

What I Learned From My \$190,000 Surgery

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The author of "America's Bitter Pill" recounts his own experience with our broken healthcare system

I usually keep myself out of the stories I write, but the only way to tell this one is to start with the dream I had on the night of April 3, 2014.

Actually, I should start with the three hours before the dream, when I tried to fall asleep but couldn't because of what I thought was my exploding heart.

Thump. Thump. Thump. If I lay on my stomach, my heart seemed to push down through the mattress. If I turned over, it seemed to want to burst out of my chest.

When I pushed the button for the nurse, she told me there was nothing wrong. She even showed me how to read the screen of the machine monitoring my heart so I could see for myself that all was normal. But she said she understood. A lot of patients in my situation imagined something was going haywire with their heart when it wasn't. Everything was fine, she promised, before giving me a sedative.

All might have looked normal on that monitor, but there was nothing fine about my heart. It had a time bomb appended to it. It could explode at any moment—that night or three years later—and kill me almost instantly. No heart attack. No stroke. I'd just be gone, having bled to death.

That's what had brought me to the fourth-floor cardiac-surgery unit at New York–Presbyterian Hospital. The next morning I had open-heart surgery to fix something called an aortic aneurysm.

It's a condition I had never heard of until a week before, when a routine checkup by my extraordinarily careful doctor found it.

And that's when everything changed.

Until then, my family and I had enjoyed great health. I hadn't missed a day of work for illness in years. Instead, my view of the world of health care was pretty much centered on a special cover story I had written for TIME a year before about the astronomical cost of care in the U.S. and the dysfunctions and abuses in our system that generated and protected those high prices.

For me, an MRI had been a symbol of profligate American health care—a high-tech profit machine that had become a bonanza for manufacturers such as General Electric and Siemens

and for the hospitals and doctors who billed patients billions of dollars for MRIs they might not have needed.

But now the MRI was the miraculous lifesaver that had found and taken a crystal-clear picture of the bomb hiding in my chest. Now a surgeon was going to use that MRI blueprint to save my life.

A week before, because of the reporting I had done for the TIME article, I had been like Dustin Hoffman's savant character in Rain Man—able and eager to recite all varieties of statistics on how screwed up and avaricious the American health care system was.

We spend \$17 billion a year on artificial knees and hips, which is 55% more than Hollywood takes in at the box office.

America's total health care bill for 2014 was \$3 trillion. That's more than the next 10 biggest spenders combined: Japan, Germany, France, China, the U.K., Italy, Canada, Brazil, Spain and Australia. All that extra money produces no better, and in many cases worse, results.

There are 31.5 MRI machines per 1 million people in the U.S. but just 5.9 per 1 million in the U.K.

Another favorite: We spend \$85.9 billion trying to treat back pain, which is as much as we spend on all of the country's state, city, county and town police forces. And experts say that as much as half of that is unnecessary.

We've created a system in which 1.5 million people work in the health-insurance industry while barely half as many doctors provide the actual care.

And all those high-tech advances—pacemakers, MRIs, 3-D mammograms—have produced an ironically upside-down health care marketplace. It is the only industry in which technological advances have increased costs instead of lowering them.

When it comes to medical care, cutting-edge products are irresistible and are used—and priced—accordingly. I could recite from memory how the incomes of industry executives continued to skyrocket even during the recession and how much more the president of the Yale New Haven Health System made than the president of Yale University.

I even knew the outsize salary of the guy who ran the supposedly nonprofit hospital where I was struggling to fall asleep: \$3.58 million.

Which brings me to the dream I had when I finally got to sleep.

As I am wheeled toward the operating room, a man in a finely tailored suit stands in front of the gurney, puts his hand up and orders the nurses to stop. It's the hospital's CEO, the \$3.58

million-a-year Steven Corwin. He, too, had read the much publicized TIME article, only he hadn't liked it nearly as much as Jon Stewart, who had had me on his Daily Show to talk about it.

"We know who you are," the New York–Presbyterian CEO says. "And we are worried about whether this is some kind of undercover stunt. Why don't you go to another hospital?" I don't try to argue with him about gluttonous profits or salaries or the possibility that he was overusing his MRI or CT-scan equipment. Instead, I swear to him that my surgery is for real and that I would never say anything bad about his hospital.

In real life, I could have given hospital bosses like him the sweats, making them answer questions about the dysfunctional health care system they prospered from. Their salaries. The operating profits enjoyed by their nonprofit, non-tax-paying institutions. And most of all, the outrageous charges—\$77 for a box of gauze pads or hundreds of dollars for a routine blood test—that could be found on something they called the chargemaster, a massive menu of list prices they used to soak patients who did not have Medicare or private insurance. How could they explain those prices, I loved to ask, let alone explain charging them only to the poor and others without insurance, who could least afford to pay?

But now, in my dream, I am the one sweating. I beg Corwin to let me into his operating room so I can get one of his chargemasters. If one of the nurses peering over me as he stopped us at the door had suggested it, I'd have bought a year's supply of those \$77 gauze pads.

1. Why U.S. Health Care Is So Hard to Fix

Health Care is America's largest industry by far, employing a sixth of the country's workforce. And it is average Americans' largest single expense, whether paid out of their pockets or through taxes and insurance premiums.

So the story of how our country spent years trying to overhaul this vast portion of the economy—and still left the U.S. with a broken-down jalopy of a health care system—is an irresistible tale.

The story of how what has come to be called Obamacare happened—and what it will and will not do—is about politics and ideology. In a country that treasures the marketplace, how much do we want to tame those market forces when trying to cure the sick? And in the cradle of democracy, or swampland, known as Washington, how much taming can we do when the health care industry spends four times as much on lobbying as the No. 2 Beltway spender, the much feared military-industrial complex?

It's about the people who determine what comes out of Washington—from industry lobbyists to union activists, from Senators tweaking a few paragraphs to save billions for a home-state

industry to Tea Party organizers fighting to upend the Washington status quo, from turf-obsessed procurement bureaucrats who crashed the government's most ambitious Internet project ever to the selfless high-tech whiz kids who rescued it, and from White House staffers fighting over which faction among them would shape and then implement the law while their President floated above the fray to a governor's staff in Kentucky determined to launch the signature program of a President reviled in their state.

But late in working on the book from which this article is adapted, on the night of that dream and in the scary days that followed, I learned that when it comes to health care, all that political intrigue and special-interest jockeying play out on a stage enveloped in something else: emotion, particularly fear.

Fear of illness. Or pain. Or death. And wanting to do something, anything, to avoid that for yourself or a loved one.

When thrown into the mix, fear became the element that brought a chronically dysfunctional Washington to its knees. Politicians know that they mess with people's health care at their peril.

It's the fear I felt on that gurney, not only in my dream but during the morning after the dream, when I really was on the gurney on the way into the operating room.

It's the fear that continued to consume me when I was recovering from my operation. The recovery was routine. Routinely horrible.

After all, my chest had just been split open with what, according to the website of Stryker, the Michigan-based company that makes it, was a "Large Bone, Battery Powered, Heavy Duty Sternum Saw," which "has increased cutting speed for a more aggressive cut." And then my heart had been stopped and machines turned on to keep my lungs and brain going.

It's about the fear of a simple cough. The worst, though routine, thing that can happen in the days following surgery like mine, I found out, was to cough. Coughing was torture because of how it assaulted my chest wounds.

I developed a cough that was so painful, I blacked out. Not for a long time; there was a two-two count on Derek Jeter just before one of the episodes, and when I came to, Jeter was about to take ball four. However, because I could feel it coming but could do nothing about it, it was terrifying to me and to my wife and kids, who watched me seize up and pass out more than once.

In that moment of terror, I was anything but the well-informed, tough customer with lots of options that a robust free market counts on. I was a puddle.

There were occasions during those eight days in the hospital when the non-drug-addled part of my brain wondered, when nurses came in for a blood test twice a day, whether one test was enough and what the chargemaster cost for both was going to look like.

But most of the time the other part of my brain took over, the part that remembered my terror during those blackouts and the overriding fear, reprised in dreams that persisted for weeks, that lingered in someone whose chest had been sawed open and whose heart had been stopped. As far as I was concerned, they could have tested my blood 10 times a day if they thought that was best. They could have paid as much as they wanted to that nurse's aide with the scale or to the woman who flawlessly, without even a sting, took my blood. The doctor who had given me an angiogram the afternoon before the surgery and then came in the following week to check on me became just a nice guy who cared, not someone who might be trying to add on an extra consult bill.

In the days that I was on my back, to have asked that nurse how much this or that test was going to cost, let alone to have grilled my surgeon—a guy I had researched and found was the master of aortic aneurysms—about what he was going to charge, seemed beside the point. It was like asking Mrs. Lincoln what she had thought of the play.

When you're staring up at someone from the gurney, you have no inclination to be a savvy consumer. You have no power. Only hope. And relief and appreciation when things turn out right. And you certainly don't want politicians messing around with some cost-cutting schemes that might interfere with that result.

That is what makes health care and dealing with health care costs so different, so hard. The Obamacare story is so full of twists and turns—so dramatic—because the politics are so treacherous. People care about their health a lot more than they care about health care policies or economics. That's what I learned the night I was terrified by my own heartbeat and in the days after when I would have paid anything for a cough suppressant to avoid those blackouts.

It's not that this makes prices and policies allowing—indeed, encouraging—runaway costs unimportant. Hardly. My time on the gurney notwithstanding, I believe everything I have written and will continue to write about the toxicity of our profiteer-dominated health care system.

But now I also understand, firsthand, the meaning of what the caregivers who work in that system do every day. They achieve amazing things, and when it's your life or your child's life or your mother's life on the receiving end of those amazing things, there is no such thing as a runaway cost. You'll pay anything, and if you don't have the money, you'll borrow at any mortgage rate or from any payday lender to come up with the cash.

Most of the politicians, lobbyists, congressional staffers and others who collectively wrote the story of Obamacare had some kind of experience like that, either directly or vicariously through a friend or loved one. Who hasn't?

The staffer who was more personally responsible than anyone else for the drafting of what became Obamacare had a mother who, in the year before the staffer wrote that draft, had to take an \$8.50-an-hour job as a night-shift gate agent at the Las Vegas airport. She worked every night, not because she needed the \$8.50—her semiretired husband was himself a doctor—but because a pre-existing condition precluded her from buying health insurance on the individual market. That meant she needed a job, any job, with a large employer. Her daughter’s draft of the new law prohibited insurers from stopping people with pre-existing conditions from buying insurance on the individual market.

And then there was Senator Edward Kennedy, for 50 years the champion of extending health care to all Americans. Beyond his brothers’ tragic visits to two hospital emergency rooms, Ted Kennedy’s firsthand experience with health care began with a sister’s severe mental disabilities, was extended by a three-month stay in a western Massachusetts hospital following a near fatal 1964 plane crash and continued through his son’s long battle with cancer.

Everyone involved in the writing of the Affordable Care Act similarly saw and understood health care as an issue that was more personal and more emotionally charged than any other. Accordingly, they struggled with one core question: How do you pay for giving millions of new customers the means to participate in a marketplace with inflated prices—customers with a damn-the-torpedoes attitude about those prices when they’re looking up from the gurney? Is that possible? Must the marketplace be tamed or tossed aside? Or must costs be pushed aside, to be dealt with another day?

Even the seemingly coldest fish among politicians—the cerebral, “no drama” Barack Obama—drew on his encounters with people who desperately needed health care to frame, and ultimately fuel, his push for a plan.

“Everywhere I went on that first campaign, I heard directly from Americans about what a broken health care system meant to them—the bankruptcies, putting off care until it was too late, not being able to get coverage because of a pre-existing condition,” Obama would later tell me.

Should we be embarrassed and maybe even enraged that, as my book chronicles, the only way Obama ended up being able to reform health care was by making backroom deals with the industry interests who wanted to make sure that reform didn’t interfere with their profiteering?

Of course. We’ll be paying the bill for that forever.

But should we blame Obama for making those deals?

I don’t think so.

Obamacare gave millions of Americans access to affordable health care, or at least protection against being unable to pay for a catastrophic illness or being bankrupted by the bills. Now everyone has access to insurance and subsidies to help pay for it. That is a milestone toward erasing a national disgrace. But the new law hasn't come close to making health-insurance premiums and out-of-pocket costs low enough so that health care is truly affordable to everyone, let alone affordable to the degree that it is in every other developed nation. Worse, it did little beyond some pilot projects and new regulations to make health care affordable for the country. Instead, it provided massive government subsidies so that more people could buy health care at the same inflated prices that so threaten the U.S. Treasury and our global competitiveness.

The Obama Administration trumpeted Obamacare as a modern innovation that would force another hidebound industry to be more competitive. Expedia for health insurance was a winning political bumper sticker in an age when even Democrats were wary of being accused of anything that could be labeled as income redistribution. But the real bumper sticker might have read Money for the poor and middle class so they can get insurance to buy the same product everyone else does at the same price that makes everyone in the health care industry so rich.

2. How To Fix It: Let the Foxes Run the Henhouse

Is there something we can now do to fix that? How can we go beyond Obamacare?

That's the puzzle I was struggling with before my operation, so when I was able to move around afterward, I went back to New York–Presbyterian to talk to its top executives. We discussed the aggressive chargemaster bills I had gotten following my surgery—totaling more than \$190,000—and the fact that the hospital's brand name was so strong, it had to offer only a 12% discount off those exorbitant prices (\$451 for each of the eight times a portable X-ray machine took a picture of my battered chest) to my insurer, UnitedHealthcare. I then discovered that for massive hospital systems like New York–Presbyterian—a product of the merger of New York City's two most prestigious hospitals—this kind of leverage over even the largest insurers, like United, was not unusual.

But we also talked about how the kind of care I received wasn't an accident. For example, only a third of CEO Corwin's annual bonus (which accounts for about half his annual pay) is based on the hospital's financial results. The rest is based on an elaborate patient-satisfaction survey and an even more elaborate set of metrics related to patient care.

It was then that my idea for how to fix Obamacare and American health care gelled: Let these guys loose. Give the most ambitious, expansion-minded foxes responsible for the chargemaster but also responsible for providing stellar care of the kind Corwin gave me even more free rein to run the henhouse—but with conditions that would cut costs and, in fact, kill the chargemaster.

Several months before, I had begun toying with the same thought after encountering other leaders of high-quality hospital systems who were fast expanding their footprints and in the process gaining leverage over insurers.

At one event, I had been intrigued by Delos “Toby” Cosgrove, CEO of the Cleveland Clinic, a vast network of hospitals, clinics and doctors’ practices that dominated northeast Ohio and had such a good reputation that patients traveled there from all over the world.

Cosgrove, a celebrated heart surgeon, had built the Cleveland Clinic’s heart program into one of the world’s best. He was also regarded as one of the savviest hospital executives in the world, widely admired for the way he ran what he had propelled into a \$6 billion, 75-facility enterprise.

I had watched Cosgrove blanch while participating in a program about health care reform when another panelist implied that he dominated his market. “Not possible,” he said. “If we expand too much, the FTC will be all over us.”

Should the Federal Trade Commission really want to stop a guy like Cosgrove from dominating health care in Cleveland? I wondered.

But then I remembered Jeffrey Romoff, CEO of the University of Pittsburgh Medical Center (UPMC), who had long been enmeshed in litigation over whether he had conspired to control his market. By buying up doctors’ practices, clinics and other hospitals, Romoff truly did dominate health care in and around Pittsburgh. Furthermore, he once told me that he saw any attempts to hold him back as “impediments” he needed to overcome.

By now, UPMC had settled litigation with, and was about to complete a divorce from, Highmark Insurance—the Blue Cross Blue Shield company it had been accused of conspiring with to control the provider and insurance markets, respectively, in western Pennsylvania.

Through 2014, UPMC was filling the Pittsburgh area airwaves and every billboard not already taken by Highmark with touts for its own insurance company as the one that patients could use to get full access to its facilities—because, beginning in 2015, UPMC would no longer recognize Highmark insurance.

At the same time, Romoff was fighting a lawsuit from the city of Pittsburgh that might have embarrassed other hospital executives. The city charged that UPMC’s prices and profits were so high and its salaries, including Romoff’s—which by then was more than \$5 million—were so exorbitant that it did not deserve nonprofit tax-exempt status and should therefore be subject to the city’s payroll tax. That would mean a lot to Pittsburgh, because UPMC was the biggest nongovernment employer in Pennsylvania.

UPMC’s first defense was that it didn’t have any employees; only its subsidiaries did. By the summer of 2014, a state judge would agree. He dismissed the case, though the city would be

allowed to file the same action against the various subsidiary hospitals. Nonetheless, the suit highlighted UPMC's status as perhaps the world's most tough-minded, profit-oriented nonprofit.

So to put it charitably, Romoff, who is not a doctor, didn't seem to be the kind of hospital leader that Corwin or Cosgrove was.

Yet it was when I went to see Romoff (once I was able to travel) that the idea I had begun playing with after those talks with Corwin and other hospital leaders became fully formed.

Sitting in front of a window in his suite atop the U.S. Steel Tower, overlooking his city's football and baseball stadiums, Romoff laid out a vision for health care that put it all together for me.

We spent much of the time talking about his UPMC insurance company and its competition with Highmark.

By then, Highmark's insurance market share in the Pittsburgh region had shrunk from 65% to 45%. Romoff calculated that with all the business he was taking away with his own insurance company, plus the inroads made by other insurers with whom he had signed network deals, Highmark's share would be 25% by the end of 2014 and still sinking. He expected that his insurance company would end up the leader in the market—and he was going to do everything he could to get to 100%.

Would he be worried about being so successful that he would drive out all the other insurance companies? I asked. "Of the things that keep me up at night, that is not one of them," Romoff answered with a smile.

He was unabashedly trying to become the dominant insurer. And he was already by far the dominant provider through his 20 hospitals and hundreds of clinics, labs and doctors' practices.

In other words, like the Geisinger Health System in Pennsylvania, only on a much larger scale and with little competition in the market, Romoff could sell me health insurance, which would cover me when I used Romoff's hospitals, clinics, doctors and labs.

3. Cutting Out the Middleman

There would be no middleman. No third-party insurance company.

To me this was a hugely appealing idea, despite UPMC's record of high prices and its take-no-prisoners approach to competition. Why? Because it was the structure that made sense, not the particulars of Romoff and UPMC.

The insurance company would have not only every incentive to control the doctors' and hospitals' costs but also the means to do so. It would be under the same roof, controlled by Romoff. Conversely, the hospitals and doctors would have no incentive to inflate costs or overtreat, because their ultimate boss, Romoff, would get the bill when those extra costs hit his insurance company.

As Romoff put it, "All the incentives are aligned the right way. It's the beauty of being the payer and provider at the same time. The alignments of interest are just so pure."

"When the incentives are not aligned," he added, supplying a quote that could easily be read the wrong way, "it's why seniors dying of cancer get chemo when they should just get hospice care."

Maybe, but how could we know that those cancer patients—who would have no place to go in and around Pittsburgh except to UPMC if Romoff had anything to say about it—wouldn't be denied chemotherapy that they actually needed if Romoff-employed doctors were the ones holding the prescription pads?

Wasn't Romoff's interest the one that was the most purely aligned of all?

That's where doctor-leaders like Corwin and Cosgrove come in—along with strong oversight and regulation.

Hospitals are already consolidating. It is happening all over the country, including in Corwin's New York City and Cosgrove's Cleveland.

Let's let them continue. More important, as they continue, let's encourage them to become their own insurance companies, à la Romoff, so they can cut out the middleman and align those incentives.

Let's harness their ambition to expand, rather than try to figure how and when to contain their ambition.

Why shouldn't I be able to buy Cosgrove's Cleveland Clinic health insurance? What a great brand! I would know that I could use all his facilities and doctors, and he would know that his incentive—which, he says, has always been the same—was to provide good care, not expensive care full of unnecessary and overpriced CT scans and blood tests. And I would know that doctors whom I could hold accountable would determine the nature of that care, not insurance companies.

But let's ensure that accountability by insisting on tight regulation, mostly through the smarter use of federal antitrust law and state regulatory authority, in return for giving doctor-leaders the freedom to expand and also the freedom to become their patients' insurance companies.

The first regulation would require that any market have at least two of these big, fully integrated provider–insurance company players. There could be no monopolies, only oligopolies, as antitrust lawyers would call them. The larger markets, such as New York City, Los Angeles and Chicago, might have to have four, five or even more players to make the competition real and to make sure that, with accompanying regulatory requirements, their footprints were big enough and their marketing plans robust enough to serve patients throughout their regions, not just in the wealthier areas.

That would mean the hospital and all the doctors it controlled would be subject to pricing and service-delivery standards that liberal reformers have sought since the mid–20th century. Health care in the U.S. would finally be treated as a public good, not a free-market product. However, the change would have come jujitsu-style, not by a government takeover. It would have come because the private players had driven it to that state.

These fully integrated brands could pursue recent innovations that offer less expensive, more consumer-friendly health care, such as storefront urgent-care centers that are smart alternatives to expensive, time-wasting hospital emergency rooms. These urgent-care centers are now being opened piecemeal by for-profit and often lightly regulated companies. Why not put them under the banner and branded accountability of the big hospital systems? In fact, Cosgrove’s Cleveland Clinic has already opened a dozen urgent-care and express-care (for more routine needs) centers. I’d rather pay him to care for me than pay a walk-in center owned by a private-equity fund.

The second regulation would cap the operating profits of what would be these now-allowed dominant market players, or oligopolies, at, say, 8% a year, compared with the current average of about 12%. That would force prices down. Better yet, an excess-profits pool would be created. Those making higher profits would have to contribute the difference to struggling hospitals in small markets.

A third regulation—which, again, the hospital systems would have to agree to in return for their being allowed to achieve oligopoly or even monopoly status—would prevent hospital finance people from playing games with that profit limit by raising salaries and bonuses for themselves and their colleagues (thereby raising costs and lowering profits). There would be a cap on the total salary and bonus paid to any hospital employee who did not practice medicine full time of 60 times the amount paid to the lowest salaried full-time doctor, typically a first-year resident. (Under that formula, Corwin’s and Cosgrove’s salaries would stay about the same but Romoff in Pittsburgh would take a big cut.)

A fourth regulation would require a streamlined appeals process, staffed by advocates and ombudsmen, for patients who believed they were denied adequate care or for doctors who claimed they were being unduly pressured to skimp on care.

A fifth regulation would require that any government-sanctioned, oligopoly-designated integrated system have as its actual chief executive (not just in title) a licensed physician who

had practiced medicine for a minimum number of years. Sorry, Mr. Romoff. The culture of these organizations needs to be ensured, even if that means choosing leaders based on something in addition to their business acumen and stated good intentions.

Sixth, any sanctioned integrated oligopoly provider would be required to insure a certain percentage of Medicaid patients at a stipulated discount.

Wait a minute, I can hear my readers thinking. These guys generate thousands of those obscene chagemaster bills a year. Now you're going to put them in charge?

Which brings me to my final regulation: These regulated oligopolies would be required to charge uninsured patients no more than what they would charge competing insurance companies whose insurance they accepted, or else a price based on their regulated profit margin if they didn't accept other insurance. In other words, no more chagemaster.

All of this may seem complicated, but the rules required to set up this structure would be a drop in the bucket compared with the thousands of pages of laws and millions of pages of rules and regulations that are now on the books. And it is certainly more realistic than pining for a public single-payer system that is never going to happen.

Combining the work that the Corwins and Cosgroves of the world do with Romoff's plan boils down to this: Allow doctor-leaders to create great brands that both insure consumers for their medical costs and provide medical care.

Let them act on their ambitions. Let them compete with other legitimate players in their markets, or even with one another if they want to expand.

That kind of competition is already happening. But as things stand now, an employer who wants to get health care for his workers, or an individual who is shopping on the Obamacare exchanges, has to figure out which insurance company has which hospitals and doctors in its network and what discounts it has negotiated. This change would create a new, clearer competitive process.

Instead of hoping for the best with UnitedHealthcare, I could just go on the exchange and pay Corwin to use all of his New York–Presbyterian doctors and facilities to keep me healthy. Period. Full stop. There would be total clarity about which facilities and doctors are in my network.

Or my employer could pay him after negotiating the price.

It would be insurance the way it's supposed to work—the risk associated with the cost of my heart surgery would be spread across a pool of premiums that Corwin collected from tens or hundreds of thousands of New Yorkers, most of whom won't have the kind of medical mishap I had.

If Corwin and his integrated system charged too much or didn't do a good job, either my employer or I (if I were in the individual market) could switch to another competitive New York City brand like Mount Sinai Hospital or NYU Langone Medical Center. And all that competition would be fortified by advances in data transparency that would make each competitor's quality ratings for various types of care readily available.

Corwin's high price for my open-heart surgery would truly be tested in the market, because he would be competing with other high-quality health systems to capture all of my business or my employer's business. He and his network of hospitals, clinics and doctors would insure me not only against heart surgery but for routine treatment and X-rays in case I twisted my ankle or got the flu.

4. Hundreds of Billions in Savings

I bet that with this plan, we could cut 20% off the two-thirds of our health care bill not paid by Medicare or Medicaid. Here's a sketch of how the math could work:

First, administrative costs for insurance—including vetting claims, paying bills, paying managers and executives and distributing profits to shareholders—account for 15% to 20% of private health care costs. Couldn't half or more be saved by cutting out middleman insurance companies? Corwin or Cosgrove would still have to employ managers, actuaries, accountants and salespeople on the insurance side of their integrated operations, but surely not to the extent that an insurance company responsible for paying bills from multiple third-party hospitals and other providers would. Nor would they have to deliver profits to shareholders.

Let's say we could save 10% by eliminating middlemen.

Second, on the provider side of the equation, the main culprit in driving costs up—the incentive for overtreatment and overtesting that comes with billing for each patient encounter and procedure instead of billing for overall treatment—would be eliminated. And the general incentive to maximize revenue would be tamped down by the new regulation capping operating profit at 8%.

That could likely save another 10%.

The total, then, could be 20% of nongovernment health care costs, or \$400 billion a year, and maybe \$100 billion more saved by allowing Medicare and Medicaid to pay those integrated providers this way.

That would go a long way toward bringing American health care costs as a percent of our gross domestic product closer to those of the countries we compete with.

One of Corwin's competitors, the giant North Shore–LIJ Health System, is now selling its own insurance. Corwin told me that although he is more comfortable being on the provider side of the street, he would consider doing the same if he thought his hospital system were big enough to provide that full spectrum of quality care and if he needed to do it in order to be competitive.

"The first thing we can agree on about the health care system in the United States," the Cleveland Clinic's Cosgrove said, "is that it is not a system at all. It's just a collection of disparate providers. So, yes, we are consolidating," he continued, noting that although the number of hospital beds in the U.S. had declined in recent years from 1 million to 800,000, "there is still only 65% occupancy."

Doctors, said Cosgrove, have consolidated their practices, often under the umbrella of hospital systems like his, "because medical knowledge doubles every two years. So you continually need to specialize still more to keep up. And the more you consolidate, the more you can specialize. The more you specialize and do a lot of just one or two things, the better you are at them and the more cost-effective you are. That's why they call it 'practicing' medicine."

Would integrating insurance into that system be the next logical step beyond consolidation? "That seems right," Cosgrove said. In fact, he added, "we recently applied for an insurance license."

The momentum for the consolidation I have in mind is clearly there. We just need to seize it rather than resist it, and then control it and push it in the right direction.

Editor's note: In 2013, Steven Brill wrote TIME's trailblazing special report on medical bills. His subsequent book, America's Bitter Pill—a sweeping inside account of how Obamacare happened and what it does, and does not do, to curb the abuses Brill chronicled in TIME—was published Jan. 5. This article is adapted from that book.