REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-A-09

Subject: Appropriate Hospital Charges

Presented by: David O. Barbe, MD, Chair

Referred to: Reference Committee G
(J. Leonard Lichtenfeld, MD, Chair)

At the 2008 Annual Meeting, the House of Delegates adopted Resolution 706, which asked the American Medical Association (AMA) to study the consequences of hospital cost-shifting upon individuals who are not covered by large purchasers of health care and report the suggested remedy. The Board of Trustees assigned this item to the Council on Medical Service, for a report back to the House of Delegates at the 2009 Annual Meeting.

This report provides background on hospital pricing and mechanisms that fund care for the uninsured, examines hospital cost shifting, describes recent state and federal activity on hospital charges and price transparency, summarizes relevant AMA policy, and presents policy recommendations.

BACKGROUND ON HOSPITAL PRICING

Every hospital establishes a standard set of prices—known as list prices or gross charges—for all of its services. Hospital list prices are frequently compared to the "rack rates" that hotels use. Hospital charges are often times unrelated to the cost of providing any given service. Hospitals, like other stakeholders in the health care system, cost shift between privately insured, publicly insured and uninsured patients to meet their bottom line, which can result in a lack of relationship between costs and charges. There is growing concern that hospital list prices have increased at a much greater rate than their respective costs. Hospital charges and fee scales vary significantly, both between states and within most states, which affects physicians in hospitals in many ways, including prompting an overall lack of knowledge of the cost of the tests, procedures or interventions they order.

Most patients are not charged the hospital's list price. For privately insured individuals, their respective health plan negotiates discounted prices as part of their contract with the hospital. For individuals insured by a government health plan, hospital charges are governed according to state and federal law and regulations. However, the uninsured can be billed part or all of a hospital's full charge for a service. The amount an uninsured individual is charged by a hospital depends on the hospital's pricing policy, whether the institution offers any discounts for the uninsured, and state law and regulations if applicable.

The Council used caution to differentiate between charges, prices, costs and payment. In general, cost can be thought of as the outlay of financial resources required to provide a service, such as a test, procedure, or intervention. A charge for, or price of, a service is the amount billed to patients, public and private health plans and other third party payers. Payment is the total amount that a hospital, physician or other provider receives for providing a given service.

With an estimated 46 million individuals in the United States who are uninsured, the issue of hospital pricing has gained scrutiny in several states. Since its launch in 2007, the AMA "Voice for the Uninsured" campaign has raised awareness about the uninsured and their experiences in accessing care in hospitals, physicians' offices and other health care settings, as well as underlying AMA policy for covering the uninsured and expanding choice. The AMA proposal advocates providing individuals with refundable and advanceable tax credits that are inversely related to income so that patients with the lowest incomes will receive the largest credits.

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires emergency departments of all Medicare-participating hospitals to provide stabilizing care to patients with critical conditions, regardless of the patient's ability to pay. However, EMTALA does not govern how the emergency care provided to uninsured patients is charged. Uninsured individuals face significant financial constraints for emergency care and all other health services rendered in hospitals. A study, using 2004 Medical Expenditure Panel Survey (MEPS) data, found variation in the proportion of total charges paid for outpatient ED visits between Medicare, Medicaid, the privately insured and the uninsured. The proportion of charges paid for privately insured visits was 56 percent, compared to 38 percent for Medicare visits, 33 percent for Medicaid visits, and 35 percent for visits of uninsured patients (Hsia et al., *Annals of Emergency Medicine*, 2007).

In estimating hospital charges for the uninsured, a study using 2004 data found that the uninsured pay nearly three times more for comparable hospital services than what health insurers pay, and that self-paying patients were charged on average $307 for every $100 in Medicare-allowed costs for hospital charges. The same study found that the difference between what the uninsured and Medicare beneficiaries are charged for hospital care has more than doubled in the past 20 years (Anderson, *Health Affairs*, 2007). Since 2004, hospitals have increasingly implemented discount policies and changed their billing practices, partly as a result of the Office of Inspector General (OIG) clarifying that nothing in OIG rules or regulations prohibits hospital discounts to uninsured patients. In California, hospitals were found to charge the uninsured similar prices to those of Medicare patients. The study also found that prices charged to the uninsured in California had increased along with prices paid by Medicare (Melnick and Fonkych, *Health Affairs*, 2008). There are significant differences in what hospitals are paid by different health plans. For example, there was a 259 percent variance in what hospitals were paid by private insurers participating in the Federal Employees Health Benefits Program in 2001. Regardless of health insurance status, insurmountable hospital charges can quickly accumulate medical debt, which may not only lead to bankruptcy, but also serve as a barrier to affected individuals accessing future medical care.

HOSPITALS AND THE UNINSURED

According to the American Hospital Association (AHA), hospitals in the United States provided $34 billion in uncompensated care in 2007, up from $31.2 billion in 2006, equaling 5.8% of total hospital expenses. Uncompensated care includes charity care provided to uninsured patients with low incomes and bad debts of individuals and third party payers. By combining hospital estimates of charity care and bad debt, uncompensated care figures can be compared across hospitals.

The AHA has developed a document entitled "Hospital Billing and Collection Practices: Statement of Principles and Guidelines," which addresses hospital charity care programs and discounts for the uninsured. More than 4,200 hospitals have committed to the AHA principles and guidelines. The Council believes that the widespread commitment of hospitals to "Hospital Billing and Collection Practices: Statement of Principles and Guidelines," originally created by the Board of Trustees of the AHA, provides a sound foundation from which to address hospital charges faced by the

uninsured and indigent. The document includes key guidelines that hospitals should follow to ensure uninsured patients have access to hospital care and relevant financial information, including:

- Hospitals should have policies to offer discounts to patients who do not qualify under a charity care policy for free or reduced care and who, after receiving financial counseling from the hospital, are determined to be eligible under the hospital's criteria for such discounts;
- Hospitals should make available to the public information on hospital-based charity care policies and other known programs of financial assistance;
- Hospitals should communicate information on charity care and other financial assistance policies to patients in a way that is easy to understand, culturally appropriate, and in the most prevalent languages used in their communities; and
- Hospitals should make available for review by the public specific information in a meaningful format about what they charge for services, and provide financial counseling to patients about their hospital bills.

Hospitals use many funding sources to help support care of the uninsured. Hospitals that treat a high percentage of low-income patients receive disproportionate share hospital payments from Medicare and Medicaid. Hospitals can also receive an indirect medical education adjustment from Medicare, which acknowledges that hospitals with graduate medical education programs provide a significant amount of care to the uninsured and indigent.

In addition, hospitals can receive assistance by participating in the federal 340B Drug Pricing Program, which results in significantly reduced drug acquisition costs. Drug manufacturers that agree to participate in the Medicaid Drug Rebate Program are required by the 340B Drug Pricing Program to provide qualified public and non-profit disproportionate share hospitals deep discounts for drugs and biologics. Actual savings on prescription drugs vary greatly among hospitals participating in the 340B program. According to Safety Net Hospitals for Pharmaceutical Access, an organization of more than 500 public and private non-profit hospitals and health systems that participate in the 340B drug discount program, hospital participants save on average $2 million annually. In the case of rural hospitals, a 2007 study showed that the average monthly savings for participating rural hospitals was approximately $19,700 on total outpatient drugs. Rural hospitals reported a wide range of savings, from $600 to $158,000 per month, with some hospitals reporting saving an average of 24 percent of the pharmacy budget.

Non-profit hospitals, in return for providing a "community benefit," can qualify for a tax-exempt status. In 2002, the Joint Committee on Taxation estimated the value of the major tax exemptions non-profit hospitals receive from federal, state and local governments to be $12.6 billion. Of this estimate, federal tax exemptions accounted for roughly half of the total. Other estimates of the value of the tax exemptions private non-profit hospitals receive are higher and reach $20 billion per year. Hospitals can also receive supplemental provider payment from states that increase their rates above Medicaid payment rates, but no higher than Medicare rates.

HOSPITAL COST SHIFTING

As is the case with other health care providers, hospitals cost shift as a result of uncompensated care and inadequate levels of payment from Medicare and Medicaid. Uncompensated care is funded in part by hospital profit margins. Hospitals receive higher payments from privately insured patients, which can be used to support other activities, including caring for the uninsured. Not all hospitals increase charges in response to increased levels of uncompensated care.

However, hospitals with sufficient market power, including major teaching hospitals, can negotiate higher payments from private insurers. Studies, including those of Families USA and Urban Institute, have shown that uncompensated care impacts the premiums of privately insured individuals. However, the results vary in terms of estimating the overall impact.

Hospitals also cost shift as a result of insufficient Medicare and Medicaid payment levels. These public programs support more than half of all hospital care provided. AHA estimated that in 2007, Medicaid hospital payments relative to costs resulted in a $10.4 billion shortfall nationally, and Medicare payments resulted in a $21.5 billion shortfall. The Agency for Healthcare Research and Quality reported that in 2006, Medicare incurred approximately $444 billion in total inpatient hospital charges, with inpatient hospital stays billed to Medicaid totaling $135 billion. These estimates do not include hospital charges billed to Medicare and Medicaid for hospital outpatient care, emergency care for patients not admitted to the hospital and physician fees for the admissions. Studies have shown that public sector underpayment leads to a significant cost shift from Medicare and Medicaid to commercial payers.

STATE AND FEDERAL ACTIVITY

More than 30 states have enacted price transparency legislation requiring hospitals to make pricing information available to the public through differing means, including via a government Web site or at the request of individual patients. Other states have voluntary price reporting systems. In addition to addressing the issue of price transparency, states have initiated various approaches to hospital charges for care provided to the uninsured. In 2008, New Jersey enacted a law that caps hospital charges for low- and middle-income uninsured patients. Under the law, hospitals cannot charge residents who have incomes less than 500 percent of the federal poverty level (FPL) more than 15 percent above the Medicare payment rate. In 2009, 500% FPL is $54,150 for an individual and $110,250 for a family of four. The New Jersey law also contained a provision that requires the state Department of Health and Human Services to develop a sliding fee scale based on family income to help determine reasonable costs for hospital services.

A Nevada law requires all hospitals to maintain and use a uniform list of billed charges for units of services or goods provided to all inpatients. The law stipulates that a hospital may not use different billed charges for inpatients receiving the same goods or services. Since 1971, the Maryland Health Services Cost Review Commission has had the authority to set the rates that hospitals in the state may charge. The Commission requires that all payers – commercial, government and self-pay – be charged the same rates for the same services and goods provided at the same hospital. Accordingly, the uninsured in Maryland pay the same amount for care as any other patient. In California, hospitals are required to offer discounts to uninsured patients who earn as much as 350 percent of FPL.

In addition to legislative activity, dozens of class-action lawsuits have been filed and continue to be filed against hospitals for charging higher rates to the uninsured. Many hospitals, particularly non-profits, have been acutely affected by these lawsuits, which have served as a strong catalyst to establish and publicize discount policies for the uninsured. In many of these settlements, the affected hospitals have been required to retroactively provide discounts to uninsured patients. State attorneys general—including those of Illinois, Montana, Connecticut and Wisconsin—have also intervened on this issue.

In the 110th Congress, federal legislation was introduced related to hospital price transparency and disclosure. Rep. Pete Sessions (R-TX) introduced H.R. 6015, the Hospital and ASC Price Disclosure and Litigation Protection Act of 2008. If enacted into law, H.R. 6015 would have

required hospitals and ambulatory surgical centers to disclose and report to the Secretary of Health and Human Services charge-related information for treatments not covered by insurance as conditions for receiving protection from charge-related legal actions. In particular, hospitals would have been required to provide patients with and include in any itemized bill the hospital's established price or the price charged for the treatment. To facilitate comparison, hospitals would also have been required to provide patients with both the payment rate for the treatment that is negotiated with the network plan or managed care plan that has the largest number of enrollees, as well as the Medicare payment rate for the treatment.

Rep. Daniel Lipinski (D-IL) introduced H.R. 5033, the Hospital Price Reporting and Disclosure Act of 2007, which would have required hospitals and ambulatory surgical centers to report data to the Secretary of Health and Human Services regarding the frequency of performing certain services and administering certain drugs and the charge by the hospital or center for such services or drugs. The Secretary, in turn, would have been required to publicly post such information in a manner that promotes charge comparisons among hospitals and centers. It is expected that similar legislation regarding hospital price transparency will be introduced in the 111th Congress.

RELEVANT AMA POLICY

The AMA has established policy that addresses hospital costs and charges. Policy H-240.999 (AMA Policy Database) calls for hospitals to adopt pricing policies that more specifically relate the charge for a given item or service to the actual cost of that item or service, including an adequate profit margin. This policy also urges hospitals to standardize their nomenclature for services, and to group these services in the general service charge or room rate consistently from one hospital to another so as to simplify comparison. Policy D-155.992 calls for the AMA to work with the AHA to develop a transparent pricing system, develop patient education information explaining individual hospital billing processes and discounts available, and educate patients on their bill-paying rights and responsibilities. Policies H-155.998 and H-155.966 support increased and improved physician awareness and education of hospital charges. Policy H-373.988 outlines AMA support for health care stakeholders, including hospitals, being required to make information readily available to patients on fees/prices charged for frequently provided services, procedures and products prior to the provision of such services. Policy H-215.975 supports not-for-profit and for-profit hospitals being held to the same standards of care, community service, professional education and commitment to their respective communities.

With respect to cost shifting, Policy H-240.996 notes AMA opposition to changes in the Medicare and Medicaid hospital reimbursement systems that result in cost shifting to private patients; and supports continued efforts to widely publicize the deleterious effects on the private sector of such cost shifts in efforts to save dollars for federal programs. Policy H-160.971 supports communicating to the public the problem of uncompensated care and the ever-increasing regulations involving such care as well as the detrimental effect that uncompensated care has on the availability of necessary health care services to many citizens. Policy H-160.923[1] acknowledges that hospitals, and not physicians, receive funding to cover uncompensated care and supports the transitional redistribution of public funds currently spent on uncompensated care provided by institutions for use in subsidizing private health insurance coverage for the uninsured.

DISCUSSION

The Council on Medical Service recognizes that hospitals, like physicians, have implemented forms of cost shifting between privately insured, publicly insured and uninsured patients to remain financially viable. One of the main root causes of this cost-shifting, which is not a sustainable

practice, is inadequate Medicare and Medicaid payment. The Council notes that such cost-shifting, however, has sometimes resulted in a lack of relationship between costs and charges. The Council believes that Medicare and Medicaid payment reform is an essential component of overall health system reform, and that consistent with Policy H-240.996, the AMA should continue to oppose changes in the Medicare and Medicaid hospital payment systems that result in cost shifting to private patients.

The Council believes that price transparency in health care can serve as a useful tool to educate patients, physicians and other health care stakeholders regarding health care costs, and may lead to more appropriate utilization of the health care system. Improved transparency, as advocated by Policy H-373.998[3], would make hospital price information more publicly available, which would benefit uninsured patients as well as some of those who are enrolled in health savings accounts and other similar mechanisms. The Council notes that cost and charge transparency would also likely increase the time physicians spend with their patients, as they discuss the pros and cons of medical tests, treatments and other interventions. Overall, the Council believes that increased transparency is needed across the spectrum of health care—for hospitals, insurers and physicians.

Hospital charges should not serve as an obstacle to uninsured patients accessing needed medical care. The Council believes that hospital charity care and discount policies are essential tools to promote access to and affordability of care for the uninsured. Hospitals must continue to adopt, implement and monitor policies on patient discounts, charity care, and fair billing and collection practices to ensure they are meeting the needs of the patient population. For these tools to have maximum benefit, uninsured patients also need to be educated and have access to information on hospital charity care and discount policies.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-373.998[3], which supports requiring hospitals, physicians and other health care providers to make information on fees/prices on frequently provided services and procedures readily available to consumers. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-240.996, which opposes changes in the Medicare and Medicaid hospital reimbursement systems that result in cost shifting to private patients, noting the adverse effects on the private sector of such cost shifts in efforts to save dollars for federal programs. (Reaffirm HOD Policy)

3. That our AMA encourage hospitals to adopt, implement, monitor and publicize policies on patient discounts, charity care, and fair billing and collection practices, and make access to those programs readily available to eligible patients. (New HOD Policy)

Fiscal Note: Staff cost estimated to be less than $500 to implement.

References are available from the AMA Division of Socioeconomic Policy Development.