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Further Discussion of High Hospital Charges

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I had written an article in the June 2002 issue of *Health Section News* entitled "Hospital Charges Become A Significant Issues Again" based on our analysis of FY 2000 Medicare hospital charges. As pointed out, these Medicare charges are highly correlated with commercial charges and thus, this data is representative of global hospital charges. More recently, there has been a lot of news generated about the charge levels at the Tenet hospitals and the impact on its revenue resulting from Medicare outlier payments.

There are two other important factors that these news stories have omitted. The first is that Tenet hospitals are not alone in these high charge levels. Second, the impact of high charges is felt significantly on hospital payers other than Medicare, and the full impact of these charges is often not well understood by the payers themselves.

2001 Increases

Based on recently released FY 2001 data, the range of inpatient medical/surgical charges per day, after adjusting for case-mix severity and geographic differences, is over 17 to one. This compares to a ratio of just over 14 to one in FY 2000 (based on hospitals with at least 1000 admissions reported). The highest charging hospital is nearly five times the adjusted average, and has a Medical/Surgical charge per day of nearly $19,000. The top ten hospital charge per diems increases ranged from 13 percent to 58 percent between FY 2000 and FY 2001. Seven of the 10 increases were between 23 percent and 38 percent, while the average charge per day over all hospitals increased less than 10 percent during this period.

When we look at the list of highest charging hospitals, in addition to a number of Tenet hospitals, there are also other for profits and many non-profit hospitals (including government owned). There are a couple of small non-profit chains in Pennsylvania and New Jersey that have several entries on the high charge list. Often, charges are marked up four to five times costs, or higher. Hospitals may believe they have legitimate reason for these charges, however, this divergence just points out the irrationality of the system.

The common assumption was that charges didn't mean anything since most payers had negotiated fixed price contracts. Although this may have been partially true in the mid-1990's, it is far from the truth today. Maybe this argument had been put forth since very few payers reimburse at 100 percent of charges. However, many contracts pay some portion of reimbursement based upon a specified percent of charges. And, in any event, if a hospital offers a 25 percent discount but charges three times the average, this still represents more than twice the cost of an average charge hospital with no discount.

Charge Based Reimbursement

The following is a description of common charge based reimbursements:

1. **Inpatient Outlier Provisions**
   Many HMO and PPO contracts have outlier provisions where once the charge for an admission reaches some predetermined threshold such as $35,000 or $50,000, the reimbursement (for the entire admission) then reverts to a percentage of charges (commonly 65 percent to 100 percent). In some areas and at some hospitals these cases may represents at least 50 percent to over 90 percent of inpatient charges. Thus, in many of the cases, the majority of reimbursement will be based on discount from charges

2. **Straight Discount from Charges**
   Many hospital contracts call for reimbursement based upon some specified discount from charges. Clearly, as charges increase, the reimbursement will increase proportionately. Many PPO contracts and some HMO contracts are on this basis.

3. **Outpatient Charges**
   The typical outpatient hospital reimbursement for commercial insurance is based on a percentage discount from charges. Outpatient charges are approaching 50 percent of total hospital charges on average, and are well over 50 percent in many hospitals. Individual itemized outpatient charges are the same line by line as the individual inpatient ancillary charges, and also generally have the highest mark-ups over cost compared to room and board rates. Thus, high inpatient charge hospitals are also high outpatient charge hospitals. These reimbursement contracts are common in HMOs, PPOs and Blue Cross Plans.

4. **Out-of-Network and Out-of-Area Charges**
   Many HMO and PPO networks operate in limited geographic areas and have limited participating hospitals. If patients use services out-of-area, the payer is stuck with dealing with hospital charges—especially since reasonable and customary payments limits are not well developed and are difficult for most payers to determine. This can lead to disputes in settling claims. Furthermore, the same situation would apply to out-of-network usage in-area. For out-of-network services, the patient is usually required to pay a higher co-payment, but is usually protected with an out-of-pocket limit. In fact, in most of the situations discussed above the insureds are protected from these egregious charges because of fixed deductibles and out-of-pocket limits.

One reaction by insurers to these high charges structures has been the development of tiered contracts, that vary the patient copayments by hospital charge (or reimbursement) level. However, because of the out-of-pocket limits, patients are still mostly immunized from these high charges, even with the tiered contracts.

Possible Actions

These high charges necessitate the consideration of a number of actions by insurers/payers:

1. Achieve a thorough understanding of the contracts, the reimbursements and the relative charges of hospitals. It is important to be able to compare competing facilities on an apples to apples basis. Otherwise, payers are negotiating from a weak position.

2. Consider the impact of out-of-pocket limits or out-of-network and out-of-area liabilities. Consider pegging out-of-network and out-of-area reimbursements to some relationship to Medicare payments. For example, if Medicare has a 50 percent discount, the liability could be defined by Medicare plus 20 percent based on Medicare's discount. This puts the onus on the hospital to justify higher levels. Alternatively, contractually define reasonable and customary levels that can be enforceable.

3. Consider the impact of high charges on outpatient reimbursements and contract provisions. This is a major factor. Modest discounts to charges that are marked up 400 or 500 percent or more over costs is not the way to go. Consider benchmarking to Medicare's APCs as a way to control reimbursement.

4. When contract impasses occur, consider publicizing the facts about egregious charging hospitals. Generally, the providers win the sympathy vote in the press when these contractual deadlocks occur. They use images of sick patients who need help to generate support. However, the payers never get the story out about their charge levels versus other hospitals or about their demanded reimbursement versus Medicare payment levels. Let's put the payer's facts on the table.

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