

The Pricing Of U.S. Hospital Services: Chaos Behind A Veil Of Secrecy

An economist's insights into what causes the variation in pricing, and what to do about it.

by **Uwe E. Reinhardt**

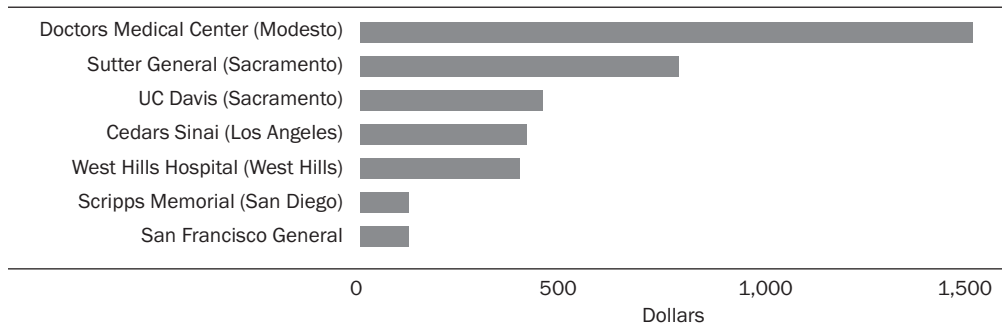
ABSTRACT: Although Americans and foreigners alike tend to think of the U.S. health care system as being a “market-driven” system, the prices actually paid for health care goods and services in that system have remained remarkably opaque. This paper describes how U.S. hospitals now price their services to the various third-party payers and self-paying patients, and how that system would have to be changed to accommodate the increasingly popular concept of “consumer-directed health care.” [*Health Affairs* 25, no. 1 (2006): 57–69]

ASKED BY A WALL STREET JOURNAL REPORTER to explain how U.S. hospitals price their services, William McGowan, chief financial officer of the University of California, Davis, Health System and thirty-year veteran of hospital financing, responded: “There is no method to this madness. As we went through the years, we had these cockamamie formulas. We multiplied our costs to set our charges.”¹

Exhibit 1 illustrates his point. Although the list prices reflected in Exhibit 1 vary by only a factor of slightly more than 4, they reportedly vary by as much as seventeenfold across all hospitals in California. However, these “charges” are much higher than the prices U.S. hospitals are actually paid. In 2004, for example, U.S. hospitals were actually paid only about 38 percent of their “charges” by patients or their insurers.² The actual prices they were paid appear to vary much less than “charges” do, although even that variation is remarkable large. For example, in 2001 the prices hospitals were actually paid by private health insurers serving the Federal Employees Health Benefits Program (FEHBP) varied by “only” 259 percent across the United States.³

Only a handful of Americans truly comprehend the complex payment system for U.S. hospitals—mostly those whose job it is to set, negotiate, and study hospi-

.....
 Uwe Reinhardt (reinhard@princeton.edu) is the James Madison Professor of Political Economy, Center for Health and Well Being, Woodrow Wilson School of Public and International Affairs, Princeton University, in Princeton, New Jersey.

EXHIBIT 1**Charges For A Chest X-Ray (Two Views, Basic) At Selected California Hospitals, 2004**

SOURCE: L. Lagnado, "California Hospitals Open Books, Showing Huge Price Differences," *Wall Street Journal*, 27 December 2004.

tal prices. Self-paying, uninsured patients certainly do not understand these practices. Quite aside from the incomprehensible variation of list prices across hospitals within a state, these patients might wonder why their neighborhood hospitals billed them more than twice the amount for a given procedure than what that same hospital billed their neighbor's insurance carrier for the same procedure.⁴

This paper has several purposes. First, I attempt to describe more fully the manner in which hospitals now price their services to the fiscal intermediaries who provide the bulk of the hospital's revenue, and also to self-paying individual patients. I should note at the outset, however, that any such description overlooks local variations to more general patterns. Next, I offer an economist's perspective on the widespread practice of "price discrimination" in the hospital industry—that is, the practice of charging different payers different prices for identical health care goods or services. I conclude by giving some thought to the problem of how prospective patients could be apprised of a hospital's prices under what has come to be known as "consumer-directed health care." Although the cost of a single inpatient episode typically will exceed the deductibles of consumer-directed plans and revert the matter to third-party payment, many consumer-directed policies require sizable coinsurance in addition to the deductible, which gives prospective patients a financial stake even in the prices charged for inpatient care.⁵ Furthermore, a growing fraction of total hospital revenue now comes from outpatient services—36 percent of hospitals' total gross patient revenues in 2004.⁶

How Hospitals Set Their Prices, And How They Are Paid

■ **The hospital's chargemaster.** Overarching the U.S. hospital payment system is each individual hospital's "chargemaster." The data shown in Exhibit 1, for example, were taken from the chargemasters of the hospitals featured in the exhibit. A hospital's chargemaster is a lengthy list of the hospital's prices for every single procedure performed in the hospital and for every supply item used during those procedures. A sample chargemaster posted on the Web site of California's state govern-

ment, for example, contains close to 20,000 items.⁷

Traditionally, each U.S. hospital has had its own chargemaster, but through the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Congress has sought to impose a standard national format on that nomenclature, a process that is yet to be completed.⁸ Hospitals update their chargemasters at least annually but often more frequently. Typically, a hospital will submit, for all of its patients, detailed bills based on its chargemaster, even to patients covered by Medicare. An advantage of these bills is that at least in principle, patients can check whether all of the supplies and services listed on the bill were actually delivered. A disadvantage, for hospitals, is that these bills are very lengthy and add up to large totals that do not bear any systematic relationship to the amounts third-party payers actually pay them for the listed services. As noted earlier, these actual payments tend to be less than half of the amounts that originally were billed.

Hospitals do not follow a common practice in updating their chargemasters. Some hospitals might simply raise every price in the list by the same percentage once a year. Others might update prices for particular items or procedures separately, by different percentages, which makes it difficult to know by what overall percentage a hospital has increased its prices. These updates sometimes occur more than once a year. In general, the process appears to be ad hoc, without any external constraints—the “madness” alluded to by McGowan.⁹

With the exception of California, which now requires hospitals to make their chargemasters public, hospitals are not required to post their chargemasters for public view. It may be just as well. If the sample chargemaster posted by California’s state government is any guide, prospective patients would be hard put to make sense of these price lists.

An individual hospital might be paid by a dozen or more distinct third-party payers, each with its own distinct set of rules for and levels of payment, which are negotiated separately with each private insurer once a year. Medicare and Medicaid have their own extensive rules for paying hospitals. Relative to hospitals paid under the much simpler national health insurance schemes in other countries, the contracting and billing departments of U.S. hospitals therefore are huge enterprises, often requiring large cadres of highly skilled workers backed up by sophisticated computer systems that can simulate the revenue implications of the individual contract negotiations. Furthermore, because violations of contracts with the government programs can trigger severe civil or criminal penalties, hospital billing departments are strictly monitored and supervised by sizable internal control operations.

■ **Medicare hospital payments.** U.S. hospitals now receive about 31 percent of their net revenues from Medicare. About 88 percent of Medicare’s total payments to hospitals directly for patient care is for inpatient services; the remainder goes for outpatient services.¹⁰

For inpatient services, Medicare pays hospitals flat fees per hospital case, ac-

according to a schedule of close to 600 distinct diagnosis-related groups (DRGs). The system assigns relative payment weights to each DRG. To arrive at the actual payment for a particular DRG in a given year, that DRG's relative payment weight is multiplied by that year's monetary conversion factor (the "base payment amount," in dollars). That payment is then further adjusted for regional variations in the cost of labor and of other hospital inputs, and for other local factors that might affect a hospital's cost of producing care.¹¹ To accommodate complex cases whose resource use greatly exceeds that foreseen in the closest DRG, the system provides for "outlier" payments that, in principle, are set to reflect the hospital's estimated cost of providing the additional supplies and services used.

The DRG weights used in this system were originally based on the relative average costliness of cases in DRGs in the early 1980s. They have been recalibrated regularly on the basis of average standardized, billed charges for all cases falling into each DRG in the most recent Medicare file.¹² Congress updates the monetary conversion factor annually, to reflect changes in technology, practice patterns, and economywide market conditions—for example, in the so-called market-basket price index of hospital inputs (such as energy) affecting hospitals in all regions.

The DRG system, which is, in essence, a system of centrally administered prices, has had its critics in the United States over the years. None other than Tom Scully, the Medicare administrator during President George W. Bush's first term, has disparaged Medicare as a "dumb price fixer."¹³ Ironically, that very system was originally put into place by none other than the staunchly market-oriented Ronald Reagan. In any event, since it was first introduced in 1983, the DRG system has had a number of imitators abroad, notably in Australia and Germany.

For outpatient services, Medicare originally reimbursed hospitals retrospectively for allowable, incurred costs, for which beneficiaries were required to make copayments. By 1997 these copayments had come to equal about 50 percent of total Medicare payments to hospitals for outpatient care.¹⁴ In the Balanced Budget Act (BBA) of 1997, Congress mandated Medicare to replace that inherently inflationary, retrospective, full-cost reimbursement system with a prospective fee schedule, whose basic payment unit is either a service or a particular procedure. This schedule went into effect in 2000.

In developing the new fee schedule, Medicare bundled—as much as is sensible—entire sets of supplies and services associated with each major procedure into one lump-sum fee for that procedure. These procedure categories are classified into some 600 distinct groups, each of which contains major procedures that "are clinically similar and use comparable amounts of resources."¹⁵ The grouping was made according to an ambulatory payment classification (APC) scheme developed through health services research. These APCs are still evolving, as Medicare gains experience with them and as new technology emerges.

As in the DRG system, the dollar amount paid hospitals for a particular APC is determined by multiplying the relative cost weight of that APC (based on median

costs for that APC) by a monetary conversion factor. Further adjustments are made for regional variations in input costs, especially wages, and other factors thought to affect hospital outpatient costs. Once again, there is a provision for outlier payments. There is also provision for pass-through payments covering costly new technology (such as drugs) going into particular treatments.

The Medicare payment system is highly complex, in part because government payment systems must observe rules of fairness, strict accountability to taxpayers, and other social goals not imposed on private payers. Critics of the system sometimes overlook the fact that these requirements pose administrative challenges not shared by private enterprise. However, the myriad of distinct payment systems for U.S. private insurers are very complex as well, by international standards, and often still based on paper claims.

■ **Medicaid hospital payments.** Medicaid now accounts for about 17 percent of total national spending on hospital care.¹⁶ Payment methods vary from state to state, but two methods dominate for inpatient payments: flat fees per DRG or flat per diem payments.¹⁷ The DRG payments are unilaterally set by the state governments, usually as a percentage of Medicare DRGs. For outpatient services, the most common approach traditionally has been what is called “cost reimbursement,” or fee schedules set by the state governments. Many states, however, are considering switching to the APC system pioneered by Medicare.¹⁸

As Allen Dobson and his colleagues show elsewhere in this volume, on average, for the nation as a whole, Medicaid’s payments to hospitals fall well short of fully allocated costs, even after the separate disproportionate-share hospital (DSH) subsidies paid by the federal government and the states to hospitals with disproportionately large loads of uninsured or Medicaid patients are accounted for.¹⁹ That shortfall must be covered by other payers—mainly private insurers.

■ **Private insurance.** Hospitals receive roughly one-third of their net revenues from private health insurers, which pay hospitals on the basis either of steeply discounted charges (with discounts in excess of 50 percent), negotiated per diems, or flat charges per entire episode (DRGs). Usually an insurer pays most claims on one base (for example, per diems), although an insurer may pay some hospitals on other bases as well.

Discounted charges tend to be used by smaller insurance companies for inpatient services. They are used by all insurers for outpatient services, although insurers often bundle all of the services going into a major procedure (such as a laparoscopic cholecystectomy) into one code, just as Medicare and Medicaid do with the APC system. Case-based payments are each insurer’s own adaptation of the Medicare DRGs. Usually the insurers will use the Medicare DRG groupings, but each will assign its own relative weights to the individual DRGs.

Whatever an insurer’s base for paying hospitals might be, the dollar level of payments is negotiated annually between each insurer and each hospital. Under a DRG system, for example, the item to be negotiated is the monetary conversion

“The failure to attain uniform coding standards provides a continued reason for the clearinghouse industry to stay in business.”

.....

factor for the year and, possibly, some of the DRG weights. These actual dollar payments have traditionally been kept as strict, proprietary trade secrets by both the hospitals and the insurers. Recently Aetna announced that it will make public the actual payment rates it has negotiated with physicians in the Cincinnati area.²⁰ That this small, tentative step toward transparency made national news speaks volumes about the state of price-transparency in U.S. health care. It remains to be seen whether that first step will trigger a larger industrywide move toward removing, at long last, the veil that has been draped for so long over the actual prices paid in the U.S. health system.

■ **Uninsured patients.** Until recently, only uninsured, self-paying U.S. patients have been billed the full charges listed in hospitals’ inflated chargemasters, usually on the argument that the Medicare rules required it.²¹ This is how even uninsured middle-class U.S. patients could find themselves paying off over many years a hospital bill of, say, \$30,000 for a procedure that Medicaid would have reimbursed at only \$6,000 and commercial insurers somewhere in between.²²

Because uninsured patients often are members of low-income families, many of them ultimately paid only a fraction of the vastly inflated charges they were originally billed by the hospital, but only after intensive and morally troubling collection efforts by the hospital.²³ After a series of searing exposes of these collection efforts in the press—notably by staff reporter Lucette Lagnado of the *Wall Street Journal*—Congress held hearings on these practices.²⁴ Partly under pressure from consumers and lawmakers and partly on their own volition, many hospitals now have means-tested discounts off their chargemasters for uninsured patients, which bring the prices charged the uninsured closer to those paid by commercial insurers or even below.²⁵ Some very poor patients, of course, have received hospital care free of charge all along, on a purely charitable basis.

■ **Payment clearinghouses.** Traditionally, both the structure of hospitals’ chargemasters and the prices they contained varied from hospital to hospital, and they did not match the diverse nomenclatures used by insurance carriers to describe hospital services. The resulting chaos brought forth new business ventures, such as WebMD, as clearinghouses.²⁶ Their proprietary software was designed to translate invoices expressed in a hospital’s nomenclature into the different nomenclature used by the relevant insurer.

To eliminate this chaos, and the persistence of paper claims it begot, in 1996 Congress passed HIPAA, whose “administrative simplification” provisions sought to impose a uniform format and data content on all U.S. health care transactions, to ease electronic transactions among all payers and providers. In the meantime, the health industry has made strides toward that goal. As of this writing, however,

full “HIPAA compliance” with complete, direct, two-way information exchanges between providers and payers has not yet been attained in the United States; insurers are the main laggards.²⁷ This failure to attain uniform coding standards throughout the industry provides a continued reason for the clearinghouse industry to stay in business.²⁸ It also adds to the health system’s administrative overhead.

Price Discrimination By Hospitals

It might be argued that because hospitals initially bill all of their patients at their chargemaster prices, they do not engage in “price discrimination”—the practice of charging different customers different prices for identical goods or services. Invoices at chargemaster prices, however, are insincere, in the sense that they would yield truly enormous profits if those prices were actually paid. The reality is that hospitals accept different payments from different payers for identical services, and that can properly be called price discrimination.

Price discrimination is sometimes decried as unfair, and it may be so. It is, however, commonly practiced by the hotel, airline, pharmaceutical, and telecommunications industries; by public utilities; and by universities, where different classes of students are granted widely varying discounts off full tuition, partly as a reward for intellectual acumen, or on the basis of the family’s ability to pay. Price discrimination also is a perfectly natural phenomenon in any health system not subject to price regulation.

All of these industries have several things in common: They have high annual fixed costs relative to the incremental cost of producing additional services; they can segment their markets into distinct classes of customers, each with different degrees of price-sensitivity; and customers cannot resell their products among themselves, because it is either technically impossible (such as for physician or hospital treatments) or illegal (such as for pharmaceutical products).

■ **The objective of price discrimination.** The sellers of a good or service might practice price discrimination in the pursuit of two quite distinct objectives. First, sellers might simply seek to maximize the total amount of revenue that can be extracted from society for a given volume of output and, thus, their profits. By charging some groups more than others, profit-seeking sellers can extract from the buy side more revenue and profits for a given sales volume than they could with a single price. The distinguishing characteristic of such sellers is that they would never sell any output to any market segment at prices below incremental production costs, unless that had profitable public relations value or they were mandated to do so by law—such as under the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986.²⁹

Alternatively, sellers—especially not-for-profit sellers—might price-discriminate merely to cover their fully allocated total costs (plus, perhaps, a modest profit margin) in a way that conforms to prevailing distributive, social ethics. Physicians

have always defended their erstwhile sliding fee scales on those ethical grounds, although not all economists have been persuaded by that rationale.³⁰

Richard Steinberg and Burton Weisbrod recently presented a model in which nonprofit institutions price-discriminate to achieve ethically desirable distributional goals.³¹ An important, relevant insight from their model is that competition from either for-profit or nonprofit organizations in a market area severely limits the nonprofit's ability to pursue that policy. Under truly severe competition, the authors show, even nonprofit organizations will behave more and more like profit-maximizing enterprises, to survive in the long run. That is, of course, precisely the situation in which many nonprofit U.S. hospitals now find themselves. In that market context, price discrimination probably is profit-maximizing more often than practiced to pursue ethical goals.

What prevailing distributive ethic in U.S. society, for example, would dictate that uninsured patients be billed the highest prices for hospital care and then be hounded, often mercilessly, by bill collectors? What prevailing distributive ethic dictates that large insurance carriers with market muscle be granted steeper discounts off charges by hospitals than smaller insurance carriers with less bargaining power?

Probably the best defense hospitals can make for their current patterns of price discrimination is that both the federal and state governments can use their monopsony power to impose unfunded mandates in the form of shortfalls of payments from fully allocated costs. That practice, along with lingering excess capacity in most hospital market areas, can explain why for-profit and nonprofit hospitals alike now have little choice but to price their services to private payers essentially as profit-maximizing enterprises.

Hospital Pricing And Consumer-Directed Health Care

Until now, the U.S. health care "market" has been analogous to an imaginary world in which, say, employers offered to reimburse their employees 80 percent of the "reasonable cost" of all attire deemed "necessary" and "appropriate" on the job but, under the contracts negotiated with department stores by the fiscal intermediaries administering this "Clothes Benefit Program," employees had to enter department stores blindfolded. Only months after a shopping trip would the employee receive from the fiscal intermediary a so-called Explanation of Benefits (EOB) statement, explaining how much the employee had to pay for whatever he or she had stuffed, blindfolded, into the shopping cart on that shopping trip. Framed in bright red on that EOB would be the statement: "Pay X amount." X would represent 20 percent of what the intermediary would have judged, ex post, to be "reasonable prices" for those garments in the shopping cart deemed by that intermediary, ex post, to have been "appropriate" attire for the particular employee's circumstances. It also would include 100 percent of the prices charged by the stores for items in the cart that were deemed by the intermediary, ex post, as

“‘Consumer empowerment’ can only occur if prospective patients actually have easy access to user-friendly, reliable information.”

.....

“not necessary” or “inappropriate” and that were therefore not covered by the Clothes Benefit Program.

Ridiculous though it sounds, such an arrangement closely resembles the current payment system for U.S. health care. It is difficult to reconcile this picture with increasing demands by employers, insurers, and policymakers that patients be forced to act as more responsible “consumers” of health care, a movement now gathering force under the banner of consumer-directed health care.

■ **Consumer-directed health care.** This term has come to describe health insurance policies with annual deductibles ranging anywhere from \$2,000 to more than \$10,000 per family and, often, coinsurance in addition. The costs borne by the insured can be defrayed out of health savings accounts (HSAs) into which both employers and families can make annual deposits that are not taxable income to the employee. Amounts in the HSA not spent in a given year can be rolled over to the following year, which means that for chronically healthy families, the HSA can become a major, tax-preferred savings account earmarked for future out-of-pocket payments on health care.

This construct can be offered by employers, in lieu of the traditional, more comprehensive employer-sponsored insurance. It also can be procured by households in the market for individual insurance.³² A major advantage to both is that the premiums for the construct are lower than those for more generous insurance coverage.

The central idea of consumer-directed care is that the high degree of cost sharing will force patients to take a more active interest than they hitherto have had in the cost-effectiveness of their care. This “consumer empowerment,” as it is sometimes called, can only occur, however, if prospective patients actually have easy access to user-friendly, reliable information on at least three dimensions of their care: the prices charged by competing providers of health care; the costliness of practice styles adopted by these various providers—that is, the prices times the quantities of services and supplies they package into the treatments they render; and the quality of these providers’ services. If such a transparent information infrastructure now exists anywhere in the United States, it would be the rare exception.

In connection with hospital care, of course, it could be argued that prospective patients (“consumers”) require only better information on “quality,” because the cost of even moderately expensive hospital stays typically will exceed the patient’s annual deductible, so that “price” and “costliness” are no longer important to the patient. That argument overlooks the fact that a growing fraction (now more than a third) of all hospital revenue comes from outpatient services, whose individual costs might be below the deductible. Furthermore, patients increasingly face coinsurance payments for inpatient care, too, which gives them an inter-

est in the actual prices of those services. Thus, the question remains how the prices charged by hospitals could be revealed to prospective patients in ways they could digest and act upon as “consumers.”

■ **The Porter-Teisberg proposal.** In June 2004, Michael Porter and Elizabeth Teisberg published a paper titled “Redefining Competition in Health Care.”³³ Much of that paper repackages familiar ideas that have long been espoused by policy analysts such as Ellwood, Enthoven, and Etheredge; Pauly, Danzon, Feldstein, and Hoff; Herzlinger; and numerous other authors who have wrestled with the idea of forcing genuine price and quality competition onto the U.S. health system.³⁴ But Porter and Teisberg do offer some radical ideas on the pricing of health care services, which makes them relevant to the present inquiry.

In a nutshell, they would replace the current payment system with an all-payer system, albeit one centered on individual providers. Thus, a hospital could set its own prices, but it would have to post them for public view and apply them to all patients, without price discrimination. Where possible, prices for individual services and supply items would be bundled into lump-sum prices for major procedure categories, akin to Medicare’s DRG and APC systems.

■ **National DRG and APC weights.** In 1993 I proposed a somewhat similar idea.³⁵ I proposed that the government should expand the DRG system to all hospital patients (which would now include the recently established APC for outpatient services). There would be only one national set of weights for the various DRGs and APCs, which every hospital would have to adopt. These weights would be developed and continuously kept up to date by an authoritative national body of experts—perhaps the current Medicare Payment Advisory Commission (MedPAC).

To avoid the potential pitfalls of centrally administered, uniform prices for the entire hospital system of as far-flung a nation as the United States, each hospital would be free to set its own monetary conversion factor for DRGs and APCs. That hospital-based conversion factor would then translate the national relative value scales into hospital-specific, case-based fee schedules. Each hospital, of course, would be required to make its monetary conversion factor publicly known. It would be a one-dimensional index of the hospital’s absolute level of case-based prices and could be easily understood and used by patients.

Even streamlined systems such as these would still confront prospective patients with lists containing more than 1,000 prices for the various hospitals’ DRGs and APCs. But these price lists could be supplemented by smaller lists, showing the total cost billed by a hospital for the far fewer cases that constitute, say, half of its total revenues. Furthermore, software could be written that would enable prospective patients to obtain, from a dedicated Web site, comparative averages or medians of the total prices actually billed by a hospital in the past year for a specific case not on the smaller list. Although never perfect and easy, any such system would be a step far ahead of the chaos that now reigns behind the opaque curtain of proprietary prices in the U.S. hospital system.

Such proposals are, of course, more easily stated than implemented. To transit from the current payment system to the proposed system in a way that would not unfairly create winners and losers raises a host of conceptual and practical questions, even leaving aside for the moment the nettlesome problem of the uninsured and underinsured.

■ **The potential of reference pricing.** There is, for example, Porter and Teisberg's recommendation that hospitals must accept third-party payments as payment in full, without balance billing of patients (aside from regular coinsurance or deductibles that may be extracted from patients by the third-party payer). Is that imperative? An alternative approach might be reference pricing, which might also be called "defined-contribution pricing." Here third-party payers (perhaps even Medicare) would pay hospitals no more than a stipulated conversion factor, benchmarked perhaps on lower-cost hospitals in a market area, which would leave patients to pick up the entire difference between the conversion factor covered by the third-party payer and the conversion factor the hospital has announced publicly and actually charges. It would be a version of the tiered pricing now being contemplated by some private insurers.

■ **Price discrimination.** There is the other open question of whether a system of common relative value scales for inpatient and outpatient care would continue to allow individual hospitals to charge different payers different, negotiated monetary conversion factors. A case can be made for permitting it, as long as patients with high-deductible policies would be charged by a hospital only the conversion factor that was negotiated with that hospital by their catastrophic insurer. To shop around for cost-effective care among hospitals in a market area, patients then would have to know all of the conversion factors that their own insurer had negotiated with all of the competing hospitals in the relevant market area. That information, in turn, would reveal to all the world all of the negotiated conversion factors. In the end, the system would most likely lead to something approximating an all-payer system in a market area, without the need for added regulation.

■ **The uninsured.** Under any such novel payment system, separate provisions would have to be made for low-income households and self-paying patients, whether or not price discrimination among third-party payers were to be allowed. One approach would be to have hospitals post their means-tested conversion factors, which presumably would be income related and might be zero for genuine charity cases. As Porter and Teisberg also observe on this point, however, in the long run any U.S. hospital payment system will be seriously impaired by the presence of large numbers of uninsured Americans.

Concluding Observations

The bewildering and sometimes troublesome picture of contemporary U.S. hospital pricing is not entirely of hospitals' own making. They are part of a wider system of health care financing whose administrative expense now ranks as a major

cost component of U.S. health care (as much as 25 percent).³⁶

An old adage has it that “the only good tax is an old tax.” The idea is that all economic agents in society have fully adjusted to an old tax, however inefficient, and that changing it may unfairly create winners and losers. It is surely so also with a hospital payment system. To move from the present, chaotic pricing system toward a more streamlined system that could support genuinely consumer-directed health care will be an awesome challenge. Yet without major changes in the present chaos, forcing sick and anxious people to shop around blindfolded for cost-effective care mocks the very idea of consumer-directed care.

.....
The author gratefully acknowledges the constructive criticism of an earlier draft by three anonymous peer reviewers. Thanks are due also for valuable insights provided by Al Dobson of the Lewin Group; Stuart Guterman of the Commonwealth Fund; Chip Kahn, president of the Federation of American Hospitals; Caroline Steinberg of the American Hospital Association; Mike Parsons, chief operating officer of Triad Hospitals Inc.; Karen Flinn, who negotiates contracts with private insurers on behalf of Triad Hospitals Inc.; and Becky Yang, who negotiates contracts with hospitals on behalf of WellPoint-Anthem. None of these contributors is responsible for any errors or shortcomings in this paper.

NOTES

1. L. Lagnado, “California Hospitals Open Books, Showing Huge Price Differences,” *Wall Street Journal*, 27 December 2004.
2. American Hospital Association, *Hospital Statistics 2005* (Chicago: AHA, October 2005), Table 3.
3. U.S. Government Accountability Office, *Federal Employees Health Benefits Program: Competition and Other Factors Linked to Wide Variation in Health Care Prices*, Pub. no. GASO-05-856, August 2005, <http://www.gao.gov/new.items/d05856.pdf> (accessed 10 September 2005).
4. See, for example, L. Lagnado, “Anatomy of a Hospital Bill,” *Wall Street Journal*, 21 September 2004.
5. As exemplified by plans listed at <http://eHealthInsurance.com>.
6. AHA, *Hospital Statistics 2005*, Table 3.
7. See California Office of Statewide Health Planning and Development, “Sample Chrgemstr,” 16 June 2005, <http://www.oshpd.cahwnet.gov/HQAD/Hospital/SampleChrgmstr.pdf> (accessed 10 September 2005).
8. See, for example, WebMD, “HIPAA Implementation: The Case for a Rational Roll-Out Plan,” 19 July 2004, <http://www.aao.org/aaosite/compliance/upload/Practice-Management-HIPAA-Implementation.pdf> (accessed 10 September 2005).
9. Lagnado, “California Hospitals.”
10. Medicare Payment Advisory Commission, *A Data Book: Healthcare Spending and the Medicare Program*, June 2004, http://www.medpac.gov/publications/congressional_reports/Jun04DataBook_Entire_report_links.pdf (accessed 10 September 2005), Charts 5-9 and 6-7.
11. MedPac, *Report to the Congress: Medicare Payment Policy* (Washington: MedPAC, March 2003), Appendix A.
12. *Ibid.*, 227.
13. U.E. Reinhardt, “The Medicare World from Both Sides: A Conversation with Tom Scully,” *Health Affairs* 22, no. 6 (2003): 167–174.
14. MedPac, *Report to the Congress*, Appendix A, 231.
15. *Ibid.*
16. See Centers for Medicare and Medicaid Services, “National Health Expenditure (NHE) Amounts by Type of Expenditure and Source of Funds: Calendar Years 1965–2014 in PROJECTIONS Format,” <http://www.cms.hhs.gov/statistics/nhe/default.asp> (Click “Data files for downloading” and select “NHE65-14.zip”) (accessed 10 September 2005).
17. See, for example, S.G. Lane, E. Longstreth, and V. Nixon, *A Community Leader’s Guide to Hospital Finance*, 2001,

- http://www.accessproject.org/downloads/Hospital_Finance.pdf (accessed 10 September 2005).
18. ACS State Health Care, "Paying Hospitals for Outpatient Services: A Guide to Medicaid Programs," <http://208.63.63.72/dloads/Paying%20for%20Hospital%20Outpatient%20Services%202004.pdf> (accessed 10 September 2005).
 19. A. Dobson, J. DaVanzo, and N. Sen, "The Cost-Shift Payment 'Hydraulic': Foundation, History, and Implications," *Health Affairs* 25, no. 1 (2006): 22–33.
 20. Henry J. Kaiser Family Foundation, "Aetna Posts Physician Fees Online for Health Plan Members," *Daily Health Policy Report*, 18 August 2005, http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=32095 (accessed 10 September 2005).
 21. SEIU District 1199 Care for Ohio, "Twice the Price: What Uninsured and Underinsured Patients Pay for Hospital Care," March 2005, <http://s57.advocateoffice.com/vertical/Sites/{56490583-267C-4278-BC56-A7128CE248A8}/uploads/{374CBAD9-740D-48BC-8536-92ECD76D1444}.PDF> (accessed 1 July 2005).
 22. Lagnado, "Anatomy of a Hospital Bill."
 23. The reported payment-to-cost ratio is about 0.14. See Dobson et al., "The Cost-Shift Payment 'Hydraulic'." Regarding hospital collection efforts, see L. Lagnado, "Hospitals Try Extreme Measures to Collect Their Overdue Debts," *Wall Street Journal*, 30 October 2003.
 24. L. Lagnado, "Jeanette White Is Long Dead but Her Hospital Bill Lives On," *Wall Street Journal*, 13 March 2003; and L. Lagnado, "House Panel Begins Inquiry into Hospital Billing Practices," *Wall Street Journal*, 17 July 2003.
 25. L. Lagnado, "Hospitals Will Give Price Breaks to Uninsured, If Medicare Agrees," *Wall Street Journal*, 17 December 2003.
 26. See U.S. Securities and Exchange Commission, "Form 10-K, WebMD Corporation," http://www.webmd.com/corporate/content/investor/WebMD_2002_Form_10-K.pdf (accessed 10 September 2005).
 27. See, for example, WebMD, "HIPAA Implementation."
 28. *Ibid.*
 29. In principle, EMTALA applies only to hospitals that participate in Medicare. In practice, this means that all hospitals are bound by the statute.
 30. See, for example, R.A. Kessel, "Price Discrimination in Medicine," *Journal of Law and Economics* 1 (1958): 20–53.
 31. R. Steinberg and B. A. Weisbrod, "Give It Away or Make Them Pay? Price Discrimination and Rationing by Nonprofit Organizations with Distributional Objectives," 28 June 2002, <http://www.nationalcne.org/papers/rationnew.pdf> (accessed 20 June 2005).
 32. Examples of individually purchased consumer-directed health plans can be found at eHealthInsurance.com, a user-friendly, electronic farmers market, so to speak, for a great variety of health insurance products offered by various U.S. health insurers.
 33. M.E. Porter and E.O. Teisberg, "Redefining Competition in Health Care," *Harvard Business Review* (June 2004): 1–14.
 34. P.M. Ellwood, A.C. Enthoven, and L. Etheredge, "The Jackson Hole Initiatives for a Twenty-First-Century Health Care System," *Health Economics* 1, no. 3 (1992): 149–168; M.V. Pauly et al., "A Plan for 'Responsible National Health Insurance'," *Health Affairs* 10, no. 1 (1991): 5–25; and R.E. Herzlinger, *Market-Driven Health Care: Who Wins, Who Loses in the Transformation of America's Largest Service Industry* (Reading, Mass.: Addison-Wesley, 1997).
 35. U.E. Reinhardt, "An 'All-American' Health Reform Proposal," *American Health Policy* 3, no. 3 (1993): 11–17.
 36. S. Woolhandler, T. Campbell, and D.U. Himmelstein, "Costs of Health Care Administration in the United States and Canada," *New England Journal of Medicine* 349, no. 8 (2003): 768–775.