



Hospital Prices: Who is the Real Victim?

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Pricing Transparency

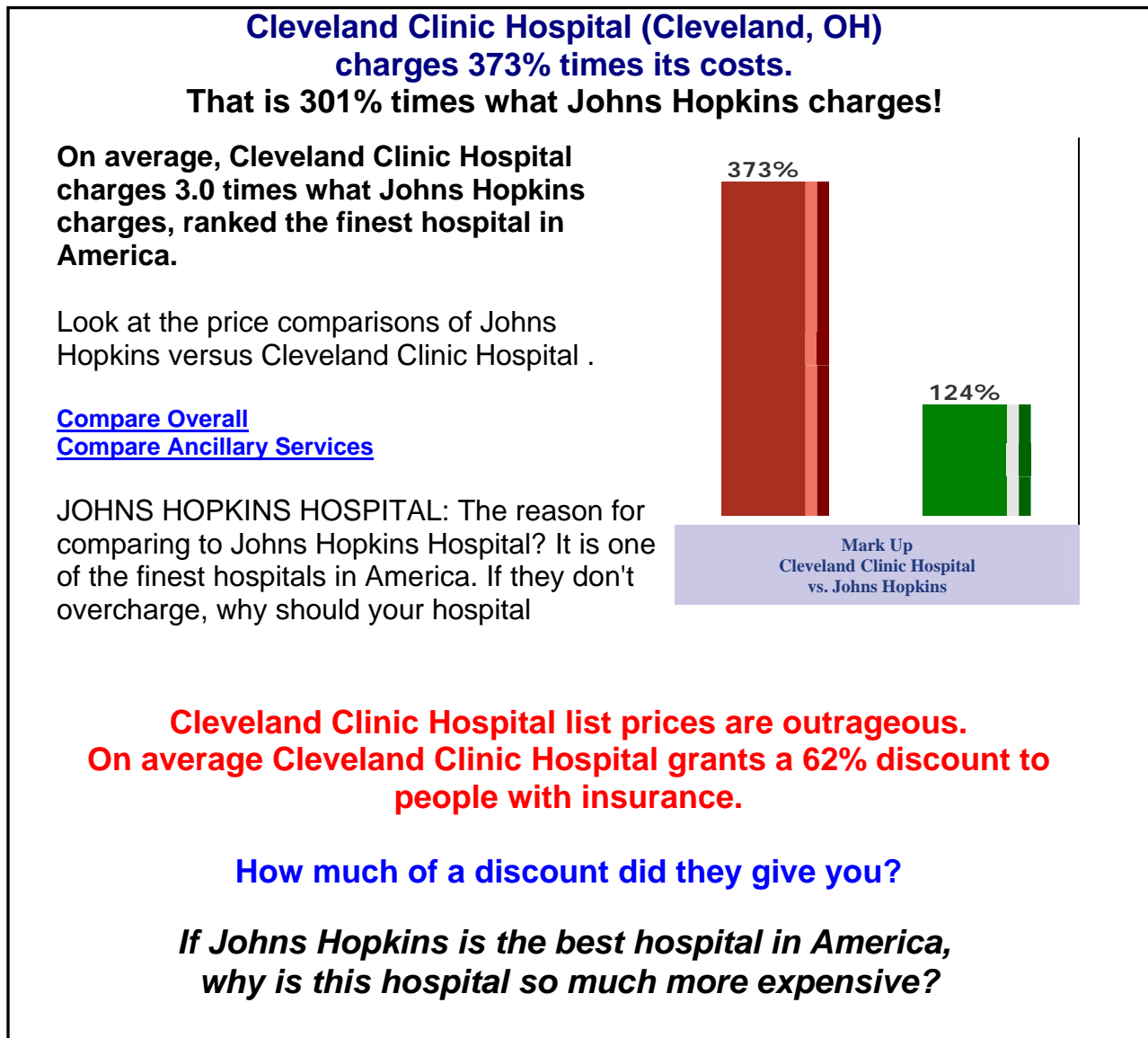
The dialogue surrounding hospital pricing transparency has done little to bring clarity to the issue for health consumers. In fact, the increased attention has led to added ambiguity at a time when greater understanding is required. Quite simply, hospital pricing is complex.

The country seems headed for hospital-pricing disclosure. Take into consideration the following evidence:

- In March US Department of Health and Human Services secretary Mike Leavitt announced plans to post the prices it pays for common medical procedures. The effort has been linked to a White House initiative for increased publication of healthcare pricing and quality data.
- Representatives Daniel Lipinski (D-IL) and Bob Inglis (R-SC) introduced legislation last July under the heading of the Hospital Price Reporting and Disclosure Act. The bipartisan effort is currently being considered and, if enacted, would require hospitals to report pricing for their twenty-five most commonly performed inpatient and outpatient procedures as well as their fifty most frequently administered medications. Several states have already passed similar legislation, and several more are in the process.

Certainly, the reality of pricing transparency is gaining momentum. While legislative efforts at the state and national levels have added logs to fire, other private groups have become involved as well.

Figure 1. hospitalvictims.com/hv_hosp_main.asp?mpn=360180



A significant amount of the increased public attention to pricing is related to the web site, hospitalvictims.com shown above. A number of our clients have contacted us regarding this site, complaining about the validity of the data presented and the increased use of the web site by patients, payers, and other interested parties. Upon review of the web site, we discovered a number of very interesting points:

1. The web site is maintained by Fairness Foundation, Inc., a non-profit tax-exempt 501(C)3 organization. This organization was founded in 1998 to assist low-income children in getting access to better education and to assist the uninsured in getting good healthcare.
2. The Fairness Foundation, Inc., was founded by J. Patrick Rooney, who was the former chairman and chief executive office of Golden Rule Insurance Company.

Golden Rule is described in the web site's biography of Mr. Rooney as the largest insurer of individual health policies in the country. After leaving Golden Rule, Mr. Rooney acquired Medical Savings Insurance Company (MSIC), of which he is currently chairman and chief executive officer. MSIC sells health policies largely to individuals and small groups. These plans have large deductibles and promote the freedom-of-choice feature in their web sites' promotional materials. MSIC contends that it pays all reasonable charges after the deductible is met. Many hospitals may be familiar with MSIC. Usually MSIC does not contract with hospitals and tenders payment on a basis different than charges. Usually, the payment is stated as reasonable because it is related to Medicare payments.

3. The web site states that patients may not have to pay charges. It advocates challenging the reasonableness of the bill under the federal Fair Debt Collection Practices Act. It further offers to provide a letter to be sent to the hospital or its collection agent.
4. Regarding the reasonableness of a hospital's charges, the site's authors explain, "If you wish to dispute to the hospital the amount the hospital has charged you, it is important for you to know (a) what the hospital's costs are in relation to what the hospital normally charges; and (b) what Medicare would pay." This statement highlights much of the underlying logic behind the website material. The site's authors believe that the Medicare payment rate is a good beginning point for discussion with the hospital regarding payment and cite Dr. Gerard Anderson of Johns Hopkins Hospital, who has testified before Congress that Medicare plus 25% is more than reasonable. This, of course, bears a similarity to the payment rules that MSIC says it has adopted.
5. The real concern expressed about this web site by our clients is related to the data. The data points provided on the site include:
 - Relationship of charges to cost
 - Relationship of charges for the hospital to charges at Johns Hopkins Hospital
 - Average discount given people with insurance
 - Additional ancillary service-charge comparisons

Validity

The data presented in the hospitalvictims.com web site should be reviewed for its accuracy. We believe the primary data used are filed Medicare Cost Reports. Figure 1 presents the actual page printed for the Cleveland Clinic on April 12, 2006. We chose the Cleveland Clinic because, like John Hopkins, the Cleveland Clinic is routinely ranked one of the top five US hospitals: they both have wage indexes close to 1.00, they are similar in size, and both are major teaching hospitals. With this backdrop, let us review the numbers reported and the logic behind them.

1. **Website claim: The Cleveland Clinic charges 373% times its costs.**
Validity: The Cleveland Clinic's 2004 Medicare Cost Report shows total gross patient revenue of \$3,425,289,832 and total expenses of \$918,725,605 from Worksheet G. This yields a mark-up of 3.73, or 373%.

2. **Website claim: Charges at Cleveland Clinic are 301% what Johns Hopkins charges.**
Validity: This statistic is very misleading and simply is not true. The 301% is derived (we believe) by multiplying the Cleveland Clinic's costs (\$918,725,605) by the average mark-up at Johns Hopkins (1.24) to yield what total charges would have been at the Cleveland Clinic if Johns Hopkins' mark-up were used (\$1,139,219,750). While this computation may yield a 301% multiple, it is a long way from proving actual charges for identical case-treatment categories are 301% higher at the Cleveland Clinic. The table below shows costs, charges, and payment for Medicare patients in 2004 for the Cleveland Clinic and Johns Hopkins. One set of values is for all Medicare inpatient cases on a case-mix-adjusted basis, and the other set is for the highest volume Medicare DRG (# 127 heart failure & shock)

	<i>Johns Hopkins</i>	<i>Cleveland Clinic</i>	<i>All US</i>
Average charge (CMI adj)	\$12,292	\$18,717	\$15,241
Average cost (CMI adj)	9,601	6,279	6,267
Average payment (CMI adj)	11,358	6,402	5,667
DRG 127 charge (CMI adj)	\$12,384	\$20,180	\$15,357
DRG 127 cost (CMI adj)	9,568	7,149	6,701
DRG 127 payment (CMI adj)	10,726	6,511	5,502

The data above show charges at the Cleveland Clinic are not 301% of charges at Johns Hopkins; on average, they are 152%. That 152% is still large, but it is a far cry from 301%. It is also interesting to compare costs. Johns Hopkins is not a low-cost provider. It is 53% above the Cleveland Clinic. Why, then, can charges at Johns Hopkins be so low when costs are so high? The answer relates to Medicare payment in Maryland. Medicare pays 94% of charges in this rate-regulated state, as does Medicaid. Furthermore, other payers in Maryland pay either 98% or 100% of charges. Is it any wonder charges are so low in Maryland in general and at Johns Hopkins in particular? Johns Hopkins is clearly receiving significantly larger payments for its Medicare and Medicaid patients than are other US hospitals. Because of these larger payments, charges can be significantly lower. In short, Johns Hopkins is receiving a subsidy from the US taxpayer that other hospitals do not receive.

3. **Website claim: On average, Cleveland Clinic grants a 62% discount to people with insurance.**

Validity: The 62% figure cited in the web site is the ratio of deductions to gross patient revenue reported in Worksheet G of the Medicare Cost Report. The number includes discounts to both Medicaid and Medicare patients, which are clearly not commercial insurance programs. While discounts to commercial insurance patients are high, they are usually substantially less than Medicaid and Medicare allowances. By citing this statistic, the inference being made is that individuals or insurance firms without contracts should get hospital discounts that will be better than most commercial insurance firms, who have negotiated a hospital contract, receive.

The Real Problem

There is no question regarding the relative relationship of hospital charges to cost. Everyone recognizes that hospitals have very high mark-ups. The problem, however, is not hospital prices but rather payment rates by major third-party payers. The table below provides a simple example to illustrate an issue that is painfully obvious to most hospital executives. In our example, the hospital has 100 patients who each incur costs of \$100 per treatment episode (total costs of \$10,000). The hospital also requires a 4% margin (\$400) to provide for working capital and capital-replacement needs.

Revenue	
Medicare (50 patients at \$92.50)	\$4,625
Medicaid (13 patients at \$75.00)	975
Uninsured (5 patients at \$5.00)	25
Total revenue before commercial	\$5,625
Cost and required profit	\$10,400
Amount required from 32 commercial patients	\$4,775
Amount required per case	\$149.22

The payment rate for Medicare (\$92.50) is the MedPAC estimated Medicare amount in 2004 for non-teaching hospitals (Table 2A-6, March 2006 Report to the Congress – Medicare Payment Policy). The distribution of patients is similar to the revenue composition of US acute-care hospitals in 2004.

The table shows that if all commercial patients paid 100% of charges, the mark-up would be 149.22%. The reality for most hospitals is that a small portion actually pay at that rate. Assume that of the 32 commercial patients, 28 pay at levels that are approximately 125% of cost, given existing negotiated contracts (total payment of \$3,500). MedPAC reported the private payer payment-to-cost ratio was approximately 1.25 in 2003 (Figure 2A-10). This now leaves \$1,275 to be paid by the remaining four patients, or \$318.75 per case.

Charges or prices in our example are 318.75% of cost, but the hospital has a modest 4% margin. Some would argue this proves that hospital prices are not related to cost, but this is clearly not true. Hospital prices are directly tied to costs. The problem is that payment rates by major governmental programs and the rising incidence of uninsured patients create a very large payment gap that is covered by a majority of patients.

Summary

Perhaps the Fairness Foundation should consider a name change for its web site from hospitalvictims.com to payervictims.com. The underlying issue is not hospital *pricing* but hospital *payment*. The use of Johns Hopkins Hospital as the standard for other hospitals points this out very clearly. When every payer pays between 94% and 100% of billed charges, as they do in Maryland, the relationship of price to cost will resemble mark-ups in other industries.