From Soak the Rich To Soak the Poor: Recent Trends in Hospital Pricing

Gerard Anderson, PhD
Professor
Johns Hopkins University
Why are providers charging the uninsured so much more than they charge people with health insurance?

AND WHAT CAN BE DONE TO HELP THE UNINSURED?
Price Discrimination In Medicine

- Initially justified in 1958 by the economist Rueben Kessel using the following example that he obtained from one of his doctor friends:

“\textit{I operated today upon two people for the same surgical condition- one a widow whom I charged $50, the other a banker whom I charged $250.}”
Justification For Price Discrimination In Medicine

- “I don’t feel that I am robbing the rich because I charge them more when I know that they can well afford it; the sliding scale is just as democratic as the income tax.”

- Kessel then goes on to make a more theoretical economic argument for price discrimination in medicine

- Has remained the thinking among health economists in medicine for 50 years
However

- The situation is now reversed – the rich pay the lowest prices and the uninsured are asked to pay the full charges.
- The old price discrimination arguments do not justify charging the poor more than the rich.
What has changed since 1958

- All medical care prices are higher
- The widow is covered by Medicare
- The self pay person is asked to pay the highest price
Who Are Self Pay Patients?

- Uninsured
- International visitors
- People insured by health plans without contracts
- People with automobile insurance
- People with a workers compensation claim
Study Methods

- Focus on hospitals primarily because the data on hospitals is better
  - Physicians, etc are equally likely to charge the self pay patients the highest prices
- Medicare Cost Reports From 2004
- Details in May 2007 Health Affairs article
Charge to Cost Ratios

- What hospitals actually charge for services / what it costs hospitals to provide the services
- Ratio of 3.0 means the charges are three times the Medicare allowable costs
Charge to Cost Ratios In 2004

- 3.07 – Overall
- 2.49 - Government
- 2.99 – Voluntary
- 4.10 - Proprietary
Charge to Cost Ratios By State

- **Highest Ratios**
  - 4.56 NJ
  - 4.33 PA
  - 4.04 CA

- **Lowest Ratios**
  - 1.42 MD
  - 1.85 WY
  - 1.89 VT
Gross to Net Ratios

- Total charges / amounts actually collected

- Ratio of 2.5 means that for every $2.50 billed the hospital collected only $1.00 from all sources or 40% of billed charges
Gross to Net Ratios

- 2.57 Overall
- 2.27 Government
- 2.50 Voluntary
- 3.26 Proprietary
Widening Gap Since 1984

- 1.35 in 1984 to 3.07 in 2004
  - Charge to cost ratio

- 1.25 in 1984 to 2.57 in 2004
  - Gross to net revenues ratio
Hospitals Justify Their Higher Charges at Trial

- Patients’ responsibility
  - Should have negotiated a discount before admission
- Charity care policies
  - Hospital provides discounts to uninsured
- Solvency
  - Cost shifting
Hospitals Justify Their Higher Charges at Trial

- **Negotiating Strategy**
  - Brings managed care plans to the table

- **Medicare Outlier Payments**
  - Additional payments – no longer allowed

- **Geographic Competitors**
  - Other hospitals in the area have similar charges
Options for Obtaining Lower Rates

- Cover the uninsured – they would then have negotiated rates
- All payors pay one rate (including uninsured) – Maryland and many countries
Options for Obtaining Lower Rates

- Price Transparency - Post Prices
  - Prices must be in same units as patient pays - charge master file
  - However, 25,000 items on charge master file
  - Charge master file written in code
  - Does not improve bargaining power of uninsured
Maximum Allowable Rate

- What is the maximum above costs that a hospital should be allowed to charge?

- My proposal is Medicare plus 25%
  - Testified in Congress and in numerous court cases
  - AHA has proposed this option for uninsured people between 100% and 200% of FPL
Who Should Set the Maximum Allowable Rate?

- Voluntary Effort By Hospitals
- Litigation
- Legislation
For More Information

- From Soak the Rich To Soak the Poor: Recent Trends in Hospital Pricing
  Health Affairs May/June 2007