Dear HFMA Member,

The recent TIME Magazine cover story “Bitter Pill: Why Medical Bills Are Killing Us” has generated a new wave of media attention related to provider billing practices and the price of health care. While the tone of this article is unfortunate and misleading, it presents us with an excellent opportunity to share the steps that our members have taken (and are continuing to take) to improve the healthcare system from within.

The information contained in this document is intended as a resource. The first section, “HFMA’s Perspective for Members,” contains point-by-point analyses of some of the claims in the TIME article. It is provided to help you navigate these topics with community members, patients, fellow executives, and your board, if the need arises.

The second section, “Additional Resources for Members,” is a brief overview of the past, present, and future projects of HFMA and its members to address the financial issues the industry faces today.

As the debate about the price of health care continues, it is important to make clear that HFMA and its members have been at the leading edge of system reform for over a decade. It is our professional duty to make patient financial communication as clear as possible and that includes moving to rational and defensible pricing practices.

We should never hesitate to remind anyone that—as HFMA members—we stand at the vanguard of those moving the healthcare system move toward value and transparency. That means that sometimes it’s necessary to lead the discussion in our communities. This is one of those times.

All my best,

Joseph J. Fifer, FHFMA, CPA
President & CEO
**HFMA’s Perspective for Members**

The TIME article discusses many industry stakeholders, but calls out hospitals on a number of issues. The main criticisms of hospitals are outlined below, with HFMA’s suggested perspective in response to these criticisms highlighted in blue.

### Chargemaster issues

**TIME says…**

> In most instances, charges bear little relationship to underlying costs.

> At most hospitals, those most likely to be confronted with bills based on chargemaster prices are those under 65, without insurance, who cannot qualify for financial assistance (whom the article describes as the “almost poor”).

> The chargemaster should be outlawed.

*Note: in one instance cited in the article, a patient claimed she requested financial assistance, but the hospital had no record and the patient couldn’t produce any copies of an application.*

**HFMA’s Perspective:**

> HFMA supports movement to a more rational pricing system, as called for in its [PATIENT FRIENDLY BILLING®](#) Project’s 2007 report, “Reconstructing Hospital Pricing Systems.” A key principle defined in that report is that pricing systems should “be established using a framework that is rational and defensible in relation to objective benchmarks, such as cost and market price.” Changing chargemasters, which are often the basis of discounted rates with commercial insurers, to more accurately reflect actual costs will require the cooperation of commercial insurers.

> Statement 15 of HFMA’s Principles & Practices Board (“Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers”) notes that state regulations on charity care criteria represent minimum standards; HFMA advises individual organizations to build flexibility into their criteria for charity care eligibility, including employment status, other financial obligations, and the potential for medical indigence resulting from the amount and frequency of healthcare bills.

> The existence of the chargemaster is not the problem. Without a chargemaster, efforts to increase transparency would be jeopardized and confusion about pricing would likely ensue.

### Ability to make profit/margin on Medicare

**TIME says…**

> Jonathan Blum, deputy administrator of CMS, notes the extent to which hospitals in Medicare-heavy marketplaces, such as Central Florida, advertise to Medicare patients: “you can’t tell me they’re losing money … Hospitals don’t lose money when they serve Medicare patients.”

> The article cites “hospital finance people” who say they lose as much as 10% on an average Medicare patient; but argues that adding 10% to prices that Medicare pays would still result in charges dramatically lower than those reflected in chargemasters.

**HFMA’s Perspective:**

> Hospitals are aware of increasing pressures on Medicare reimbursement and are working to adjust their cost structures accordingly. A common sentiment among hospitals and health systems interviewed for HFMA’s Value Project, for example, is the need to reconfigure cost structures so that the organization can break even on Medicare reimbursement.

> The facts based on MedPAC data are that hospitals, on the average, had a negative 5.8% margin on Medicare in 2011.
Charity care/not-for-profit status

**TIME says...**

> The article confuses “not for profit status” which is typically synonymous with tax exemption as meaning that these hospitals should not be profitable.

> The article says hospitals base reports of charity care amounts on charges, not costs.

> The article alleges that charitable contributions make up a tiny portion of revenues, but help cement a hospital’s status in a community.

> The article repeatedly calls out high levels of executive compensation at many large not-for-profits.

**HFMA’s Perspective:**

> All reasonable financial management requires healthcare organizations to be profitable to allow for adequate recapitalization.

> HFMA’s Principles and Practices Board Statement 15 clearly states that “although charges are the basis for charity care recordkeeping purposes, costs, not charges, should be the primary reporting unit for valuing charity care.” Financial Accounting Standards Board “Accounting Standards Update – Health Care Entities (Topic 654): Measuring Charity Care for Disclosure” similarly requires that cost be used as the measurement basis for charity care. The method used to identify and estimate costs should be clearly disclosed in financial reporting on charity care valuation.

> Charitable donations received as a percentage of revenue are not relevant to the not-for-profit status of a hospital. The provision of charitable care and other societal benefits and the investment of margin in improved services for the community are hallmarks of not-for-profit status.

> Despite the $1 million+ compensation packages referenced in the article, most hospitals executives earn much less. HFMA’s 2011 compensation survey, for example, indicates the average cash compensation for a chief financial officer in a hospital or health system is less than $250,000. Large systems compete for talent in the marketplace with other large organizations, both inside and outside of health care, and must pay market prices to secure that talent.

“Over-doctoring” and unnecessary care

**TIME says...**

> The article calls for tort reform, stating that defensive medicine plays at least some role in overtreatment and overtesting.

> The article claims that in-house labs and imaging centers are over utilized, because of financial incentives to maximize utilization.

**HFMA’s Perspective:**

> HFMA supports the article’s call for tort reform.

> Acquisition of physician practices by hospitals enables “right-sizing” of the number of labs and imaging sites available within a marketplace. Changes in the payment system that reward value over volume should further reduce overutilization of testing.

> Hospitals and health systems are already working to improve the value of care by collaborating with physicians to identify unnecessary variation in practice patterns and develop standardized protocols and procedures.

> Hospitals have both employed medical staff and independent medical staff, and physicians order all tests in a hospital. (They are not ordered by the hospitals.) To suggest financial incentives at hospitals are the cause for overutilization suggests the author is more knowledgeable about necessary healthcare than ordering physicians are.
Consolidation

TIME says...

> The author cites hospital/provider consolidation as a driver of costs.

HFMA’s Perspective:

> The Federal Trade Commission and the Department of Justice already provide oversight for anti-competitive consolidation.

> The article provides little evidence to support its argument that provider consolidation is driving higher prices. The effects also need to be examined in a broader context including insurance premiums within the marketplace and current Medicare reimbursement regulation.

> According to a January 2013 Fitch Ratings report, hospital consolidations are increasingly driven by the need to coordinate care.

> This need must be reconciled with the antitrust concerns flagged in the article. Indeed, in recognition of the imperative to provide better coordinated care, the Federal Trade Commission and the Department of Justice’s Antitrust Division have collaborated on a policy defining an antitrust safety zone for organizations forming accountable care organizations (ACOs) pursuant to the Medicare Shared Savings Program authorized by the Affordable Care Act. The policy also provides for expedited antitrust review of organizations trying to form an ACO that fall outside the safety zone (see Federal Register, vol. 76, no. 209, Oct. 28, 2011).

Lack of patient exposure to costs, and lack of price transparency

TIME says...

> Medicare patients with supplemental (i.e., “first dollar”) coverage lack incentives to avoid unnecessary care.

> Lack of price transparency is an issue between patients and provider organizations and pharmaceutical and medical device companies.

HFMA’s Perspective:

> HFMA believes that greater attention should be paid to the role of the patient in controlling healthcare costs. For example, HFMA’s comment letter on CMS’s Shared Savings Program proposed regulations (June 3, 2011) noted that the program “misses an opportunity to align incentives for quality and cost-effectiveness among all stakeholders by ignoring the role beneficiaries play in their care.” In that instance, HFMA encouraged the development of compelling incentives to encourage beneficiaries to seek care from their insurer to facilitate efforts to improve care coordination and value.

> HFMA recognizes the demand for and supports the movement toward greater price transparency in health care. Its 2007 Patient Friendly Billing report on “Reconstructing Hospital Pricing Systems” noted the growing imperative for price transparency and called for “a price system that inspires trust [and] has a clear rationale that relates to objective data and is communicated in a way that is easy to understand.” HFMA’s current work on its Value Project urges hospitals and health systems to define and quantify their value proposition in a way that is meaningful to patients and other purchasers of care.

> HFMA also agrees with the call for increased transparency in provider/supplier transactions.
The place of an academic medical center within a university setting

TIME says...

- Running a hospital is “easier” than running a university.
- Because this is true, executive compensation at an academic medical center should not exceed that of the university with which it is affiliated.

HFMA’s Perspective:

- A multitude of evidence points to these assertions being untrue (or, indeed, the opposite being true).
- Federal judges have consistently railed against the complexity and opaqueness of the federal reimbursement regulation surrounding things like Medicare and Medicaid. Hospitals also face OSHA, environmental, and state level regulations, private sector accreditations like the Joint Commission, and similar factors that have to be maintained and managed.
- Hospitals face complicated and unpredictable compensation models.
- The compensation of hospital and health system CEOs falls in line with CEOs of comparably-sized publicly-traded organization.
- Compensation of not-for-profit hospital executives is subject to IRS oversight, and cannot be excessive or unreasonable based upon relevant market comparability data.

Finally, it is important to note that the fundamental notions that underpin this article are at best unfounded (and, at worst, are proved to be incorrect). The author calls for price regulation as a solution. He attaches no study or evidence that this would solve problems he identified. The author also seems to operate on a premise that “outrageous pricing and egregious profits are destroying our health care.” This is simply factually incorrect, and there is no evidence to support this notion.

Additional Resources for Members

Since 2001, HFMA’s ongoing Patient Friendly Billing Project has worked with leaders across the healthcare spectrum to promote clear, concise, and accurate patient financial communications. Its recommendations have resulted in real, tangible reforms that have grown patient satisfaction and improved measurable aspects of the care experience. For more information, visit: hfma.org/patientfriendlybilling

“Reconstructing Hospital Pricing Systems,” an initiative of the Patient Friendly Billing Project, advocated industry-wide changes to bring fair and rational pricing systems to healthcare consumers.

The 2006 “Consumerism in Health Care” report, also an initiative of the Patient Friendly Billing Project, provided practical steps to move the industry toward price transparency,
simplified charges, and easy patient access. The report sought to forge better agreement on payment expectations between payer and provider. To access the full report, visit: hfma.org/healthcareconsumerism/

In the 2005 report, “The Relationship of Community Benefit to Hospital Tax-Exempt Status,” HFMA also addressed the need to develop and implement communication plans around the benefits provided by tax-exempt healthcare providers. This report encouraged members to:

> Regularly involve the community, providing a dialogue about the value and cost of care with those most likely to require it.

> Talk about unprofitable essential services, including services that are well managed but still unprofitable due to community need.

> Build health education partnerships that include the comprehensive reporting of community benefits.

Finally, more than any other initiative, HFMA’s ongoing Value Project research (hfma.org/valueproject/) has worked to help all healthcare institutions increase quality and reduce costs to purchasers. The Value Project reports highlight hospitals and health systems that are creating value and improving price transparency to consumers.

HFMA takes pride in its long history of providing balanced, objective financial healthcare information. In the face of renewed interest in the value proposition of healthcare, we should continue to do exactly that. ●