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a close call for 'usual charges'

"[Value] is adjusted ... not by any accurate measure, but by the haggling and bargaining of the market, according to that rough equality which, though not exact, is sufficient for carrying on the business of common life."
—*Adam Smith*, The Wealth of Nations

On June 18, 2007, the Office of Inspector General (OIG) of the Department of Health and Human Services withdrew a rule it proposed in 2003 that would have changed the definition of "usual charges" to "usual amounts paid" and would have exposed hospitals to OIG sanctions for charging Medicare more than 120 percent of the usual amounts paid. If promulgated, the proposed regulation would also have created a new and complex calculation of receipts, potentially confused the market for commercial rates, and, as the OIG came to understand, had the unintended consequence of increasing the price of health care.

AT A GLANCE

- In June, the Office of Inspector General (OIG) withdrew a rule it proposed in 2003 that would have changed the definition of "usual charges" to "usual amounts paid."
- If promulgated, the proposed regulation would have had the unintended consequence of increasing the price of health care.

The commonly understood definition of a hospital's "charges" is the amount billed on the UB-04 at the hospital's normal nondiscounted rates maintained on its chargemaster. All payers are charged at the hospital's chargemaster rates. Indeed, this may be required by state law. For example, in California, hospitals are required by statute to comply with systems and procedures set forth in the *Accounting and Reporting Manual for California Hospitals*; the manual requires hospitals to bill at their chargemaster charges.

Of course, most hospital services are not paid at full charges. Government payers pay at rates established by the government program. Commercial payers contract for discounts from hospital charges and pay full charges only when their beneficiary obtains emergency services from a hospital with whom the payer chose not to contract. Underinsured and uninsured patients typically pay a sliding-scale percentage of full charges or nothing at all. Healthcare financial executives understand the distinction between the concept of the hospital's *charges* and the typically reduced amounts that are *paid*, and the accounting of the difference between the *charged* and *paid* amounts as contractual allowances, charity care, or bad debt.

By using doublespeak instead of asking Medicare to mind its shop, the OIG's proposed rule threatened mischief in the commercial market by clouding the customary definition of "usual charges."

Medicare's definition of "customary charges" in its *Provider Reimbursement Manual* was, and remains, consistent with this industry definition. Medicare's definition excludes patients who are "represented by a plan or agent under contract or agreement to make payment directly to the provider on a basis other than full charges" from those claims used to calculate a provider's customary charges (*Provider Reimbursement Manual* section 2604.3).

Ostensibly in concert with this definition, 42 U.S. Code section 1320a-7 and 42 Code of Federal Regulations section 1001.701 give the OIG authority to permissively exclude a provider from federal healthcare programs for, among other things, submitting bills containing charges for items or services "that are substantially in excess of such individual's or entity's usual charges ... for such items or services."

In a rule proposed Sept. 15, 2003 (68 *Federal Register* 53939), the OIG explained that many Medicare payment provisions continue to be charge-based in the sense that Medicare is obligated to pay only the lower of the actual charge or the fee schedule amount. However, because full charges were paid by an increasingly small number of payers, there was a concern that the amount actually paid by non-Medicare payers might be less than the amount on the Medicare fee schedule. Because the test of the lesser of fee schedule or charges had become largely meaningless, the OIG was looking for an alternative to obtain the lowest rate for Medicare.

An Unusual Definition for 'Usual Charges'?

The OIG's proposed solution was an Orwellian redefinition of the phrase "usual charges" to mean not what was *charged*, but the average amount that was paid by various categories of payers:

> We propose to define the term 'usual charges' to include the amounts billed to cash paying patients covered by indemnity insurers with which the provider has no contractual arrangement; and any fee-for-service rates it contractually agrees to accept from any payor, including any discounted fee-for-service rates negotiated with managed care plans. Given the changes in the healthcare marketplace, negotiated rates have become a substantial portion of many healthcare providers' revenues. To the extent a provider agrees to discount its rates, the discounted contract rate is its 'charge' to those patients.

In its 2003 proposed rule, the OIG also proposed to define the level of charges that would expose a provider to OIG sanctions for overcharging Medicare as anything more than 120 percent of "usual charges" (as redefined in the proposed rule) and with some exceptions for OIG discretion. "In other words, providers submitting charges ... that were equal to or less than 120 percent of their usual charges would not be subject to OIG's permissive exclusion authority under section 1128(b)(6)(A) of the Act" (72 *Federal Register* 33430 [June 18, 2007]).

As a government payment program, Medicare can, of course, set whatever rates Congress will not override. As the OIG acknowledged in its recent decision not to promulgate its proposed rule, "the principal protection against overpaying for items and services furnished to Medicare and Medicaid beneficiaries is timely and accurate updating of the fee schedules" (72 *Federal Register* 33432). By using doublespeak instead of asking Medicare to mind its shop, the OIG's proposed rule threatened mischief in the commercial market by clouding the customary definition of "usual charges" as the reasonable value of services to noncontracting payers who give no consideration in return for negotiated discount rates and a benchmark against which commercial contract rates based on charges are measured.

In its June 18, 2007, notice, the OIG withdrew the proposed rules for two reasons. First, it "concluded that we do not have sufficient information at this time to establish a single, fixed numerical benchmark for 'substantially in excess' that could be applied equitably across healthcare sectors and across items and services, as we originally proposed." Instead, the OIG will continue to evaluate billing patterns of individuals and entities on a case-by-case basis.

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Second, the OIG decided that it had "insufficient information ... to assure ourselves that a final rule would not have the unintended effect of increasing healthcare costs across the industry":

> As several commenters had noted, 'providers that were charging Medicare and State healthcare programs in excess of the 120 percent benchmark could either lower charges to Medicare and State healthcare programs or increase charges to other payors. The commenters were concerned that some providers would opt to raise their prices to other payors rather than lower their charges to Medicare and State healthcare programs. This behavior, the commenters noted, could result in increased healthcare costs across the healthcare industry (72 *Federal Register* 33431-32).

It is ironic, to say the least, that a government payer that was largely responsible for the growth of the large disparity between a hospital's costs and its charges chose to redefine the industry definition of "charges" upon which hospitals depended to obtain an operating margin. The OIG apparently believed that hospitals would reduce their charges to come within compliance of the new limit of 120 percent of the average amount paid. This would never have happened because hospitals rely on their current charge levels to make up the shortfalls created by Medicare and other government payment programs.

For example, in 2002, Medicare paid 95 cents of each hospital dollar spent on its beneficiaries and accounted for 38.5 percent of hospital costs, thereby reducing total hospital margins by 1.93 percentage points (Dobson, A., DaVanzo, J., and Sen, N., "The Cost-Shift Payment 'Hydraulic': Foundation, History, and Implications," *Health Affairs*, January-February 2006). Based on the simple concept that "as some pay less, others must pay more," Medicare is a major contributor to the widening gap between a hospital's costs and charges. As summarized by healthcare economist Uwe Reinhardt, "[p]robably 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" ("The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy," *Health Affairs*, January-February 2006).

Government, Manage Thyself

The OIG's decision not to promulgate its proposed rule is a welcome recognition that the hospital industry is market based and that hospitals need to generate an adequate operating margin. Most state legislatures decline to control hospital charges by rate setting, but leave the financing of hospital care to the marketplace. Courts also generally recognize the right of hospitals, as businesses (albeit highly regulated), to make decisions based on business justifications. Government health programs have many options to control their costs and will do better by managing their programs than the marketplace. ●

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