The Gathering War over Hospital Pricing

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Abstract: *Is the hospital industry a relative pauper, as the industry itself contends, or an aggressive bill-collecting bully with vastly inflated prices, as some of its critics insist? This paper explores some of the issues at the center of the struggle over hospital billing. In addition, it describes attempts by one sector of the industry—hospital audit firms hired by plan administrators to augment third-party claims administration—to audit hospital bills on behalf of their client plans.*

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America's hospital industry contends that it is under assault. Battered from one side by a severe nursing shortage[1] and from another by the financial pressures arising from managed care, it has also been hit in recent years by lower reimbursement rates for treatment of Medicare patients, mandated by Congress under the Balanced Budget Act of 1997. "Many of America's hospitals are sitting on the edge of financial viability," the American Hospital Association darkly warned in a recent white paper on the industry's shaky financial position,[2] which maintains that one-third of hospitals operate at a deficit.

Still, there are others who see a glass half full. Hospitals, after all, are a crucial part of the massive American health care industry, on which $1.7 trillion was spent in 2003, 13% more than the previous year.[3] And demographic trends are putting the wind at its back: the giant baby boom age group, consisting of about 76 million Americans born from the end of World War II to 1964, will soon begin hitting their peak years of hospital usage. With the industry having eliminated thousands of excess beds from its total capacity in recent years,[4] and with managed care having mostly failed to serve as an effective gatekeeper to hospital care,[5] even some top hospital industry officials concede that they're finding themselves in the best bargaining position in many years.[6] As they begin to approach capacity, hospitals are less willing to offer discounts. And with the advent of increasing

automation and savvier financial management, many hospitals are also able to shift their emphasis to higher-margin (and better reimbursed) lines of business, such as coronary care. In addition, hospitals are growing more sophisticated about shifting the costs to those payers with the least bargaining leverage, especially the ever-swelling ranks of working Americans who are uninsured.

While net profit margins for the industry as a whole are no doubt low—by one reckoning down from just 5.5% in the late '90s to about 2% currently[7]—another large industry, grocery stores, operates on just a 1% margin. Moreover, hospitals see far more profitable niches that the better managed systems are racing to serve. A recent boom in hospital construction seems to bear that out. As many as 105 new acute care hospitals were built in 2003, up sharply from the 80 or so added in both 2001 and 2002.[8] The proliferation of outpatient surgery and diagnostic centers, often satellites of the central hospital system, have followed even steeper curves.

Some industry critics, brandishing so-called "cost-to-charge" ratios and their own proprietary costing data, insist that hospitals have far healthier finances than they admit, and that their rates are massively inflated over their true costs.[9] To prove their case, they point to hospital executive pay packages, which are among the highest of any industry.

An even more telling indicator of the industry's relative financial strength, these hospital industry critics say, is the experience of the nation's only state that regulates hospital charges, Maryland. Hospitals in that state charge far lower rates than counterparts in unregulated states operating without Medicare waivers.[10]

Hospital Customer Satisfaction

Put aside for a moment the question of the industry's financial health. There's a much clearer case to be made that hospitals are on the defensive when it comes to customer satisfaction. Along with airlines and broadcasting, the industry generally finishes at or near the bottom of multi-industry customer satisfaction surveys.[11] Its customers, meanwhile, are finding far too many overcharges in their bills. In a survey of more than 21,000 of its readers in 2001, for instance, *Consumer Reports* magazine found that of the 11,000 individuals who had reviewed their itemized hospital bills, about 5% reported "major errors"[12] (or about the same ratio found by professional hospital-bill auditors [13]). Among the six most common billing errors the survey found were

- incorrect basic charges,
- "upcoding," or the misclassification of procedures so as to produce a higher charge,
- "unbundling" of charges, resulting in double billing for services,
- cancelled work nevertheless being billed,
- operating room usage billed based upon incorrect times, and
- billing above the chargemaster (hospital price list) rates.

Even less flattering for the industry was a 1998 study[14] conducted by the Institute for Operations Research and the Management Sciences (INFORMS), an international scientific society whose members include several Nobel laureates. Based on data collected at three nonprofit hospitals in a single geographic area, the authors found that the hospitals in question used a public relations tool, called "impression management," to subtly persuade patients not to challenge apparent discrepancies in their bills. Even as hospital consumers are becoming more educated about their bills and are looking more closely at them, the study found that "hospitals are countering that with their own efforts to discourage people from becoming involved with challenges or audits because it costs them a great deal of time and money.... The goal is to persuade patients to give up on formal inquiry," wrote the authors.

To its credit, the Healthcare Financial Management Association and its partner organizations[15] have responded with a broad-based "patient-friendly billing" initiative that seeks to streamline and simplify hospital bills. The project began with focus groups conducted in 2001 among hospital patients and health care workers around the country. By the summer of 2003, initiative leaders had crafted 14 suggestions for making the hospital billing process more patient friendly. They include

- better training of hospital staff and the use of stan-

dard telephone protocols and scripts,
- more convenient hours for billing offices, and the use of standardized bills and statements, written in plain English,
- simplified contracts with managed-care organizations and other insurers (the source of many billing errors),
- consolidated billing wherever possible, and
- making online billing and payment options more widely available.

Approximately 1,000 hospitals and health systems have thus far adopted the suggestions.[16]

Cold War with Third-Party Administrators

As it extends the olive branch to individuals, perhaps in part to ward off regulation, the hospital industry's cold war with business payers has been heating up lately. Its relationship with third-party administrators (TPAs) provides a telling window into its singularly aggressive financial management tactics.

More than a decade ago, responding to the then-modest mounting incidence of audits of hospital bills, a consortium of health care groups published guidelines on billing audits.[17] The groups began by conceding that they "acknowledge that the current mechanisms for health care payment indicate a need to conduct some billing audits."

However, the voluntary guidelines sought to reduce the frequency of such audits. Unfortunately, they left some large gray areas by explicitly failing to address "the level or scope of care, medical necessity, or the pricing structure of items or services delivered by providers." In other words, by their very design, the guidelines exclude from consideration some of the areas of billing that are most frequently subject to dispute.

At the same time, these audit guidelines also managed to cast doubt upon the inherent credibility of a small outsourcing industry that had sprung up to audit hospital bills on behalf of health plans, and which generally charged on the basis of capturing a percentage of any overcharges recovered. "Individual audit personnel should not be placed in a situation through their remuneration, benefits, contingency fees, or other instructions that would call their findings into question," the guidelines note.

A year later, in 1993, with the controversy picking up steam, the Society of Professional Benefit Administrators formally asked the Department of Labor for a clarification of its responsibilities under the Employee Retirement Income Security Act (ERISA), the 1974 law that set the ground rules under which self-funded employee health care and retirement plans are regulated and taxed.[18] In an advisory opinion, the Department (then under the control of the labor-friendly Clinton Administration) said that such representatives were acting within their legal rights under ERISA to withhold payment of any claims until providers furnished proper billing documentation, often consisting of itemized bills, medical records and chargemaster data.

The new cop on the beat is the Health Insurance Portability and Accountability Act, or HIPAA, a new federal law that contains tough antifraud provisions. It calls for heavy fines and/or prison terms of up to 10 years for anyone convicted of fraudulently obtaining funds or services in connection with the delivery of health care services.

Bill Collecting or Bounty Hunting?

Notwithstanding these federal and state laws, the controversy has recently been intensified[19] with a renewed wave of collection activity, no doubt sparked at least in part by the tenuous financial condition of many hospital systems that see this as a chance to bolster ailing balance sheets. Only this time, there are apparently at least a couple of new twists. Many health systems are insisting on hefty fees for any audits (in addition to the "reasonable," though generally nominal, copying fees contemplated by the '92 auditing guidelines and under most state laws). Some health systems are even threatening the equivalent of a nuclear option—delinking, or a declaration that the health plan is ineligible for any further negotiated discounts—if auditing challenges persist.

Some industry observers[20] are calling this increased bill-collection activity a form of bounty hunting, pursued with the same ruthlessness as any other collection activ-

ity. But in dunning these TPAs, the collectors are also working from a premise that seems up for debate. Unlike insurance companies, which pay claims out of their own (or their investors') pockets, TPAs have little incentive for slowing down claims. Instead, their goal is to close files, rather than keep them open through rounds of appeals and counterclaims. At the same time, however, the legal, fiduciary obligation to guard the assets of the health plans exists. Indeed, some industry attorneys have issued advisory opinions suggesting that a plan administrator (or sponsor) that does not audit a sample of the plan's hospital bills is failing to meet its fiduciary responsibilities under ERISA.[21]

Both sides have their share of horror stories about the other. Auditors tell tales of $75 charges for a single diaper for a newborn baby and bills for intensive care stays that are double what is considered "usual and customary" for a particular area.[22] Uncommonly large bills for services rendered to premature babies seem to be an especially rich source of overbilling lore. One TPA recounted a tale of marching in to see a hospital administrator in Patterson, New Jersey, to register his outrage over an $18,000 charge for X-rays supposedly administered on a premature baby.[23] And there is the case in which a prestigious Ohio health care institution kept one patient for eight days of supposed inpatient care, at charges totaling over $100,000, and yet neither the facility nor the patient could explain what care was provided during that time.

Hospital officials counter by pointing out how some unsavory auditors have been known to steal certain documents that are central to proving a hospital's case about particular costs, which is why most health systems insist that all audits take place on their premises. Still, they acknowledge that hospitals inevitably do make billing errors, given the system's massive government-driven complexity.[24]

Price List Complexity

One of the major problems is the sheer complexity of the hospital industry: in most hospitals, the price list can contain as many as 15,000-20,000 items. These categories are themselves mandated by the federal government through its complicated diagnosis-related group reimbursement system, established in 1983 to try to hold down costs for Medicare by codifying services and components of care so as to assign appropriate prices. This leads to hospital administrators observing that the regulations they deal with are more complex than the tax code.[25] There is cause for optimism though: as hospitals increasingly automate, the billing complexities grow less severe.

Until recently, both sides of the debate were lobbying for federal action, hoping to add their pet scheme for either spurring prompt payment of claims[26] or a stiffer defense against bill collectors as an attachment to the so-called Patient's Bill of Rights. But with the Bush Administration philosophically opposed to such legislation, the regulatory action has shifted to the 50 states and their individual insurance commissions. There is only one problem: under ERISA, the plans are mostly exempt from state regulation, except in the aforementioned case of Maryland.

There is one bright spot on the horizon for those who would curb alleged hospital abuses. A House Energy and Commerce subcommittee, reacting to national media reports last year on apparent abuses by the for-profit chain Tenet Healthcare, launched an investigation into possible antitrust violations in the industry. In April 2003, the committee issued subpoenas to 20 health systems (which together own and operate nearly 1,000 hospitals), seeking data on their practices. The preliminary investigation pointedly noted that the U.S. Department of Health and Human Services found that urban hospitals in California marked up prices more than 300% over costs in 2002.[27]

Still, Congressional observers believe that the combination of an impending presidential election and the greater urgency of dealing with the nation's troubled electricity grid in the wake of the massive North American blackout will leave this investigation on a back burner, at least for now.[28] The smaller controversies will no doubt continue to rage while the larger issue—America's broken health care system—remains. Some think that this balkanized system is beginning to cause severe dislocations in access, price and coverage. Until these

and other deep structural problems are dealt with comprehensively—and there's no prospect of that happening anytime soon—look for continued controversy and dissension over hospital billing. ■

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(1) Bain & Company research report and American Nurses Association, *www.bain.com/bainweb/publications/printer_ready.asp?id=7599.*
(2) American Hospital Association white paper, *www.aha.org.*
(3) BusinessWeek Online, January 13, 2003 (*www.businessweek.com/magazine/content/03_02/b3815749.htm4:05:34*).
(4) "Capacity Planning—Seeing the Forest for the Trees," *Healthcare Financial Management Magazine*, October 2003, (*www.hfma.org/publications/HFM_Magazine/cover.htm*).
(5) "Why managed care failed," *Detroit News,* May 26, 2002 (*www.detnews.com/2002/health/0205/30/a15-499127.htm*).
(6) Richard Clarke, CEO of the Healthcare Financial Management Association, interview with author.
(7) "Nursing: On the Critical List" *BusinessWeek,* June 3, 2002 (*www.wxii12.com/money/1486742/detail.html*).
(8) *Modern Healthcare,* December 16, 2002, (*www.modernhealthcare.com/article.cms?articleID=31506*), and American Hospital Association statistics.
(9) Randy Suttles, president of Indianapolis-based Medical Savings Insurance, interview with author.
(10) Suttles, interview.
(11) American Customer Satisfaction Index (*www.theacsi.org*), an independent survey compiled by the University of Michigan business school and the American Society for Quality.
(12) *Consumer Reports,* January 2003.
(13) Donna Ugan, RN, director of Cleveland-based MedAudits, LLC, interview with author.
(14) "Hospitals Discourage Consumer Questioning of Bills, Study Suggests," INFORMS press release, March 11, 1998 (*www.informs.org/press/HospitalsDiscourageQuestioning.html*).
(15) HFMAs partners on this initiative include the American Hospital Association, the Medical Group Management Association, and "other leading provider, consulting and technology organizations."
(16) *www.patientfriendlybilling.org.*
(17) Published audit guidelines, as adopted March 13, 1992, by the American Health Information Management Association, the American Hospital Association, the Association of Healthcare Internal Auditors, Blue Cross and Blue Shield Association, the Healthcare Financial Management Association, and the Health Insurance Association of America.
(18) Fred Hunt, executive director of the Society of Professional Benefit Administrators, Washington, DC, interview with author.
(19) Robert C. Gerald, Staten Island, NY-based consultant to self-funded employee benefit plans, interview with author.
(20) Hunt, interview.
(21) ERISA Attorney Paul L. Jackson of the Akron law firm Roetzel & Andress, interview with author.
(22) Donna Ugan of MedAudits, interview with author.
(23) Gerald, interview.
(24) Clarke, interview.
(25) Clarke, interview.
(26) Bill Finerfrock, counsel to the Healthcare Billing and Management Association, interview with author.
(27) Arturo Silva, staff member of the U.S. House of Representatives' Committee on Energy and Commerce, interview with author.
(28) Silva, interview.