



# The Council for Affordable Health Insurance's Issues & Answers

Solutions for Today's Health Policy Challenges

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## *Hospital Pricing: The Outrage of Our Time*

There once was a time, not that long ago, when the U.S. health care system was geared to help the poor and uninsured. Today, it is geared to dramatically overcharge them. Wealthy and middle-income workers with insurance get the best price for a hospital stay; poor uninsured people get the highest price — and an aggressive collection agency if they can't pay the bill (which they usually can't).

**How the Hospital Pricing System Got Perverted.** Prior to the explosion of managed care in the late 1980s and early 1990s, most health care providers charged a fee for their services and fully expected patients — or their insurers — to pay it. However, they also recognized a commitment to helping the poor and frequently reduced their bill or provided the care free.

But change was in the air. Although the Medicare program initially paid hospitals their “usual and customary” charges, Congress imposed on Medicare a system of hospital price controls beginning in 1984. Eventually, the Medicare reimbursement schedules became the benchmark for the HMOs, which leveraged large numbers of patients to negotiate hospital prices slightly higher than what Medicare paid. Preferred Provider Organizations (PPOs) also negotiated discounts, but they were usually calculated as a percentage of the hospital's gross charges.

Medicare is required to “set rates that cover the costs efficient providers would incur in furnishing care to beneficiaries.” However, while Medicare's target is to pay hospitals 1 percent above costs, the estimated average for 2003 will be 3.9 percent, according to the current MedPAC Commission Report.

Through the 1990s, as managed care expanded to cover almost all of the under-age-65 insured population, hospitals boosted

their gross charges dramatically. This increase had little impact on Medicare and the HMOs, which still paid their negotiated rates. But it had a major adverse effect on PPOs and the uninsured. Here's why:

- Giving a PPO, say, a 30 percent discount off an artificially inflated charge would bring in a lot more money than hospitals would receive from Medicare and most HMOs, which meant PPO premiums would have to rise even more dramatically.
- The number of uninsured is so small, their political and economic power so weak and their knowledge of how the system really operates so limited that hospitals can charge whatever they choose — and in most cases get it.

Thus, the health care system flip-flopped from one in which insured workers and the wealthy paid the most to one in which they get the lowest prices — which they don't have to pay anyway because of their insurance — while the uninsured are stuck with the highest bills.

**The Cost-to-Charge Ratio.** Every hospital has a “chargemaster,” a master file of all costs and charges for every hospital service, drug or procedure, which is used to generate both a hospital invoice and the standard required federal UB-92 form that accounts for all inpatient or outpatient hospital procedures.

The Centers for Medicare and Medicaid Services (CMS) compiles this information annually in its Medicare Cost Reports. These reports detail every hospital's costs and charges by department and cost centers. Thus, Medicare knows each hospital's average daily costs, or operating expenses, to provide care for a patient. Moreover, Medicare knows what every hospital collects from Medicare, managed care and the “self-pay” (i.e., the uninsured). The ratio between what a day in the hospital costs and what the hospital charges is called the “cost-to-charge ratio” (i.e., the cost divided by what the hospital charges); the closer a cost-to-charge ratio is to 1, the less difference there is between the actual costs and the hospital's gross charges.

The cost-to-charge ratio varies from state to state. As Table 1 shows, the average cost-to-charge ratio for California is .328, which means hospitals there are charging roughly three times their costs. According to CMS, Nevada, with an average hospital cost-to-charge ratio of .282 — or about 3.5 times the actual cost — charges more than any other state, followed by California and Alabama (.338). By contrast, Maryland has the best statewide ratio, .769, which translates into

**Table 1: Best and Worst  
Statewide Average Operating Cost-to-Charge Ratios (2002)**

Best		Worst	
Maryland	0.759—32% above cost	Nevada	0.282—255% above cost
North Dakota	0.609—64% above cost	California	0.328—205% above cost
Washington	0.581—72% above cost	Alabama	0.338—195% above cost
Vermont	0.580—72% above cost	Florida	0.343 —192% above cost
Maine	0.580—72% above cost	Arizona	0.345—190% above cost

Note: To find the percentage the hospital is charging above its cost, enter 1, which stands for what the hospital charges, into a calculator. Divide by .759, which is the average statewide cost in Maryland. The answer is 1.32, which means the hospital gets 32% above costs. Nevada has a cost-to-charge ratio of .282. When you divide 1.00 by .282, the answer is 3.55, or 355% of the cost, which means 255% above costs.

Source: Centers for Medicare and Medicaid Services, Table 8A, Federal Register, August 1, 2002.

charging 30 percent more than the actual costs, and North Dakota's is .609, or an average charge of 64 percent above cost.

Of course, insured patients don't pay the full charge because of Medicare, Medicaid or managed care discounts. The only ones actually paying the gross charge are the uninsured, who are typically poor and minorities, especially Hispanic.

**The Magnitude of the Outrage.** How much more do the uninsured pay than those with health insurance? Table 2 identifies the cost-to-charge ratios at three urban hospitals. As the table shows:

- The average operating cost per patient per day at St. Louise Regional (Catholic) Hospital in West Gilroy, California, is \$1,376. But an uninsured patient would be billed \$5,508.
- Palm Beach Gardens Hospital in Florida reports a daily cost of \$1,501, but it charges the uninsured \$7,414.

On average, HMOs pay 12 percent above what Medicare pays, according to the MedPAC Commission (Table D-13, March 2003). But the uninsured receive artificially inflated bills that can be 200 to 1,100 percent more than what Medicare or insured patients pay.

**Insult to Injury.** Unfortunately, gross overcharging is not the extent of the outrage. After charging the uninsured several times more than an insured person would pay, some hospitals aggressively try to collect the inflated bills.

*Case Study: Carlos Colon.* The *Chicago Sun-Times* tells of Carlos Colon, a Home Depot employee, who had a cyst removed from his lower back before his employer-provided policy kicked in. He was hospitalized for a week and billed \$74,396 — “10 times what an insurance company would pay,” according to the *Sun-Times*. He was sued and his wages garnished for \$300 per month, about 20 percent of his income.

*Case Study: Quinton White.* A recent *Wall Street Journal* article disclosed that White's wife, Jeanette, an uninsured cleaning woman, was treated for throat cancer in 1982 at Yale-New Haven Hospital in Connecticut. She died in 1993. Over the 20 years since the treatment, Mr. White, now 77 and a retired dry-cleaning worker, had paid \$16,000 of the original \$18,740 bill. The hospital seized \$10,000 from his bank account and placed a lien on his home, imposed a 10 percent interest charge on the unpaid balance, plus legal fees and other expenses. By March of 2003, Mr. White still owed \$39,000. Once the paper publicized the story and readers expressed their outrage, the hospital decided to forgive the debt in its entirety.

**Who Are Affected by the Practices?** These practices disproportionately affect minorities, who tend to have lower incomes and work for employers who do not provide health insurance. For example, while 11.6 percent of whites were uninsured in 2001, 20.1 percent of blacks and 34.8 percent of Hispanics lacked coverage, according to the Employee Benefit Research Institute.

**Table 2: How Much Do Hospitals Charge Their Patients?**

	O'Connor Hospital San Jose, CA	St. Louise Regional (Catholic) W. Gilroy, CA	Palm Beach Gardens Community Hospital (Tenet Healthcare) Palm Beach Gardens, FL
<b>Operating Expense</b>	\$1,631.42	\$1,376.00	\$1,501.37
<b>Collected from Managed Care</b>	\$1,940.00	\$1,773.00	\$1,774.41
<b>Billed the Uninsured</b>	\$5,951.00	\$5,508.00	\$7,414.08
<b>Cost-to-Charge Ratio</b>	.258	.289	.205
<b>Collection Rate from Uninsured</b>	97%	96%	32%

The *Denver Post* reports that “almost half of the defendants [being sued by Denver-area hospitals] have recognizable Hispanic surnames.”

**Can These Practices Be Justified?** Hospitals claim that Medicare reimbursements are so low they *must* shift the costs to other patients. But, as mentioned above, government figures show that hospitals are making, on average, 3.9 percent profit from Medicare in 2003.

Hospitals also claim that they don't actually collect the money from the uninsured because they can't pay. But again, state data tell a different story. Many hospitals collect roughly 95 percent of the gross charges they impose on the uninsured — often by using very aggressive collection practices. For example, St. Louise Regional Hospital, cited above, collected 96 percent of what it billed the uninsured. However, Palm Beach Gardens Hospital only collected 32 percent.

**One Solution.** One reason this overcharging continues is that it is almost impossible for the uninsured to find out what they will be charged before they receive care. If hospitals were required to provide patients up front with comparisons of their gross charges and what Medicare and the typical HMO plan would pay after discounts, the uninsured would at least have some information to determine whether they wanted to stay at that hospital or go to another. And the media and consumer advocates would have some basis for informing the public where to find quality care at a reasonable price. It would, in essence, create the kind of price transparency that dominates almost every other sector of the economy.

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