Health Issues Brief

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Variation in Hospital Costs and Charges

The Centers for Medicare and Medicaid Services (CMS) recently released provider charge data for the 100 most frequent diagnoses paid under Medicare. This data was generated from the more than 3,000 U.S. hospitals that receive payments from the Medicare Inpatient Prospective Payment System (IPPS). Because the charges vary so much, the report has generated a great deal of discussion and a significant amount of misunderstanding.

This Health Issues Brief *explains the variation of hospital costs and charges, and answers pressing questions such as: How are hospital charges set? Why do hospital charges vary so much across the country and within a given region? What is the difference between what hospitals charge and what they are actually paid?*

How are Hospital Charges Set?

The answer lies with Medicare policy that was established nearly 50 years ago. When Medicare was initiated in 1969, it paid hospitals at the lesser rate of actual costs or 80 percent of charges. CMS also required a uniform billing system for each hospital and detail on the nature of the services provided.

This uniform billing system created what is known as the "charge master". The charge master comprises the services, pharmaceuticals, supplies and procedures (including diagnostics) that a patient can receive at a specific hospital. The original charge master was a product of all actual hospital item costs and a markup factor that reflected administrative and basic facility costs, in addition to other items. Different hospitals had different items and costs.

Today, Medicare payments are not based on the charge master. Instead, Medicare sets and pays pre-determined rates based on the condition being treated. This is known as a Diagnosis Related Group (DRG) payment. Regardless of what a hospital charges, or the actual costs incurred, Medicare pays a relatively uniform fee for the same service nationwide. In contrast, insurance providers negotiate payment methods directly with hospitals. Some insurers pay a discount off charges, some pay on a per-day basis, and some pay DRG-type set rates. Discounts, which can be significantly high, depend on the hospital market area, size of the hospital, the extent of the mark up and other factors.

For the consumer, the more meaningful issue is their individual financial obligation for services provided to them in a hospital. For uninsured patients, hospitals use the charge master but provide a discount based on the lowest contracted insurance rate and the patients' household incomes. Most uninsured pay very little (Florida Hospital collects about three cents on the dollar), and much if not all of the bill is written off to charity. This means that, overall, few hospitals in even fewer instances get paid what they charge.

Florida Hospital offers charity discounts for uninsured patients whose household incomes are below 400% of the federal poverty level – $45,960 for an individual or $94,200 for a family of four.

Why do Hospital Charges Vary? ***A look at Today's Charge Master***

Certain principles are used to generate hospital charge masters. In general, low-cost items are marked up at a higher percentage than high-cost items. The logic is that the associated administrative expense – such as breaking down a large box of items, transporting them to various hospital units, and actually handing them to the patient – is proportionately higher than the same activity for high cost items. For some institutions, this can create the oft-cited 10 dollar aspirin. However, this very outcome is why some hospitals have eliminated charges altogether for certain low-cost items. This has negative implications. Other factors include the size of the hospital, mix of business (more Medicare, Medicaid and uninsured can result in high charges) and what real difference exists in cost structure.

Can the Charge Master be Fixed?

Many in the hospital sector – including Florida Hospital – would like to revamp the charge master and re-establish a closer relationship between charges and cost. This would likely require a change in Medicare policy so that outlier payments (payments greatly exceeding the DRG reimbursement) would be based upon actual costs. This would also require a recalibration of the insurance industry discount structure, which would mean that insurance companies would get less of a discount on paper but still pay the same amount.

Why do Charges and Costs Vary?

The natural question is why charges vary so much among hospitals across the country and within a city or county. When hospitals and insurers first began to negotiate payment rates, there was a strong correlation between costs and charges. Over time, the gap between costs and charges (while still an internal mathematical formula of cost and other factors) grew wider. This practice can largely be explained by two factors:

1. **Hospitals seek to recoup discounts:** Since the early days of Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO), discounts provided to managed care companies passed along these inflated charges in the form of higher charges to traditional health insurance companies. As a result, instead of a charge-to-cost ratio, for example, of 1.2 to 1, the ratios were 2 to 1. There are some hospitals with ratios as high as 10 to 1.

2. **Medicare policy:** When a patient is very sick, as indicated by long length of stay or high cost, payment is outside of the DRG system (which pays a flat amount for a particular disease state). This policy has created a serious problem. By using charges as a proxy for costs, Medicare incentivized hospitals to increase charges in order to ensure a hospital was paid for their more expensive Medicare "outliers" whose care greatly exceeded the DRG payment. This further distorts the difference between charges and costs.

Conclusion

The most important consideration in looking at the charge issue is not what is charged, but what is paid by Medicare, insurance companies, and individuals. For consumers, the more meaningful issue is their individual financial obligation for hospital services. For Medicare and insured patients, this is determined by their co-pays and deductibles. For uninsured patients, the financial obligation is based on steep discounts according to their ability to pay.

Emotion can be generated by charges. Value is determined by what is received and what actually is paid for. After all, the patient's outcome is what matters, which comes down to value.

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