# Hospital billing inconsistent throughout U.S.

**By Chad Terhune and Ben Poston, Los Angeles Times**

New Medicare data reveal wildly varying charges among the nation's hospitals for 100 of the most common in-patient treatments and procedures, calling into question medical billing practices just as U.S. officials try to rein in rising costs.

The escalating price of medical care may complicate the rollout of the new federal healthcare law, which is designed to make health insurance affordable for millions of uninsured Americans next year. And federal officials said they hope the data will encourage more price competition and make consumers better healthcare shoppers.

In the Los Angeles area, for instance, one hospital's average price for knee and hip replacements in 2011 was as high as $223,373. That's seven times as much as the lowest charge of $32,022 in the Southland.

The average hospital charge for treating pneumonia ranged from $17,000 to nearly $70,000 in the L.A. area.

"We want to shine a much brighter light on practices that don't seem to make sense to us," said Jonathan Blum, deputy administrator for the Centers for Medicare and Medicaid Services. "We do not see any business reason for why there is so much variation in the data."

Hospitals said they support efforts to simplify an overly complex medical billing system and arm consumers with more information. The California Hospital Association agreed, but warned that the newly available federal data "may confuse patients as well as the public." (**Note:** Search Tahoe in the

data for comparisons of Barton Memorial Hospital and Carson Regional Medical Center.)

Health-policy experts called the government's move to release prices from more than 3,000 U.S. hospitals unprecedented in its scope, and they said it could accelerate related efforts to pry more detailed cost information from health insurers and other medical providers.

Many employers and consumers still struggle to unravel the closely guarded secrets of medical pricing even though they are being asked to shell out ever-increasing amounts for care.

Medicare and private insurers pay only a fraction of these billed charges disclosed by the government. Regardless of the bills, Medicare pays standardized amounts for specific conditions, and insurers negotiate lower rates.

Nonetheless, experts say the actual amounts insurers and consumers pay follow a similar pattern of wildly divergent prices with little correlation to the quality of patient care or the underlying costs.

"This is evidence of an incredibly dysfunctional and arbitrary pricing system in healthcare," said Renee Hsia, an assistant professor of emergency medicine at UC San Francisco who studies these cost variations. "It affects us all because the insured pay for this through their premiums and the uninsured face the sticker price. People are really being hurt by this."

Critics say hospitals benefit from inflating these listed prices because some health insurers still peg their reimbursement to a percentage of full charges. They also say hospitals gain from higher charges by taking credit for writing off larger amounts for low-income and uninsured patients.

"There's an incentive to have your charge as high as possible," said Ateev Mehrotra, a policy analyst for Santa

Monica-based Rand Corp.

The American Hospital Association said it supports efforts at greater transparency and noted that more than 40 states, including California, already require or encourage pricing information to be reported publicly.

“The complex and bewildering interplay among charges, rates, bills and payments across dozens of payers, public and private, does not serve any stakeholder well, including hospitals,” said Rich Umbdenstock, chief executive of the hospital trade group.

Researchers have documented for years some of the surprising variations in medical costs across the country and within the same city. But this move by Medicare marked the first time so much data on the topic were released directly to the public.

There are valid reasons for some disparity in costs, researchers say, such as geographic differences in the cost of living and wages or the fact that teaching hospitals bear additional costs. Some hospitals also treat a higher percentage of low-income or sicker patients.

In Wednesday’s data, two Southern California hospitals held the dubious distinction of billing the highest amounts nationwide for a joint replacement surgery without complications.

Monterey Park Hospital charged $223,373 on average, and Centinela Hospital Medical Center in Inglewood billed $220,881.

In contrast, L.A. County Harbor/UCLA Medical Center posted the lowest local rate — charging $32,022 for new artificial hips and knees.

Officials at Monterey Park couldn’t be reached. A spokesman for Prime Healthcare’s Centinela Hospital said the higher rate

reflects “a sicker and older patient population” compared with other area hospitals.

Similar price disparities were seen in the treatment of simple pneumonia in the Southland. Providence Holy Cross Medical Center in Mission Hills billed $69,574, on average, for treating pneumonia without complications, federal data show. At the low end, L.A. County/USC Medical Center billed $19,852, on average, for that illness, and Citrus Valley Medical Center charged $17,174.

As policyholders’ deductibles have risen and they have more of their own money at stake, insurers have introduced new online tools enabling members to get a range of prices among network providers. But consumer advocates still see significant resistance among hospitals and insurers to disclose detailed information.

“Everybody in the industry is so scared about what it would mean if all the pricing information was available,” said Suzanne Delbanco, executive director of Catalyst for Payment Reform, an employer-backed group in San Francisco pushing for more healthcare transparency. “Medicare is sending a message that American consumers have a right to know what’s driving up their healthcare costs.”