

SETTING THE RECORD STRAIGHT

The Urgency of Achieving Hospital Fair Price



*Charting the Course from Revenue Focus to Value Alignment
for American Families and Businesses*



Employers for Healthcare Value Since 1980



National Alliance
of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

Table of Contents

The Urgency of Achieving Hospital Fair Price	1
Understanding the Revenue Cycle Management Industry	3
Setting the Record Straight: Hospital Pricing Myths and Facts	5
Resources	13

Acknowledgment

The National Alliance gratefully acknowledges support from [Arnold Ventures](#) for its Hospital Fair Price initiative and industry partners National Academy for State Health Policy (NASHP), RAND Corporation, and Rice University for invaluable technical and subject-matter expertise.

RESET Coalitions



Partner Coalitions



The Urgency of Achieving Hospital Fair Price

Two worrisome realities are all too common due to outrageous and indefensible hospital prices. Employees are being pushed into medical debt and forced to forego total compensation enhancements, and employers are facing unprecedented profitability headwinds.

New data transparency reinforces what we have long known: Hospital prices are out of control, and we can't rely on health systems and health plans to course correct. In fact, data indicate that for most hospitals a "fair price" for patients privately insured by employers is 140%–200% of what Medicare pays for the exact same products, procedures and services at the exact same facilities—with some hospitals charging more than 500% of Medicare prices. A fair price should allow for a reasonable markup from verifiable costs.

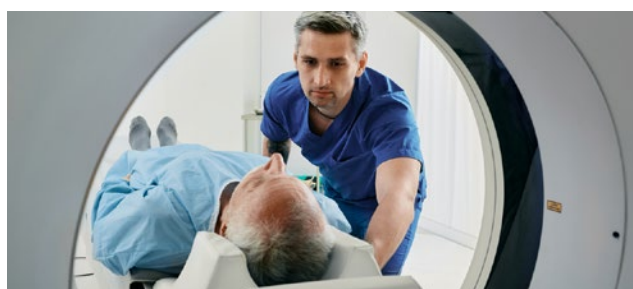
The National Alliance playbook, "[Beyond Hospital Transparency: Getting to Fair Price](#)," helps purchasers navigate and understand how to best leverage newly available hospital price and quality transparency data and tools from [Sage Transparency](#) which incorporates content from [RAND Corporation](#), the [National Academy for State Health Policy](#) (NASHP), and other sources. It also offers guidance on rights and responsibilities of plan sponsor fiduciaries to determine fair prices for hospital services, market- and policy-based strategies, and ways to work individually and through coalitions to achieve fair pricing for hospital services.

This resource, "Setting the Record Straight: The Urgency of Achieving Hospital Fair Price," is in response to various hospital association assertions that continue to support industry opacity, rather than collaborating with employers and other plan sponsors to chart the course from revenue focus to value alignment. In short:

- ▶ **Hospital prices** are high, rapidly rising, and not justified.

"We know there are hospitals out there doing the right things to ensure the overall health of the people and communities they serve. We're looking to all hospitals to do right by their customers—their patients—by working in good faith to negotiate fair prices with employers and other plan sponsors who provide healthcare coverage to more than 70% of workers."

— *Michael Thompson*
National Alliance president & CEO



Examples of Inexplicable Hospital Costs:

- > An MRI costs enrollees in United's HMO plan \$1,093, but \$4,029 if they have United's PPO plan at a Milwaukee hospital. At a Florida hospital, an MRI costs \$2,455 with a Blue Cross plan, but just \$262 with a Medicare plan.
- > A hospital patient in Texas received a bill for \$17,850—for a urine test.
- > Tests and scans performed in an emergency department (ED) can be hundreds of times more expensive than if they were performed outside of the hospital. An abdominal CT scan cost one patient \$8,897 in the ED, but \$268 for the same scan using the same machine at a nearby imaging center.
- > About 45% of nonprofit hospitals routinely send bills (and bill collectors) to patients who have income low enough to qualify for charity care.

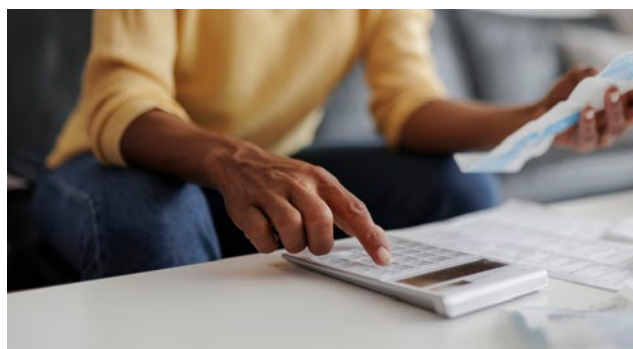
Source: "Hospitals and Insurers Didn't Want you to see these Prices. Here's Why." (The New York Times, August 22, 2021)

- ▶ **Consumers are feeling the brunt** of cost increases.
- ▶ **The era of cost-shifting** has run its course.
- ▶ **Employers as fiduciaries** are demanding a seat at the table to understand how plan assets are being spent.
- ▶ **There is a need** for more responsible stewardship and accountability by hospitals and health systems.

Hospitals can truly contribute to the health of their communities by realigning interests and delivering fair and equitable care. The updated “myths and facts” in this guidebook complement an [earlier version](#) developed by the [National Alliance](#).

Families are Stretched Thin and Falling Behind

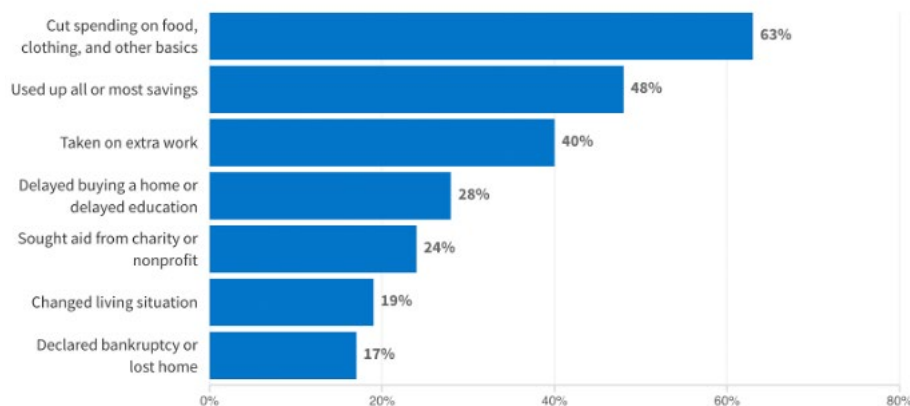
Working families worry about their ability to afford healthcare costs, with 100 million or more already drowning in medical debt. In fact, a recent survey found that an overwhelming 91% of Americans worry about increases in the amount individuals pay for healthcare. Not surprisingly, [health equity challenges](#) are also exacerbated by unrestrained increases, with Black adults 50% more likely and Hispanic adults 35% more likely than Whites to carry medical debt.



The average annual premium for employer-sponsored coverage was \$7,911 for an individual policy in 2022 and \$22,463 for a family plan. According to the [Kaiser Family Foundation](#), premiums for family coverage increased a whopping 20% over the past five years, and 43% over the past 10 years, due in large part to skyrocketing hospital prices.

What people sacrificed to pay medical debt.

Share of indebted adults who have done the following because of health care debt:



Source: [KFF Health Care Debt Survey](#) of 2,375 U.S. adults, including 1,674 with current or past debt from medical or dental bills, conducted Feb. 25 through March 20. The margin of sampling error for the overall sample is 3 percentage points.

Credit: Daniel Wood/NPR and Noam N. Levey/KHN.



Medical bills are reportedly the number-one cause of US bankruptcies, accounting for over 61% of bankruptcy filings.

High Costs Crowd Out Wages and Harm Employer Competitiveness

High and rising healthcare costs don't just impact America's families—they take an enormous toll on the employers and other plan sponsors that provide healthcare coverage. The ripple effect across the economy includes lower wages as employers allocate more of their total compensation toward healthcare; reduced business innovation and productivity as employers have less money to spend on research development and updates; and reduced competitiveness in the global market.

Hospital Prices are the Leading Driver of Higher Healthcare Costs

There are many reasons US healthcare costs are so high, including a relatively unregulated pharmaceutical market to high rates of chronic conditions. But the primary reason is clear and unambiguous: **Hospital prices make up about half the bill of employer healthcare costs—by far the largest cost of any sector—and have consistently been the fastest growing.**

Beware the Burgeoning Revenue Cycle Management Industry

[Healthcare revenue cycle management](#) (RCM) is the financial process facilities use to manage the administrative and clinical functions associated with claims processing, payment, and revenue generation. The process consists of identifying, managing and collecting patient service revenue.

RCM is a [massive and growing industry](#) and, “despite rhetoric to the contrary, optimizing revenue is the organizing principle for healthcare companies across all segments, says David Johnson. “It’s not mission or value or customer service or wellbeing. Where and whenever possible, incumbents exploit complex payment formularies negotiated or arranged among payers, providers and manufacturers to maximize profits.”

RCM runs contrary to the goal of ensuring every American receives appropriate and cost-effective care.

Excerpted from David Johnson's blog, "[Rewiring Healthcare's Smartest Professionals \(Hint: It's not Physicians\)](#)"

“It’s hard to imagine that the devil itself could create a more inhumane, ineffective, costly, and change-resistant system. Hospitals consume more and more societal resources to maintain an inadequate status quo. They’re a major part of America’s healthcare problem, certainly not its solution. Even so, hospitals have largely avoided scrutiny and the public’s wrath. Until now.”

— David W. Johnson, CEO, 4sight Health
From his blog: "[In American Hospitals: Healing a Broken System, Pride Comes Before the Fall](#)"

Of particular concern is the growing body of evidence demonstrating that employers and other plan sponsors in the commercial market pay between 150%–700% of Medicare for hospital services—with the national average roughly 250% of Medicare. These hugely inflated prices are borne by America’s businesses and passed on to employees and their families through higher insurance premiums, increased deductibles, and lower wages.

High and rising hospital prices are largely the result of industry consolidation and the use of anti-competitive contracting practices to gain market power. Large health systems and payers use their size to force purchasers to agree to anti-competitive clauses in contracts, making it harder for people to get access to high-quality, affordable health care. The lack of transparency in the healthcare system generally allows anti-competitive behavior to proliferate unchecked.



Hospital-associated costs form the largest healthcare expenditure for employers and their families.



SETTING THE RECORD STRAIGHT

MYTH 1:

Hospital prices are based on the cost of providing care to patients and the ability to invest in improvements in quality and infrastructure.

FACT 1:

There is no correlation between hospital prices and the actual cost of providing that care. It is not clear that what is being charged or investing in “improvements” has anything to do with providing care for patients, since there has been no demonstrated improvement in quality or care. Instead, it appears that vertical integration is being used to raise prices to what the market will bear without any cost accounting—and for profit maximization. Hospitals are not transparent about investments, surplus, staffing, overhead costs, acquiring practices, or how they are spending the money or setting prices.

MYTH 2:

Medicaid reimburses hospitals well below the cost of care.

FACT 2:

While base Medicaid payment rates are often—though not always—below the cost of care, hospitals receive significant supplemental payments through various streams, including [Medicaid Disproportionate Share \(DSH\) payments](#), [Upper Payment Limit Supplemental Payments](#), [uncompensated care pools \(UCPs\)](#), [Medicaid Graduate Medical Education \(GME\)](#), and other sources. When all Medicaid payments are accounted for, reimbursements match Medicare payments.

Taking these streams into account, the Medicaid and the Children’s Health Insurance Program (CHIP) Payment and Access Commission ([MACPAC](#)) has found that Medicaid hospital payments are comparable to Medicare—a rate that [MedPAC](#) has consistently found is sufficient to cover hospitals’ costs on average. Even where such payment falls short of the cost of care, this shortfall is nowhere near able to justify the extraordinary overcharges on commercial rates.

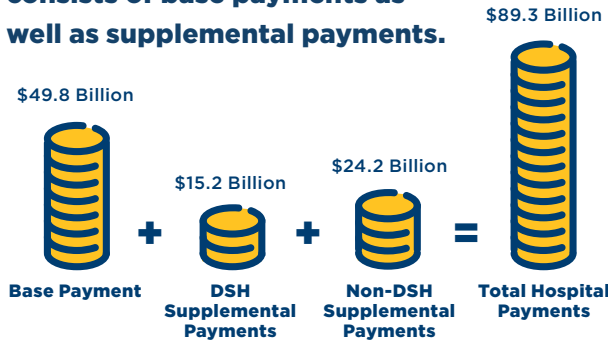
“Hospital market structure is strongly associated with price levels and contract structure. Prices at monopoly hospitals are 12% higher than those in markets with four or more rivals. Monopoly hospitals also have contracts that load more risk on insurers.”

Source: National Library of Medicine, [The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured](#)

“Like other public payers, Medicaid payments have historically been (on average) below costs, resulting in payment shortfalls. However, hospital payment rates are often bolstered by additional supplemental payments in the form of Disproportionate Share Hospital Payments (DSH) and other supplemental payments.”

Source: KFF, [Understanding Medicaid Hospital Payments and the Impact of Recent Policy Changes](#)

Medicaid payment to hospitals consists of base payments as well as supplemental payments.



*Includes UPL, IGT, provider taxes and 1115 Waiver payments.
 Note: Based on fee-for-service payments only. Data is for 2014.
 Source: Medicaid and CHIP Payment and Access Commission. MACStats, Section 3, Exhibit 2. Medicaid Supplemental Payments to Hospital Providers by State, FY 2014, <https://www.macpac.gov/publication/medicaid-supplemental-payments-to-hospital-providers-by-state/>.



MYTH 3:

Hospitals are currently in an unsustainable workforce crisis that threatens their ability to care for patients.

FACT 3:

It's clear that wages need to be raised, particularly for nurses and other frontline workers, but the existing prices are still not justifiable even when considering the amount of raises currently being offered. Even with necessary wage adjustments, the gap between NASHP and RAND is unacceptable. The prices weren't justifiable before, and salary increases don't justify them now.

The “unsustainable workforce crisis” was brought on by a strategy of the hospitals to maximize profits. Employers are not responsible for paying for this mistake. [As an example](#), the percentage pay increases for nurses and staff was half that of administrative pay over the past decade.

“Some of the individual hospital CEOs covered in the study saw their salaries increase by more than 700% in just a few years, while doctors and nurses got a fraction of that salary increase, 15% to 20%, from 2010 to 2021.”

Source: Hospital Executive Compensation: A Decade of Growing Wage Inequity Across Nonprofit Hospitals

“The pay gap between hospital CEOs and nurses is expanding even faster than we thought. Some hospital CEOs quadrupled their salaries in a few years, while nurses’ pay largely remained stagnant.”

Source: A Decade of Growing Wage Inequity Across Nonprofit Hospitals

Raises for Executives, Not Workers.

11 HOSPITAL CEOs



EQUAL TO 572 REGISTERED NURSES



North Carolina's nine largest non-profit hospital systems paid 11 current or former CEOs a total of \$38.7 million in 2019—enough to pay 572 registered nurses, who made an average of \$67,730 in North Carolina hospitals in 2019.

\$187M

Nine hospitals' 2019 executive pay equals...

858

family medicine physicians.

7,207

home health aides.

9,072

families' average health insurance premiums.

As reported on page 5 of "Hospital Executive Compensation: A Decade of Growing Wage Inequity Across Nonprofit Hospitals"

MYTH 4:

Hospitals use facility fees to help operate outpatient clinics that expand access to care and increase care coordination, particularly in underserved neighborhoods and other areas that may not be able to sustain a full hospital.

FACT 4:

Hospitals have used facility fees to systematically raise prices and create an ROI on vertical integration that has otherwise not provided value.

Hospitals have the ability to purchase independent private practice clinics and charge substantially higher amounts—often double—without making [any meaningful change](#) in the scope or quality of care provided at the same clinic.

These acquisitions then increase the market leverage of hospitals systems, allowing them to increase prices on all lines of service.

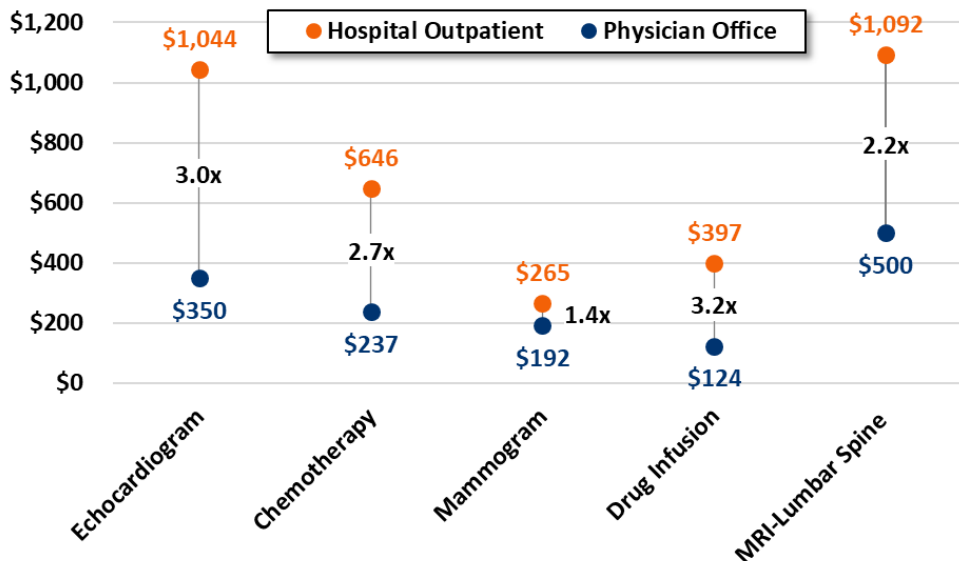
“Average hospital outpatient department prices for common imaging, colonoscopy and laboratory services can be double the price for identical services provided in a physician’s office or other community-based setting.”

Source: National Institute for Health Care Reform, Location, Location, Location: Hospital Outpatient Prices Much Higher than Community Settings for Identical Services and OneLive, Hospital Outpatient Care 60% Higher, Leads to More Emergency Visits

“Concern is growing that hospital outpatient facility fees are adding to consumers’ and employers’ health care costs—both through higher out-of-pocket charges and rising insurance premiums.”

Source: Georgetown University, Regulating Outpatient Facility Fees: States are Leading the Way to Protect Consumers

Examples of Median Price Differentials Based on Site-of-Service



Source: [Health Savers Initiative](#) analysis of large- and small-group commercial claims data from 2019. CPTs: Echocardiogram-Transthoracic; Chemotherapy Infusion-1 hr.; Mammogram-Bilateral Screening; IV Infusion-Single or First Drug; MRI-Lumbar Spine w/o Contrast.

MYTH 5:

Mergers help keep hospitals open—particularly hospitals that are financially challenged. This is especially evident in rural communities that are faced with low patient volumes and a heavy reliance on Medicare and Medicaid programs that reimburse below the cost of care.

FACT 5:

Decades of research overwhelmingly show that consolidation increases prices 10%–20%. While operating expenses may decrease, profits increase through ever-increasing prices. This is a revenue maximization strategy.

Mergers have not improved quality and access, but they have systemically increased prices and forces and need to be regulated.

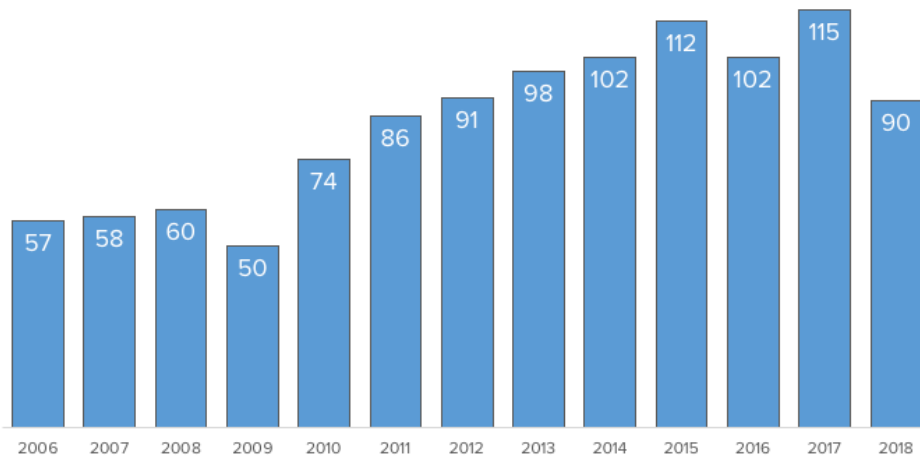
If the goal is to save rural hospitals by raising prices, it's not working or benefiting communities.

“As hospital consolidations swept the country over the last three decades, their executives predicted the moves would produce lower costs. But decades of health services research focused on the actual results of this trend have found the opposite. Consolidation has consistently produced higher care prices. Nevertheless in 2023, health care merger mania not only continues, but is expanding in increasingly complicated and more costly ways.”

Source: Penn Leonard Davis Institute of Health Economics, “Hospital Consolidation Continues to Boost Costs, Narrow Access, and Impact Care Quality”

Significant Consolidation Activity in Hospital Sector in Recent Years

Announced Hospital Consolidations



For full side deck and all references see <https://www.nihcm.org/categories/hospital-consolidation-trends-impacts-outlook>

MYTH 6:

Hospitals are not able to dominate contract negotiations. For example, in Texas three private insurance companies control 84% of the market, resulting in significant advantages in negotiations.

FACT 6:

The evidence is in: **Larger hospital systems are able to extract higher-than-market prices with health plans.**

Hospitals are the largest asset for health plans, so there is no incentive to force lower prices. The more money spent on hospital care, the more the health plans make. Public arguments between hospitals and health plans commonly focus on who gets to keep more of the profit.

While hospitals need to be held accountable for using consolidation to extract ever higher prices, employers and other plan sponsors have a key role in ensuring that their contracted insurers are negotiating aggressively for lower prices.

MYTH 7:

Hospitals are not overcharging payers, and in fact provide tremendous amounts of uncompensated care and discounted care.

FACT 7:

NASHP's Hospital Cost Tool demonstrates that hospitals are, in fact, overcharging purchasers and consumers and making record profits.

The amount of uncompensated care is minimal, discounted care is a misnomer, and charge master pricing is unintelligible. The time for talking about “discounts” is over. It's time to focus on cost plus margin.

Hospitals are charging what they charge because they can.



Hospitals that have implemented lean practices demonstrate that high-quality care costs less to produce than low-quality care. True value includes cost and quality considerations.

“Many hospitals are able to sustain profits and high prices because of their market power, which has grown as competition has dwindled and providers have consolidated through mergers and acquisitions.

“While the high expenditures in some regions of the country are at least partly explained by local input costs, utilization, or medical practice style, price variation is responsible for most of the geographic variation in expenditures among people with private insurance.”

Source: CAP, [The High Price of Hospital Care](#)

MYTH 8:

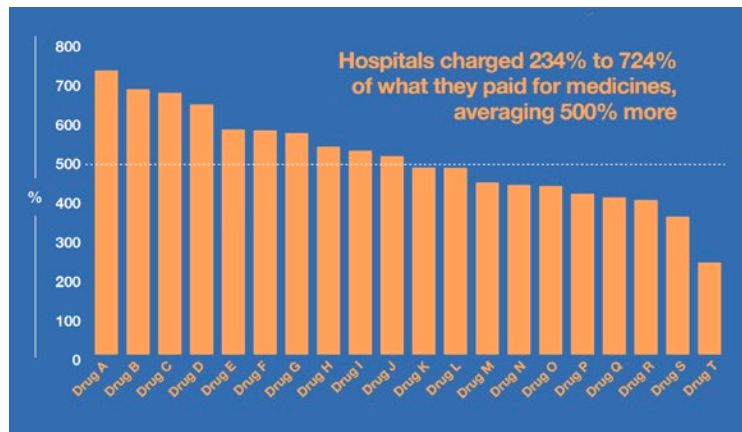
Hospitals do not inflate the cost of life-saving drugs. The cost of new and existing drugs has skyrocketed and hospital expenses for drugs have risen in kind.

FACT 8:

Evidence is clear and growing. Hospitals vastly mark-up the price of life-saving drugs. A [recent study](#) found that average hospital price mark-ups for cancer drugs ranged between 118%–633% of the hospital acquisition cost.

Further, hospitals have exploited the [340B Drug Pricing Program](#) and are making record profits off hospital-administered drugs, often charging employers [600%](#) of the acquisition cost. Some are marked up by more than [11 times](#) acquisition cost. Outsize 340B profits are a leading driver of hospital vertical integration as newly acquired clinics can price arbitrage on 340B drugs.

Alternative sites of care such as non-hospital outpatient infusion, physician office, and home infusion services are well accepted, high-quality alternatives that cost significantly less than hospital-administered infusion services.



Source: [PhRMA, August 2, 2023](#)

“When it comes to negotiating for fair healthcare prices, no single employer has the market power to effect change. Uniting for impact and setting shared expectations, though, will help make healthcare more competitive and create downward pressure on prices.”

*— Chris Skisak, PhD
Executive Director, Houston Business Coalition on Health*

MYTH 9:

Rural hospitals are at serious risk of closure as they continue to face skyrocketing expenses and depleted resources.

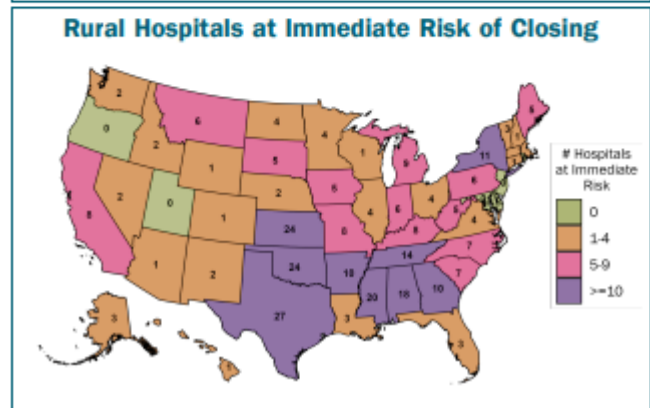
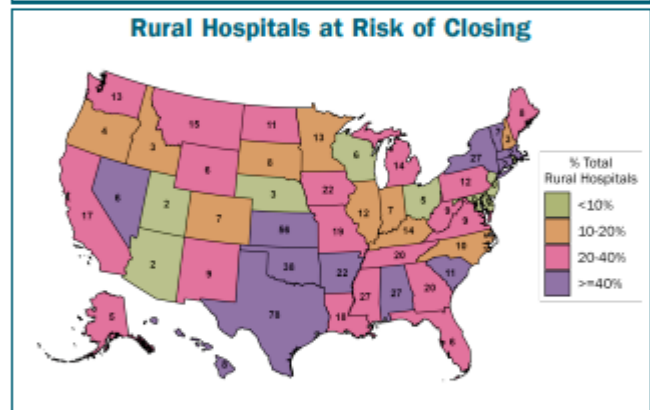
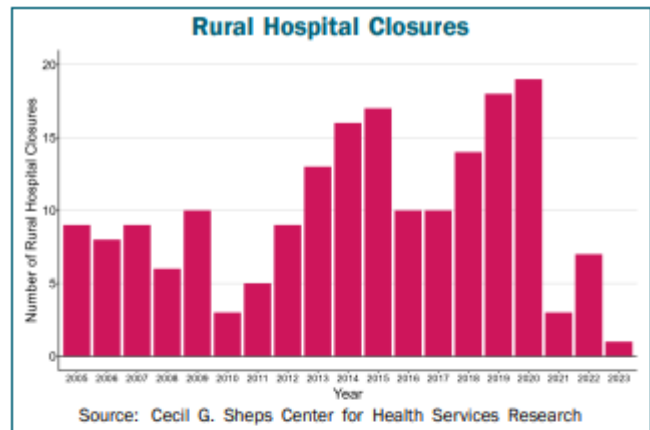
FACT 9:

Many rural hospital closings are the direct result of urban hospital consolidation. Rural hospitals and the communities they serve need help that can and should be provided by their urban counterparts.

The waves of consolidation we've seen in the hospital industry have [conspicuously left off rural hospitals](#). Profit motivation precludes larger hospitals from investing in rural. Health reform should consider the plight of rural hospitals but we should not let that plight disguise the broader trends toward exorbitant and unjustifiable pricing by abusive hospitals.

“The US healthcare system puts small, locally controlled hospitals at a disadvantage. Revenue is based almost entirely on the volume of medical services a hospital provides and, by their very nature, hospitals serving rural or otherwise remote communities do not see as many patients. That has put many of them in poor financial condition. Over the last 10 years, more than 130 rural hospitals have closed; hundreds more are projected to be in danger of closing soon.”

Source: VOX, [Community Hospitals are Facing an Impossible Dilemma: Should they be Taken Over by a Bigger System or Close Entirely?](#)



Source: https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2018/08/Rural-Hospital-Mergers.pdf

MYTH 10:

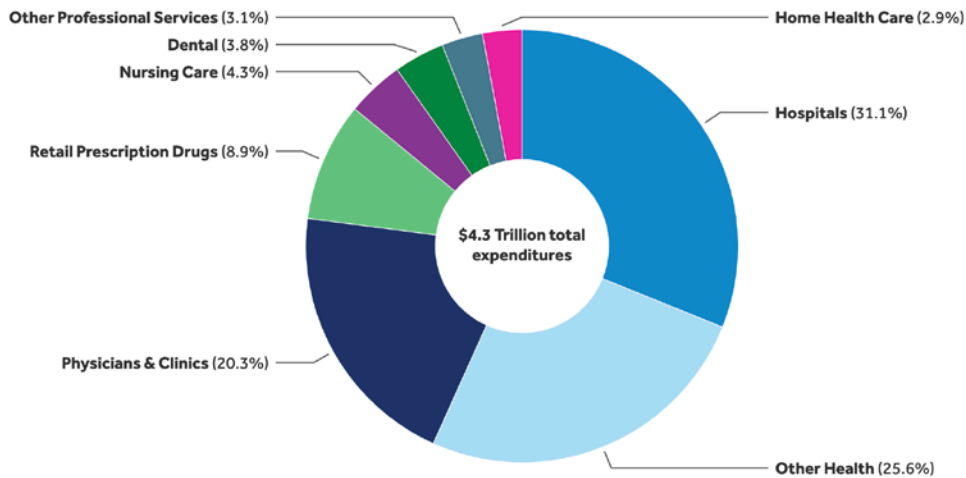
Hospitals employ thousands of workers, helping keep many communities afloat. Pressure to lower prices results in staff downsizing, job burnout, compromised care, and hospital closings.

FACT 10:

Getting to fair price by eliminating opacity and addressing the issues outlined in this document not only will ultimately preserve hospital jobs, but will boost pay and healthcare benefits for **all** American workers. Failure to achieve hospital fair price is traumatic and utterly unaffordable for Americans and the organizations that employ them.

Hospital and physician services represent half of total health spending

Relative contributions to total national health expenditures, by service type, 2021



Note: 'Other Health' includes spending on durable and non-durable products; residential and personal care; administration; net health insurance; and other state, private, and federal expenditures. 'Other professional services' includes spending for services provided by chiropractors, optometrists, physical, occupational, and speech therapists, podiatrists, private-duty nurses, and others. Nursing care represents expenditures for nursing care facilities and continuing care retirement communities.

Source: [KFF analysis of National Health Expenditure \(NHE\) data](#)

Peterson-KFF
Health System Tracker



RESOURCES

1. [Hospital Fair Price Playbook](#)
2. [Myths and Facts: Revealing Hospital Price Transparency Truths](#)
3. [Sage Transparency \(Employer Hospital Price Transparency Project\)](#)
4. [NASHP interactive hospital cost tool](#)
5. [Facility Fees 101: What is all the Fuss About?](#) (*HealthAffairs*, August 4, 2023)
6. [Hospitals Mark up Medicine Prices 500%](#) (*PhRMA*, August 2, 2023)
7. [Your Exorbitant Medical Bill, Brought to you by the Latest Hospital Merger](#) (*The New York Times*, July 23, 2023)
8. [How Has U.S. Spending on Healthcare Changed Over Time?](#) (*Peterson-KFF Health System Tracker*, February 7, 2023)
9. [Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills](#) (*KFF*, June 16, 2022)
10. [100 Million People in America are Saddled with Health Care Debt](#) (*KFF Health News*, June 16, 2022)
11. [The Public's Health Priorities for the New Congress](#) (*KFF Health Tracking Poll*, December 2022)
12. [Hospitals and Insurers Didn't Want you to See These Prices. Here's Why.](#) (*The New York Times*, August 22, 2021)

National Alliance of Healthcare Purchaser Coalitions
1015 18th Street, NW, Suite 705
Washington, DC 20036
(202) 775-9300 (phone)
(202) 775-1569 (fax)



The National Alliance of Healthcare Purchaser Coalitions (National Alliance) is the only nonprofit, purchaser-aligned organization with a national and regional structure dedicated to driving health and healthcare value across the country. Its members represent private and public sector, nonprofit, and union and Taft-Hartley organizations, and more than 45 million Americans, spending over \$400 billion annually on healthcare. To learn more, visit nationalalliancehealth.org and connect on [Twitter](#) and [LinkedIn](#).

9/19/23