rose 50 percent or more between 1995 and 2012, even when adjusted for inflation, while those for primary care physicians rose only 10 percent and lag far behind, since insurers pay far less for traditional doctoring tasks like listening for a heart murmur or prescribing the right antibiotic.

**Sharp Climb**

Salaries in some medical specialties have risen much more sharply than in others.

By 2012, dermatologists — whose incomes were more or less on par with interns in 1985 — had become the fourth-highest earners in American medicine [in some surveys](http://www.nytimes.com/2014/01/19/health/patients-costs-skyrocket-specialists-incomes-soar.html), bringing in an average of $471,555, according to the Medical Group Management Association, which tracks doctors’ income, though their workload is one of the lightest.

In addition, salary figures often understate physician earning power since they often do not include revenue from business activities: fees for blood or pathology tests at a lab that the doctor owns or “facility” charges at an ambulatory surgery center where the physician is an investor, for example.

“The high earning in many fields relates mostly to how well they’ve managed to monetize treatment — if you freeze off 18 lesions and bill separately for surgery for
1995 Source: Medical Group Management Association

2012 each, it can be very lucrative,” said Dr. Steven Schroeder, a professor at the University of California and the chairman of the National Commission on Physician Payment Reform, an initiative funded in part by the Robert Wood Johnson Foundation.

Doctors’ charges — and the incentives they reflect — are a major factor in the nation’s $2.7 trillion medical bill. Payments to doctors in the United States, who make far more than their counterparts in other developed countries, account for 20 percent of American health care expenses, second only to hospital costs.

Specialists earn an average of two and often four times as much as primary care physicians in the United States, a differential that far surpasses that in all other developed countries, according to Miriam Laugesen, a professor at Columbia University’s Mailman School of Public Health. That earnings gap has deleterious effects: Only an estimated 25 percent of new physicians end up in primary care, at the very time that health policy experts say front-line doctors are badly needed, according to Dr. Christine Sinsky, an Iowa internist who studies physician satisfaction. In fact, many pediatricians and general doctors in private practice say they are struggling to survive.

Studies show that more specialists mean more tests and more expensive care. “It may be better to wait and see, but waiting doesn’t make you money,” said Jean Mitchell, a professor of health economics at Georgetown University. “It’s ‘Let me do a little snip of tissue’ and then they get professional, lab and facility fees. Each patient is like an ATM machine.”

For example, the procedure performed on Ms. Little, called Mohs surgery, involves slicing off a skin cancer in layers under local anesthesia, with microscopic pathology performed between each “stage” until the growth has been removed. While it offers clear advantages in certain cases, it is more expensive than simply cutting or freezing off a lesion. (Hospitals seeking to hire a staff dermatologist for Mohs surgery had to offer an average of $586,083 in 2010, even more than for a cardiac surgeon, according to Becker’s Hospital Review.)

Use of the surgery has skyrocketed in the United States — over 400 percent in a little over a decade — to the point that last summer Medicare put it at the top of its “potentially misvalued” list of overused or overpriced procedures. Even the American Academy of Dermatology agrees that the surgery is sometimes used inappropriately. Dr. Brett Coldiron, president-
elect of the academy, defended skin doctors as “very cost-efficient” specialists who deal in thousands of diagnoses and called Mohs “a wonderful tool.” He said that his specialty was being unfairly targeted by insurers because of general frustration with medical prices. “Health care reform is a subsidized buffet and if it’s too expensive, you go to the kitchen and shoot one of the cooks,” he said. “Now they’re shooting dermatologists.”

**Pricing 100 Mohs Procedures**

A random sample of 100 similar outpatient Mohs surgeries shows an enormous range in how much was paid for the procedure. The difference between the most expensive and the least expensive is more than $7,000.

![Graph showing the pricing of 100 individual Mohs surgeries](image)

*Source: Healthcare Bluebook*

*Note: Does not include the fee for repair after the cancer is removed, if performed by another doctor.*

The specialists point to an epidemic, noting there are two million to four million skin cancers diagnosed in the United States each year, with a huge increase in basal cell carcinomas, the type Ms. Little had, which usually do not metastasize. (A small fraction of the cancers are melanomas, a far more serious condition.) But, said Dr. Cary Gross, a cancer epidemiologist at Yale University Medical School, “The real question is: Is there a true epidemic or is there an epidemic of biopsies and treatments that are not needed? I think the answer is both.”

**Patient Given No Choice**

A fair-skinned redhead who teaches history at the University of Central
Arkansas, Ms. Little had gone to a private dermatology practice in Heber Springs, Ark., to check some moles on her arms when the physician's assistant on duty noticed a whitish bump — like a “tiny fragment of thread” — on her face, she said. Her family practitioner had told her it was just a clogged pore.

A diligent medical consumer, Ms. Little had read up on the Mohs technique (invented by Dr. Frederic Mohs in 1938) before she and her husband arrived for her surgery in November 2012 in a doctors’ office building at Baptist Health Medical Center here. Pressed for time as the end of the semester approached, she asked Dr. Randall Breau, the dermatologist, why the tiny growth needed the specialized surgery, as she had asked the physician’s assistant earlier. They both answered that it was because it was on her eyelid, a delicate area where Mohs surgery is always required; she repeatedly insisted that it was on her cheekbone below her eye.

After the 30-minute removal, the dermatologist told her that she would have to go across the street to the Arkansas Center for Oculoplastic Surgery, another private doctors’ office on the hospital’s campus, to have the wound closed by a plastic surgeon with “a couple of stitches.”

When Ms. Little protested that she did not want a plastic surgeon and did not care about having a tiny scar, the doctor told her she had no choice, she said. The vast majority of Mohs procedures are sewed up by the dermatologist or just bandaged and left to heal. Yet when Ms. Little arrived at the second practice, nurses took her clothes, put in an IV, and introduced her to an anesthesiologist who would sedate her in an operating room.

Sitting in her cozy office recently, Ms. Little, who has a faint scar under her eye on her right cheek, still fumes at the thought. “It was no bigger than many cuts that heal on their own, and it definitely could have been repaired by one doctor, but at that point what was I going to do?” she recalled. “I have an IV in my arm and a hole in my face that Dr. Breau refused to stitch. And the anesthesiologist is standing there with his mask on.”

Her bills included $1,833 for the Mohs surgery, $14,407 for the plastic surgeon, $1,000 for the anesthesiologist, and $8,774 for the hospital charges.

Mohs surgery is preferable when the removal of a skin cancer is complicated or in a sensitive area, because it typically excises less tissue and leaves less of a scar than other treatments and allows dermatologists to see the borders of a growth and be confident that it is removed entirely. The surgery is generally not used for melanomas, which require more extensive cutting.
Rich Doctors, Richer Doctors

Specialists who perform medical procedures command the highest incomes among doctors. The following are median annual compensation by specialty for physicians who are paid by hospitals or health networks.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Income</th>
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<tr>
<td>Orthopedic surgery: hip and joint</td>
<td>$920,555</td>
</tr>
<tr>
<td>Orthopedic surgery: spine</td>
<td>$820,569</td>
</tr>
<tr>
<td>Surgery: neurological</td>
<td>$707,252</td>
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<tr>
<td>Cardiology: invasive-interventional</td>
<td>$583,837</td>
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<tr>
<td>Dermatology: Mohs surgery</td>
<td>$516,081</td>
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<tr>
<td>Gastroenterology</td>
<td>$488,200</td>
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<tr>
<td>Hematology/Oncology</td>
<td>$425,006</td>
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In an email, Dr. Breau declined to discuss Ms. Little's case, but noted, “When I make decisions concerning patient care, I have only the patient’s best interests in mind.” He said that he and one partner own the Arkansas Skin Cancer and Dermatology Center and receive no payments from the hospital or the doctors to whom they refer patients. In most cases, he said, he takes care of the wound left by Mohs surgery himself. The plastic surgeon did not respond to requests for comment.

It is often impossible in any one case to determine whether a course of treatment was necessary or cost-effective. Even among doctors there are differences of opinion about optimal treatments. That is partly because the guidelines for when to perform many procedures are often ill-defined or based on the specialists' experience rather than carefully controlled research.

“Though Mohs surgery is disseminating rapidly, there are very few comparative studies and the evidence is still evolving about when it’s beneficial,” said Dr. Gross, the Yale epidemiologist. “When people are trained to perform a procedure, and believe in it, and equip their offices to do it, they will do it. That’s just human nature.”

The same specialties tend to appear at the top of physician earners: orthopedics, cardiology, anesthesiology, radiology, dermatology, plastic surgery, urology, gastroenterology and ophthalmology. Physicians in those fields typically earn more than $350,000 annually, according to American Medical Group Association, a trade organization. In many specialties, income has risen more than 10 percent since 2011, according to Medscape, a Web company that follows the industry.

Physicians often complain that government and commercial insurance reimbursements for seeing patients are decreasing while their office expenses are going up to deal with
mountains of paperwork and demands from insurers. Congress currently is considering a bill that would freeze doctors’ Medicare fees for the next decade. Still, many doctors have found alternative income streams that do not show up on surveys.

Dr. Mitchell of Georgetown University estimates, for example, that many urologists make 50 percent of their income from dealing with patients and the rest from investing in the machines that deliver radiation for prostate cancer or to treat kidney stones. In 2012, urologists had an average income of $416,322, according to Medical Group Management Association data, which often does not include the investment income.

Oncologists benefit from the ability to mark up (and profit from) each dose of chemotherapy they administer in private offices, a practice increased dramatically in the late 1990s. The median compensation for oncologists nearly doubled from 1995 to 2004, to $350,000, according to the M.G.M.A. One study last year attributed 65 percent of the revenue in a typical oncology practice to such payments.

When policy makers reduce one type of payment, some specialists find another. Though orthopedists’ reimbursement from Medicare for performing joint replacements has gone down in the last two decades, the Medscape survey on physician income showed that orthopedists’ average compensation has risen 27 percent since 2011. They are still paid handsomely by many private payers for many minor procedures, and — more important — often own the surgery centers, scanners and physical therapy offices they use.

In a country where top hospital executives typically make more than a million dollars a year, American physicians may feel entitled to high fees, especially because they face costs that their European counterparts do not: Medical school is expensive and new doctors graduate with an average of about $150,000 in debt. Likewise, some specialists face malpractice premiums of over $100,000 a year.

Though medical societies tend to point to the long haul of medical training and the unpredictable hours to justify generous salaries, health economists
point out there is often little correlation between compensation and that investment of time. Obstetricians, for example, arguably have the most rigorous schedules but are relatively modest earners. A number of high-income specialties — radiology, ophthalmology, anesthesiology and dermatology — are often called the “lifestyle specialties,” because training is more compatible with a home life than some other disciplines and there are fewer emergencies in these fields. Eighty percent of dermatologists see patients 40 hours or fewer each week, according to a 2013 Medscape report, less than the average doctor.

Profitable Dermatology

In America’s for-profit, fee-for-service medical system, dermatology has proved especially profitable because it offers doctors diverse revenue streams — from cosmetic treatments that are fully paid by the patient to medical treatments that are covered by insurance.

Cosmetic dermatology is a big moneymaker in high-income markets like New York and Miami. Botox injections take 15 minutes and cost a minimum of $500; doctors pay about $100 for the amount of medicine needed for a typical session, according to dermatologists. Still, cosmetic work makes up less than 10 percent of all skin procedures, studies show, and their volume tends to fluctuate with the economy.

For medical treatment, many dermatologists have been able to compensate for cutbacks in insurance payments by offering new services and by increasing their patient volume through hiring “physician extenders” — nurse practitioners and physicians’ assistants — to do basic tasks like biopsies and chemical peels. Whether the physician or the nurse wields the scalpel, the charge is generally the same.

The dermatology office where Ms. Little’s initial biopsy was performed is one of six satellite offices operated by the Arkansas Skin Cancer and Dermatology Center. They are often staffed by physician assistants, who refer patients to the dermatologists in Little Rock for Mohs surgery. The dermatologists also do their own pathology, meaning that they can sometimes bill extra for that service. (That also means there is no independent confirmation of a cancer diagnosis.)

With such practices, even minor dermatology procedures can lead to big bills. When Ashley Lanning, 28, of Oregon was seen by a nurse practitioner for a mole removal, the tab came to $915.46 — “way more than I’d
anticipated,” she said. The growth was scraped off with a scalpel and no stitches were required. In New York last year, Kyle Snow Schwartz, 26, went to a dermatologist at New York University Medical Center to have a wart removed from his foot. The visit took five minutes, including a chat about his plans to teach English in Vietnam and a squirt of liquid nitrogen on the growth. The invoice from the billing office: $500.

Both patients have insurance with high deductibles, so they faced large out-of-pocket payments.

In contrast, in Germany where private doctors’ allowable charges are set by the government, dermatologists are paid $30 for a whole body skin check, $40 for a standard biopsy and $20 for a pathology exam, said Dr. Matthias Augustin, who studies the practice of dermatology at the University Medical Center of Hamburg-Eppendorf. There is far less use of Mohs surgery in Germany than in the United States, he said. Most patients with a possible skin cancer get a biopsy and come back a few days later for full removal if it is positive.

Harris Williams and Company, a consulting firm, estimates the $10.1 billion dermatology market in the United States will grow to over $13 billion by 2017, in part because of an aging population. The Affordable Care Act requires 100 percent coverage for preventive dermatology screening sessions for seniors, which will inevitably lead to more biopsies and treatment. With more doctors being trained in Mohs surgery — generally an extra year of training, though it is not required — it has become a go-to
treatment. Dr. Coldiron, who is a past president of the American College of Mohs’ Surgery, said it was “not generally overvalued,” adding that the cure rate after a single treatment was somewhat higher than with other techniques, avoiding the need for a second procedure. He said that Mohs typically cost only 30 percent more than the standard procedure. But Healthcare Blue Book, which tracks pricing in the private market, found that payments by insurers for Mohs surgery were typically twice as high.

Dr. Coldiron acknowledged that Mohs was not appropriate for “every little bitty thing.” Indeed, to stem the use of Mohs surgery where cheaper procedures would suffice, the American Academy of Dermatology in 2012 issued “appropriateness” guidelines about what kinds of cancers should be treated with the technique — such as those on the eyelids or nose, or those that were large or deep.

At the annual meeting of the Pacific Dermatology Association this fall, Dr. Sumaira Aasi, a Stanford dermatologist, told her colleagues that Medicare would come after dermatologists if those guidelines were not heeded, noting: “We might be killing the goose that laid the golden egg ourselves.”

The Medical Lobby

More than 750 lobbyists represent groups of health professionals in Washington, pushing back on any effort to limit their incomes. The biggest spenders on lobbying — $80 million annually by health professionals — closely align with the highest-paid specialties.

Medicare’s valuation of physicians’ services is based on a complex algorithm that is intended to take into account the time and skill required to perform a medical task, with an adjustment made for a specialty’s malpractice rates. Many insurers follow Medicare’s lead, often paying anywhere from 80 percent to 200 percent of the Medicare fee. But “time and skill” are easier to quantify for procedures than continuing patient management. And, experts say, Medicare has not reduced payments for many procedures that now take far less time than when they were invented, because of improvements in efficiency or technology.

But renegotiating payments involves a highly contentious process that plays out behind closed doors at the American Medical Association’s Relative Value Scale Update Committee, which consists of doctors representing 26 medical disciplines who advise Medicare. In dermatology trade journals, Dr. Coldiron, who has served on the committee, describes it like this:
“Everybody sits around a table and tries to strip money away from another specialty.” It’s like “26 sharks in a tank with nothing to eat but each other.”

Primary care doctors — who make up only 12 percent of physicians in practice — say they have little clout, with at most five representatives on the panel. “That committee keeps the perverse incentives in place,” said Brian Crownover, a family physician from Boise, Idaho.

Indeed, less than two years ago, Dr. Coldiron predicted that reimbursement for Mohs surgery could drop 20 percent. But that did not happen. When Medicare placed Mohs on its list of potentially misvalued procedures last summer, it was deluged with protests from dermatologists, and the A.M.A. Update Committee declared Mohs surgery worthwhile.

This year, Medicare reimbursement will drop only about 2 percent to about $1,000 for a typical procedure. (In recent years, the American Academy of Dermatology Association — the dermatology academy’s political action committee — has also fought proposed Medicare requirements that dermatologists provide preoperative pictures of lesions they had treated with Mohs surgery, and it has pushed states to classify Botox injections as well as skin procedures using lasers as “the practice of medicine,” to prevent spas from offering such services.)

Critics say the robust revenues from doing procedures has led to overuse — colonoscopies by gastroenterologists, steroid injections by pain specialists and M.R.I. scans by orthopedists, to name a few. Dr. Thomas Balestreri, a recently retired anesthesiologist from Washington State, said in an interview that to increase revenue, some fellow specialists used an ultrasound to guide placement of a nerve block when it was not really needed.

But in some cases dollars from procedures keep practices afloat, because insurers pay so little for time with patients. Dr. Stephen Asher, a neurologist in Boise, Idaho, said his 50 to 60 hours a week seeing patients accounts for only about 10 percent of his income. To cover office expenses he relies on revenue from performing a few procedures — Botox injections for eye movement disorders and muscle conduction studies — as well as from an M.R.I. scanner that he co-owns with a group of orthopedists and neurologists.
Outrage at Charges

Ms. Little left Baptist Health Medical Center with a tiny skin flap and more than two dozen stitches. For five days she said she was “hung over” from the IV sedation that she had not wanted — a problem because she drives 60 miles on rural Arkansas roads to her university each day.

She spent months arguing down her bills, which were finally reduced: About $1,400 for the Mohs surgeon, $765 for the anesthesiologist, $1,375 for the ophthalmological plastic surgeon, plus $1,050 in operating-room charges from the hospital.

For her follow-up, she refused to return to Baptist Health and went instead to the University of Arkansas Medical Center, where a dermatologist told her she likely had not needed such an extensive procedure. But that was hard to judge, since the records forwarded from Baptist did not include the photo that was taken of the initial lesion.

And she was outraged as she wrote checks for the nearly $3,000 she owed to the doctors under the terms of her insurance. “It was like, ‘Take out your purse, we’re robbing you,’ ” she said.

Paying Till It Hurts

*Articles in this series are examining the high costs of common medical encounters and how they contribute to health care spending in the United States.* 

A version of this article appears in print on January 19, 2014, on page A1 of the New York edition with the headline: Patients’ Costs Skyrocket; Specialists’ Incomes Soar. Order Reprints | Today’s Paper | Subscribe