Seattle Lawsuit Settlement Shines Light On 'Facility-Based' Hospital Pricing: A Major Medical Center Implements Price Disclosure And Also Reduces Its Prices, Possibly Setting An Example For Greater Price Transparency At More U.S. Hospitals

'Health Care Consumerism' gets teeth.

"These pricing practices would not survive in an open market in which people have the information to make informed choices." Attorney for Plaintiffs

Questions: Will price transparency force big changes at 'facility-based' hospital clinics? Are noncompetitive hospital clinics vulnerable in a 'transparent' environment?

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Two class actions were filed in Seattle (King County Superior Court[2]) relating to the pricing differential between 'facility-based' and 'freestanding' clinics, the first suit as a complaint against the Virginia Mason Medical Center in January of 2005 and the second suit against the University of Washington Medical Center in March of 2006. Both suits: (a) relate to amounts charged for procedures in 'provider-based' settings compared with prices for the same procedures in 'freestanding' settings and (b) seek to enjoin the respective institutions from "…continuing…unfair and deceptive pricing practices…" On September 1, 2006 the plaintiffs' counsel and the University of Washington Medical Center announced an agreement[3] in respect to that lawsuit. The other class action, the suit respecting Virginia Mason Medical Center, remains in active litigation.
Some case materials and an interview with legal experts can be found on the web site:
http://www.healthbusinessandpolicy.com/PricingLawsuits.htm

A $1,133 Outpatient Toenail Clipping Incident Angers An Insured Consumer

The plaintiff in the Virginia Mason Medical Center case, Lori Mill, had a bothersome toenail. She lived near suburban Kirkland, Washington where her regular physician had an office in a Virginia Mason facility, but she worked in downtown Seattle and in that area Virginia Mason had an outpatient 'provider-based' clinic[4] on the general campus of the hospital. She chose to go to that facility on May 20, 2004 where a physician clipped her toenail and checked the area for fungus. No fungus was found, no other procedure was performed and no medication was prescribed during a procedure that took about 30 seconds according to her testimony.

The total bill amounted to $1,133, of which $418 amounted to the hospital's 'facility fee' portion. Lori Mill was insured but, like many insured persons, was responsible for a 20% co-payment. Looking into the matter, she contacted a billing coordinator at Virginia Mason's facility in suburban Kirkland who told her that the total bill at that location would have been under $300 with no charge for the hospital overhead costs or 'facility fee.' Among other allegations in the January 2005 complaint is the allegation that this differential in Virginia Mason's charges in respect to its own clinics—'provider-based' versus 'freestanding'—was not disclosed to Ms. Mill before, during or following the medical treatment.

A second plaintiff named in the January 2005 original complaint, DeLois Gibson—also an insured person—had a similar experience with a bill from the same Virginia Mason 'provider-based' facility in downtown Seattle following a minor procedure performed on September 7, 2004. The essence of the allegations is stated in the original complaint:

…Lori's shock to discover that if she had gone to Virginia Mason's outpatient clinic in Kirkland instead of the downtown outpatient clinic, the toe nail clipping procedure would have cost at least five hundred dollars less is at the heart of this Washington Consumer Protection Act suit on behalf of persons who have visited defendant's outpatient clinic in downtown Seattle and been similarly overcharged and who, like Lori Mill and her co-plaintiff DeLois Gibson, must pay some portion of their medical bills because they are uninsured, only partially insured, or are required to pay a percentage deductible or co-pay amount under their health insurance…This lawsuit seeks to recover the amounts that Virginia Mason has overcharged plaintiffs…for medical procedures…at its downtown outpatient clinic in excess of what it charges for the same procedures, treatment and care at its other outpatient clinics. It also seeks an injunction preventing Virginia Mason from continuing its unfair and deceptive pricing practices toward its patients at the Virginia Mason downtown outpatient clinic…[5]

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[2] Case Numbers: 05-2-02198-5SEA (Virginia Mason) and 06-2-08569-8SEA (University of Washington Medical Center)
[3] For full text of the settlement agreement see: http://www.healthbusinessandpolicy.com/PricingLawsuits.htm
[4] 'Provider-based' is a very specific defined term a la Medicare reimbursement; see regulations in 42 CFR ç413.65
[5] January 12, 2005 complaint, pp. 2-3. For full text see: http://www.healthbusinessandpolicy.com/PricingLawsuits.htm

The Argument "But hey, Medicare Says This Is Legal!" … Doesn't Fly With The Judge

Like the now-famous 'uninsured' lawsuits, the interpretation of a hospital's status under *federal law* and its ability to defend itself against federal claims—as in the far-fetched legal arguments of the plethora of federal court Scruggs' class action lawsuits initiated in June of 2004—can differ markedly from *state law* interpretations of a hospital's status and/or behavior, evidenced now by the significant number of settlements by major hospital systems of state court class actions in respect to the 'uninsured' pricing/collections/charity care controversies.[6] It is not coincidental that the body of *state laws* in respect to 'consumer protection' or 'consumer fraud' that has been embraced by plaintiffs' lawyers—quite successfully in many instances—was also in play in these 'facility-based' pricing matters.[7]

In any case, leaning on its solid federal regulatory position, defendant Virginia Mason argued, in essence, that:[8] (a) the downtown Seattle outpatient clinic is really part of an actual 'hospital'; (b) "…hospitals must meet greater patient care requirements than clinics…such as emergency medicine and comprehensive laboratory and radiology services…" and "…must meet strict safety and quality requirements that are not applicable to physician clinics…"; (c) thus, "…all of these obligations make hospitals more costly to operate than freestanding physician clinics"; (d) "…Medicare permits a system known as 'hospital-based billing' for facilities such as Virginia Mason's downtown hospital. Private health insurers and other government payers also follow this system…"; and (e) "…Thus, the charge about which plaintiffs in this action complain is entirely lawful. ***In fact, on information and belief, the practice of hospital-based billing is widespread across the United States***" (emphasis added here).

This article is written because *it is exactly the widespread nature of these 'hospital-based' or 'facility-based' billing practices—outside the purview of actual hospital emergency rooms or legitimate inpatient areas—that makes these legal cases and, in particular, the University of Washington Medical Center's settlement, highly significant.*

At any rate, on September 6, 2005 Judge Gregory P. Canova issued an order granting the plaintiffs' motion for what is known as 'class certification'—meaning that this legal action could proceed to trial as a class action lawsuit:[9]

"…The Court…finds that a class action is superior to other available methods for the fair and efficient adjudication of this controversy, and that a class action is manageable. A class action is manageable due to the predominance of the common issues identified above, namely (1) whether Virginia Mason has unfairly or deceptively charged its patients more at its downtown outpatient clinic than it charges for the same procedures at its satellite clinics, and (2) whether Virginia Mason has unfairly or deceptively failed to disclose that disparity in charges to its patients…that the certified Class be defined as follows: All persons who received medical procedures, treatment or care at the Virginia Mason outpatient clinic in downtown Seattle who were charged more than they would have been charged for the same procedures, treatment or care at another Virginia Mason outpatient clinic and who were obligated to pay all or any portion of that excess cost."[10]

Enter The Second Similar Class Action: The University Of Washington Medical Center Is Sued, Then Settles Six Months Later

Since in the context of this article similar legal issues pervade the two cases, there is no need to elaborate on the second of the two cases, the class action against UWMC filed in March 2006; the court docket of this case contains the relevant documents.[11] In the context of this article, the most relevant document is the settlement agreement.[12] The following was agreed to by UWMC:

-- UWMC is implementing "an estimating process" that "is designed to provide patients with the information they need to work with their insurers to determine their personal financial responsibility for the medical services they receive at UWMC before those services are provided" with such process to be in place by 7/31/07.[13]

-- This estimating process will apply to outpatient services, and UWMC "will support the estimating process with two full-time equivalent staff positions."

-- Information about this estimating process will be posted at UWMC facilities themselves and on its website.

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[6] In January of 2005 Richard Scruggs announced a change in legal strategy, filing class actions under state law legal theories.

[7] In fact, the Seattle plaintiffs' lawyer, John Phillips, who brought the two 'facility-based' pricing suits mentioned here, had been part of the Scruggs class action plaintiffs' legal team that filed state 'uninsured' class actions in Oregon, successfully obtaining settlements from two large hospital systems there in June and July of 2006 (the two systems are Legacy Health System and Providence Health System, respectively.)

[8] The following quotes are excerpted from the February 25, 2005 defendant's answer to the complaint. The full texts of the original complaint and answer can be found at: http://www.healthbusinessandpolicy.com/PricingLawsuits.htm

[9] The full text of the judge's order can be found at: http://www.healthbusinessandpolicy.com/PricingLawsuits.htm

[10] Excerpted from the judge's order that can be found at: http://www.healthbusinessandpolicy.com/PricingLawsuits.htm

[11] King County Superior Court, case #06-2-08569-8SEA

[12] The full text of the settlement agreement can be found at: http://www.healthbusinessandpolicy.com/PricingLawsuits.htm

[13] The key elements of the settlement agreement appear on pp. 5 and 6 of that agreement.

-- Patients will be informed:
- The specific UWMC facilities "that charge facility fees"
- That at such facilities "they will receive two bills, one from UWMC and one for professional services"
- That "facility fees may be greater than their charges for professional services"
- Web site information "about the facility fee and physician charges for the 20 most common" procedures

-- In addition to the 'disclosure' aspects mentioned above, the agreement indicates that UWMC will adjust prices for "Minor Surgery Procedures" downward in relation to the prices at other hospitals, to a level "at approximately the 25th percentile of the market through June 30, 2008." It should be noted that this move was taken at least as much in response to competitive market conditions—especially the growing number of physician-owned clinics and ASCs that performed the same procedures at relatively lower costs—as it was in response to the class action, although the plaintiff also asserted that the 'facility fees' were unreasonable *per se*.

-- It should be noted that UWMC is not making any refunds to patients as part of this settlement concerning alleged excessive prices, overpayments, etc. In this context, the settlement involves only 'going-forward' changes. According to plaintiffs' counsel, this has to do with the state law problem of suing a public, state university under consumer fraud arguments. However, the plaintiffs are expected to seek restitution/refunds in the Virginia Mason class action in that Virginia Mason is a Washington nonprofit corporation, not a 'state' entity.

UWMC's Chief Executive Gets The Message
Says Lisa Brandenberg, Interim Executive Director of the University of Washington Medical Center:
"We feel like these are the right things to do, so I think this is a good settlement."

Past experience in such matters told me that I would get a closed-mouth 'we can't elaborate on the agreement' and other legalistic mumbo jumbo statements when trying to interview the defendant in the UWMC case … refreshingly, exactly the opposite happened. UWMC's chief executive, Lisa Brandenberg, talked unhurriedly and extensively about the settlement and, importantly, the philosophy underlying it:

On the reason for the relatively quick settlement (the suit was filed in March, settled by Sept. 1st):

"We had definitely been moving toward more pricing disclosure even before this lawsuit...things that we have either implemented now going forward or that we are in the process of implementing…things that we have been moving towards and were working on already. These included better information to our patients about our billing practices, the system for estimating which is rolling out through our clinics now, and a tool for helping patients to work with their insurance company to better understand what the patient portion of their bill will be."

On some of the settlement's key features:

"What the settlement is aimed towards is greater transparency to the patient in making sure the patient knows as much information as possible ahead of time, so a key portion of the settlement is a process to estimate charges for the patient when they request it, before they get service. Another part of it is making sure the patient knows they will get two bills, that they will get a separate facility bill from the hospital. We also wanted to make sure that people know that we have some clinics that are off-site, clinics that are not on the main hospital campus, so we wanted to make sure that people knew those clinics were also hospital-based, owned by the hospital.
In addition, as part of this agreement, we looked at a reduction in pricing for minor surgical procedures, which are those procedures that are performed in a physician's office."

On the effect of the local competitive situation, especially competition from physicians:

"There are certainly a greater number of physician-owned clinics, surgicenters and other health care services in the community. When we looked at our minor surgical procedure pricing, we decided that we wanted to be more competitive in that market, and so this price reduction in the settlement agreement helps us be more competitive."

On the backdrop of the national trend towards pricing disclosure:

"Greater hospital pricing transparency is a very big national issue as I'm sure you know. This particular patient {referring to the plaintiff} had insurance. More and more patients with insurance also want a greater level of detail about their health care costs. They are looking at their co-pays and there are also many more people with high-deductible insurance. Consumers want more and more information about their health care including what their health care is going to cost. We feel like these are the right things to do, so I think this is a good settlement."

Analysis and Comment

These lawsuits and the UWMC settlement evoke a number of subjects:

(a) 'Facility-based' versus 'freestanding' hospital clinics' differential *price levels* and price disclosure to patients

(b) Whether physicians at higher priced facilities, faced with the possibility losing patients in a 'transparency' environment, will pressure hospitals to change their pricing levels and pricing disclosure practices

(c) Hospital pricing strategies in respect to a possible pricing difference between: (1) truly 'on-campus' (adjacent) outpatient clinics[14] with more comprehensive medical services as opposed to (2) 'off-campus' hospital-owned clinics with respect to which hospitals file attestations to qualify for 'facility-based'[15] pricing and reimbursement

(d) Growing 'consumerism' by patients—and not just the uninsured—including demands by insured patients who have co-pays and/or high deductibles for:

> (1) R*easonableness of comparative pricing* in respect to 'facility-based' versus 'freestanding' clinics (including patients' own research into and juxtapositions against 'physician-only' offices, clinics and surgicenters),
> (2) U*p-front disclosure before service* and/or disclosure at time of service of procedure-specific or incident-specific pricing…not 'charges' but actual pricing defined as "how much are you guys, the hospital and the doctor, actually and truly asking my insurance company and me to pay"? inclusive of information concerning the amount of the insured person's financial obligation as per the insurance contract,
> (3) The disclosure of hospital and physician pricing information *in terms that are clearly understandable*,
> (4) Disclosure of *procedure-specific* or *medical episode-specific* information (including inpatient medical episodes that can be commonly described by DRG, case type, etc.) on web sites including *the ability to compare hospitals and other types of providers* on the basis of understandable pricing information … again, not 'charges' but actual prices,
> (5) The availability of repayment plans on reasonable terms in instances where the patient's portion of the financial obligation to a hospital and/or a physician is significant in comparison to the patient's resources.

(e) Growing competition from physician-owned practices, clinics, surgicenters, etc. that may, and often do, perform identical procedures, diagnostic tests, urgent care interventions and other medical services that are performed by hospitals, hospital 'clinics' and similar facilities.

(f) The obvious 'branching-out' of the plaintiffs' bar beyond just the 'uninsured' population and uninsured issues in respect to the filing of class action lawsuits that deal with hospital pricing.

(g) The legal exposure to hospitals in respect to differential pricing, in the context of 'state law' issues.

(h) The broader question from a regulatory standpoint: will these 'facility-based' versus 'freestanding' pricing controversies arouse federal agencies to shut down or limit this kind of differential pricing on the part of hospitals and hospital-affiliated and/or hospital-owned 'clinics'?[16]

Leaving aside future potential legal and regulatory events, the most interesting facets of the settlement to this analyst in the UWMC case and the accompanying interview with the Medical Center's chief executive are: (a) a recognition by UWMC that meaningful, understandable, consumer-friendly pricing disclosure is inevitable and (b) UWMC's proactive lowering of certain procedure prices that, in her words, "helps us be more competitive."

Let us first examine the issue of consumer-friendly pricing disclosure and its ramifications. It seems logical that the sheer act of disclosing 'real prices' to consumers (meaning what they themselves are asked to pay as opposed to the often distorted reference point of 'charges') will, in itself, force hospitals to equalize the pricing of certain types of services *in respect to their own affiliated 'facility-based' and 'freestanding' medical offices and clinics*.

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[14] "Outpatient clinics" used here is distinguished from legitimate hospital 'emergency rooms' in this discussion.

[15] The terms 'facility-based' hospital pricing and 'hospital-based' pricing are often used interchangeably.

[16] This is not wild speculation on the author's part; in September of 1999 and again in August of 2000 the OIG Inspector General recommended that HCFA basically eliminate "the provider-based designation" and eliminate "provider-based status" stating in its 1999 recommendation: "…HCFA should require that hospitals treat all purchased physician practices and those they currently own, as free-standing entities. This would financially benefit Medicare beneficiaries by **eliminating the coinsurance inequities they are currently experiencing when they receive services in provider-based, rather than free-standing, facilities**." (emphasis added; cite is from June Gibbs Brown, the OIG Inspector General, report entitled 'Hospital Ownership of Physician Practices.')

In addition, the act of disclosing actual prices could very well result in hospitals ceasing the counterproductive practice of charging uninsured persons 'list prices' or 'chargemaster' prices since, even in the absence of class action and/or attorneys general litigation in this area, hospitals may eventually 'get' that disclosure in the context of greater consumer sophistication and greater consumer proactivity is here to stay. In this regard, the economic and business reality that hospitals never have really collected more than a fraction of 'list prices' from their uninsured patients may, finally, bring the industry around to more prudent business practices, focusing on collecting more money from the uninsured through fair pricing and fair repayment terms as some hospitals are now actually doing.[17] The bottom line here: the kind of disclosure *per se* that organizations like UWMC are taking may, in itself, cause the uninsured 'pricing/collections/charity care' controversy to be dealt with through means other than litigation, governmental investigations, etc.

It is also probable that pricing disclosure—in concert with 'quality' information—will combine to cause the 'value proposition' to be much better understood and acted upon by consumers, something that will eventually have a marked impact on all hospitals for better or worse depending on the organization.

Turning to the action of UWMC in reducing pricing for certain procedures and services, this is highly significant in the contexts of: (a) consumer choice, (b) hospital-to-hospital competition and (c) hospital-physician competition. In my view, the most significant ramification of the kind of pricing disclosure that UWMC is undertaking concerns competition between hospitals and medical practices inclusive of ASCs and the like. The chief executive of UWMC remarked on the hospital-physician competitive implications of UWMC's pricing moves during our interview.

This is not at all surprising, and UWMC is to be complimented for moving on the price reductions in the context of competition from physicians, totally apart from the plaintiff's complaint in the lawsuit. Lisa Brandenberg and her colleagues clearly 'got' the unassailable logic of how one thing leads to another, to wit: *when you disclose true prices to consumers, you might need to change prices to remain competitive now that those prices are able to be known even if you attempt to purvey a better 'value' proposition*.

Logical and inevitable though this kind of re-pricing examination is, in respect to hospital-operated 'clinics' the implementation of price 'transparency' is also a direct challenge to their own management capabilities, for whereas pricing that is obscure or unknown does not bring inefficiencies to light, pricing that is 'known' on a comparative basis for essentially the same services can expose management shortcomings. This can be particularly true when one lines up 'hospital-based' facilities against 'physician-owned' facilities that, in essence, provide identical or similar services.

I did not ask Lisa Brandenberg whether their pricing adjustments would, in turn, require management changes within their 'facility-based' enterprises; however, her tone of confidence and determination told me that they will do what they need to do to remain competitive and not have their market share eroded by physicians just because they are disclosing prices to consumers.

Going beyond the UWMC situation, the analyst looks at what has happened in Seattle as a two-edged sword. On the one hand, the positive community relations and forward-looking consumer relations steps are unquestionable. On the other hand, 'transparency' can expose serious management vulnerabilities that, unaddressed, can lead to a 'facility-based' hospital outpatient enterprise becoming untenable in respect to its market positioning. The question then becomes: can 'facility-based' hospital or hospital-physician enterprises survive transparency?

The answer to this question, as in many aspects of business, will probably depend on: (a) the specific circumstances in particular markets, especially the degree of physician-driven market share vis-à-vis hospital market share, (b) the sophistication and skill of a hospital's operational management and (c) in situations where, on the basis of sheer pricing, a hospital appears noncompetitive, the hospital/medical center can convincingly sell the 'value' proposition to consumers and to the community in general.

Many hospital associations express reservations about true price 'transparency' in the context of hospital-to-hospital competition and relative hospital market shares. However, as the management of UWMC evidently knew, when it comes to the outpatient arena it is, in general, not other hospitals that will put a particular hospital out of business. It's the physicians.

[17] See this author's research and commentary on these matters at: www.healthbusinessandpolicy.com/ExemptHospitals.htm