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How Much Should Insurers Pay Hospitals For COVID-19 Care?

By **Matthew List**
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The ongoing COVID-19 pandemic has disrupted the care delivery system in the U.S. Hospitals have cancelled elective procedures to ensure there is adequate capacity for COVID-19 patients requiring care and many facilities have set up separate COVID-19 wards to control the spread of disease.

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In areas of the country where the outbreak is particularly severe or hospitals are facing capacity constraints, some patients with employer-sponsored health plans may find themselves receiving care at out-of-network hospitals.

The cost of a hospitalization related to COVID-19 can be high. Patients may be admitted to intensive care units and require mechanical ventilation, with some patients requiring a ventilator for more than two weeks.[1] For out-of-network hospitals, there is no agreement that sets forth the reimbursement rates the hospital will be paid for providing this care.

Under the Coronavirus Aid, Relief, and Economic Security Act, providers who receive CARES Act grants are barred from charging out-of-network patients more than what the patient would pay to receive care from an in-network provider.[2] While this provides guidance on how much a patient may have to pay for receiving COVID-19 care at an out-of-network hospital, the CARES Act says nothing about how much the patient's health plan should pay the hospital.

Without such guidance, health plans and out-of-network hospitals may find themselves disagreeing on the appropriate payment for care related to COVID-19. To see the extent to which hospitals' charges for care related to COVID-19 may vary, I use data from the Centers for Medicare & Medicaid Services that provide an annual summary of average charges by the Medicare severity diagnosis related group, or MS-DRG, for each hospital.

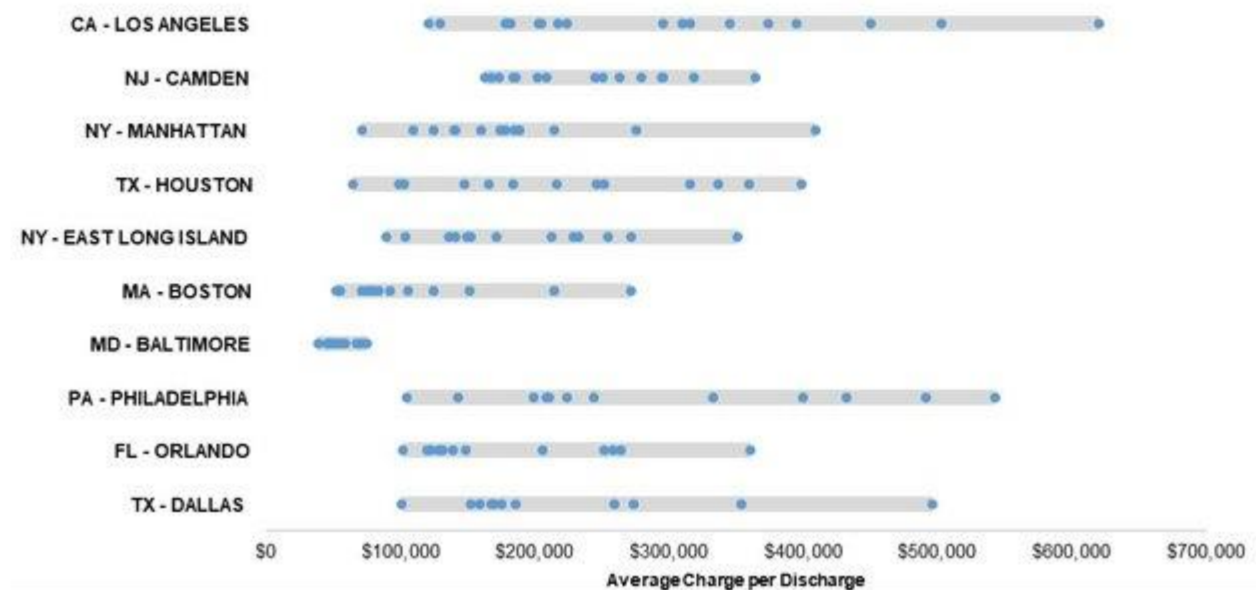
Medicare assigns a single MS-DRG to each inpatient stay based on a patient's characteristics and diagnoses as well as the procedures that were performed on the patient during his hospital stay.[3] I combine MS-DRG-level charge information with data from the annual cost reports that hospitals file with CMS; these data provide information on the costs associated with providing care in intensive care units.

Hospitals' Costs and Charges Vary Widely

Hospitals' costs and charges for providing care to COVID-19 patients are likely to vary widely. MS-DRG 207, which is used for inpatient hospital stays where a patient requires ventilator support for more than 96 hours, offers a useful example. All of a hospital's charges for a single inpatient stay for a patient with a respiratory infection requiring long-term ventilator support would be assigned to this MS-DRG. Hospitals' charges associated with MS-DRG 207 differed substantially in fiscal year 2017, even within the same hospital referral region.[4]

The figure below summarizes the range of charges for this MS-DRG within and across 10 regions. Each dot in this chart indicates the average charge for a single hospital for MS-DRG 207. With the notable exception of Baltimore, Maryland, where hospital prices are regulated by the state, there is wide dispersion within each region.

Figure 1: Hospital charges for MS-DRG 207 respiratory system diagnosis with ventilator support 96+ hours by hospital referral region.



Source: Charles River Associates analysis of CMS data.

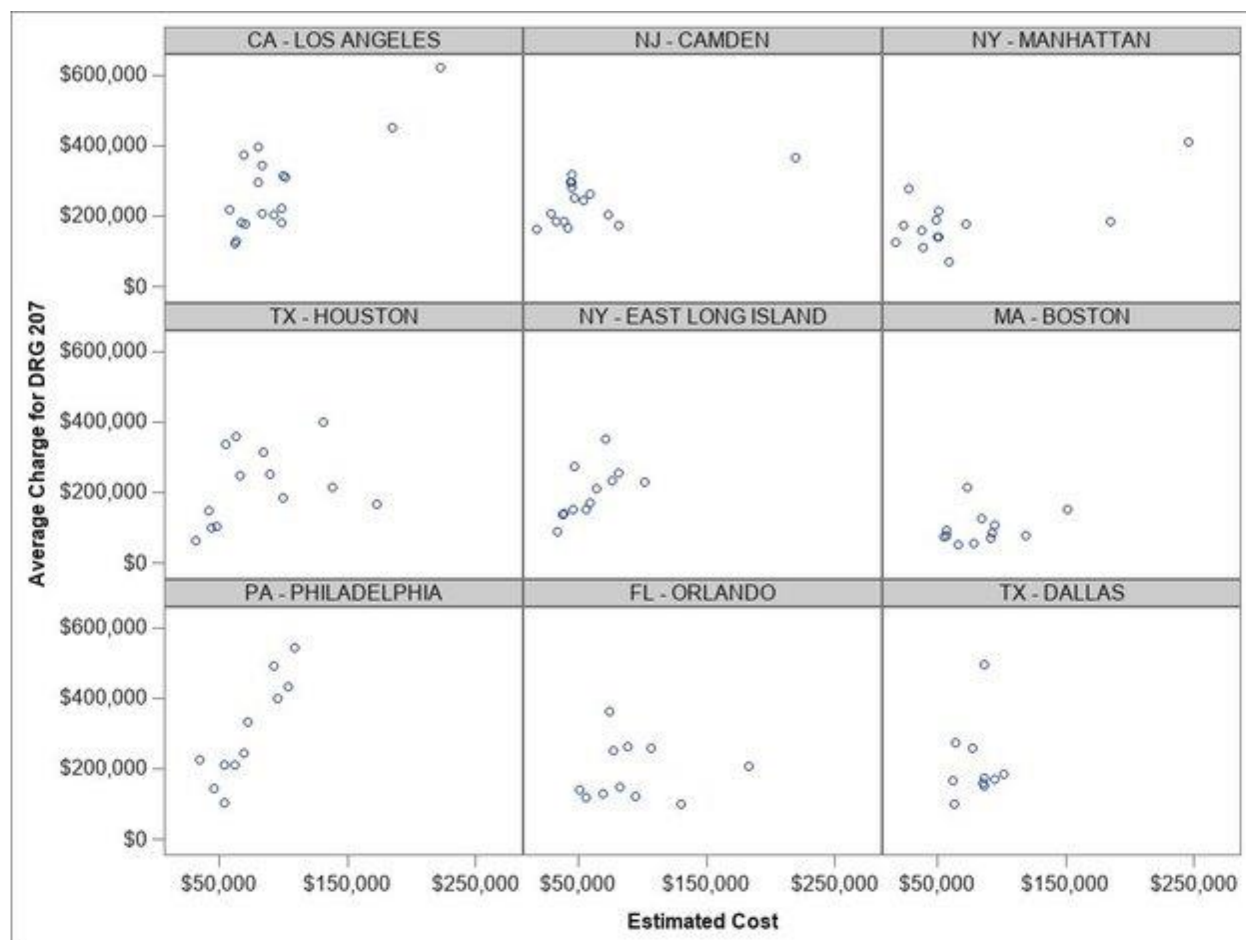
A single hospital referral region may include hospitals with diverse patient, service and payor mixes, and patients with hospital stays assigned to the same MS-DRG may each have different comorbidities or severity of illness. As such, some of the differences in hospitals' charges may be related to differences in hospitals' costs of providing care.

Although MS-DRG-specific costs are not included in a hospital's annual cost reports, these reports do include a hospital's charges and costs for its intensive care unit, where most patients requiring mechanical ventilation will be admitted. To estimate each hospital's cost of providing care for inpatient stays with MS-DRG 207, I calculate the ratio of costs to charges for each hospital's intensive care unit

and apply this ratio to the hospital's average charge for MS-DRG 207.

Figure 2 compares these estimated costs to average charges for select hospital referral regions. If charges and costs were strongly correlated, the dots in this figure would fall along an upward-sloping 45 degree diagonal line. While there is generally a positive correlation between costs and charges for MS-DRG 207, it is clear that some of the variation in hospitals' charges within the same region is not explained by differences in costs.

Figure 2: Hospital charges and estimated costs for MS-DRG 207 respiratory system diagnosis with ventilator support 96+ hours by hospital referral region.



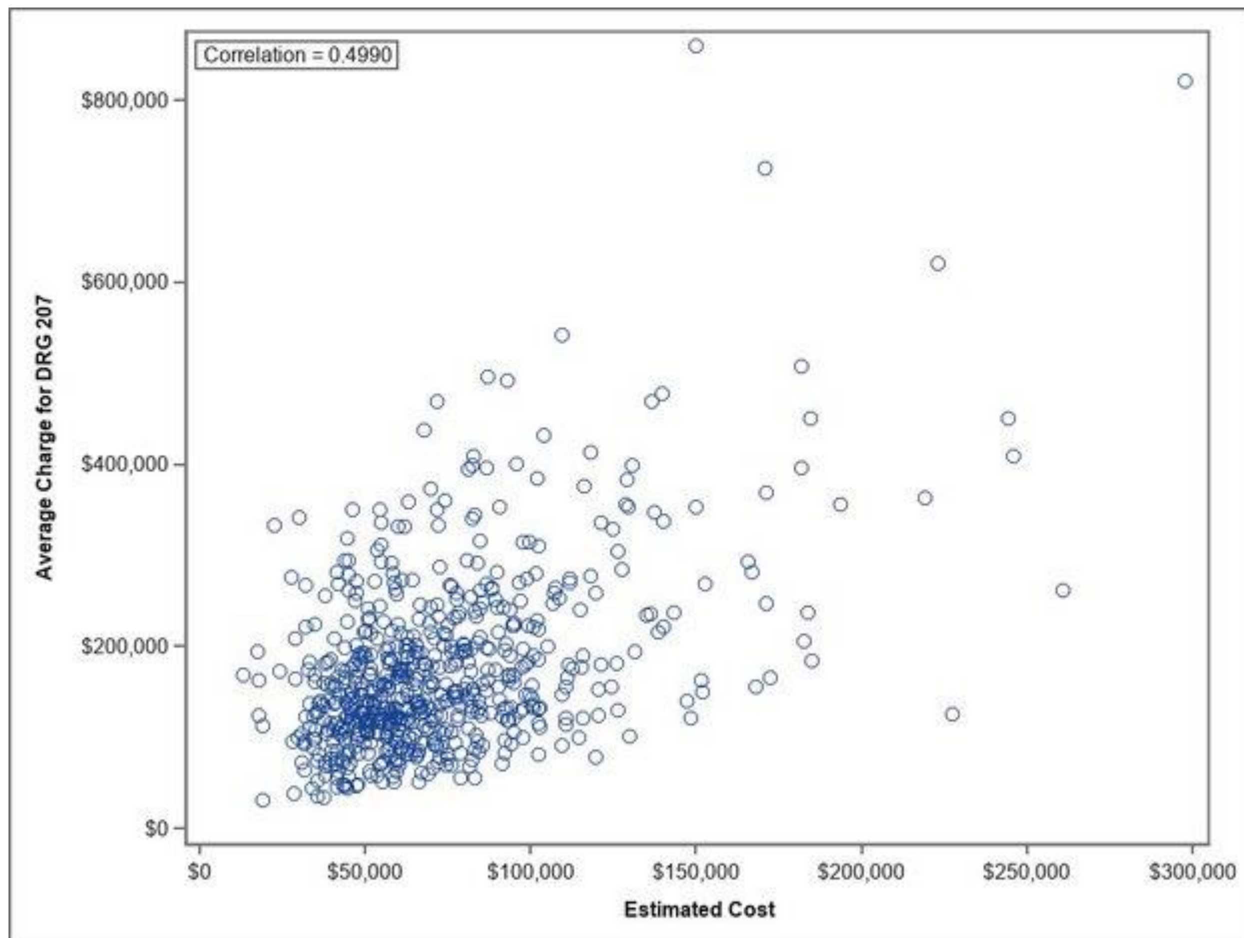
Source: Charles River Associates analysis of CMS data

Figure 3 extends this comparison nationally. Across the country, hospitals' charges and costs of care vary widely. Indeed, for some hospitals the cost of providing ICU care can exceed the facility's billed charges. Among the hospitals included in Figure 3, 3.5% report that their costs for ICU care exceeded their charges.

Many more hospitals may find that their costs have increased during the pandemic. As the American

Hospital Association noted, hospitals have faced increased costs associated with constructing new triage and treatment areas for COVID-19 patients, compensating staff and acquiring beds, ventilators, testing supplies, personal protective equipment, and pharmaceuticals.[5]

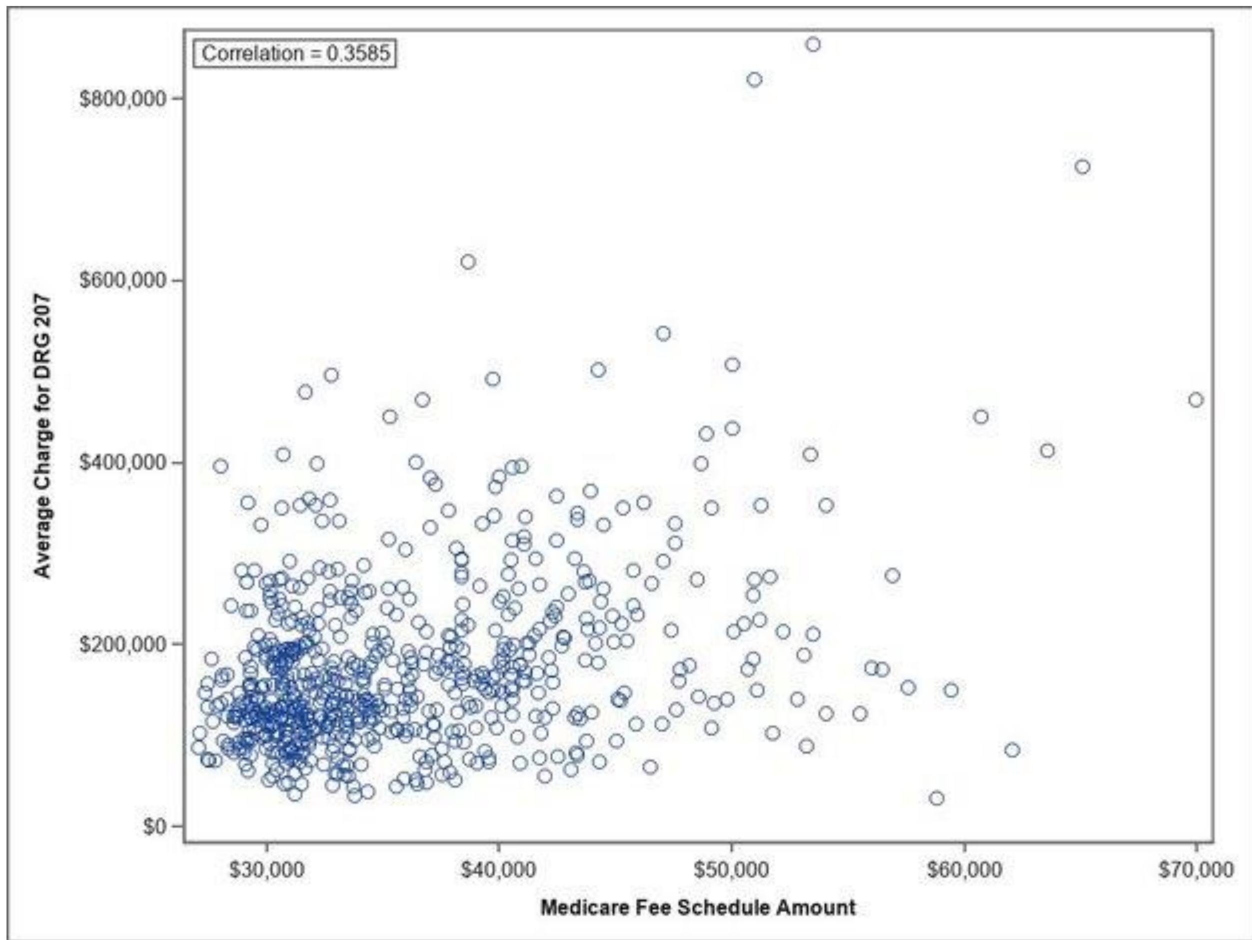
Figure 3: Hospital charges and estimated costs for MS-DRG 207 respiratory system diagnosis with ventilator support 96+ hours.



Source: Charles River Associates analysis of CMS data.

A similar pattern can be seen when hospitals' charges are compared to Medicare fee schedule amounts. Nearly 39% of adult inpatient hospital stays in 2017 were covered by Medicare,[6] but the amount Medicare pays for these stays at most hospitals is determined through CMS's inpatient prospective payment system rather than based on hospitals' charges. As Figure 4 shows, there is not a strong relationship between hospitals' billed charges and the rates that hospitals are paid for treating Medicare patients.

Figure 4: Hospital charges and medicare fee schedule rates for MS-DRG 207 respiratory system diagnosis with ventilator support 96+ hours.



Source: Charles River Associates analysis of CMS data

How to Resolve Payment Disputes

While the variation in hospitals' charges and costs is interesting, hospitals are rarely paid their full charges and hospitals could not be financially viable in the long term if they only covered their costs. So how much should hospitals be paid for providing out-of-network care to patients with COVID-19?

One possibility is to look to the Medicare fee schedule for guidance, although Medicare's payments to hospitals are often far less than what hospitals receive from private insurance.

One study found that Medicare pays hospitals less than half of what private insurance plans pay for inpatient care.[7] Using claims data from three of the five largest private health insurers in the U.S., the authors found that while private health plans paid hospitals 48% of billed charges for inpatient care, Medicare would have only paid 22% of billed charges for the same care.

And the American Hospital Association found that Medicare reimbursement rates on average cover only 87% of hospitals' costs.[8] However, the CARES Act increased Medicare payments to hospitals by 20% for inpatient stays related to COVID-19.[9]

Another alternative is to look to the rates that health plans pay similar in-network hospitals in the area,

though there can be substantial variation in the in-network rates that hospitals are paid. Not only can different hospitals in the same area be paid different in-network rates by the same health plan, but different health plans can have substantially different in-network rates at the same hospital.[10]

Moreover, rates negotiated between hospitals and health plans for in-network care are closely guarded by hospitals and health plans alike, with the American Hospital Association currently challenging a proposed CMS rule that could result in these rates being publicly disclosed.

Conclusion

Although recent legislation provides guidance for how much health plan members should pay for COVID-19 care at out-of-network facilities, there is little nationwide guidance for how health plans should determine reimbursements to hospitals. Hospitals' charges, costs and Medicare payment rates vary widely, and studies have shown that even in-network rates can differ substantially across plans for the same hospital.

Disputes over hospital reimbursement for COVID-19 care will require careful analysis of the particular facts of each local area. Future legislation related to the pandemic may also provide guidance.

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[1] Kelly Servick, "For survivors of severe COVID-19, beating the virus is just the beginning," Science, April8, 2020.

[2] Rachel Cohrs, "Surprise billing banned for providers that get CARES Act grants," Modern Healthcare, April 9, 2020.

[3] MedPAC Payment Basics, Hospital Acute Inpatient Services Payment System, October 2019, available at http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_19_hospital_final_v2_sec.pdf.

[4] Data for fiscal year 2017 are the most recent available.

[5] Letter from Richard J. Pollack, President and Chief Executive Officer of the American Hospital Association, to Health and Human Services Secretary Alex M. Azar and CMS Administrator Seema Verma, March 31, 2020.

[6] HCUP Fast Stats, Healthcare Cost and Utilization Project (HCUP), December 2019, Agency for Healthcare Research and Quality, Rockville, MD, available at http://www.hcup-us.ahrq.gov/faststats/statepayer/states.jsp.

[7] Zack Cooper, Stuart V. Craig, Martin Gaynor, and John Van Reenen, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured,"Quarterly Journal of Economicsvol. 134, no. 1 (2019): 51-107 (hereinafter "Cooper, et al.") at 65-67.

[8] American Hospital Association, "Fact Sheet: Underpayment by Medicare and Medicaid," January 2020, available at https://www.aha.org/system/files/media/file/2020/01/2020-Medicare-Medicaid-Underpayment-Fact-Sheet.pdf.

[9] Rich Daly, "Increased Medicare payments for COVID-19 care to stretch back to late January," Healthcare Financial Management Association, April 21, 2020, available at https://www.hfma.org/topics/news/2020/04/increased-medicare-payments-for-covid-19-care-to-stretch-back-to.html.

[10] Cooper, et al. at 72-80.