MarketWatch

From ‘Soak The Rich’ To ‘Soak The Poor’: Recent Trends In Hospital Pricing

Three policy prescriptions to change hospitals’ practice of charging “self-pay” patients more than other payers.

by Gerard F. Anderson

ABSTRACT: In 2004, the rates charged to many uninsured and other “self-pay” patients for hospital services were often 2.5 times what most health insurers actually paid and more than three times the hospital’s Medicare-allowable costs. The gaps between rates charged to self-pay patients and those charged to other payers are much wider than they were in the mid-1980s, and they make it increasingly more difficult for some patients, especially the uninsured, to pay their hospital bills. This has triggered lawsuits and some recent government efforts involving price transparency. Three specific policy options that could lower the markups are a voluntary effort by hospitals, litigation, and legislation. [Health Affairs 26, no. 3 (2007): 780–789; 10.1377/hlthaff.26.3.780]

Fifty years ago the poor and uninsured were often charged the lowest prices for medical services. In a classic health economics article, Reuben Kessel explained in 1958 why it was rational for physicians to charge the wealthiest the most and to discount prices for the poor. It included a quote from a “highly respected surgeon” that, according to Kessel, “presents the position of the medical profession”:

I don't feel that I am robbing the rich because I charge them more when I know that they can well afford it; the sliding scale is just as democratic as the income tax. I operated today upon two people for the same surgical condition—one a widow whom I charged $50, the other a banker whom I charged $250. I let the widow set her own fee. I charged the banker an amount which he probably carries around in his wallet to entertain his business friends.

Almost fifty years later, uninsured and other “self-pay” patients are often presented with bills by hospitals, doctors, and other health professionals with charges that are 2.5 times what most public and private health insurers actually pay. This paper focuses on relative prices in the hospital industry because there are better cross-sectional and longitudinal data on hospitals, not because hospitals are any more likely than other providers to charge higher rates to the “uninsured” and other self-pay patients.

I begin by examining the rates that uninsured and self-pay patients were expected to pay for hospital services in 2004. Hospitals often present such patients with bills that reflect the hospital’s full charge, derived from the its chargemaster file, or a price list that it has established containing undiscounted prices for all of the services it provides. I then examine some of the factors that have caused the gaps between charges and costs and between

Gerard Anderson (ganderso@jhsph.edu) is a professor of health policy and management at the Johns Hopkins Bloomberg School of Public Health in Baltimore, Maryland.
charges and what most insurers actually pay to widen over the past twenty years. I conclude by examining three policy options that could lower the amounts that uninsured and other self-pay patients would be expected to pay.

Self-Pay Patients

In 2004, five categories of patients were routinely presented a bill based on the prices in the hospital’s chargemaster file: (1) the uninsured; (2) international visitors; (3) people insured by health plans lacking contracts with hospitals (most commonly health savings accounts, or HSAs); (4) people covered by automobile insurers; and (5) people covered by workers’ compensation plans. These patients are often categorized as “self-pay” because they or their insurer does not have a contract with the hospital. Of these five categories, the forty-five million uninsured Americans represent the preponderance of self-pay patients in most hospitals.4

Examining hospital pricing from the perspective of the self-pay patient is in contrast to most of the previous literature, which has explored the need for hospitals and other providers to shift costs, because some public and private insurers might not pay the full cost of care and because many uninsured patients do not pay their full hospital bills.5 In this literature, much less attention has been given to the perspective of uninsured and self-pay patients, who are expected to pay increasingly high charges.5

Viewing the cost-shifting debate from the perspective of the uninsured or self-pay patient partially explains some of the recent policy interest in hospital pricing. One objective is to improve price transparency so that the market can operate more effectively. Recently, the Centers for Medicare and Medicaid Services (CMS) published a list of the prices Medicare pays for thirty different procedures. State governments, state hospital associations, private insurers, and private vendors have also begun posting hospital prices. A second objective is to protect patients. More than sixty class-action lawsuits have been filed against hospitals concerning how much they charge the uninsured. Lawsuits also have been filed by other self-pay patients and some private insurers.7 The American Hospital Association (AHA) recently published guidelines concerning how much hospitals should charge low-income, uninsured people.8

Markups And Markdowns

Two commonly used ratios—the ratio of charges to costs and the ratio of gross to net revenues—illustrate the magnitude of the markup that uninsured and other self-pay patients are being asked to pay.9

- **Charge-to-cost ratios.** The ratio of charges to costs measures the relationship between actual hospital charges for services (what self-pay patients are generally asked to pay) and Medicare-allowable costs (what the CMS has determined to be the costs associated with care for all patients, not just Medicare patients).10 This ratio for all U.S. hospitals was 3.07 in 2004 (Exhibit 1).12 In other words, for every $100 in Medicare-allowable costs, the average hospital charged $307. Considerable variation appears in the ratio of charges to Medicare-allowable costs by hospital characteristics. Proprietary hospitals had the highest charge-to-cost ratio (4.10); public hospitals, the lowest (2.49); still, public hospitals’ charges were two and one-half times their Medicare-allowable costs. The markup of charges over costs was much greater in small urban hospitals (3.25) than in rural hospitals (2.42). Exhibit 2 shows the same ratios for the five states with the highest charge-to-cost ratios and the five states with the lowest.

- **Gross to net revenues.** If the hospital had actually collected these charges from every patient in 2004, the profit margin per hospital would average more than 200 percent. However, according to AHA data, U.S. hospi-
tals had a profit margin of only 5.2 percent in that year. Exhibits 1 and 2 also report the ratio of gross to net revenues. Gross revenues are similar to the sum of total hospital charges, although non-patient-care services and other activities might cause a difference between the two measures. Net revenues are the amount that the hospital actually collects from all payers, including self-pay patients.

In 2004, the overall ratio of gross to net revenues was 2.57, which means that for every $100 the hospital actually collected from all sources, it initially charged $257. Certain categories of hospitals have higher ratios of gross to net revenues than others. For example, hospitals in Alabama, California, Florida, New Jersey, Nevada, and Pennsylvania had gross-to-net ratios above 3.0; hospitals located in eighteen other states had ratios below 2.0. The inverse of the gross-to-net ratio (net-to-gross) is 0.39, which suggests that the typical hospital collected only thirty-nine cents of every dollar charged in 2004.

**Widening Gaps Since 1984**

In 1984, hospital charges averaged only 35 percent above costs, and gross charges were only 25 percent above net revenues (Exhibit 3). Since 1984, both ratios have widened steadily, and much of the divergence has accelerated since 2000. The charge-to-cost ratio increased from 1.35 in 1984 to 3.07 in 2004; the ratio of gross to net revenues increased from 1.25 in 1984 to 2.57 in 2004.
The gap widened because hospital charges increased much faster than costs during this time period, while net revenues have kept pace with costs. Hospital charges per admission rose an average of 10.7 percent per year between 1984 and 2004, while Medicare-allowable costs per admission rose only 6.3 percent per year. Also, the annual rate of increase in net revenues (6.6 percent per year) has mirrored the rate of increase in Medicare-allowable costs (6.3 percent per year), not the annual rate of increase in charges (10.7 percent per year) or gross revenues (10.8 percent per year). This suggests that payments to hospitals by most public and private insurers are rising at the same rate of increase as Medicare-allowable costs and not hospital charges. Net revenues—the amount that public and private insurers actually pay—increased an average of 6.6 percent per year during this period, compared with 6.3 percent for Medicare-allowable costs. In contrast, charges increased an average of 10.7 percent during this period.

### EXHIBIT 2
**Hospital Charge Markups And Amounts Actually Paid, Selected States, 2004**

<table>
<thead>
<tr>
<th>State</th>
<th>Total charges/total costs</th>
<th>Gross/net revenues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top 5 states in charge-to-cost ratio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NJ</td>
<td>4.56</td>
<td>3.94</td>
</tr>
<tr>
<td>PA</td>
<td>4.33</td>
<td>3.48</td>
</tr>
<tr>
<td>CA</td>
<td>4.04</td>
<td>3.59</td>
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<tr>
<td>AL</td>
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<td>3.29</td>
</tr>
<tr>
<td>NV</td>
<td>3.90</td>
<td>3.10</td>
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<td>Bottom 5 states in charge-to-cost ratio</td>
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<td></td>
</tr>
<tr>
<td>MT</td>
<td>1.93</td>
<td>1.58</td>
</tr>
<tr>
<td>ID</td>
<td>1.89</td>
<td>1.64</td>
</tr>
<tr>
<td>VT</td>
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<td>1.67</td>
</tr>
<tr>
<td>WY</td>
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<td>1.54</td>
</tr>
<tr>
<td>MD</td>
<td>1.42</td>
<td>1.23</td>
</tr>
</tbody>
</table>

**SOURCE:** Author’s analysis of Healthcare Cost Report Information System (HCRIS) computer files obtained from the Centers for Medicare and Medicaid Services (CMS) for 2004.

### EXHIBIT 3
**Increases In Ratio Of Hospitals’ Charges To Cost And Ratio Of Gross To Net Revenues, Selected Years 1984–2004**

<table>
<thead>
<tr>
<th>Ratio</th>
<th>1.00</th>
<th>1.50</th>
<th>2.00</th>
<th>2.50</th>
<th>3.00</th>
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<td>1988</td>
<td>1.00</td>
<td>1.50</td>
<td>2.00</td>
<td>2.50</td>
<td>3.00</td>
</tr>
<tr>
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<td>1.00</td>
<td>1.50</td>
<td>2.00</td>
<td>2.50</td>
<td>3.00</td>
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<tr>
<td>1996</td>
<td>1.00</td>
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<td>2.00</td>
<td>2.50</td>
<td>3.00</td>
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<tr>
<td>2000</td>
<td>1.00</td>
<td>1.50</td>
<td>2.00</td>
<td>2.50</td>
<td>3.00</td>
</tr>
<tr>
<td>2004</td>
<td>1.00</td>
<td>1.50</td>
<td>2.00</td>
<td>2.50</td>
<td>3.00</td>
</tr>
</tbody>
</table>

**SOURCE:** Author’s analysis of Healthcare Cost Report Information System (HCRIS) files obtained from the Centers for Medicare and Medicaid Services, selected years 1984–2004.
I performed two analyses to see if hospitals obtained greater net revenues when they increased charges. Comparing the charge-to-cost ratio to the ratio of gross to net revenues showed that hospitals with lower charge-to-cost ratios also had lower gross-to-net ratios. The simple correlation between the two ratios was 0.82. When I performed pooled cross-sectional regression to examine the relationship between increases in charges and net revenues over the period 1984–2004, I found that hospitals received only a very small proportion of the increase in charges above the rate of increase in costs. The exact relationship depends on the functional form and model used.

From this analysis I concluded that when hospitals increase their charges more than their Medicare-allowable costs increase, private insurers are able to negotiate greater discounts. Most public insurers set their rates independent of the hospital’s actual charges anyway, so increasing charges does not affect public insurance payments.¹⁷ When the hospital increases its charges, most of the increase is not paid for by insurers, as demonstrated by the continually increasing ratio of gross to net charges; only self-pay patients are expected to pay the higher charges. This leads to the question, Why have hospitals been increasing their charges much more rapidly than their costs since 1984?

**Hospitals Justify Their Higher Charges**

Hospital charges are determined by a chargemaster file and the services the patient receives. The hospital or hospital system has sole discretion in determining the prices on hospital’s chargemaster. The methodology that hospitals use to set charges was discussed in a recent Medicare Payment Advisory Commission (MedPAC) report, a Wall Street Journal article, and a Health Affairs paper by Uwe Reinhardt.¹⁸ All three suggest that hospitals lack a rigorous methodology to set charges. In a series of lawsuits by self-pay patients, hospitals have attempted to justify the higher-chargemaster file rates in six ways.⁹⁹

- **Patients’ responsibility.** One justification is that the self-pay patient should have attempted to negotiate a discount from the hospital in advance. There are, however, several problems with this argument. First, price negotiation is generally not feasible in emergencies or during an actual hospital stay.²⁰ Second, uninsured patients already have difficulty obtaining hospital care; trying to negotiate rate reductions simultaneously would exacerbate their access problems.²¹ However, the larger question becomes how much of a discount an uninsured person actually could have obtained if he or she had negotiated. Clearly, this varies from hospital to hospital and case by case. However, there are some general guidelines. Most auto insurers, workers’ compensation plans, and high-deductible health plans can obtain only a 10 percent discount from full billed charges.²² Some hospitals give larger discounts to uninsured patients who request them—often as much as 30 percent.²³ However, the patient must know to ask in advance and be declared eligible by the hospital; also, a 30 percent discount from charges is still much less than what most insurers actually receive (Exhibits 1 and 2).

- **Role of charity-care policies.** A second justification is that many uninsured patients do not actually pay their bills, and the hospital has a charity-care policy that reduces or eliminates obligations if the patient has an income below a certain threshold. In fact, most hospitals have such a policy, and the collection rate from uninsured patients averages only 10 percent. However, there are a number of problems with this response. First, hospitals no longer have a Hill-Burton obligation that requires them to publicize the fact that they offer free care. A review of the Web sites of many hospitals suggests that they do not publicize their free-care policies. Second, many hospitals calculate the value of their free care at full charges, dramatically inflating the value of their charity care, and still many hospitals are having difficulty meeting the charity-care obligations that are required under some state laws.²⁴ Finally, many uninsured patients are subject to aggressive collection attempts by hospitals and collection agencies; as a result,
medical care costs are a major reason why people declare personal bankruptcy.25

- Solvency. A third response from hospitals is that they need the money to remain solvent. Many hospitals justify “cost shifting” because they are being “squeezed” by Medicare, Medicaid, managed care plans, and other insurers that are dictating or negotiating prices they consider to be below their actual costs. There are two problems with this argument. First, the need to earn a profit is not a justification for charging uninsured and self-pay patients more than twice what most public and private insurers are actually paying. Second, the medical care costs of treating an uninsured patient are nearly identical to those of treating an insured patient. The difference in the cost of treating insured and uninsured patients occurs primarily in the processes of billing and collections. These departments represent only a small proportion of hospital spending.

- Negotiating strategy. A fourth justification made by some hospitals is that high charges are a good negotiating strategy with managed care plans. If a plan does not have a contract with the hospital, then it is expected to pay full charges. The higher the charges, the greater the incentive to sign a contract with a hospital.

- Medicare outlier payments. A fifth justification is that in the past, some hospitals increased their charges to obtain higher outlier payments in Medicare—payments based on the hospital’s own charges.26 Both the negotiation strategy and the attempt to get additional outlier payments ignore the fact that uninsured and other self-pay patients are actually expected to pay these higher charges.

- Geographic competitors. A sixth argument is that other hospitals in the same geographic area are charging similar rates. One problem with this argument is that chargemaster rates are never published by most hospitals, and the chargemaster file is generally not accessible to the public. As a result, it is impossible for patients to do any real comparison shopping. Also, very few insurers actually pay based on full charges, so the prices are not based on what is actually paid.

### Options For Obtaining Lower Rates For Self-Pay Patients

Assuming the argument that uninsured and other self-pay patients should pay reasonable rates is accepted, then the relevant questions become as follows: (1) What is the reasonable rate for uninsured and other self-pay patients to pay, (2) should the rate that other patients are expected to pay vary by income, and (3) who should determine the reasonable rate? These issues are being litigated in court and being actively discussed by state and federal policymakers.27

There are a number of ways to lower the rates charged to uninsured and self-pay patients. The most obvious is to provide health insurance to the forty-six million uninsured Americans. They would then pay negotiated rates, and the cost-shifting argument would lose most of its relevance. A second option is to have all payers pay a single rate. Countries such as Germany and Japan hold annual negotiations to set hospital rates. Insurer and hospital representatives sit on opposite sides of the table, with the government acting as the referee. However, current antitrust laws prohibit this from occurring in the United States. Alternatively, the government could set the rates. In Maryland, hospital charges are set by the Health Services Cost Review Commission, a state regulatory body.28 All payers in Maryland (including self-pay patients) pay nearly identical rates to hospitals. Different hospitals in Maryland have different rates based on their case-mix, labor costs, and other factors, but rates do not vary by payer. Hospitals in Maryland have the lowest charge-to-cost ratios and the lowest ratios of gross to net revenues (Exhibit 2).
Price Transparency

Price transparency has been suggested as one way to allow patients to comparison shop. Hospitals (except those in California) are not required to publish their rates.29 President Bush and Secretary of Health and Human Services (HHS) Michael Leavitt have made price transparency one of the administration’s health priorities. There have been congressional hearings on this issue, and legislation has been drafted.30 Adopting the objective of price transparency, some entities have already begun making hospital pricing data available over the Internet.31 However, most of these sources do not post chargemaster information; instead, they aggregate the data at the diagnosis-related group (DRG) level. However, since self-pay patients are billed based on the prices in the chargemaster file, the value of this information is questionable.

Several problems will need to be resolved if price transparency is to reduce prices to uninsured and other self-pay patients. First, it is not sufficient to simply compare the prices of only twenty-five items on the chargemaster, as California is doing, since hospitals can lower prices for just those twenty-five items. Second, although a typical hospital bill contains ten to fifty items, the chargemaster contains an average of 25,000 items. As a result, any given patient will use only a small percentage of the items on the chargemaster. Without knowing what services they will use in advance, it is impossible for patients to comparison shop.

Third, most of the items on the chargemaster are written in code, so that only hospital administrators and a few experts in the field can interpret them. I recently examined a hospital bill for a person who was charged more than $30,000 for an outpatient procedure.32 Many of the services on the bill were written in a language that only a coding expert could understand. One of the items was a “Bairhugger upper body cov,” with a charge of $77.55. The same hospital bill contained the following additional items and associated charges: Versed 1 MG/ML 2CC VIA—$11.37; Lactated Ringers 2B2324—$189.00; Valve IV—$715; Pack Custom Cysto—$58.00; Set Tur—$35.35. How would a patient know if these were reasonable charges for these items?

Fourth, hospitals are allowed to change their prices at any time.33 If patients are going to engage in comparative shopping, then hospital prices must remain constant during the hospital stay. Finally, posting prices is unlikely to improve an uninsured person’s bargaining position because uninsured people are still unlikely to be able to negotiate discounts with hospitals even if they know the prices of nearby hospitals.

Instead of requiring hospitals to post chargemaster rates, another approach to promote price transparency is to allow hospitals to charge a certain percentage above the Medicare rate. Hospitals could advertise that their charges are 110 percent or 130 percent of the Medicare rate. This would simplify price transparency because patients would have to compare only one price. The implementation cost would be minimal, as all hospitals already know their Medicare rates. It would, however, require hospitals to set rates for uninsured and self-pay patients on the basis of DRGs.34

Setting Maximum Rates For All Payers

Another option would be to establish a maximum rate that can be charged to all payers. Three possible ways to set the maximum rate are (1) to have the hospital voluntarily set the maximum rate; (2) to have the rate determined by the courts; or (3) to have the rate determined legislatively.

■ Voluntary efforts by hospitals. Until recently, many lawyers advised their hospital clients that the hospital could not discount charges to self-pay patients because giving such discounts would violate Medicare rules. This was clarified by the HHS Office of Inspector General in 2004, and now hospitals understand that they can provide discounts without violating Medicare rules.35 On 29 April 2006 the AHA board of trustees approved a set of policies to lower the rates for poor, uninsured people.36 The nonbinding principles state that uninsured patients with incomes below 100 percent of the federal pov-
Property level should receive care at “no charge.” Patients with incomes of 100–200 percent of poverty should be asked to pay no more than the price paid to the hospital under contract by a public or private insurer, or 125 percent of the Medicare rate for applicable services. With patients at incomes above 200 percent of poverty, hospitals have discretion to set their rates under the AHA guidelines.

Because the AHA principles were published so recently and are not binding on hospitals, it is unclear whether or not they will be adopted by all hospitals. Not all previous voluntary efforts by the hospital industry have proved successful. Many court cases are still ongoing, and it appears that some hospitals continue to be unwilling to lower their rates to the uninsured in spite of the AHA guidelines.

Litigation. This issue is being litigated in many federal and state courts. One of the first cases was Peggy Smallwood vs. HCA. In this case, class certification was not granted, so the case did not proceed. It turns out that the major legal hurdle for the uninsured to overcome is obtaining class certification. Because an uninsured person probably does not have sufficient resources to contest the hospital’s rates alone, class-action lawyers acting on behalf of all of the uninsured must prove that there is a class and that the class has certain characteristics in common. Class certification on behalf of the uninsured was attempted in federal court by a team of class-action lawyers led by Richard Scruggs, the attorney known for successfully suing the tobacco companies. His initial attempt to obtain class certification was not granted by the courts. Recently, however, several courts have granted class certification; when it is granted, hospitals commonly settle. Often, the settlements give discounts to the uninsured with incomes at a higher federal poverty level than the AHA guidelines—sometimes as high as 400 percent of poverty. Some of the settlements also include an asset test.

Some of these options have been the basis of court settlements. One way is to establish a rate that is slightly above what the health plan with the highest rate is paying or by establishing a percentage discount from charges that is equivalent to what the average private health plan receives. Another approach is to set a maximum that hospitals can charge any patient based on what Medicare pays. In 2004 I testified to Congress that the maximum that a hospital could charge should be the Medicare price plus 25 percent, based on four principles. First, the payment rate should not interfere with the marketplace. Second, the payment rate should be above what most managed care plans and private insurers are paying hospitals. Third, the method for determining payment rates should be transparent to the patient. Fourth, the system should be easy for the hospital to administer. The testimony explains how the 25 percent was derived. The AHA subsequently used this approach as one of its measures of appropriate payment for the uninsured.

Legislative remedy. Third, the states or Congress could legislate a maximum amount that hospitals can charge. This might be an option if hospitals do not follow the voluntary guidelines and the court proceedings become too onerous. In this instance, the hospitals might actually prefer legislation because it clarifies their obligations.

Concluding Comments

I have proposed three main policy prescriptions for ensuring that uninsured and self-pay patients do not continue to be charged rates that are two and a half times those charged to other payers: voluntary rate setting by hospitals, litigation, and legislation. It is unclear exactly how the lower rates would affect hospital revenues, collections, personal bankruptcies, or access to care. The financial impact would vary from hospital to hospital and patient to patient. Hospitals collect approximately 10 percent of their charges from the uninsured; however, they collect a much higher percentage from other categories of self-pay patients and from people with certain types of insurance. The impact on hospital revenues would vary by hospital and would depend on the mix of uninsured and self-pay patients and on the level at which rates are set. Collections would most likely increase, and personal bankrupt-
cies would probably decline since it would be easier for an uninsured person to pay an amount that is two-thirds lower than the rate being charged now. It is unlikely to have much impact on access, since most hospitals do not expect the uninsured to pay the charges and the other self-pay patients will still be paying relatively high rates.

The author has participated in numerous lawsuits on behalf of the uninsured and other self-pay patients. The Henry J. Kaiser Family Foundation supported the writing of this paper but was not involved in the analysis or in drafting the recommendations.

NOTES
2. Ibid., 22.
3. The ratio of what doctors charge and what they collect is similar to the ratio for hospitals according to some studies. See, for example, D.L. Pennachio, “How Do Your Fees Mesh?” Medical Economics 81, no. 21 (2004): 26–30.
4. As an expert witness in federal and state courts, I analyzed the revenue statements in more than 100 hospitals. The documents are all sealed under court order.
9. These ratios are the inverse of the usual way they are presented. The inverse is more illustrative of the issue from the perspective of the uninsured and self-pay person since it is the markup that they experience.
10. Medicare’s definition of allowable costs differs from the hospital industry’s definition of costs in two important ways. First, the Medicare definition of allowable costs gives hospitals less flexibility to allocate costs than the generally accepted accounting practices used by hospitals. Second, the CMS does not allow certain items to be considered costs; Medicare disallows costs if it does not consider them directly related to patient care. Two examples are amenities such as television and telephone costs and physician recruitment.
11. I used the Medicare cost reports for fiscal year 2004 from the Healthcare Cost Report Information System (HCRIS) file obtained from the CMS. In conducting the analysis, I truncated cost-to-charge and net-to-gross ratios at <0.50 and >1.0. Values outside this range were considered to be data errors.
13. The simple correlation between gross revenues and total charges for all U.S. hospitals is 0.99.
14. For publicly traded companies, bad debt is calculated after net revenues are calculated. As a result, reported net revenue is greater than what a publicly traded hospital actually collects.
16. To obtain the rates of increase, I analyzed the Medicare cost reports for 1984–2004 for all hospitals that report to Medicare.
17. There are exceptions; I return to this point later.
19. These assertions have been made by hospital executives and expert witnesses testifying on behalf of hospitals in numerous court cases. I have read the reports and attended many of the depositions on behalf of uninsured and other self-pay patients and insurers. The materials are all sealed under court order and not publicly available.
20. Under Emergency Medical Treatment and Active
Labor Act (EMTALA) rules, everyone is entitled to receive care in emergencies; the rules do not address how much a person will be charged.

21. See Coverage Matters, a series of six Institute of Medicine reports that document the difficulties the uninsured have in getting medical care.

22. Documents prepared for trial often contain information on the extent of the discount that the hospital has negotiated with each managed care plan. I have reviewed such documents in preparation for trial or prior to a deposition.

23. For example, Hospital Corporation of America’s Web site states that HCA “provides free care for any patient who receives non-elective treatment and whose household financial resources and/or income is at 200 percent or below the Federal Poverty Level.” Some patients above 200 percent of poverty will qualify for “a managed care like discount.”


29. Pennsylvania, Wisconsin, Oregon, Louisiana, New Hampshire, and New Mexico hospital associations make some price data available but generally at the DRG level and not the charge/master file level.


31. State governments (for example, the Florida Agency for Health Care Administration), state hospital associations (for example, Wisconsin), private insurers (for example, Aetna, United-Healthcare in Colorado), and private vendors (for example, the American Hospital Directory at http://AHD.com) are making pricing data available online.

32. This information comes from a patient’s bill that cannot be disclosed according to agreements with the hospital and the plaintiffs.

33. Most hospitals update their prices quarterly or annually.


39. Defining the class is of critical importance because it identifies the people (1) entitled to relief, (2) bound by the final judgment, and (3) entitled under Rule 23(c)(2) to the best notice practicable in a Rule 23(b)(3) action. Federal Judicial Center, Manual for Complex Litigation 21.222 (Washington: Federal Judicial Center, 2004).

40. Examples include Cleveland Clinic in Ohio, Lakes Region General Hospital in New Hampshire, St. Elizabeth’s Hospital in Illinois, Washington Regional Medical Center in Arkansas, Saint Mary’s Hospital in Arkansas, Legacy Health System in Oregon, the Fairview and Allina Health Systems in Minnesota, and Homestead Hospital in Florida.