
Section III:

Factors Affecting the Economics and Performance of New Jersey Hospitals

The previous section of the report provided a description of New Jersey's acute care hospital market including its relatively poor financial situation. In addition, it included the Commission's projections of a worsening oversupply of hospital beds in the State that will likely lead to greater financial distress of hospitals in the future. This section seeks to uncover additional causes of financial distress of New Jersey hospitals and provides the Commission's recommendations to mitigate these detrimental factors. In many cases, factors influencing hospitals' economic situation lie outside the direct control of institutional management and governance. However, all stakeholders share responsibility in addressing many of the factors outlined in this chapter including:

- Adequate reimbursement by public payers;
- Alignment of the hospital-physician relationship to improve efficiency and quality;
- Transparency of performance data for physicians and hospitals;
- Smart regulation that is evenly applied and minimizes perverse incentives;
- Effective and accountable hospital governance and management;
- An adequate ambulatory safety net that ensures people get the right care, in the right place, at the right time minimizing the inefficient use of hospital resources.

Chapter 6 provides New Jersey policymakers and the public with a primer on the economics of hospitals – this chapter is central to understanding the current challenges confronting hospitals across the state. The remaining chapters review the issues outlined above and provide a series of policy recommendations for the Governor, legislators, and health sector leaders.



Chapter 6: Hospital Economics 101

Key Points

- **Many complex factors influence the economics of hospitals in peculiar ways resulting in strain on a given hospital's finances.**
- **The nature of the hospital-physician relationship allows doctors to exert significant influence over the use of resources – the lack of a traditional employer-employee relationship prevents the hospital from exercising effective managerial control.**
- **Most New Jersey hospitals are non-profit institutions – many of the boards of these respective institutions have not generally kept pace with changes in best practices for governance despite the increasing complexity and scope of health care institutions.**
- **The prices for hospital services vary widely by payer and operate with little to no transparency.**
- **Hospitals function as a financial hydraulic system – they continually attempt to shift costs from one payer to another or from one service line to another based on relative profitability. Underpayment by public payers, particularly Medicaid, leads to intense efforts to shift costs onto private payers.**
- **American health policy suffers from “half-hearted competition” and “half-hearted regulation” – the combination cannot be expected to produce a rational system.**

To appreciate fully the problems that beset New Jersey's hospital sector – and of its health system in general – it will be helpful to explore briefly the peculiar economics of the hospital sector in the United States, to which New Jersey furnishes no exception.

It will be seen that most of the problems besetting the hospital sector are derivatives of these peculiar economics. They also make the problems faced by our hospital industry close to intractable, unless these peculiar economics undergo major changes. No other industrialized country has loaded quite this yoke on its health care sector nor has similar problems. They are unique features of American health care.

I. The Managerial Structure of the Hospital

Imagine an engineering firm, Apex, Inc. The firm's engineers are not employees of the firm, but self-employed entrepreneurs who can, free of charge to them, use Apex's laboratories and other facilities, along with draftsmen and other personnel, to develop the products these engineers sell on their own account.

The self-employed engineers are free to use Apex's facilities, to direct Apex's staff to perform work for them and to use in that task whatever of Apex's supplies and other resources the engineers see fit to have used. The engineers bill their clients for their own professional work. Apex bills these same clients separately for work or supplies or the use of Apex facilities that the engineers had requisitioned to perform their own professional work.

Imagine now that, in addition to being allowed to use Apex's facilities as a free workshop for their own products, the engineers also are allowed to establish their own engineering company – call it ACME PLC -- which employs its own support staff and procures its own supporting supplies. ACME PLC competes head on with Apex Inc. in the sale of engineering services.

Finally, imagine that the engineers are free to decide where they will have their own work supported: in their own facility, ACME PLC, or at their free workshop, ACME, Inc.

It is hard to imagine an industry that would be set up in this fashion – save, of course, America's hospital industry, which operates in precisely this fashion. A hospital's affiliated, self-employed physicians are the analogues of the entrepreneurial engineers described above. From a strictly economic perspective, self-employed physicians are business entrepreneurs. They can use the hospitals at which they have "privileges" as free workshops. Within fairly broad limits, they can direct the hospital's staff to perform whatever functions the physicians deem desirable and for which the staff is trained, using in the process whatever hospital-owned supplies or facilities the physicians wish to see used. In the process, they act as one of the hospital's major cost drivers, albeit without owing anyone any accountability for their use of the hospital's resources. If it is difficult for the reader to imagine how such an enterprise can be efficiently managed in society's best interest, the reader is perceptive.

The theory underlying the American model of physician-hospital affiliation appears to be that, by having physicians straddle both the ambulatory and inpatient sectors and follow their patients into the hospital and back into the ambulatory care sector, the overall quality of patient care is enhanced. That may well be so³⁹. In virtually all other industrialized nations, however, the work of physicians in the inpatient setting is performed by physicians who are fulltime employees of the hospital and thus fully under the hospital management's control. Through the hospital, these physicians can more easily be held accountable by management for their use of the hospital's resources, and also for the quality of their professional services.⁴⁰

The Wennberg Variations: The extraordinary autonomy that the American model of the physician-hospital relationship affords the individual, self-employed physician may be a major contributor to the enormous geographic variations in the per-capita use of health spending in general, and hospital resources in particular, that have been observed for some two decades now by physician and epidemiologist John Wennberg and his research associates at the Dartmouth Medical School and reported in their well-known Dartmouth Atlas⁴¹.

According to that research, per capita health spending for seemingly identical Medicare beneficiaries tend to vary across the United States by a factor of close to 3, without any commensurate, observable difference in the quality of health care processes, clinical outcomes or patient satisfaction⁴². Remarkably, one research study even suggested a negative correlation between health spending per capita and quality⁴³.

These so-called Wennberg variations are observable even within smaller regions, such as the State of New Jersey. Table 6.1 below, for example, exhibits the use of hospital resources in the care of Medicare patients during their last two years of life in a select number of hospitals in New Jersey. Differences in the characteristics of the beneficiaries' medical cases may play some role in explaining the observed differences in the use of hospital resources. However, the fact that the reported numbers represent *averages* for entire hospitals rather than individual patients limits that explanation. It can be doubted that, *on average*, all Medicare beneficiaries in their last two years at one New Jersey

³⁹ As models of integrated health care go, many health policy experts regard consider vertically integrated delivery systems such as the Kaiser Permanente health plan a superior approach.

⁴⁰ To be sure, the chiefs of departments in German hospitals, although employees of the hospital, do have the privilege of treating privately insured patients as if they were merely affiliated physicians. The number of patients so treated is quite small, however. Furthermore, the chiefs must actually pay the hospital a rental fee per patient day for patients they treat on a private basis in the hospital. And only the chiefs are permitted this privilege in the first place.

⁴¹ See <http://www.dartmouthatlas.org/> and http://www.dartmouthatlas.org/atlas/atlas_series.shtml.

⁴² See <http://www.annals.org/cgi/content/abstract/138/4/288>.

⁴³ Katherine Baicker and Amitabh Chandra, "Medicare Spending, The Physician Workforce, And Beneficiaries' Quality Of Care," *Health Affairs* Web Exclusive, April 7, 2004

hospital truly required three times as much care than did all such beneficiaries at another hospital. In any event, the Dartmouth research team has long been persuaded that the bulk of these geographic differences in health care utilization are driven by differences in the practice style preferred by physicians and that these practice styles, in turn, are driven by either professional or economic considerations, or both.

Whatever the factors that drive the Wennberg Variations may be, however, they clearly stand as both an economic and a moral challenge to the physicians in areas with high health care utilization per capita to justify that

utilization on the grounds of differences in the characteristics of patients, in the quality of health care processes, in clinical outcomes, or in patient satisfaction. It is not only an economic but also a moral challenge, because the high cost of health care in the United States is driving more and more families of the middle- and lower-income groups out of health insurance and thus out of timely, appropriate health care. Furthermore, in case of illness, it visits financial distress on increasingly large numbers of uninsured American families, many of which have been reported to be driven into personal bankruptcy over unpaid medical bills⁴⁴.

Table 6.1:
Medicare Payments for Inpatient Care During the Last Two Years of Life of Medicare Beneficiaries
(Ratio of New Jersey Hospital's Data to Comparable U.S. Average, 1999-2003)

	Inpatient Reimbursements	Hospital Days	Reimbursements per Day	CMS Technical Quality Score
St. Michaels Medical Center	3.21	2.34	1.37	0.91
Kimball Medical Center	2.32	1.26	1.83	0.95
Raritan Bay medical Center	1.86	1.85	1.01	0.81
Christ Hospital	1.83	1.83	1	0.59
St. Mary's Hospital Hoboken	1.75	1.72	1.02	0.74
Beth Israel Hospital	1.58	1.86	0.85	0.83
Overlook Hospital	1.27	1.36	0.94	0.90
Medical Center at Princeton	1.17	1.26	0.93	0.94
Atlantic Medical Center	1.11	1.12	0.97	0.89

Source: Data supplied to the Commission by John H. Wennberg, M.D., Director of the Dartmouth Atlas Project, December 2006.

⁴⁴ See, for example, David U. Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler "Illness And Injury As Contributors To Bankruptcy," *Health Affairs* Web Exclusive, February 2, 2005, available on website http://content.healthaffairs.org/cgi/search?ck=nck&andorexactfulltext=and&resourcetype=1&disp_type=&author1=Elizabeth+Warren&fulltext=&pubdate_year=&volume=&firstpage= .

So far the medical profession everywhere in the United States has not risen to this challenge and preferred largely to ignore the Wennberg Variations. Physicians argue that they are accountable only to their patients but should not be asked to worry in their work about the overall health care budgets of governments, health insurers or employers. A case can therefore be made that these large payers must take the lead in developing an information infrastructure that can hold physicians more fully accountable for the use of health care resources authorized by them. Since neither employers nor the private health insurance industry has stepped up to that task, a good case can be made for government to do so, on behalf of taxpayers who now shoulder roughly half of all health care spending in the United States.

Recommendation

As part of its work, the Commission had a presentation on software capable of tracking the order entries of every physician for every medical case by type of service or supply ordered in a hospital. The Commission recommends that the State, in cooperation with leaders of the hospital industry and the medical profession, explore the availability of such software from sundry sources and its adaptability to New Jersey hospitals, with the aim of enabling every hospital to track, for every physician affiliated with the hospital, the average cost per well-identified inpatient case by severity-adjusted DRG (it being understood that exceptions must be made for so-called non-standard “outlier” cases.) If such an information infrastructure is feasible, all New Jersey hospitals should be required to use it, and financial assistance of hospitals by the State should be made contingent on the submission of such information to the State.

Affiliated Physicians as the Hospital’s Competitors:

As noted above, a hospital’s affiliated physicians can establish competing imaging centers, ambulatory surgery centers and, in many parts of the country, surgical specialty hospitals. These competing facilities may be only a stone’s throw away from the hospital that grants their physician owners the privilege of using the hospital as a free workshop.

In principle, there is much to be said for subjecting each and every provider of health care to competition, and ambulatory care centers and physician-owned specialty hospitals do so as far as hospitals are concerned. If properly and fairly structured, such competition can keep all providers of health care on their toes in their quest to deliver high quality, customer-friendly and price-competitive health care. The leaders of ambulatory care and imaging centers, and of specialty hospitals, make the case that this is precisely what they are doing. They argue that their services are more customer-friendly than is the delivery of similar, hospital-based services and that, moreover, they charge less for their services than hospitals charge for the same services.

Table 6.2 supports that contention. The table shows the average payment in 2007, averaged over all commercial insurance products (i.e., excluding Medicare Advantage and Medicaid), one large New Jersey health insurer made to physicians and facilities for hospital- and ASC-based colonoscopies. Although the insurer pays physicians in the ASC setting more for the procedure than is paid physicians in the hospital setting, the savings on payments for the facility are such that the total cost of the procedure to the insurer is considerably lower for ASC-based than for hospital-based colonoscopies. This overall price differential gives insurers a strong incentive to favor ASCs over hospitals in the performance of the procedure, an incentive that could be mitigated if hospitals priced colonoscopies more competitively.

As is shown in Table 6.3, there is considerable variance around the averages presented in Table 6.2. The high facility payment and the wide range of hospital payments is particularly remarkable. These variances about the averages inevitably open a generalization based on averages to counter-arguments with appeal to

particular anecdotes – e.g., that Hospital A's total payment are lower than ASC X's total payments. But the general thrust of the assertion based on Table 6.2 nevertheless appears valid, namely, that on average ASCs tend to be cheaper in the delivery of colonoscopies.

Table 6.2:
A Large New Jersey Insurer's Payment for Colonoscopies Performed in Hospitals and Ambulatory Surgical Centers

Insurer's Average Payment	In-Network
Physician component	\$194
Hospital facility payment	\$1,516
Insurer's total payment for hospital-based colonoscopy	\$1,710
Physician component	\$393
Ambulatory Surgery Center payment	\$612
Insurer's total payment for ASC-based colonoscopy	\$1,005

Notes:

- * Colonoscopy procedure codes used in this study are 45378 - 45392 & 45355
- * Cost per procedure is calculated based as the weighted average mean
- * Incurred claims date between 1/1/07 and 10/31/07 for all product lines.
- * Physician reimbursements at the Hospital is reduced by the site of service reduction.

Table 6.3:
Large New Jersey Insurer's Payment for Colonoscopies Performed in Hospitals and Ambulatory Surgical Centers – Minimum Cost Per Procedure versus Maximum Cost Per Procedure

Cost per Colonoscopy	In-Network Minimum to Maximum Range
Physician	\$178 to \$431
Hospital	\$716 to \$3,717
ASC	\$443 to \$1,395

For their part, however, hospital executives complain that, given the autonomy they enjoy, hospital-affiliated physician owners of ambulatory care centers tend to allow physicians to direct relatively less problematic and more profitable patients to their own establishments and relatively more problematic and less profitable patients to the hospitals with whom they are affiliated. The higher payments to physicians in the ASC setting provide physicians with additional incentives to refer patients to ASCs. Of course, those are precisely the economic signals one should expect under the rationale of a market-based health system, if these higher payments to physicians in the ASC setting yield the insurer (and the insured) overall savings on colonoscopies and similar procedures.

Furthermore, argue hospital leaders, the ambulatory care centers are not subjected to nearly the same rigorous regulations imposed on hospitals. Finally, they argue that this arrangement allows physicians over time to siphon off from the hospitals' services – with relatively higher profit margins – what hospitals would otherwise use to finance the uncompensated or underpaid healthcare they are required to deliver to uninsured or Medicaid patients (a requirement not imposed on ambulatory care centers).

In principle, a hospital could, of course, use economic credentialing to combat the growth of competition from ambulatory care centers. Under economic credentialing, physicians known to use hospital resources excessively or to divert profitable patients to their own ambulatory care centers would be denied hospital privileges. In practice, the admissions decisions of affiliated physicians are the main source of a hospital's revenue, which makes controlling the economic behavior of affiliated physicians a highly delicate issue. Furthermore, such economic credentialing would be bound to be challenged in court.

The time and resources available to the Commission did not permit it to delve into this complex issue in the depth it warrants. Some recommendations on it will be offered in other chapters. They pertain mainly to some regulatory measures, including quality assurance. A lingering and unresolved question is whether the presence of ambulatory care centers as competitors of hospitals saves society money overall and, if so, how much. A related question is whether the services

provided by ambulatory-care centers are of the same quality, including patient safety, than those delivered in a hospital setting. Answers to both questions require a major research study in its own right.

In any event – and this is an important point – were it not for the inadequately compensated services hospitals routinely perform (and in many instances are mandated to perform), the entire issue of competition from ambulatory care centers would not be one of the Commission's concerns in the first place. One could simply accept it as a manifestation of disruptive medical and organizational technologies.

II. The Ownership and Governance of Hospitals

As in most other countries, the bulk of American hospitals are either private not-for-profit institutions or government-owned institutions, e.g., municipal hospitals. Only about 14% of the nations close to 6,000 hospitals are investor-owned, for-profit hospitals, and only about 12% of all beds are in those hospitals. In New Jersey, that percentage is much smaller.

Formally, not-for-profit hospitals are owned by their Trustees who are thought to represent the “community,” where the “community” could be secular, civic, or a religious order. Unlike the boards of for-profit hospitals, who are elected by shareholders, however, the “community” does not elect the board members of not-for-profit hospitals. Instead these boards are “self-perpetuating” in the sense that the boards appoint their own new members, often at the behest of the hospital's chief executive.

In principle, the managers of not-for-profit hospitals owe their owners financial accountability for the resources entrusted to them. That accountability is rendered to the Trustees at their regular board meetings. Unlike for-profit hospitals, which routinely post their annual financial reports and submissions to the U.S. Securities and Exchange Commission (SEC) on their websites, most not-for-profit hospitals do not post analogous documents (e.g., Form 990 submitted to the Internal Revenue Service) on their websites. The public at large, therefore, has little insight into the finances and

economics of the not-for-profit hospitals in their communities.

There appears to be no reason why in this regard not-for-profit hospitals should be spared the full, public disclosure now mandatory for their for-profit counterparts through the Sarbanes-Oxley strictures. In chapter 10 of this report, the Commission explores the issue of governance in some depth and makes a number of recommendations on mandatory disclosures by non-profit hospitals, including the posting on the hospital's website of the financial reports and Form 990 filings for the prior three years.

As a rule, the Trustees serving on the boards of not-for-profit hospitals are not compensated for their services, which require considerable financial sophistication and much time, if the trustees are to conscientiously fulfill their fiduciary obligations. By contrast, members of the board of for-profit hospitals are typically well-compensated for their services. The lack of compensation for trustees of not-for-profit institutions raises the question why presumably busy and savvy individuals serve on these boards. In many instances they do so because they are also allowed to have business relationships with their institutions. Such conflicts of interest are frowned upon in the for-profit sector.

The question arises as to which arrangement serves the community better: (A) not compensating trustees but allowing them to have economic conflicts of interest or (B) compensating the trustees for their services but interdicting conflicts of interest (or making them highly visible to the community). More on this issue will be said further on, in the chapter on Governance (see Chapter 10).

III. The Cost Structure of Hospitals

Students in economics learn that every economic enterprise has fixed, variable and incremental (or "marginal") costs.

Fixed, Variable and Incremental Costs: *Fixed costs* do not vary at all with the volume of goods or services produced by the enterprise in a given period. They include buildings and equipment, once in place, the salaries of upper and middle management, and the many other costs that must be incurred whether or not there is any productive activity in a period.

Variable costs do vary systematically with the volume of output. One thinks here of the labor directly involved in producing the goods or services, the energy, raw materials and other supplies used up in production and directly identifiable with units of production, and so on.

By *incremental* (marginal) costs, economists have in mind the extra cost that would be incurred to produce one more unit of output.

In the case of a hospital, we can think about it as follows:

- On any given day, with some fully staffed but empty beds available, most of the hospital's costs are fixed. The added incremental *cost* of admitting one more patient therefore is very low. They consist solely of the food eaten by the patient, the supplies used in treating her or him, the cost of washing the linen and other items used by that patient, and so on. Economists call this the short run. In the *short run*, even most labor costs in a hospital are fixed.
- The breakdown between fixed and variable costs is different when a hospital considers whether or not to staff licensed beds that are empty and not yet staffed. It might decide to do so to admit a slightly elevated patient flow day in day out. Economists would call this the intermediate run. Here the *intermediate-run incremental cost* per new patient (the total new cost from staffing the beds, plus the cost of occupancy if these beds are filled, all averaged over the added, more or less permanent new patient flow) would be higher than the *short-run incremental costs*, because now the cost of added labor and yet other added items must be considered variable.

- At the extreme, at the blueprint stage, before a hospital is being built, all costs are, of course, variable. Economists call this the long run. In the long run, there are no fixed costs.

The Arbitrariness of “Fully Allocated” Unit Costs:

When an enterprise seeks to calculate the full unit cost of particular units of output, it should be able to determine reasonably well the costs of inputs whose use vary directly with the volume of production. The problem is how to assign the enterprises fixed overhead costs that, by definition, do not vary with the volume of output to each unit of output to obtain what is known as “fully allocated unit costs.”

To accomplish that task, cost accountants use a variety of different methods –e.g., direct cost allocations, step-down allocations, or reciprocal allocations – that have the appearance of scientific exactness, but, in the end, all of them are inherently arbitrary. This arbitrariness of overhead allocation, for example, offers a hospital cost-accountant considerable leeway in allocating fixed overhead costs to particular service lines and thence to particular units of service. A good example is the cost of non-emergent care procured at the emergency departments of hospitals.

In principle, the actual incremental cost borne by the hospital for a non-emergent visit to its emergency room should be quite low when that emergency room is not fully preoccupied by emergencies at the time.⁴⁵ Emergency rooms do, after all, have the ability to shift non-emergent cases to such time periods. Yet the prices hospitals charge for the non-emergent use of emergency departments tend to be extraordinarily high, with the rationale that the cost of such care is extraordinarily high. It typically is not. Rather, the high mark-ups on non-emergent uses of the emergency room are then justified on the basis of arbitrarily high, fully allocated costs with the thought that the demand for emergency room care tends to be price insensitive, as surely it is for true emergencies.

A hospital’s emergency department is not different from a community’s fire department and it should be financed analogously. All members of the community derive peace of mind from knowing that a hospital emergency department is nearby in case of a true emergency. The community should pay for that piece of mind with an annual budget to cover the full cost of the emergency department, including enough slack, whether or not it is fully used for emergencies. Any use of the facility in non-emergency downtimes for non-emergent care should then be priced closer to incremental costs. Providing such care in downtimes at those low prices would be highly efficient from a strictly social perspective. That this pricing policy is rarely ever used reflects tradition and practicality, rather than sound economic reasoning.

With these somewhat pedantic preliminaries, we can now consider the relationship between a hospital’s cost structure and pricing policies.

Cost Structure, Product Pricing and Solvency: In a price-competitive product market, the cost structure of enterprises has important implications on pricing of services as well as upon solvency over the long run. At issue here is the so-called “operating leverage” of the enterprise, that is, the relationship between its fixed and incremental costs (also called “marginal costs”) in any given period of time. It is distinct from the firm’s “financial leverage,” which refers to the fraction of total assets that are financed with debt. As far as their effect on the volatility of the firm’s annual net income is concerned, these two forms of leverage amplify one another.

Hotels and airlines, for example, have very high operating leverage. In an airline, the incremental (marginal) cost per passenger on any given day on any given plane with empty seats is virtually zero. It explains why, under fierce price competition and in the short run, most airlines are willing to take on added passengers at virtually any price above zero. A similar policy is used in the hotel industry. The argument is that in the short run, with fixed capacity paid for, any price above zero is pure gravy, so to speak, which means that it is a contribution to the recovery of the airline’s fixed overhead costs (or, the airlines hopes, to profits). This pricing principle applies to all enterprises with high operating leverage and tends to be applied by them unless it is prohibited by

⁴⁵ See, for example, Robert M. Williams, “The Cost of Visits to Emergency Departments,” *The New England Journal of Medicine* (March 7, 1996) 334(10): 642-46; available at the website http://content.nejm.org/cgi/content/abstract/334/10/642?ijkey=f4ae7574a2547465389e85f65013d4b6a2a7c3c1&keytype=tf_ipsecsha

regulation, or if customers can resell the product, in which case arbitrage would drive the industry toward a single-price regime.

Because airplanes can easily be leased and added to the fleet, however, even the *intermediate* incremental costs of added passengers in an airline tend to be low relative to the airline's fixed costs, which consist of the cost of maintaining hubs at various locations, headquarters, booking systems, repair facilities, and so on. In the *intermediate* run, airlines will add to their fleet only if those avoidable costs are more than covered by the prospect of added revenue, but they may still price their services below fully allocated variable and fixed costs per trip, leaving some fixed costs unrecovered.

All of which can explain why, under the fierce, cut-throat competition typical of the airline industry, they struggle to earn a profit even with planes crammed full of passengers. The airlines try to solve their problem through various co-marketing schemes – really attempts to gain monopolistic power -- and also through judicious price discrimination (the airlines prefer to call it “value pricing”) under which the same trip is sold to different customers at vastly different prices, and customers are not allowed to resell airline tickets to others.

It is worthwhile to dwell a bit on the airline industry, because its cost structure resembles in some respects that of the hospital industry in which price discrimination is rampant as well, and in which fixed-cost recovery can be problematic in markets that are over-bedded or subject to effective price competition from payers. This observation leads us directly to a consideration of pricing policies in the American hospital industry, but before doing so, it may be helpful to add a word in passing on the “cost” of charitable and otherwise uncompensated health care rendered by hospitals.

The Cost of Uncompensated Care: The preceding analysis of hospital costs also bears on the calculation of the costs hospitals incur for health care for which they are not directly compensated. There tends to be much confusion on this point, particularly because many observers do not have an intimate knowledge of *cost accounting* and *financial accounting*.

To illustrate, when hospitals proudly boast in the media that they have separated this or that pair of Siamese twins free of charge, and “at a cost of several million dollars,” the laity is made to believe that the “several million dollars” represents true costs that the hospital had to absorb, that is, for which it had to write checks. In fact, those amounts almost always represent merely the hospital's total *charges*, at charge-master levels. A hospital's “charge master,” to be described more fully further on, is merely a set of list prices that the hospital would have billed for that care to a very wealthy individual, but normally would never have collected from ordinary, self-paying or insured patients. For many hospitals, charge-master list prices for particular items can be multiples anywhere from 2 to 6 times their actual cost to the hospital. It follows that hospital bills issued at full charges tell one nothing whatsoever of hospital costs.

In the audited annual financial reports of for-profit hospitals – and probably of most not-for-profit hospitals as well – the cost of outright charity care, for which no bill was issued, is not identified as such and merely scattered among sundry line items such as “personnel,” “supplies,” etc. Estimates of uncollected accounts receivables (also called “bad debt expense”), on the other hand, are reported as the differences between the charges originally billed to patients and what is expected actually to be collected from them. Because it is based on charges, that measure, too, tells one nothing at all about the true cost of the underlying care. A more appropriate name for this expense item on the hospital's income statement would be “*charges that no reasonable person would expect ever to collect – and should never have been billed in the first place – minus what is likely to be collected with considerable effort at collection.*” The magnitude of that item varies with (a) the height of the “charges” billed to patients and (b) the collection effort made to collect these charges. For the world of for-profit hospitals, the metric has caused enormous confusion among financial analysts and in the financial press.

But even if one is interested only in the *true cost* to the hospital of providing care on an uncompensated basis, matters are not simple. At least three distinct cost measures suggest themselves:

1. **Fully allocated costs**, that is the average cost of the care patients received, including all variable and all allocated fixed overhead costs;
2. **Intermediate-run incremental costs**, assuming there will always be a steady flow of patients receiving care on an charitable basis or otherwise “uncompensated” basis;
3. **Short run incremental costs** for the occasional, specifically identified patient receiving care.

If hospitals were paid by particular patients anything more than short-run incremental costs, they would not actually lose money on those patients (unless these patients occupied beds that could otherwise have been filled with a patient paying more), but would not earn much of a contribution to overhead and profits.

Much the same can be said for situations in which payments exceed intermediate incremental costs for a steady flow of patients paying less than full costs.

In the long run, however, hospitals can remain solvent only if they are paid fully allocated costs for every patient, or if some patients pay sufficiently more than the fully allocated cost of their care to cover the shortfall of payments from fully allocated costs of other patients.

IV. The Prices Paid Hospitals for their Services

In a broadcast in October 1939, in an entirely different context, Sir Winston Churchill famously remarked: “I cannot forecast to you the action of Russia. It is a riddle, wrapped in a mystery, inside an enigma.”

Churchill undoubtedly would say the same, were he alive and asked to describe how American hospitals bill and ultimately are paid for their services.⁴⁶ It almost defies description.

A. The Variation of Prices across Hospitals and Payers

Table 6.4 below presents the payments one larger health insurer makes to a select number of hospitals for four standard medical cases treated on an inpatient basis.

Table 6.4:
Payments by a N.J. Insurer to Various Hospitals for Four Standards Services, 2007⁴⁷

	Normal Delivery ¹	CABG ²	Appendectomy ³	Hip Replacement ⁴
Hospital A	\$2,178	\$26,342	\$2,708	\$3,330
Hospital B	\$2,787	\$32,127	\$2,852	\$3,444
Hospital C	\$2,906	\$34,277	\$3,320	\$4,200
Hospital D	\$3,187	\$36,792	\$3,412	\$4,230
Hospital E	\$3,276	\$37,019	\$3,524	\$5,028
Hospital F	\$3,629	\$45,343	\$4,230	\$5,787

¹ Mother only, case rate.

² Coronary Bypass with Cardiac Catheterization (DRG 547), tertiary hospitals only.

³ Surgical per diem (DRG 167) with average length of stay of 2 days

⁴ Surgical per diem for Total Hip replacement, average length of stay 3 days.

⁴⁶ For a taste, readers are invited to consult Uwe E. Reinhardt, “The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy,” *Health Affairs* 25(1) January/February, 2006: 57-69.

⁴⁷ Rates represent managed care insurance policies.

The payment rates for the same service vary among the selected New Jersey hospitals by a factor of almost two. This variation of payment rates by the same insurer to different hospitals exists over the entire range of services rendered by hospitals. Furthermore, a given hospital will be paid quite different amounts for the same services by different private insurers, by Medicaid, by Medicare and by the uninsured, self-paying patients. There really does not exist one price for a given hospital service in New Jersey – not for a given insurer, nor for a given hospital.

This variation of hospital prices for given hospitals and for given insurers is even wider in other parts of the United States. Table 6.5, for example, shows payment rates by one large California insurer to different hospitals in California. Once again, a given California hospital will receive substantially different amounts from different payers for the same standard service.

Few citizens understand what drives these enormous variations in hospital prices. Indeed, it would be an amusing exercise to ask anyone serving on the board of a hospital to describe how that hospital bills customers for its services.

To understand why even a well-managed hospital can be pushed to bankruptcy under this payment system, and also to develop some healthy skepticism on the much touted idea of “consumer-driven health care” that would have patients shop among competing hospitals for cost-effective health care, it may be well to describe this payment system in a bit more detail.

B. The Hospital’s Charge Master

Every hospital maintains what is called in the trade a “charge master.” This is a very extensive and excruciatingly detailed list of prices that are merely “list prices,” which few payers actually pay. In California, where hospitals must make their charge masters publicly available under the law, that list of prices extends to close to 20,000 distinct services and supply-items. Figure 6.1 below shows a tiny excerpt from the model charge master for hospitals published on a website of the State of California.

Table 6.5:
Payments by One California Insurer to Various Hospitals, 2007 (Wage Adjusted)

	Appendectomy¹	CABG²
Hospital A	\$1,800	\$33,000
Hospital B	\$2,900	\$54,600
Hospital C	\$4,700	\$64,500
Hospital D	\$9,500	\$72,300
Hospital E	\$13,700	\$99,800

¹ Cost per case (DRG 167)

² Coronary Bypass with Cardiac Catheterization (DRG 107); tertiary hospitals only.

Figure 6.1:
Excerpt from California's Master Charge Master for Hospitals, 2005

3043442	CATH MARIORRAN	510.00
3043445	CATH MRI SINGLE	1,642.00
3043446	CATH MRI DUAL	2,181.00
3043448	CATH PERITONEAL TENCHOFF	396.00
3043449	CATH PORTA CATH ARTERIAL	2,842.00
3043450	CATH PORTA CATH INTRO 9FR	198.00
3043451	CATH PORTA CATH PERIT	1,878.00
3043452	CATH PORTA CATH TITANIUM	2,875.00
3043453	CATH PORTA CATH VENOUS A	2,842.00
3043454	CATH PORTA CATH VENOUS B	1,416.00
3043455	CATH ROUND 6FR	76.00
3043456	CATH TPN	99.00
3043459	CLIP APPLIER	420.00
3043462	CLIP WECK	180.00

Each hospital maintains and updates its own charge master when and as it sees fit. The charge masters of different hospitals are not strictly comparable, because they may not follow a common nomenclature and because specific items may be updated by hospitals at different intervals. As William McGowan, CFO of University of California Davis Health System, a 30-year veteran of hospital financing, was quoted in *The Wall*

Street Journal of December 27, 2004 on this practice: "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."

Not surprisingly, the price for a particular item in these charge masters can vary enormously among hospitals, as is shown in Figure 6.2 for California.

Figure 6.2:
List Pries for Various Services in California Hospitals, 2005

How Much Is That Chest X-Ray?

A new California law allows patients to look up the retail prices of many goods and services at hospitals. A survey of several hospital price lists shows dramatic differences in price.

	SCRIPPS MEMORIAL LA JOLLA, San Diego	SUTTER GENERAL, Sacramento	UC DAVIS, Sacramento	SAN FRANCISCO GENERAL, San Francisco	DOCTORS, Modesto	CEDARS-SINAI, Los Angeles	WEST HILLS HOSPITAL, West Hills
Chest X-ray (two views, basic)	\$120.90	\$790	\$451.50	\$120	\$1,519	\$412.90	\$396.77
Complete blood count	\$47	\$234	\$166	\$50	\$547.30	\$165.80	\$172.42
Comprehensive metabolic panel	\$196.60	\$743	\$451**	\$97	\$1,732.95	\$576	\$387.18
CT-scan, head/brain (without contrast)	\$881.90	\$2,807	\$2,868	\$950	\$6,599	\$4,037.61	\$2,474.95
Percocet* (or Oxycodone hydrochloride and acetaminophen) one tablet, 5-325 mg	\$11.44	\$26.79	\$15	\$6.68	\$35.50	\$6.50	\$27.86
Tylenol* (or acetaminophen) one tablet, 325 mg	\$7.06	No charge	\$1	\$5.50	No charge	12 cents	\$3.28

*Hospitals carry either generic version, brand name, or both. **Represents the added total of 14 tests that make up the comprehensive metabolic panel
 Sources: Scripps Memorial La Jolla; Sutter General; UC Davis Health System; San Francisco General; Doctors Medical Center, Cedars-Sinai Health System; West Hills Hospital and Medical Center

Source: Lucette Lagnado, "California Hospitals Open Books, Showing Huge Price Differences," *The Wall Street Journal*, December 27, 2004: A1.

As already noted, however, only a few payers still pay hospitals their full list prices. They include worker's compensation insurers, motor vehicle insurers or small insurance carriers with little bargaining power vis a vis hospitals. They also may include self-paying patients with little market clout. Among the latter may be well-to-do patients or uninsured Americans not poor enough to qualify for outright charity care. Many of these uninsured Americans struggle to pay these highly inflated hospital charges. As *Business Week* reported in its issue of December 3, 2007, to add insult to injury these patients may find their huge hospital bills factored to finance companies that charge them very high interest rates (between 10% to 30% per year) on unpaid balances and use harsh collection techniques. It is one of the dark corners of the American hospital system.⁴⁸ How commonly the uninsured in New Jersey are billed these inflated charges and what collection techniques are practiced by New Jersey hospitals are not well known, but they ought to be routinely monitored by state government.

Although charge masters are price lists, and most enterprises in the rest of the economy post at least their price lists electronically, as a general rule hospitals do not release their price list to the public, either in print or electronically on their websites. Hospitals may justify this opaqueness on the ground that so few patients actually are billed at charges. Even so, because at least some patients may be exposed to these prices and they form the basis for price discounts offered to payers, the Commission offers in Chapter 10 of this report the following recommendation reproduced below.

Recommendation

All New Jersey hospitals should be required to post their charge masters on their websites, along with their sliding scales of prices for uninsured New Jersey residents.

⁴⁸ Brian Grow and Robert Berner, "Fresh Pain for the Uninsured," *Business Week*, December 3rd, 2007. See http://www.businessweek.com/bwdaily/dnflash/content/nov2007/db20071120_397008.htm?chan=top+news_top+news+index_top+story.

C. Different Bases for Hospital Payments

As noted, the prices in a hospital's charge master are not actually relevant to all patients, because fee-for-service payment is only one of several alternative bases on which hospitals are paid. The most commonly used bases for hospital pricing are the following:

- *Fee-for-service* (FFS), either at 100% of the charge master prices or at various discounts off the charge master (up to 40% to 50%), for literally thousands of distinct services or supplies;
- *Payments per day (per diem)* of an inpatient stay, often tiered by the average complexity of cases (e.g., a different per diem for cardiac cases then for other medical cases or for gynecology);
- *Prospective payment per medical case* (e.g., the Diagnosis Related Groupings (DRG) of distinct cases developed and used nationwide by Medicare since 1983, and first tried in New Jersey during the 1970s);
- *Retrospective full-cost reimbursement*, even for per-diem- or per-case payments in cases of unusual complexity;
- *Bundles of services* rendered patients in hospital outpatient settings, classified according to the Ambulatory Payment Classification (APC) system developed by Medicare.

Thus, every hospital must cope with a Byzantine mélange of different bases and different payment rates per base on which they are paid for a given service by various payers, and for different insurance products for any given commercial insurer (e.g., Horizon Blue Cross Blue Shield of New Jersey's HMO, Preferred Provider (PPO), Point of Service (POS) and so on).

Private Insurers: It is worth emphasizing that every private insurance carrier negotiates discounts off the charge master and the per-diem or case-based rates for its various insurance products separately with each hospital or hospital system in the relevant market area, which helps explain the large variation in actual hospital payments for particular services or cases across hospitals and insurance carriers. Insurers with relatively larger shares of a hospital's patients usually arrive at

lower payment rates with that hospital than can smaller insurers with lower market shares. Negotiating these myriad deals is a highly labor-intensive and administratively expensive process.

Medicare: From the Medicare program hospitals receive case-based payments that are set nationwide, with some local adjustment for differences in labor and other costs. For inpatient care these payments are based on the diagnostically-related-grouping (DRG) method, which was first applied in practice in the State of New Jersey on an experimental basis and, from 1983-86, was introduced by Medicare nationwide. For outpatient hospital services Medicare now pays hospitals on a case-based method, the Ambulatory Payment Classification (APC) groupings.

Medicaid: Finally, the traditional, state-administered Medicaid program pays hospitals on a DRG basis as well, although these are not at the same monetary level as Medicare's DRGs. When Medicaid contracts with commercial Medicaid Managed Care companies on a flat annual capitation per insured, these companies typically pay hospitals on the basis of negotiated per diems, although other payment methods may be employed as well.

D. Varying Profit Margins by Service

Although, as noted, every hospital receives a great variety of different payments for a given service or medical case, on average the payments hospitals receive embody vastly different profit margins, which is true even of the case-based prices (DRG rates) paid by Medicare. Some service lines maintained by hospitals are known to be money losers, especially when they are heavily used by uninsured patients. Other service lines – e.g., cardiac surgery, orthopedic surgery, some procedural lines such as imaging or colonoscopies – tend to be highly profitable. As noted elsewhere in this report, for example, hospitals without surgery as a service line are much more likely to be in financial distress than are full-service hospitals.

The traditional posture on these variations of profit margins had been that they mattered little as long as the profits from the profitable product lines could be used by hospitals to subsidize money-losing services. This

system of hidden cross subsidies, however, becomes unraveled when physicians are allowed to invest in and establish competing enterprises in the more profitable product lines, thereby siphoning off the hidden cross subsidies with which hospitals had traditionally covered their money losing activities, including mandated charity, otherwise uncompensated care or potentially money losing services.

There is something awry in an ostensible “market system” in which some enterprises are saddled by government with unfunded mandates while their competitors are not so encumbered. How would the hotel industry operate if some hotels were mandated by government to house the homeless free of charge while competing hotels are not so encumbered? It is a problem in the hospital industry that New Jersey and, indeed, the entire United States, has yet to solve satisfactorily.

E. Lack of Transparency of Hospital Prices

With the exception of the payment rates made by government payers, the prices paid to hospitals by the various private insurance carriers are closely held trade secrets. A hospital’s pricing policies therefore lack any transparency whatsoever. Very few sectors in the economy enjoy a similar lack of transparency of the prices they charge or of the cost they incur.

Many health policy analysts and political candidates now talk bravely of so-called “Consumer Directed Health Care” (CDHC) by which they mean health insurance policies with annual deductibles or coinsurance of up to \$10,500 per family, coupled with tax-favored health savings accounts (HSAs). The theory is that, faced with these high out-of-pocket expenditures for their own health care, prospective patients will shop around carefully for cost-effective health care.

An irony is that none of these proponents of consumer-shopping in health care appear ever to have given a thought to how a hospital’s prices are to be revealed to these putatively prudent shoppers for health care. Given the current chaos and the secrecy surround hospital pricing, so-called CDHC in effect envisages the analogue of blindfolded individuals pushed into department stores there to shop prudently. The lack of transparency in hospital pricing makes a mockery of the very term “consumer directed.”

F. Is Price Discrimination Worth its Complexity?

It may be noted in passing that no other country pays its hospitals in the utterly confusing manner now passively accepted by Americans, nor does any hospital in any other country employ anywhere near the large number of billing clerks employed and paid by American hospitals, not even to speak of the ever growing industry of expensive consulting firms specializing in helping physicians and hospitals bill for their services. And even with these large and costly billing staffs and consultants, the U.S. approach is possible only with the help of large computer systems, which help hospitals and other providers of health care cope with the confusion but, at the same time, also enable ever more billing complexity being heaped upon the providers of health care.

It is a payment system in which the payments received by hospitals have never, so far, reflected either the cost of services or their quality, but merely the relative market moxy of hospitals and of payers. Small wonder, then, that individual uninsured patients often are charged the highest prices. As Michael E. Porter and Elizabeth Olmsted Teisberg, both well-known business school professors, sagely observe in their *Redefining Health Care*,

“The current system has resulted in pervasive price discrimination, in which different patients pay widely different charges for the same treatment, with no economic justification in terms of cost. ... The administrative cost of dealing with multiple prices adds cost with no value benefit. The dysfunctional competition that has been created by price discrimination far outweighs any short-term advantages that individual system participants can gain from it.”⁴⁹

In making their recommendation, Porter and Teisberg are thinking of a futuristic health system that will have decomposed the current U.S. health system into a myriad of distinct mini-enterprises, each arrayed around one definable type of medical episode of finite duration or around treating one particular chronic disease. The idea then is that each of these mini-enterprises would be free to quote one lump-sum fee for the entire episode (or,

⁴⁹ Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care*, Harvard Business School Press, 2006: 65-66.

presumably, per year for chronic conditions) and charge that fee to all payers. This vision, however, is highly utopian and may never become reality except for a few well defined conditions for which services can easily be bundled by episode. In the meantime, one would need to think about all-payer systems applied to the existing U.S. health system. Here two prototypical all-payer systems suggest themselves:

1. **A Price-Competitive, Hospital-Specific All-payer System:** All New Jersey hospitals could be mandated to adopt a common Relative Value Scale (RVS), based on DRG case payments as a basis for inpatient care and APC payments for ambulatory care. Each hospital would be free to set its own monetary conversion factor to the base units in the common RVS to convert it into a hospital specific fee schedule that would be applied to all payers without payer-specific discounts (except uninsured New Jersey residents, who would never be charged more than the all-payer rates but might receive sliding-scale discounts based on ability to pay). Unless specific waivers were granted, Medicare and Medicaid patients presumably would remain outside this hospital-specific all-payer system. All hospitals would have to post their monetary conversion factor on their websites and also reveal it to patients telephonically or in person upon request. To make price competition among hospitals most effective, insurance carriers could adopt various stratagems to steer their insured to lower-priced hospitals. One approach, for example, would be to adopt the analogy of reference pricing for prescription drugs, that is, reimburse patients more or less fully for lower-priced hospitals in a market area and force them to pay out-of-pocket the full difference between that “reference reimbursement price” and what the hospital actually charges.⁵⁰
2. **A Statewide All-Payer System:** An alternative would be a public-utility model, perhaps through reverting to the statewide rate-setting facilitated by Congress in 1972 in Section 222 of the Social Security Amendment and introduced during the 1970s and early 1980s in many states, including

New Jersey, only to be abandoned in one state after the other during the 1980s, after President Reagan was elected in 1980 and initiated his “pro-competitive” strategy. Today only Maryland still operates such a system. Under that approach, the Governor’s office would establish a Health Services Cost Review Commission that would set DRG- or ACP-based hospital prices based on detailed cost analyses. All hospitals would charge these prices to all payers – certainly all private payers – once again with the exception of uninsured New Jersey residents who might be offered sliding scale discounts on the basis of ability to pay.⁵¹

It may be noted in passing that in oral testimony before the Commissioners representatives of the hospital industry hearkened back with evident nostalgia to the “good old days,” when the state’s hospitals were subject to rate regulation, although neither they nor anyone else coming before the Commission formally advocated reverting to that system.

Clearly, any move away from the present, highly price-discriminatory system of hospital pricing toward a more uniform all-payer system would be a major health reform. Such a move should be made only after careful study of the full implications of the move for the cost-effectiveness and quality of health care in New Jersey and for the financial condition of hospitals. Probably for that reason, the Governor’s Executive Order 39 establishing this Commission did not include a review of this highly complex issue in the Commission’s purview. Although the Commission took cognizance of this facet of health care and comments on its implications for the financial conditions of New Jersey hospitals throughout its report, for purposes of this study it considered the matter as something akin to a state of nature – like New Jersey’s climate – and therefore offers no formal recommendation on it. Unlike New Jersey’s climate, however, the manner in which New Jersey hospitals are paid is a facet that New Jersey’s government could change, if it so chooses.

⁵¹ In Maryland, that rate setting commission has a budget of less than \$ 5million and employs a staff of 28 economists, accountants, statisticians and computer programmers. It is not a huge outlay relative to the State’s total hospital revenues of about \$10 billion. See http://www.ans.gov.br/portal/upload/biblioteca/sem_int_8_1400_RobertMurray_Health_Care_Regulation.pps#639.5, Overview of Maryland Health Regulatory Agencies

⁵⁰ For more detail, see Uwe E. Reinhardt, “The Pricing Of U.S. Hospital Services: Chaos Behind A Veil Of Secrecy,” *Health Affairs*, January/February 2006; 25(1): 57-69.

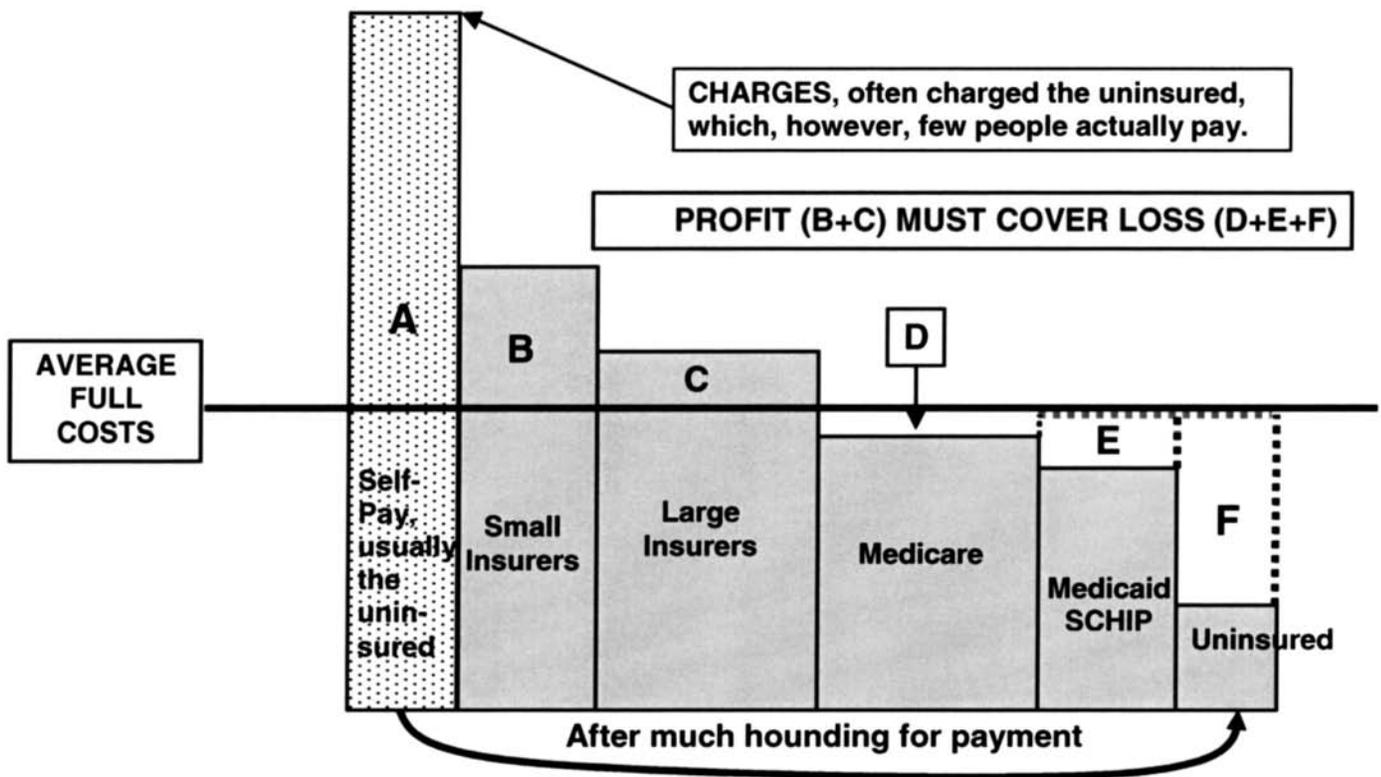
V. How Large is the “Medicaid Shortfall”?

The price discrimination rampant in American health care in effect turns every hospital into the analogue of a hydraulic financial system, such as that sketched out in Figure 6.3 below. Under that system, some payers pay sizeable mark-ups over full costs for the services used by their insured. Government, on the other hand, often chooses to pay less than full cost. The uninsured, although initially charged the highest prices by hospitals, in the end pay much less than the full cost of their services. The system requires the managers of hospitals to recover the payment shortfalls forced on them by the uninsured, by Medicare and by Medicaid, and from other payers who are willing to pay positive mark-ups over the cost of their insured’s services, or who are unable to resist high mark-ups.

By imposing on hospitals at the same time the mandate to provide health care to many critically ill, uninsured patients who cannot pay for these services with their own resources, government effectively requires hospitals to act as *catastrophic insurers of last resort* for the uninsured and then to search for paying customers from whom the cost of that care can be recovered through higher mark-ups over costs. That task is made ever more difficult when government itself elects to pay the hospital less than full cost for services rendered to publicly-insured patients.

In many parts of the country hospitals have, by and large, been able to make this system work, although in so doing they inadvertently have enabled politicians to perpetuate this unseemly approach to hospital financing.⁵² In New Jersey, the approach now threatens to push more and more hospitals to the brink of bankruptcy and closure.

Figure 6.3:
The U.S. Hospital as a Hydraulic Fiscal System

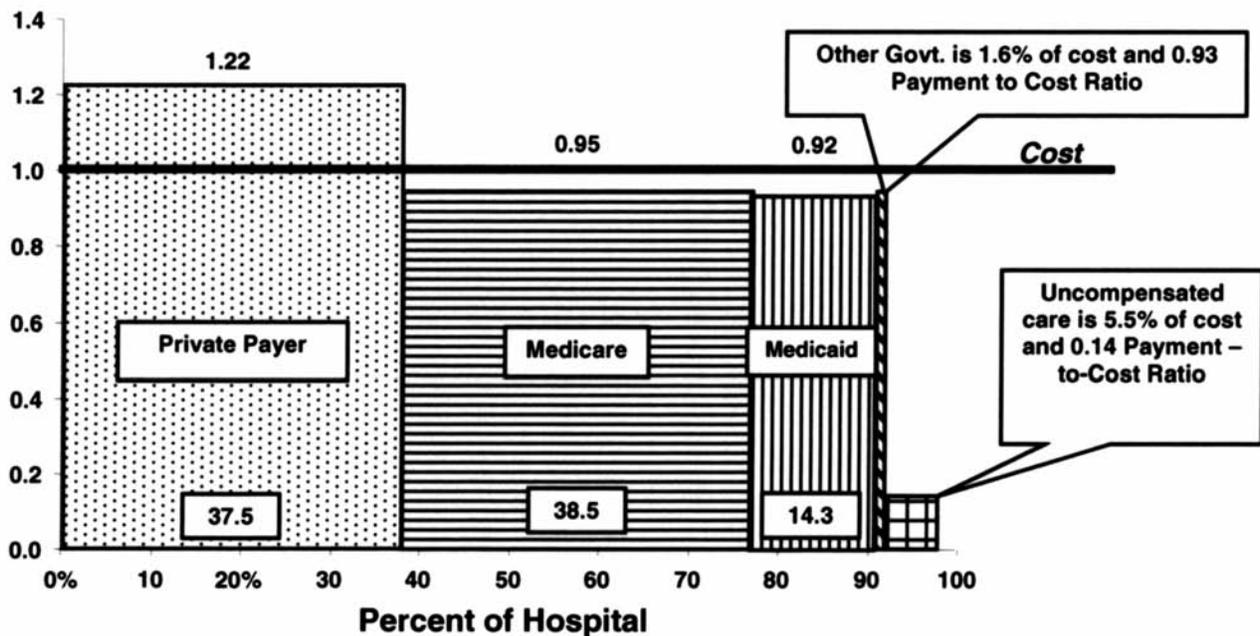


Source: Adapted from a design by Larry Lewin.

⁵² Reinhardt, U.E. “U.S. health care stands Adam Smith on his head.” *British Medical Journal* (November 17, 2007); vol. 335:1020.

Figure 6.4:
The Cost-Shift as a Payment Hydraulic – U.S. Averages, 2004

Payment-to-Cost Ratio



Source: Al Dobson, Joan DaVanzo, Namrata Sen, The Lewin Group, analysis of data presented in the American Hospital Association/ Lewin Group Trendwatch Chartbook 2005.

Figure 6.4 illustrates the hydraulic cost-shift described above with real numbers from the year 2005, albeit for the United States acute-care hospital sector as a whole. The Medicaid shortfall in 2004 was 8% for the nation as a whole.

Does New Jersey's Medicaid program underpay hospitals and, if so, by how much? Unfortunately, the answer is more complicated than may appear at first blush.

In its previously cited report, *New Jersey Acute Care Hospitals Financial Status* (October 3, 2006), the consulting firm Accenture reports that the 2004 Medicaid payment to cost ratio in New Jersey was only about 0.73, up from 0.70 in 2002. In conversations with the Commission, representatives of New Jersey's Medicaid program generally agreed with this finding that DRG payments cover approximately 70% of inpatient hospital costs.

However, the question is more complicated when one considers other payments made to hospitals (other than DRG-based reimbursements). First, outpatient hospital services are reimbursed at cost minus a 5.8% reduction for a majority of services. When inpatient and outpatient rates are combined, Medicaid covers approximately 75-80% of costs.⁵³ Second, thirty-eight New Jersey hospitals receive supplemental payments totaling \$263 million for Graduate Medical Education (\$60M) and for providing certain services to low-income populations through the Hospital Relief Subsidy Fund (HRSF - \$203M). These payments are described in more detail in Chapter 7. When these supplemental payments are added to the nominal payments, some New Jersey hospitals are actually receiving payments and subsidies that approximate the full cost of care. Hospitals that do not qualify for these supplemental funds typically receive considerably less than costs.

⁵³ In February 2007, payment for outpatient mental health services for adults was converted to a fixed fee schedule and are no longer paid at cost.

So, does New Jersey's Medicaid program underpay hospitals? The answer is yes and no and varies by hospital but, as a group, the State does pay hospitals less than it costs to care for Medicaid patients. The magnitude of the shortfall varies by hospital.

The Commission, however, is not certain that the "costs" against which shortfalls are measured are necessarily the cost that would be experienced in a highly efficient hospital. They are the costs reported by hospitals, which may or may not reflect full efficiency. The Commission, therefore, makes the following recommendation:

Recommendation

The Commission recommends that the State should commission a major study by outside expert consultants of the efficiency of all New Jersey hospitals relative to recognized national and regional benchmarks. Such a study should put in place a process of continuous

monitoring of the relative efficiency of all New Jersey hospitals. The results from this monitoring process should be available to the public. Robust data on the relative efficiency of New Jersey hospitals are essential to a yearly hospital-by-hospital assessment of shortfalls in Medicaid payments relative not to actually reported costs, but to efficient costs.

While on the topic of the Medicaid shortfall for hospitals, it may be noted in passing that, according to the Henry J. Kaiser Family Foundation, payment ratios for New Jersey physicians are even lower than those for hospitals, as is shown below. In fact, both in relation to Medicare rates for physicians and in relation to the overall U.S. average for Medicaid rates paid to physicians, New Jersey's overall Medicaid payment rates for physicians now ranks at the very bottom of the nation – a remarkable ranking for one of the richest states in the U.S.

Table 6.6:
New Jersey Medicaid Physician Payment Rates Relative to the Nation, 2003

Clinical Service	NJ Payment Rate as Percentage of National Average
All Services	56%
Primary Care	61%
Obstetric Care	41%
Other Services	65%

Source: www.statehealthfacts.org

Table 6.7:
Physician Medicaid Payment Rates as a Percentage of Medicare Rates, 2003

Clinical Service	Physician Medicaid Reimbursement Rates as a Percentage of Medicare Rates	
	NJ	US
All Services	35%	69%
Primary Care	34%	62%
Obstetric Care	31%	84%
Other Services	43%	73%

Source: www.statehealthfacts.org

Economists teach their students that relative prices signal relative social valuations. New Jersey State legislators must be aware that when they offer to pay, say, a New Jersey pediatrician only \$30 per visit by a poor child covered by Medicaid, while commercial insurers pay \$100 or more for the identical service, physicians are being signaled by these legislators that the physicians' professional work is much less socially valuable if applied to a poor child as it is when applied to a better-off child.

That New Jersey's physicians, and American physicians in general, clearly understand this signal flashed to them by legislators on behalf of the citizenry can be inferred from the fact that so many of them simply refuse to treat Medicaid patients altogether. In this regard, however, the Commission was encouraged by the addition of \$5 million (\$20 million once annualized and matched with federal dollars) to increase Medicaid reimbursement rates for services to children in Governor Corzine's 2008 budget initiative. In Chapter 11 the Commission recommends that payment rates for physicians for Medicaid patients and other state-funded health care services be set at 75% or more of current Medicare rates.

VI. Half-Hearted Markets and Half-Hearted Regulation

A final point to be made in connection with hospital economics is that, when it comes to their health care system, Americans suffer from severe *cognitive dissonance*, a mental condition in which two conflicting thoughts or theories are held at the same time.

On the one hand, Americans are deeply suspicious of their governments and, in particular, of government interference in the private sector. The mantra is that private markets invariably are more efficient and, in general, that government legislators and bureaucrats cannot "walk and chew gum at the same time," as a famous *dictum* goes. On the other hand, however, Americans are also unwilling to accept the harsh verdicts of the market in health care and many other sectors.

Whatever private markets can achieve, they cannot by themselves achieve "fairness." Instead, markets are giant bazaars in which resources flow primarily to those bidders who have the most money to bid. Furthermore, private competitive markets are bazaars in which the quick-witted and better-informed are allowed to exploit the less smart and less well-informed. In this regard, the finance sector is a perfect example of such a bazaar, as legions of desperate homeowners who assumed subprime mortgages that they did not understand and legions of investors who bought derivatives backed by those mortgages that they did not understand either are learning at this time, while others reaped huge windfall gains at the expense of the losers.

New Jersey's health system is a predictable expression of this *cognitive dissonance*.

Citizens pay lip service to the power of markets and price competition. But then they wring their hands in astonishment and despair when hospitals favored by patients with the ability to pay thrive while hospitals with a largely poor clientele, many uninsured and Medicaid patients, for whom reimbursement rates are below full costs, are pushed to the brink of bankruptcy.

Citizens also hold physicians, hospitals and providers of health care to the idea that "all men are created equal" and, therefore, all patients should be treated by the

providers of health care on an egalitarian basis. However, through their legislative representatives, those same citizens pay the providers of health care substantially less for Medicaid patients than they pay for their own families, wringing their hands in disapproval when physicians refuse to treat Medicaid patients altogether.

Hospitals already in place favor health planning through the Certificate of Need (CON) program, which effectively bestows monopoly power on providers protected by it. However, they would look askance at the price regulation that should naturally come with CON. Stuart Altman, Brandeis economist and one of the more astute observers of the American health system, has

aptly described American health policy as “half-hearted competition and half-hearted regulation.” It applies to New Jersey’s health system in force.

Such an amalgam of mutually contradictory theories cannot be expected to produce a “rational” health system. It seems designed to confuse and anger everyone, which can explain why in so many cross-national opinion surveys American respondents rate their nation’s health system much less favorably than do other nationals theirs, in spite of the abundance of resources Americans heap on their health system and the system’s undeniable clinical excellence in so many instances⁵⁴.

⁵⁴ See, for example, Robert J. Blendon, Minah Kim, and John M. Benson, “The Public Versus The World Health Organization On Health System Performance,” *Health Affairs*, May/June 2001; 20(3): 10-20.

