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THE LATEST MIGRAINES IN LIFE CARE PLANNING – DOES YOUR HEAD HURT NOW TOO?

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WHY ARE HEALTHCARE CHARGES SO MUCH HIGHER THAN REASONABLE VALUE?

The Real Reasons May Surprise You

In most U.S. industries, "list prices" serve as a sufficient measure of "market value," a concept which encompasses terms such as fair market value, reasonable value, and relative market value.[i] According to economic theory, prices convey most of the information consumers need to make a purchase and to assign a value to a product or service. However, in the health industry there is widespread agreement among industry experts and health economists that prices (which are often referred to as "charges" or "fees" in the U.S. medical and health industry) are in many cases *not* reflective of value.[ii] Indeed, there is a long tradition in the U.S. medical care industry of health care providers submitting bills and charges for services rendered and accepting much less than those amounts in full satisfaction of the charges for the services rendered.[iii]

There are three reasons for this persistent disconnect between list prices and transaction prices. First, as the U.S. health care system grew rapidly in the 1950s and 1960s, the industry was largely organized as non-profit.[iv] As the industry expanded, policymakers put more pressure on non-profit entities to show that they were providing sufficient levels of "charity" care (or alternatively carrying sufficient levels of "bad debt") to justify their tax-exempt status; that is, charity care and bad debt were considered forms of "community benefit."[v] One way for hospitals and other health care entities to report sufficient levels of charity care was to maintain comparatively high prices, negotiate *lower* rates on a per case basis, and classify the difference as either charity care or bad debt .[vi] Although the industry today contains a mix of non-profit and for-profit entities,[vii] such pricing behavior has largely continued.[viii]

Second, healthcare providers generally find it more advantageous to bargain and adjust rates from an arbitrarily high chargemaster (i.e., "price list") rather than a price list more reflective of fair market value.[ix] This behavior is not particularly unusual in the U.S. economy. In addition to healthcare, there are numerous industries in which transaction prices are routinely lower than listed prices. Some examples include automobiles, commercial and residential real estate, mortgages, sales commissions, private schooling, telecommunications, and energy.[x]

Third, healthcare providers typically have unusually high "fixed costs," which means that in order to treat one patient, providers must have significant assets in place and available for use. The implication is that the "average costs" and "marginal costs" of treating a single patient are relatively low; that is, the operating costs associated with one more surgery on a given day or one more patient seen on a given day would be relatively low, but the list prices would remain the same. Consequently, this significant gap between operating costs and prices means that providers can accept amounts considerably less than charged amounts in full satisfaction of the original charges and still earn a "normal" rate of return. In this regard, health care providers routinely practice what is called "price discrimination," whereby they are routinely able to charge different prices for the same services and accept amounts considerably less than their list prices in full satisfaction of those charges.[xi]

This widespread practice of setting medical prices arbitrarily high suggests that health and medical prices have at best only a loose relationship with fair market value. This is reflected in part by the exceedingly high rate of variation in prices for the exact same medical procedures.[xii] This variation is driven by the "disconnect" between charges, costs, and fair market value. A report from the Health Care Cost Institute reached similar findings, observing that there was "up to a 39-fold price difference for the exact same service, even after removing the top

and bottom 10% of prices to exclude outlier effects."[xiii] These variations in prices also lead to extremely high levels of variation in hospital mark-ups, irrespective of the fair and reasonable value of the services rendered.[xiv] That said, there are ways of using industry data, including charge data, to calculate fair market value.

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[i] A. Mas-Colell, M. Whinston, and J. Green, *Microeconomic Theory* (Oxford, UK: Oxford University Press, 1995).

[ii] See, for example, V. Arora, C. Moriates, and N. Shah, "The Challenge of Understanding Health Care Costs and Charges," *AMA J Ethics* 17, no. 11 (2015). Also see M.A. Morrisey, *Cost Shifting in Health Care: Separating Evidence from Rhetoric* (Washington, D.C.: The AEI Press, 1994).

[iii] See generally S.A. Finkler, *Issues in Cost Accounting for Health Care Organizations* (Gaithersburg, MD: Aspen Publishers, Inc., 1994); U.S. House of Representatives, "Pricing Practices of Hospitals," (Washington, D.C.: U.S. House of Representatives, Committee on Ways and Means, Subcommittee on Oversight, 108th Congress, 2005); Morrisey, *Cost Shifting in Health Care: Separating Evidence from Rhetoric*.

[iv] See generally D. M. Fox, "Policy commercializing nonprofits in health: the history of a paradox from the 19th century to the ACA," *Milbank Q* 93, no. 1 (2015).

[v] See generally ibid.; D.B. Rubin, S.R. Singh, and G.J. Young, "Tax-Exempt Hospitals and Community Benefit: New Directions in Policy and Practice," *Annual Review of Public Health* 36, no. 1 (2015).

[vi] See generally A. Beck et al., "Strategic reporting by nonprofit hospitals: an examination of bad debt and charity care," *Review of Accounting Studies* 26, no. 3 (2021).

[vii] For hospitals, the split is roughly 75% non-profit and 25% for profit. See generally KFF, "Hospitals by Ownership Type," in *State Health Facts* (Washington, D.C.: Kaiser Family Foundation, 2022).

[viii] See generally Subcommittee on Oversight of the Committee on Ways and Means, U.S. House of Representatives, 108th Congress, Second Session, *Pricing Practices of Hospitals*, 2004.

[ix] See generally G. Bai and G. F. Anderson, "US Hospitals Are Still Using Chargemaster Markups To Maximize Revenues," *Health Aff (Millwood)* 35, no. 9 (2016).

[x] See, for example, D.P Byrne, L.A Martin, and J.S. Nah, "Price Discrimination by Negotiation: a Field Experiment in Retail Electricity*," *The Quarterly Journal of Economics* 137, no. 4 (2022).

[xi] See, for example, R.T. Masson and S. Wu, "Price Discrimination for Physicians' Services," *The Journal of Human Resources* 9, no. 1 (1974); R.E. Santerre and S.P. Neun, *Health Economics: Theories, Insights, and Industry Studies, Fourth Edition* (Mason, OH: Thomson South-Western, The Thomson Corporation, 2007).

[xii] See generally R. Y. Hsia, Y. Akosa Antwi, and E. Weber, "Analysis of variation in charges and prices paid for vaginal and caesarean section births: a cross-sectional study," *BMJ Open* 4, no. 1 (2014); D. A. Redelmeier et al., "Charges for medical care at different hospitals," *Arch Intern Med* 160, no. 10 (2000); W. P. Welch et al., "Geographic variation in expenditures for physicians' services in the United States," *N Engl J Med* 328, no. 9 (1993); K. Kennedy et al., "Past the Price Index: Exploring Actual Prices Paid for Specific Services by Metro Area," (Washington, D.C.: Health Care Cost Institute, 2019); M. Panhans, T. Rosenbaum, and N.E. Wilson, "Prices for Medical Services Vary Within Hospitals, but Vary More Across Them," *Medical Care Research and Review* 78, no. 2 (2021).

[xiii] Kennedy et al., "Past the Price Index: Exploring Actual Prices Paid for Specific Services by Metro Area."

[xiv] See generally G. Bai and G. F. Anderson, "Extreme Markup: The Fifty US Hospitals With The Highest Charge-To-Cost Ratios," *Health Aff (Millwood)* 34, no. 6 (2015).