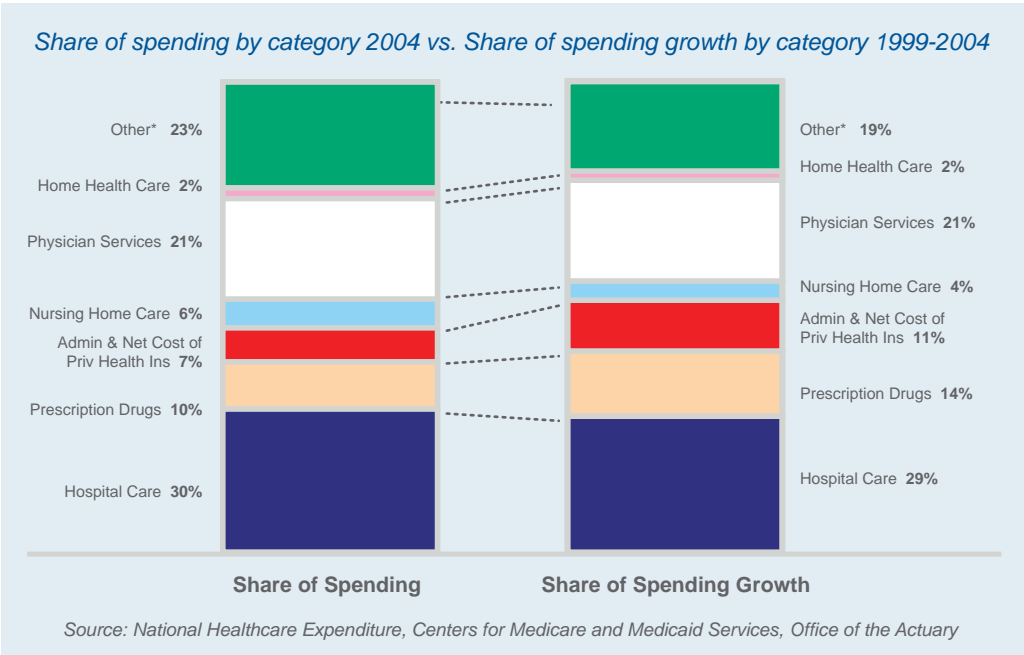


Rising Hospital Charges Under Greater Scrutiny

Pricing transparency, consumer driven healthcare and what U.S. Health and Human Services Secretary Mike Leavitt dubs “payer power” are just a few of the new buzzwords in the U.S. healthcare market. What these terms have in common is their relation to the increasing scrutiny of hospital charges. While numerous factors contribute to medical inflation, hospital costs remain the single largest contributor, representing one-third of the projected \$2 trillion spent on U.S. health care services last year. The \$570 billion spent on hospital care in 2004 represented an 8.6% increase over 2003 levels (compared to a 7.9% increase in the total healthcare expenditure from 2003-2004). The forecast is for a 7.9% increase in hospital expenditure in 2005 over 2004 levels.



According to data reported by the Agency for Healthcare Research and Quality (AHRQ), the average hospital charge increased by 24 percent from \$13,900 in 1997 to \$17,300 in 2002 (after adjusting for inflation). Four of the top 10 most costly hospital stays are related to procedures on the cardiovascular system:

- Heart transplantation (part of other organ transplantation)
- Heart valve procedures
- Other operating room (OR) heart procedures (e.g., implant of pulsation balloon, pericardiotomy).
- Other vascular bypass and shunt (e.g., intra-abdominal venous shunt, aorta-renal bypass, aorta-subclavian-carotid bypass)

“The bad news is hospital costs remain the single biggest driver of medical inflation today,” according to a spokesman for Pacific Business Group on Health, a consortium of employers who buy health insurance. “The good news is it is forcing employers and insurers to look at what they’re buying, and who they are buying it from.”

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... charge levels vary across the nation

There are substantial differences in charge levels by hospital, and these differences have not always been readily available to domestic or international claim payers. The highest charging hospitals tend to be clustered in California, Texas, New Jersey, Pennsylvania and Florida. The problem seems particularly acute in California, where hospital costs are growing twice the pace of the national average. While California's aggregate costs have risen sharply in recent years, hospital charges vary enormously across and within the state's geographic market. For example, the charge for heart surgery is three times as much in Sacramento as in San Diego, while the average charge for a hysterectomy in Sacramento ranges from \$13,921 at the lowest cost hospital to \$43,931 at the highest.

As a result of public pressure, in July 2005, California's state government required each hospital to submit a copy of its chargemaster and a list of charges for 25 commonly performed services or procedures. A sample chargemaster is posted on the government's website. For a nominal fee, anyone can purchase a chargemaster CD rom that includes pricing information on all California hospitals. This move was the first in a growing national trend towards making hospital data public to guide consumers' healthcare spending behavior.

In December 2005, the Institute for Socio-Political Change released its annual "The Nation's Most and Least Expensive Hospitals" report examining the charge to cost ratios for the major centers commonly found in hospital financial reports. These categories included operating rooms, recovery rooms, emergency rooms, intensive care units, drugs sold to patients, coronary care unit, cardiac catheterization laboratory, medical supplies charged to patients and many others. Among other data, the Report highlighted the states with the highest and lowest overall charge to cost ratios, including information on hospitals with ratios in excess of 1000%, and others at 100%.

Definition

Billed Charge – Also called gross charge, it is the "list price" for a procedure according to the chargemaster maintained by a hospital.

Definition

A hospital chargemaster (also called a charge description master) contains the prices of all services, goods, and procedures for which a individual charge exists. It is used to generate a patient's bill.

Average Total Charge to Cost Ratio by State 2003/2004

Rank	State	Average Total Charges as a % of Total Costs
1	New Jersey	447.07%
2	Florida	373.73%
3	California	371.43%
4	Pennsylvania	332.44%
5	Alabama	305.41%
6	Arizona	301.07%
7	Nevada	296.47%
8	Tennessee	273.91%
9	Texas	272.55%
10	Rhode Island	265.11%
11	South Carolina	258.59%
12	Louisiana	258.46%
13	Virginia	253.96%
14	Washington DC	240.15%
15	Illinois	236.08%
16	Georgia	232.92%
17	Kentucky	226.08%
18	New York	224.45%
19	Missouri	224.45%
20	Arkansas	222.59%

Source: Institute for Health and Socio-Economic Policy, December 2005

... factors impacting pricing

One of the reasons prices rose so much in recent years is that hospitals tried to increase the amount they collected from private payers by raising the starting point (billed charges) for reimbursement negotiations. However, providers continue to report shrinking margins, and the increasing cost and challenge of providing quality care to a growing, aging (and sometimes, uninsured) population.

So just how are billed charges calculated? There is no single formula or method. Similar to other industries, hospital "sticker prices" are determined by operational costs and profitability margins. Several factors that impact these two areas include labor costs, capital expenditures, investments in the newest technologies, drug costs, medical supplies, operational efficiencies, uncompensated care for the uninsured, declining government payments (for Medicare and Medicaid programs), bad debt write offs and medical liability insurance costs.

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... understanding net price

While payers may suffer from sticker shock at current levels of billed charges, the appropriate focus is on the ultimate payment, i.e., the net price.

Definition

Net Price – The final price after all contractually-binding discounts are applied.

One way to lower costs is provider selection. With the growing “price transparency” movement, payers will have increasing access to comparative hospital cost and quality information, which can help to proactively impact the size of the bill before it is incurred. For example, in 2004, the California Public Employee Retirement System (CALPERS) collaborated with its HMO Provider network to include only those hospitals able to meet certain cost and quality standards, and excluded 38 hospitals and 17 physician groups who failed to meet certain cost and quality standards. The excluded hospitals resulted in 10 of the hospitals meeting the price and quality standards and being added back into the network.

Hospital efficiency is another area that can contribute to achieving lower net prices. A key efficiency measurement is patient length of stay. According to Milliman USA (a firm that tracks health care spending) the average length of stay for a coronary bypass (without coronary catheterization) ranged from 6.92 days to 10.14 days for large hospitals in Boston, Massachusetts, for Medicare patients in 2003. This is evidence that practice patterns can differ even within a single area. While choosing low cost providers seems an obvious way to reduce expenses, efficiency and quality of care factors must be addressed. This is important because the lowest inpatient charge per day may come from facilities with the highest length of stay, resulting in higher final costs.

Another obvious factor impacting net prices is provider discounts. Discounts vary widely between geographic areas and carriers, and to a lesser degree, within a given geographic area. In Pennsylvania, the discount from billed charges ranges from 15% to 45%, whereas in Maryland, the maximum discount allowed is 2% because the state controls hospital charges and payments. Discounts may be lower in rural areas, as hospitals have less competition when they negotiate discount rates than those in urban areas. However, billed charges may also be lower, leading to lower net costs. Selecting the right partner to help you identify the best PPO discount arrangement for your plans is mission critical.

Finally, once a patient is discharged, there is the opportunity to lower costs through the use of bill editing and auditing programs that scrutinize a bill for errors or inappropriate over-utilization. Then through a claim arbitration process, a payment reduction may be secured with the provider.

“At Hygeia, we believe that a focus on net prices (which is a more inclusive measure than just “savings”) is the path to strategic advantage for our clients,” explains Larry Taylor, Chief Marketing Officer, Healthcare Payers. “We have the information and the tools that empower our clients to benchmark these areas, and improve their cost management.”

... regaining control through a net pricing strategy

There are many reasons for the variations in hospital charges, some more controllable than others. Domestic and international payers are challenged to determine what areas they can or should legitimately tackle, and the financial impact that can be expected.

SAMPLE HYGEIA NET COST REPORT		HOSPITAL A				HOSPITAL B			
DRG	DRG Description	Average Charge	Average LOS	Average Savings	Payer Net Cost	Average Charge	Average LOS	Average Savings	Payer Net Cost
089	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	\$18,770	5.4	40.0%	\$11,262	\$16,871	5.0	45.0%	\$9,279
143	CHEST PAIN	\$9,557	1.8	40.0%	\$5,734	\$10,749	1.6	45.0%	\$5,912
014	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	\$19,881	4.9	40.0%	\$11,929	\$22,916	5.2	45.0%	\$12,604
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	\$7,361	2.3	40.0%	\$4,417	\$8,700	2.1	45.0%	\$4,785
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	\$28,842	7.1	40.0%	\$17,305	\$25,874	6.3	45.0%	\$14,231
088	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	\$15,623	4.6	40.0%	\$9,374	\$15,581	4.4	45.0%	\$8,570
127	HEART FAILURE & SHOCK	\$16,937	5.0	40.0%	\$10,162	\$16,531	4.6	45.0%	\$9,092
526	PERCUTANEOUS CARDIOVASC PROC W DRUG ELUTING STENT W AMI	\$58,978	5.2	40.0%	\$35,387	\$64,130	4.3	45.0%	\$35,272
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	\$14,981	4.3	40.0%	\$8,989	\$15,498	3.5	45.0%	\$8,524
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	\$12,402	3.4	40.0%	\$7,441	\$13,622	3.2	45.0%	\$7,492

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So how does a payer know what the right price is (i.e. the lowest net cost) for each U.S. medical claim?

Data is key. Access to and the expert analysis of medical cost and utilization information and PPO network performance is the starting point for an in-depth evaluation of a current cost containment strategy. Through advanced data analysis, an organization can identify the targeted areas for systematically reducing costs. Then the next, obvious step is expert execution of the strategy.

After more than a decade in the U.S. cost containment business, Hygeia leverages one of the most comprehensive medical cost and utilization databases in the industry with award-winning technology to help our clients lower “total net costs” on their U.S. medical claims. We combine traditional cost containment products, cost analysis tools and technology interfaces with new, strategic methods such as Custom PPO Networks, Large Dollar Claim Early Warning Notification, Arbitration Bill Reviews, Charge Fairness Benchmarking™ and our Prospective Payment System.

For more information about a specific product or service, or to request a no obligation, no risk analysis of your U.S. healthcare claims, contact a Hygeia representative at payerpartner@hygeia.net.

Travel Health Insurance Association (THIA) Conference Report

The 8th annual THIA Conference was held at Marriott Harbor Beach Resort in Fort Lauderdale, Florida on April 4-7, 2006. Hygeia has been a conference supporter and sponsor for the last six years. The conference attracted more than 150 attendees.



Hygeia Sponsors Presentation on Florida Tourism

We were pleased to arrange the presentation by Thom Stork, Vice Chair of the Florida Tourism Commission and Chairman of Visit Florida, the official tourism marketing organization for the State during the morning session on Wednesday, April 5th. Thom provided an overview of the Spring/Summer 2006 Florida tourism season and reviewed the issues impacting Canadian visitors.

Hygeia Hosts Tour at Preferred Provider

More than 20 clients participated in a tour of Preferred Partner, Aventura Hospital and Medical Center. The group was welcomed by the hospital’s CEO. Then Chief Financial Officer Lester Eljaiek and Chief Operating Officer Rick Kennedy made a joint presentation of the hospital’s services and operational procedures, covering areas such as emergency and non-emergency admission, insurance verification, patient care, medical technology, medical record authorizations, HIPAA, discharge planning and case management protocols. Staff members representing all the key areas of the hospital were in attendance to answer any questions. After the presentation, the group received a tour of the hospital. Aventura Hospital and Medical Center represents one of the top volume Florida hospitals for Hygeia clients.

“We recognize the importance of working to reduce costs while a patient is still in hospital,” explained Reid Cawston, Director of Account Management. “This is a key reason we coordinate hospital tours to help our clients gain a greater understanding of the inner workings of U.S. hospitals to support their case management programs.



Aventura Hospital and Medical Center



Afternoon at The Races at Gulfstream Park

We were pleased to spend an afternoon with some of our valued Canadian clients and industry partners for a fun afternoon at Gulfstream Park, Florida’s premier thoroughbred racing and entertainment venue. High stakes rollers and cautious observers enjoyed the fast-paced afternoon.

From Left to Right: David Angelone – Hygeia (profile), Lester Eljaiek – Aventura Hospital and Medical Center, Chris Gilliss – Preferred Benefits Alliance, Michael Camacho – CSI Brokers, Virgil Bretz – Hygeia