Are Hospital Prices a Bigger Problem than Drug Prices?

Congress Doesn’t Know, Doesn’t Care

Stephen Barlas

When he testified before a Senate committee in June 2018, David Hyman, a professor at Georgetown University Law Center, referred to a website called Bill of the Month, published under the aegis of Kaiser Health News. The most recent entry in a string of stories about outrageous hospital bills, posted on February 27, 2019, reads:

Meow-ch! The $48,512 Cat Bite

An animal lover stopped to feed a hungry-looking stray cat outside Everglades National Park in Florida. First, the cat bit her finger—then the hospital billed her close to $50,000 for a treatment that typically costs about $3,000. The woman went to the emergency room at Mariners Hospital, not far from her house. She said she spent about two hours in the emergency room, got two different types of injections and an antibiotic, and never talked with a doctor.

“I went home happy as a clam,” she said. Then the bills came.

Pharmaceutical-company pricing practices have been the national front-page health care irritant for the past few years. The Trump administration and Congress are competing to throw solutions at the perceived problem of high drug prices. But high hospital prices, which may be a bigger problem for consumers? Not a peep. The winter 2019 issue of National Affairs carried a story, which created nary a ripple, entitled The Cost of Hospital Protectionism, by Chris Pope. Pope writes: “Over decades, the structure of state regulations and federal subsidies has encouraged hospitals to inflate their costs by protecting them from competition.”

Jumping into the topic after Pope’s article, the Cost-of-Health-Care News site published a detailed post in February: Where are Health Costs Rising Most? Hospitals. And Here is Why. It starts out with these statistics:

- Total U.S. hospital spending in 2017 reached $1.1 trillion, compared with $333 billion for prescription drugs, according to a new study by the Centers for Medicare and Medicaid Services (CMS).
- For the year ending December 31, 2017, hospital costs rose 4.6%, compared with a 0.4% rise in drug costs, again according to CMS. For the previous year, hospital costs rose 5.6%, or more than two-and-a-half times the rate of inflation. Drug costs in 2016 rose 2.3%. Hospital spending increases are outrunning drug increases again in 2018.
- Overall, hospitals represent 33% of U.S. health care costs; physician and clinical spending, 20%; and drugs, 10%.

The writer goes on to wonder: “One of the great mysteries in recent years is why pharmaceutical companies are portrayed as the villains in the story of rising U.S. health care costs while hospitals are virtually ignored.” During the first few months of the 116th Congress, both House and Senate committees have been rolling out hearings on prescription drug prices in rote, assembly-line fashion, sometimes on the same day. The House Ways and Means, Judiciary, Oversight, and Energy and Commerce committees have all been competing for the limelight on an issue that is not particularly well understood by members of Congress given the generally stable prices of most drugs, with the exception of a small percentage of biologicals, specialty pharmaceuticals, and sole-source generics.

Hospital Price Increases Receive Short Shift from Congress

Rising hospital costs and their impact on patients have been examined in zero dedicated congressional hearings, in this Congress and the last. However, in his opening statement at a March 7, 2019 hearing—where the House Judiciary Antitrust subcommittee looked broadly at health care consolidation—subcommittee chairman Representative David Cicilline (R-RI) did mention hospital price increases briefly in a statement devoted almost exclusively to drug price increases. He noted that the average cost of a hospital stay for a child with cancer is $40,000. A short ambulance ride to the hospital, without medication, can cost thousands of dollars. An organ transplant and post-operative treatment can cost more than $1 million.

Of the four expert witnesses that day, only one addressed hospital prices. Martin Gaynor, E. J. Barone University Professor of Economics and Public Policy at Carnegie Mellon University–Heinz College of Information Systems and Public Policy, talked about the large number of hospital mergers in the past decade, and how some cities now had only one hospital system. Gaynor checked off the many studies of hospital prices. Martin Gaynor, E. J. Barone University Professor of Economics and Public Policy at Carnegie Mellon University–Heinz College of Information Systems and Public Policy, talked about the large number of hospital mergers in the past decade, and how some cities now had only one hospital system. Gaynor checked off the many studies of hospital prices.

The American Hospital Association (AHA) pushed back hard in a written statement. Refuting studies on the relationship between hospital mergers and higher hospital prices, AHA said they “…typically are seriously flawed...lacking data on the largest health insurance companies in virtually every market. The studies appear to be largely academic exercises with little probative value for policymakers at every level, which routinely fail to examine the impact of widespread consolidation in health insurance markets and the impact of dominant commercial health insurers on prices and innovation.”

AHA has good reason to ward off any congressional notions that hospital price increases should be as big a public bugaboo

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as prescription-drug price increases. There is very likely to be a “health care cost-containment” bill emerging from Congress this session, taking into consideration the bipartisan support for drug price remedies at least. Senator Lamar Alexander (R-TN), Chairman of the Senate Health, Education, Labor and Pensions Committee, and ranking Democratic Senator Patty Murray (D-WA) are working with the top Republicans and Democrats on the Senate Finance Committee to develop a health care cost-improvement bill.

Alexander has asked trade groups and others to submit ideas on how those costs can be constrained. And it is clear from their submissions that hospital groups are worried that any legislation will draw blood. In a long letter to Alexander, AHA argued that drug prices and regulatory requirements had the biggest impact on the costs of their 5,000 member-hospitals, and that hospitals’ share of total health expenditures has gradually decreased over time. “Any steps to lower health care costs should be taken in a way that avoids unintended consequences, such as worse health outcomes, barriers to access, or short-term savings at the expense of long-term spending,” AHA wrote.

The impression one gets from reading the AHA missive is that prescription drug costs are the biggest factor in rising hospital-unit costs. Moreover, that those higher costs are a result of higher drug prices, not the greater use of drugs by hospitals.

Horror Stories and Comparisons to Drug Prices

One could argue that despite the posts on Bill of the Month, $50,000 hospital bills for cat bites and other seemingly ridiculous bills are exceptions. Maybe they are and maybe they’re not. I had Achilles surgery last October, in an outpatient surgical facility. The surgery took about one hour, then I went home. The bill from the facility was $33,141. Had the surgery been done in a hospital, the bill would have been even higher. Someone without insurance or a high deductible would have had to pay either the full bill or thousands of dollars. Fortunately, I am covered by Medicare and have a supplemental policy. Medicare paid the facility $2,671. I paid nothing.

Hospital prices for surgeries and procedures are certainly higher in the U.S. than in Europe and elsewhere. A story on May 18, 2018, on Vox.com compared U.S. drug and hospital prices with those in Switzerland, Spain, and Australia, using International Federation of Health Plans data. The range in cost for some high-priced products such as Harvoni, Avastin, and Humira were considerable. There were differences of $10,000 for Harvoni, which cures Hepatitis C, but those differences are something of a separate case considering the back-end savings for curing a disease. However, the dollar differences for Avastin and Humira (the world’s best-selling drug) were notably smaller than those for routine procedures requiring a single day in the hospital: $5,220 in the U.S. versus $424 in Spain, for example. An appendix removal is $12,000 cheaper in Australia. Bypass surgery costs $78,318 in the U.S., $34,224 in Switzerland, $24,059 in the UK, and $14,579 in Spain.

Perhaps one could justify higher U.S. hospital-procedure prices if the outcomes of inpatient hospitalizations were better in the U.S. than elsewhere. It is easy to find general comparison data on mortality and health status for U.S. versus foreign patients, but much harder to find data on heart-bypass success rates, for example. And even in that instance, the success or failure of the procedure may have little to do with the hospital and more to do with the condition a patient came in with, his or her post-discharge history, and other factors. That said, according to the 2011 Commonwealth Fund International Health Policy Survey, which was carried out in 11 countries, the U.S. had the highest rate of medical, medication, and labor errors. At the House Judiciary subcommittee hearings, Cicilline said, “The U.S. is dead last in health outcomes among other high-income countries.”

Cost Growth of Hospital Prices

Although drug prices, by and large, have been increasing (albeit at a much slower rate than previously) and the “bulge” has everything to do with a narrow number of drug categories, hospital prices have increased at a faster pace and will continue to do so through most of the next decade, according to CMS data. The Office of the Actuary at CMS produces annual projections of health care spending for categories in the National Health Expenditure Accounts that track spending by fund source (e.g., private health insurance, Medicare, Medicaid), type of service (hospital, physician, prescription drugs, etc.), and sponsor (businesses, households, governments). The latest projections begin after 2017, the latest historical year, and extend through 2027.

Prescription drug prices increased by 0.4% in 2017 and were projected to grow by 3.3% in 2018. Prescription-drug spending growth is projected to further accelerate to 4.6% in 2019. Through 2027, the spending is projected to grow by 6.1% per year, on average. Hospital spending is estimated to have grown by 4.4% in 2018, slightly slower than the 2017 rate of 4.6%. In 2019, spending growth is projected to increase by 0.7 percentage points to 5.1%, reaching 5.7% per year, on average, from 2020 through 2027.

Aaron Wesolowski, AHA’s vice president of policy research, analytics, and strategy, points out that the national health-expenditure data released annually by CMS reflect retail-drug spending only, and not those instances where drug manufacturers specifically target provider-administered drugs for price increases.

Even if estimates for the “real” 2020–2027 drug price increases are higher when inpatient prescriptions are included, the impact on consumers of hospital price increases is much greater, as hospitals’ share of health care costs is around 30% while their share of prescription drug costs is 10%. But hospitals do have the means to reduce costs by cutting down on waste, which theoretically should allow them to either moderate price increases or reduce them. There is a fairly rich research history on wastage in hospitals.

Brent C. James, MD, MStat, Clinical Professor in the Department of Medicine at Stanford University School of Medicine, and a member of the National Academy of Medicine, told the Senate HELP Committee last July that an Institute of Medicine (IOM) expert panel had conducted an evidence review in 2010 and estimated that a minimum of 30%, and probably more than 50%, of all money spent on healthcare delivery is wasted (e.g., on unnecessary or duplicate lab and imaging tests). This expenditure would be recoverable by implement-
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Higher Drug Prices Linked to Higher Hospital Prices

The hospital industry maintains that rising drug prices accounts for their higher prices. The AHA, Federation of American Hospitals, and American Society of Health System Pharmacists commissioned a study to evaluate their members’ experience with drug pricing. The study was released in January 2019 and follows on a 2016 study that reviewed the experience of hospitals and health systems regarding drug prices, specifically in the inpatient setting. The most recent study found that after historic increases in hospital spending on drugs of 38.7% per admission from 2013 to 2015, total inpatient and outpatient spending continued to rise by an additional 18.5% per adjusted admission from 2015 to 2017. Hospitals experienced price increases in excess of 80% across certain classes of drugs, including those for anesthetics, parenteral solutions, opioid agonists, and chemotherapy.

AHA noted in its submission this year to the HELP Committee that increased drug spending affects many aspects of their operations and that the resulting budget pressures have led to a number of measures such as identifying alternative therapies, carrying out more in-house compounding, delaying investments in or replacement of equipment, reducing staffing, and reducing the services they offer.

Some hospitals are overcoming higher drug prices, however. An example is Vanderbilt University Medical Center (VUMC), which consists of more than 60 hospitals stretching across five states. When he testified before HELP last July, Jeffrey Balser, MD, president of VUMC, explained that although drug costs to the system had averaged a 10% increase over the last decade, “If we are honest with ourselves, we must also admit that in most health care systems, unlike most businesses, we do not systematically try to manage what tests we order and what drugs we administer to patients in a manner that has the potential to optimize quality and cost.”

VUMC has married sophisticated electronic information and clinical-decision support systems in a highly successful effort run by its pharmacy and therapeutics (P&T) committee. As a result, since 2010, the increase in VUMC’s drug expense per weighted discharge has been 50% versus a median of 134% across teaching hospitals, saving VUMC approximately $30-$35 million per year compared to the average teaching hospital, according to Balser. Now VUMC is applying that same drug-ordering system to hospital tests, and again the P&T committee is in charge. In fact, VUMC has renamed the committee the “Pharmacy, Therapeutics, and Diagnostics Committee,” and has included on it key experts in laboratory medicine from the pathology department. “In one example—genetic testing—we have eliminated $1 million in costs annually by altering orders for tests that could be streamlined, reduced, or eliminated by requiring either online or verbal expert consultation prior to completing the test order.”

A spokesman for VUMC did not respond to queries wondering whether these drug- and test-cost savings resulted in lower prices to consumers.

Impact of Hospital Consolidation on Hospital Pricing

Hospital critics argue that hospitals are charging more not mainly to recoup drug costs but rather because they can, on account of industry consolidation—hospital mergers and hospital acquisition of physician practices, both of which have increased greatly in the past decade.

Carnegie Mellon’s Gaynor served as Director of the Bureau of Economics at the Federal Trade Commission (FTC) during 2013-2014, during which time he was involved in the many health care matters that come before the commission. More recently, he has carried out research with colleagues at different universities, using newly available data on approximately 90 million individuals nationwide with private, employer-sponsored health insurance, to examine variations in health care spending and prices for the privately insured. “One of our key findings is that hospitals that have fewer potential competitors nearby have substantially higher prices,” Gaynor explained. “We also examined all hospital mergers in the United States over a five-year period and found that the average merger between two nearby hospitals (five miles or closer) leads to a price increase of 6%. Further, our evidence shows that prices continue to rise for at least two years after the merger. Lastly, we [found] that hospitals that face fewer competitors can negotiate more favorable forms of payments, and resist those they dislike—a serious issue for payment reform.”

When California Attorney General Xavier Becerra filed an antitrust lawsuit in March 2018 against Sutter Health, which operates 24 hospitals with more than 4,300 beds throughout Northern California, he cited a University of California, Berkeley report released at the same time as further evidence that Sacramento’s consolidated health-care market had driven up prices. That report found that inpatient procedure prices were 70% higher in Northern California than in Southern California, or, on average, $223,278 compared to $131,586.

AHA documents 1,577 hospital mergers from 1998 to 2017, with 456 of them taking place during 2013 to 2017. As a result of this consolidation, the majority of hospital markets are highly concentrated, and many areas of the country are dominated by one or two large hospital systems with no close competitors, Gaynor told the House Judiciary Committee. This includes places like Boston (Partners), Cleveland (Cleveland Clinic and University Hospital), Pittsburgh (UPMC), and San Francisco (Sutter). Price increases from mergers include 64.9% as a result of the Evanston Northwestern–Highland Park merger in the Chicago area; 44.2% from the Sutter–Summit merger in the San Francisco Bay area; and 65.3% from the merger between Cape Fear and New Hanover hospitals in Wilmington, North Carolina.

In a statement to the House Judiciary subcommittee for its hearings on health care consolidation, AHA wrote: “An analysis released in 2017 by economists at Charles River Associates found that mergers can result in efficiencies that unleash savings, innovation, and quality improvement essential to transforming health care delivery. Importantly, the data also showed that mergers do not lead to a spike in revenues that some claim are the motivation for mergers.” An AHA spokesman was unable to comment on whether the unleashed savings led to price cuts for consumers.

Mergers are one factor in higher hospital prices. Another one may be the contract terms that hospitals insist on when continued on page 299
they agree to enter an insurance company network: that the insurance company does not use tiers, putting lower-priced hospitals on lower tiers and higher-priced hospitals on higher tiers. One lawsuit filed by the Department of Justice against Carolinas Health System was settled with the system agreeing not to use “steering restrictions.” Those restrictions prevent insurance companies from using financial incentives to direct customers to lower-priced providers. Becerra’s case against Sutter is based on the health system using its market power to prevent insurers from using steering or tiering to reduce patient costs.

There is no question that the FTC and the Justice Department could use more statutory authority to go after anti-competitive actions, not just those taken by hospitals but by all health care providers, including drug companies and physicians. There is one single bill in Congress this year devoted to hospital mergers—the Hospital Competition Act of 2019. Introduced by Representative Jim Banks (R-IN), it has one cosponsor and would increase the FTC budget for health-care merger investigations by $160 million. That sum will never be appropriated. No bills have been introduced in the House or Senate giving federal agencies more power to stop anti-competitive practices.

Meanwhile, on March 27, the House Energy and Commerce Committee approved six bills meant to speed up the introduction of generic drugs in the U.S. Three of those bills, aimed at curbing licensing deals through patent settlements (which some consider to be anti-competitive), are hotly opposed by the generics industry. The Association for Accessible Medicines says, “Settlements provide generic and biosimilar companies with essential pro-competitive benefits that could not be achieved through expensive, years’-long litigation.” Two other bills are technical in nature, and include steps to improve patent transparency and disclosure. And the remaining bill makes it harder for biologics firms to deny generic companies samples for testing.

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