INSTITUTE FOR HEALTH
IHSP & SOCIO-ECONOMIC POLICY

The Second Annual IHSP Hospital 200: Hospitals, Big Pharma, HMOs & the *Health Care War Economy*

Version 1.1, Embargoed Until September 8, 2004

The Institute for Health & Socio-Economic Policy (IHSP) is a non-profit policy and research group. The IHSP focus is current political/economic policy analysis in health care and other industries and the constructive engagement of alternative policies with international, national, state and local bodies to enhance promote and defend the quality of life for all.

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I. About the Institute for Health & Socio-Economic Policy

The Institute for Health & Socio-Economic Policy (IHSP) is a non-profit research and policy organization with a focus on health care and other industries. The IHSP has a prestigious health care advisory board which includes scholars and policy-activists from the Albert Einstein College of Medicine, Boston University, Harvard University, and the University of California.

Among past and current IHSP projects are:

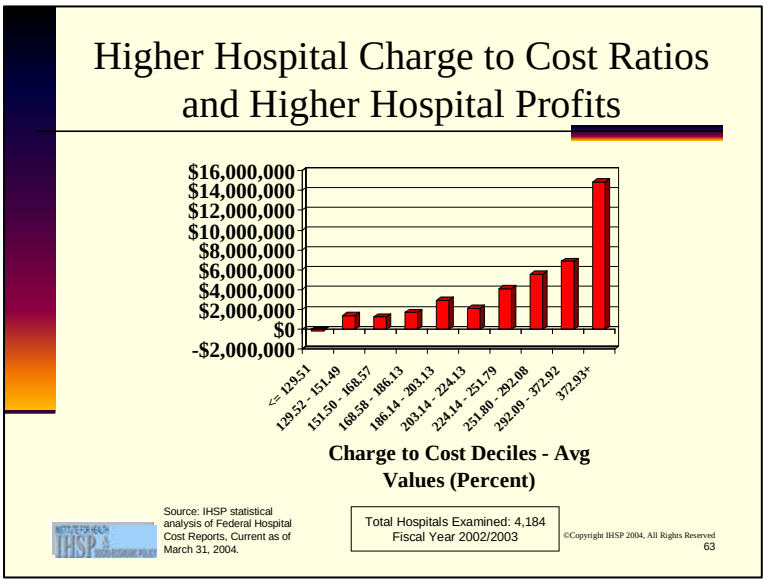
- The health care impacts of California Proposition 209 for the Public Media Center and the California Wellness Foundation. (185)
- The relationship of pharmaceutical mergers to drug prices and caregiver staffing ratios for the Office of US Congressman Dennis Kucinich, Ohio.
- An assessment of health care expert systems technologies at the request of the U.S. Congress, Office of Technology Assessment.
- A study of the impact of hospital pricing structures for fiscal years 2000/2001 for the California Nurses Association.
- Another study for Congressman Kucinich examining hospital drug pricing practices and their impact on hospital charges overall is in progress.
- Joint sponsorship with the one million member **International Federation of Automatic Control**'s (**IFAC**) *Committee on Social Impact of Automation* of an international conference in San Francisco on Human Centered Design.

This study was commissioned by the California Nurses Association.

II. Principal Findings

For purposes of calculating total charge to cost ratios, this report examines 4,184 federal hospital cost reports, current as of March 31, 2004, for federal fiscal year 2002/2003. Given the ever-increasing rate of medical inflation, the swelling numbers of the uninsured coupled with the fact that they are often billed at hospital "list prices," and the widespread charges of fiscal wrong-doing leveled against some hospitals and hospital chains in recent months, this report seeks to quantify the degree if any to which hospitals may be contributing to overall medical inflation. (177;178).It does so by examining inpatient and outpatient charge to cost ratios for the major hospital financial categories/centers commonly found in the cost reports. These categories include 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. (See Table 26 for details).

A summary of notable findings is presented below.



- The **national average total charge to cost ratio for the 4,184 hospitals examined for this report is 232.40%.** Last year the national average for 4,292 hospitals was 205.84%. This constitutes a 13% overall increase and a difference of 26.56 percentage points.

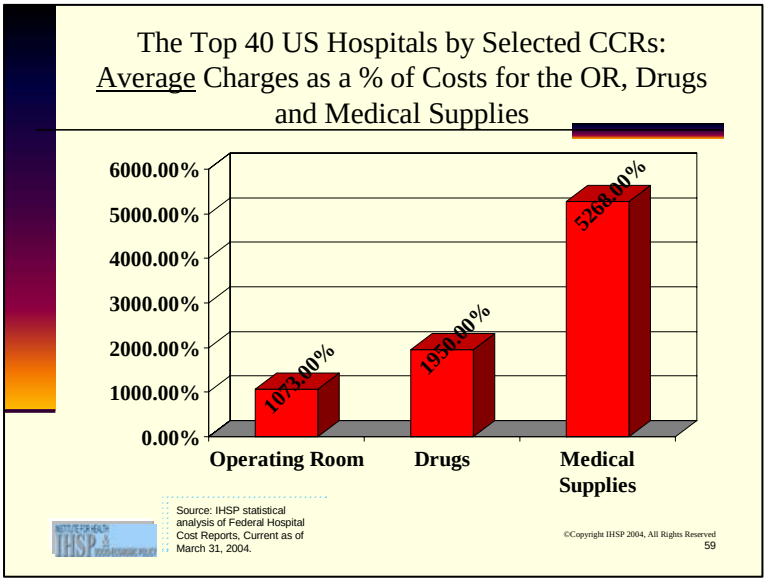
- If the Top 100 hospitals are eliminated from the calculations the national average drops to 221.62% for a total difference of 10.8 percentage points and a 5.7% decrease.

- Of the top 100, large for-profit chains account for 60 hospitals. One of those chains has sold or plans to sell a large number of their facilities. The pricing impact of such changes cannot be determined until new data becomes available.

- Last year, such chains accounted for 72 hospitals in the Top 100.

- A decile analysis linking hospital total charge to cost ratios and hospital profits reveals a strong positive correlation between them. On average, the higher the average charges to costs the higher the average profits, as the chart, *Higher Hospital Charge to Cost Ratios and Higher Hospital Profits* demonstrates.

- On average, the larger a hospital as measured by average number of beds, the higher the total charge to cost ratio **and** the higher the corresponding average profits. (Table 18)



- The **Top 40 Hospital Rankings for Total Operating Room Charges as a Percent of Total Operating Room Costs** ranged from a low of 891% to a high of 1,695%, for an average 1,073% (Table 21)

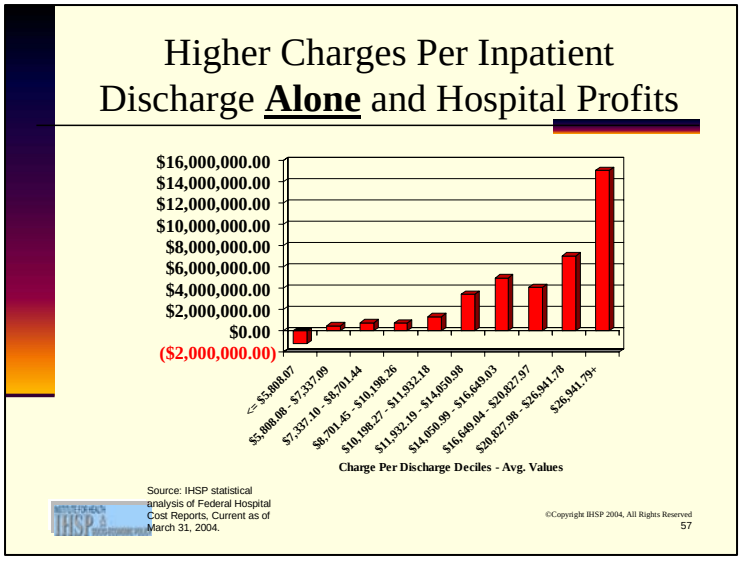
- The **Top 40 Hospital Rankings for Total Drug Charges as a Percent of Total Drug Costs** ranged from a low of 1,394% to a high of 6,796.47%, for an average of 1,950% (Table 22)

- The **Top 40 Hospital Rankings for Total Medical Supplies Charges as a Percent of Total Medical Supplies Costs** ranged from a low of 2,897% to a high of 9,593%, for an average of 5,268% (Table 23)

- The **national average hospital charge to cost ratio for drugs** charged to patients is 398.65%, an increase of about 53.7 percentage points from a previous IHSP study.(70)

- Ten hospitals in the Top 100 were not system affiliated, while 71 of the nation's least expensive 100 hospitals were not system affiliated.

- Defying conventional economic wisdom and its stress on the fiscal efficacy of unbridled markets, Maryland had the lowest charge to cost ratio of any state, with a ratio of 120.24%. It is also the most highly regulated state in the nation. *At the same time, 64% of its hospitals had a positive net income, or about the same percent as the national average.(*See Chart, *Short-Term Hospitals with Positive Net Income*)



Our finding that system-affiliated hospitals dominated the Top 100 and were scarce in the least expensive hospitals nationwide is consistent with earlier research on California hospitals. (74) That research indicated that system-affiliated hospitals exhibit marketing and not production efficiency. Any efficiencies the system-related hospitals gain and that contribute to their profit margins stem from their abilities to market themselves to the community, not

from efficiencies in the production of health care services. In part, the study stated:

> *... we did a cross-sectional analysis of local hospital systems in California in the late 1980s and then in the early 1990s.* ***In both studies we found that the benefits of) horizontal integration stem from greater efficiencies in marketing hospitals systems to the community rather than from efficiencies in the production of services. ….. These results are consistent with those we obtained in our earlier study. Systems do not, in general, exhibit production efficiencies.*** (74)

Our current study demonstrates that not only was the national average total charge to cost **ratio** associated with greater hospital profits, but in addition, **charges alone**, calculated as the *average charge per individual inpatient patient discharge*, was strongly correlated with higher average hospital profits.[1] (See the Chart, *Higher Charges per Inpatient Discharge Alone and Hospital Profits* and Table 15 for more detail). This finding undercuts any appeals to "technical efficiency" that the hospital industry may employ in the attempt to justify high charge to cost ratios.

- Total number of discharges represented is 30,422,558.

- The 10 most expensive hospital systems nationwide ranged from a low of an average 413.99% charge to cost ratio to a high of a 950.74% average.

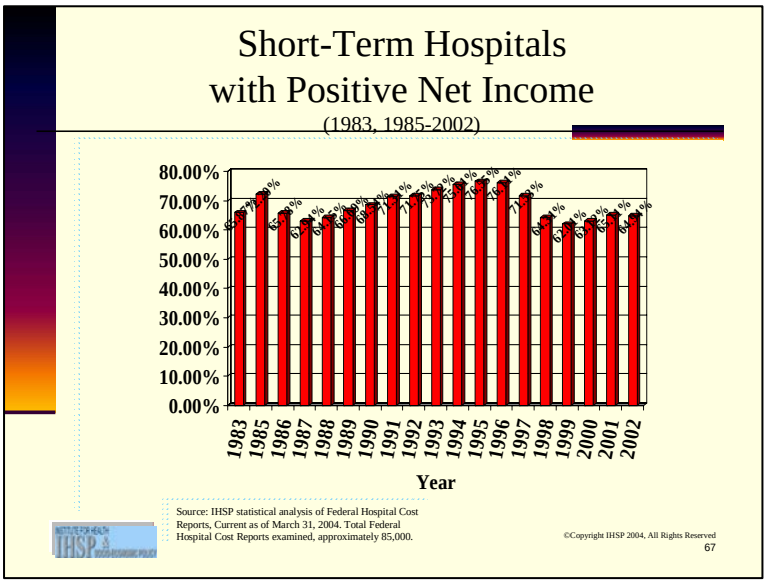
- In our earlier report, the figures were 406.34% and 584.36% for the top five systems. (28)

Concerning individual hospitals:

- Four states – California, New Jersey, Florida and Pennsylvania – accounted for 83 of the Top 100.

- The average charge to cost ratio for the Top 100 was 672.88%, compared to the 2000/2001 finding of 525.27% – a difference of nearly 148 percentage points and an approximate 28% increase.

- Average total charge to cost ratios varied considerably by hospital control type, from highs of 350.58% for proprietary corporations to lows of 216% and 185% for voluntary non-profits and government entities respectively. (Table 19)



[1] Charges per inpatient discharge are calculated by dividing total inpatient charges for each hospital by its total discharges. All hospitals with 100 or more total discharges are included in the calculations.

- Of the 4,184 hospitals employed to calculate total charge to cost ratios in this year's study, 1,365, or about 33%, reported a net loss for the time period. Another 124 hospitals reported less than $100,000 net income. In our previous study, of 4,292 hospitals examined, 1,460, or about 34% of the data set, reported a net loss for the time period. These figures are roughly consistent with aggregated national hospital performance since the early 1980s. (See, Chart, *Short Term Hospitals with Positive Net Income)*

III. Data Sources

All charge to cost data is based on federal hospital cost report filings current as of March 31, 2004. Calculations in Section VIII and the Preface also utilize California Office of Health Planning and Development patient discharge data, Public Version and/or California State Workers Compensation Data, obtainable from the California State Department of Industrial Relations. (See References section of this report).

A. Methodology Employed in this Report

All hospital charges and costs were aggregated for both inpatients and outpatients.

For purposes of calculating total charge to cost ratios, hospitals were included in our data set if and only if they met all of the following conditions:

- The hospital must be a short-term general acute care hospital.
- If a given hospital had more than one filing for the fiscal year, only that filing for the greater number of days during the time period was included in order to prevent duplication.
- The hospital must have total charges equal to or greater than its total costs. (This is a 100% charge to cost ratio).
- The total charge to cost ratio was calculated by dividing the total aggregated charges by total aggregated costs associated with the hospital's major financial categories/centers. (For a listing of those categories/centers, see Table 26 Tables).

Charges per inpatient discharge are calculated by dividing total inpatient charges for each hospital by total discharges for each. All hospitals with 100 or more total discharges are included in the calculations.

- Decile analyses were employed to facilitate the analysis on key variables:
    - Total charges to total costs (charge to cost ratio)
    - Charges to costs relative to profits
    - Charge per individual inpatient discharge relative to profits
    - Hospital size as measured by numbers of beds relative to profits

Decile analyses are a relatively straightforward but extremely powerful statistical tool by which to reveal patterns not readily observable when dealing with large data sets and thousands of variables. The process can be summarized as follows: Data are categorized based on 10 percentile groups, with each group containing approximately the same number of cases. A value of 1 is assigned to a group of cases whose values relative to select variables fall below the 10th

percentile, 2 to cases between the 10th and 20th percentile, 3 to cases between the 20th and 30th percentile, and so on.

It is accepted business accounting practice to express various expense or cost categories by calculating costs as a fraction of charges. From a business perspective, such an approach is wholly appropriate. However, from a consumer perspective – patients, employers and insurers – it may make more sense to reverse that common practice and utilize charge to cost ratios instead. For example, in a previous study for US Representative Dennis Kucinich (D-OH-10) (70) examining less recent data, we demonstrated that the national average hospital drug cost to charge ratio for patients was about .29 (costs÷charges). However, the charge to cost ratio, expressing charges as a percent of costs, (charges ÷ costs x 100) was about 345%. That is, the charge is about 345% of the actual business expense.

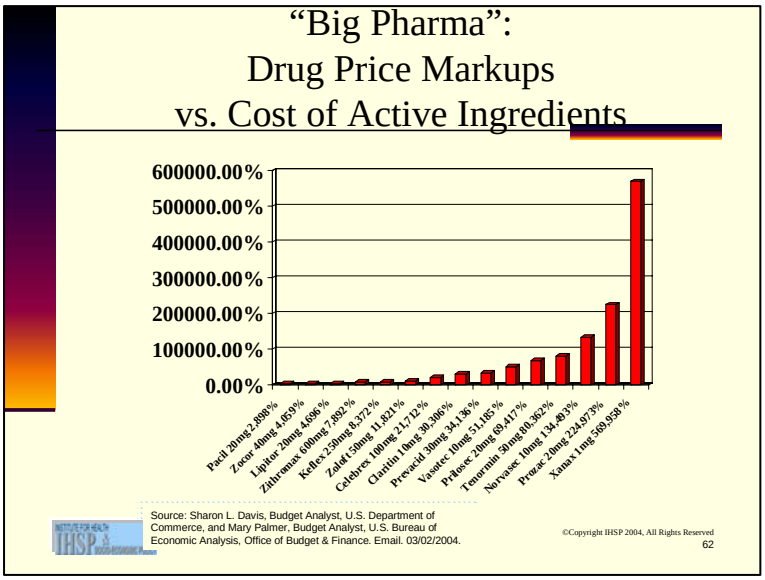
For purposes of this study, we constructed aggregated in patient and out patient charge to cost ratios for numerous hospital financial categories/centers. (See Table 26)

IV. What is Driving Health Care Costs? [2]

A. High price of Drugs and Hospital Charges

Our calculations for the current study period – fiscal year 2002/2003 – show that the **national average hospital charge to cost ratio for drugs charged to patients is 398.65%, an increase of about 53.7 percentage points** from the findings in our earlier study. (70)

Much of this increase - and hospitals' high charge to cost ratios for drugs in general - may be due to "Big Pharma's" remarkably steep markups on many of its most popular drugs.



As the chart, *Big Pharma, Drug Price Markups*…. illustrates, those markups can be staggering when compared to the actual costs incurred by Pharmas for the active ingredients in many of the most common drugs. Such markups range from 3,000% and 4,000% for Pacil and Zocor to 225,000% and 570,000% for Prozac and Xanax.(66)

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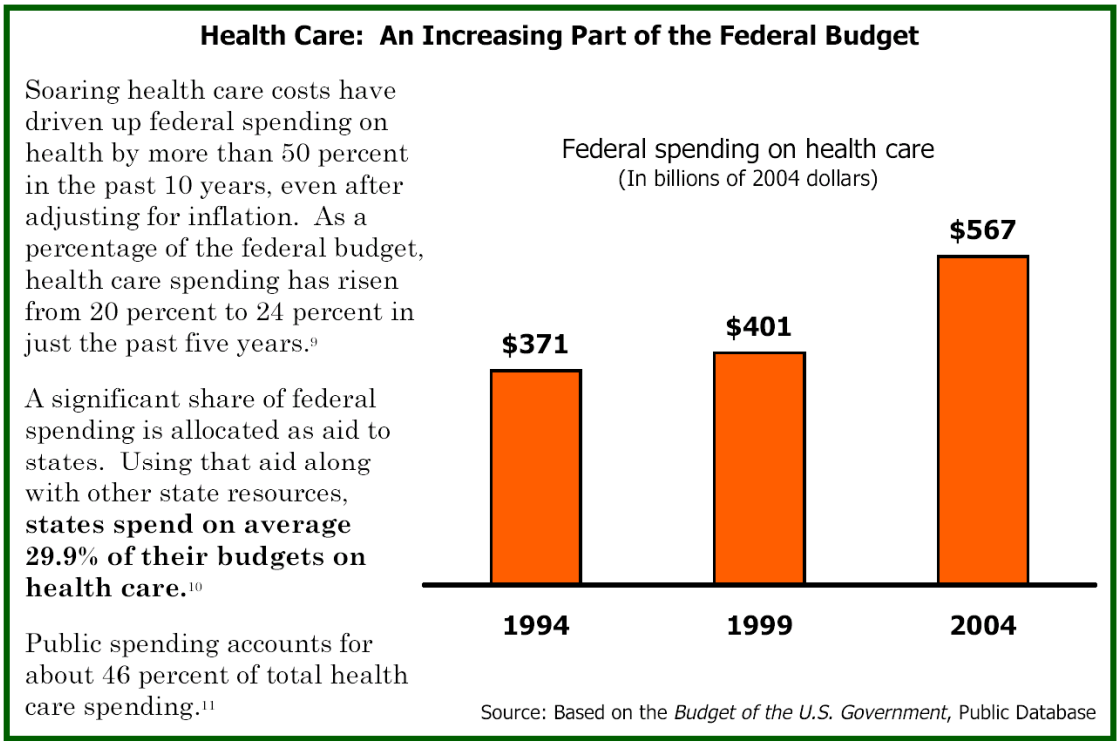
[2] Some of the following is excerpted from: Tenet Health Care Corporation, Drugs and Hospital Charges: Impact on Health Care Costs in California and Nationwide (13). Orinda: Institute for Health & Socio-Economic Policy.

B. Pharmaceutical Mergers and Acquisitions[3]

Worldwide, pharmaceutical revenues are imposing. A year 2000 study found that the United States accounts for the largest proportion of the world market for pharmaceuticals, or 34.5 percent.(176) In 2000, pharmaceutical sales in 13 key markets[4] grew an average of 10 percent (10).

Two *de-facto* pharmaceutical industry engineered policies contribute to the robust financial picture in the pharmaceutical market: the increase in drug prices in the United States and the increase in consumption. The increase in consumption is in good measure generated by the industry's recent intense direct advertising in the mass media to artificially over stimulate and maximize demand beyond clinical efficacy. All of which contributes to run-away health care costs. (See Figure 1).

Figure 1 Health Care as a Percent of the Federal Budget[5]



Sources: [6]Centers for Medicare and Medicaid Services (CMMS), National Health Expenditures, average increase from 1997-2002. [7]For more on cost estimates, see CBO, 'Letter to the Honorable Jim Nussle regarding a comparison of CBO and Administration estimates of the effect of H.R. 1 on direct spending,' Feb. 2, 2004. [8]According to Fortune 500 ratings. [9]*Budget of the U.S. Government, FY2005*; in this case health care spending includes Medicare, the government-defined function area of 'health,' and health care in the military. [10]Milbank Memorial Fund, NASBO, Reforming States Group, '2000-2001 state health care expenditure report,' April, 2003, percentage is for 2001. [11]CMMS, National Health Expenditures for 2002.

[3] Some of the materials in Part IV, Sections B and C are abstracted from (70)

[4] These 13 markets include: USA, Canada, Germany, France, Italy, UK, Spain, Japan, Brazil, Mexico, Australia/New Zealand and Argentina.

[5] Reproduced from (36)

> *To stimulate the use of prescription drugs and, particularly, new therapies, manufacturers promote prescription drugs in several ways. The largest type of promotional spending is "detailing" ($5.7 billion in 1998), where a company representative makes personal selling visits to physicians in offices and hospitals and leaves samples.* ***Direct-to-consumer advertising [DTC] ($1.3 billion in 1998) is a relatively recent phenomenon that has grown dramatically, with nearly a 5-fold increase in spending overall since 1994, and nearly a 20-fold increase for television advertising since 1994.*** *(emphasis added).[See also, (166)]. Many of the products with the most direct-to-consumer advertising are also among the top prescription drugs by sales and by number of prescriptions dispensed.*(9)

The makers of the antihistamines Claritin, Zyrtec, and Allegra spent $313 million on DTC advertising for these products in 1998. Together, these three drugs accounted for 90 percent of sales of prescription antihistamines and 2 percent of total drug spending in that year.

> *Policy changes by the FDA, particularly a 1997 relaxation of guidelines for broadcast advertising, have allowed drug manufacturers to engage in much more extensive direct-to-consumer advertising.(54)*

Pharmaceutical companies enable these policies via mergers and acquisitions that ultimately reduce competition to keep prices high and create economies of scale to fund their intensive marketing/advertising operations

1. Scope and Depth of Pharmaceutical Mergers and Acquisitions

Within the drug industry, there has been significant growth in coordination and consolidation.

Strategic alliances grew from 120 in 1986 to 635 in 1997.(125) Though there are hundreds of pharmaceutical companies, there are only 50 companies that control about two-thirds of the total world pharmaceutical market, (106) and the top 10 U.S. companies make up 39.5 percent of the domestic market.(136) In the pharmaceutical industry, between 1998 and 2000, 15 of the top 25 pharmaceutical companies publicly engaged in such merger negotiations; industry analysts believe that all 25 have negotiated privately.(35) In terms of market share, the newly merged GlaxoSmithKline is the largest, capturing about 11 percent of total net sales and 15 percent of net income for the world's top fifty drug corporations for fiscal year 2003. [See Table, *World's Top 50 Drug Corporations ….].*

Mergers and acquisitions have been increasingly profitable. The average market value of an acquired pharmaceutical company has risen three-fold since 1990.(8) While in 1989, the value of SmithKline and Beecham was $8.9 billion,(8) the 2000 Warner Lambert/Pfizer deal was worth $90.2 billion. (65)

Table 1 Pharmaceutical Mergers: 1993 through December, 2003[6]

Year	Pharma Mergers Number of Transactions	Number with Price Present	Price in 2003 Dollars
1993	11	8	$7,789,057,439.45

[6] Source: IHSP calculations of SEC and Levin and Associates Data.
Price is given only for those transactions where a price was listed for 508 transactions. Prices are unavailable for 252 transactions. It is therefore likely that the actual total price is considerably greater than the $554.6 billion figure.

Year	Pharma Mergers Number of Transactions	Number with Price Present	Price in 2003 Dollars
1994	38	35	$4,253,012,775.17
1995	23	23	$732,082,152.23
1996	53	29	$2,672,744,983.56
1997	69	41	$3,134,244,363.86
1998	54	26	$14,803,288,910.58
1999	28	15	$197,997,388,595.44
2000	63	46	$137,779,340,303.74
2001	87	69	$28,830,451,076.36
2002	148	96	$71,846,699,193.98
2003	170	110	$23,324,084,126.00
2004	16	10	$61,421,907,626.21
Total	**760**	**508**	**$554,584,301,546.57**

All this merger activity is having extraordinary market impacts:

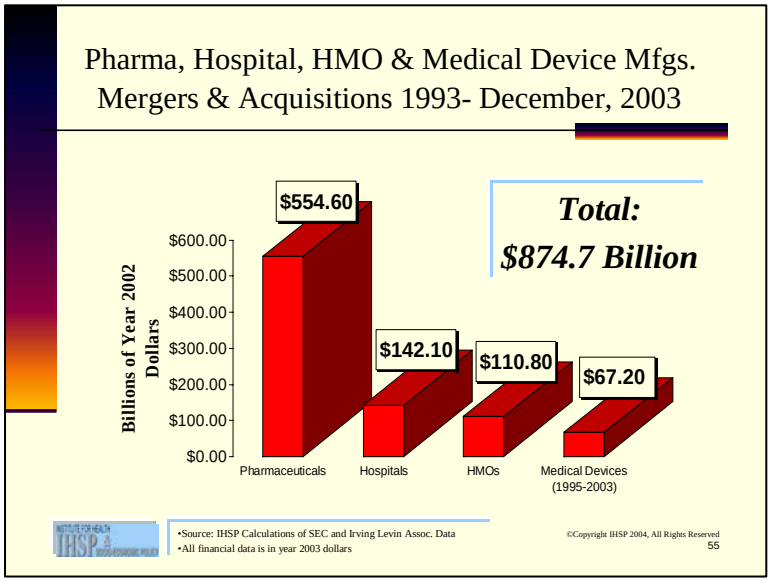
In recent years, *five of the 10 most powerful marketers in the industry recently merged.*

The list includes:

- *GlaxoSmithKline, created in December 2000 when Glaxo Wellcome joined with SmithKline Beecham.*
- *Pfizer, which took over Warner-Lambert in June 2000.*
- *Pharmacia, formed by the union of Pharmacia & Upjohn and Searle in April 2000.*
- *AstraZeneca, created by the 1999 merger of Astra AB and Zeneca.*
- *Aventis, launched in 1999 through the union of Hoechst Marion Roussel and Rhone-Poulenc Rorer.*

These five new entities accounted for more than 35 percent of all promotional spending by the pharmaceutical industry in 2000, according to Scott-Levin's marketing research audits. They also generated more than 30 percent of all retail sales, reports Scott-Levin's Source(TM) Prescription Audit.

Overall, the top 10 companies were responsible for 66 percent of the industry's promotional spending and 58 percent of retail prescription sales. (33)



The volume and value of mergers and acquisitions in the industry has been significant. From 1993 through December of 2003, the cost of such mergers in year 2003 dollars is about $554,600,000,000. This figure dwarfs hospital, HMO and medical device manufacture merger and acquisition activity. Pharma merger and acquisition activity has contributed to the industry's ability to control prices which in turn has considerably augmented its bottom line. (See Table, *World's Top 50 Drug Corporations*…)

Table 2 World's Top 50 Drug Corporations – Profits, Market Capitalization and Sales[7]

Rank	World's Top 50 Drug Corporation	Profits	Market Capitalization	Net Sales
1.	Glaxosmithkline Plc	$7,397,853,280.00	$117,035,186,991.30	$35,279,664,630.00
2.	Merck And Company Inc	$6,830,900,000.00	$102,394,802,672.60	$22,485,900,000.00
3.	Novartis- Adr	$5,015,991,781.79	$110,778,135,147.40	$24,863,959,262.82
4.	Pfizer Inc	$3,910,000,000.00	$239,661,623,511.10	$45,188,000,000.00
5.	Bristol Myers Squibb Company	$3,106,000,000.00	$45,633,957,567.72	$20,894,000,000.00
6.	Astrazeneca Plc- Adr	$3,035,980,655.22	$74,974,647,960.00	$18,848,879,897.94
7.	Abbott Laboratories Inc	$2,753,000,000.00	$64,023,032,124.99	$19,680,561,000.00
8.	Eli Lilly & Company	$2,560,800,000.00	$72,921,872,070.00	$12,582,500,000.00
9.	Sanofi-Aventis	$2,369,940,840.00	$47,349,360,545.40	$9,187,516,320.00
10.	Roche Holding Ag	$2,298,803,760.00	$66,444,082,540.85	$23,385,028,800.00
11.	Aventis Sa- Adr	$2,229,525,270.00	$64,110,247,121.61	$20,337,425,850.00
12.	Wyeth	$2,051,192,000.00	$48,390,575,391.24	$15,850,632,000.00
13.	Novo Nordisk As	$746,237,380.00	$30,369,056,234.82	$4,076,963,010.00
14.	Teva Pharmaceutical Industries Ltd.- Adr	$690,999,600.19	$15,293,996,000.00	$3,276,398,104.28
15.	Forest Laboratories	$621,988,000.00	$17,836,172,520.95	$2,206,706,000.00
16.	Genentech Inc	$562,527,000.00	$50,470,119,078.98	$3,300,327,000.00
17.	Schering Ag- Adr	$505,724,370.00	$10,506,910,000.00	$5,511,596,520.00
18.	Altana Ag - Adr	$394,101,982.98	$7,404,738,183.70	$3,122,005,491.33
19.	Serono Sa	$389,962,361.08	$7,177,213,300.40	$1,858,005,955.84
20.	Eisai Company Limited	$339,293,290.00	$8,187,263,331.50	$3,858,889,510.00
21.	Mylan Laboratories Inc	$272,353,000.00	$4,538,906,889.54	$1,269,192,000.00
22.	Watson Pharmaceuticals Inc	$202,864,000.00	$3,065,752,200.60	$1,436,722,000.00
23.	Barr Pharmaceuticals Inc	$167,566,000.00	$4,170,700,626.75	$902,864,000.00
24.	Schwarz Pharma Ag	$151,281,223.62	$1,508,861,040.00	$1,708,161,117.00
25.	Par Pharmaceutical Resources Inc	$122,533,000.00	$1,364,966,890.76	$661,688,000.00
26.	Ivax Corp.	$121,251,000.00	$4,946,904,253.92	$1,420,339,000.00
27.	King Pharmaceuticals Inc	$105,856,000.00	$2,831,078,347.92	$1,540,288,000.00
28.	Atrion Corp.	$94,036,100.20	$2,096,372,051.70	$432,262,460.58
29.	Warner Chilcott Plc- Adr	$94,036,100.20	$2,403,286,910.75	$432,262,460.58
30.	Cephalon	$83,858,000.00	$2,580,331,268.00	$714,807,000.00

[7] Source: IHSP calculations of US Securities and Exchange Commission Filings and Thomson Financial data.

Rank	World's Top 50 Drug Corporation	Profits	Market Capitalization	Net Sales
31.	Nbty Inc	$81,585,000.00	$1,617,955,116.72	$1,192,548,000.00
32.	Edwards Lifesciences	$79,000,000.00	$2,063,306,822.40	$860,500,000.00
33.	Dr. Reddy's Laboratories Limited-Adr	$75,395,610.00	$1,182,982,951.54	$354,724,308.00
34.	American Pharmaceutical Partners Inc	$71,693,000.00	$2,048,785,444.16	$351,315,000.00
35.	Eon Labs Inc	$70,135,000.00	$2,443,734,249.84	$329,538,000.00
36.	China Pharmaceutical Group Limited	$64,750,424.67	$399,297,162.00	$318,304,251.18
37.	Kos Pharmaceuticals Inc	$59,414,000.00	$1,372,458,311.45	$293,907,000.00
38.	Perrigo Company	$54,048,000.00	$1,394,071,725.90	$825,987,000.00
39.	Medicis Pharmaceuticals Corp.	$51,256,000.00	$2,041,734,644.46	$247,539,000.00
40.	Qlt Inc	$37,093,450.87	$1,172,638,447.66	$156,985,260.72
41.	Axcan Pharma Inc	$30,771,024.39	$820,879,418.87	$193,056,269.36
42.	Cangene	$28,533,656.60	$446,871,249.34	$129,965,147.48
43.	Kv Pharmaceutical Company	$28,110,000.00	$850,596,452.50	$244,996,000.00
44.	Chattem Inc	$23,371,000.00	$574,103,071.36	$233,749,000.00
45.	Usana Health Sciences Inc	$20,817,000.00	$556,882,651.26	$200,013,000.00
46.	Patheon	$20,263,115.93	$343,767,368.01	$444,073,962.32
47.	Alpharma Inc	$16,936,000.00	$740,425,481.19	$1,297,285,000.00
48.	Bradley Pharmaceuticals Inc	$16,824,716.00	$369,402,776.00	$74,679,251.00
49.	Martek Biosciences Corp.	$15,992,000.00	$1,670,585,106.63	$114,737,000.00
50.	Draxis Health Inc	$14,122,789.86	$172,673,973.58	$52,624,026.78
	Totals	**$50,086,567,783.58**	**$1,252,753,305,199.37[8]**	**$314,230,071,867.20**

2. Pharma M & As: Research and Development (R&D) Mythology

The industry cites a number of reasons for merger and acquisition activity: enhanced research and development, the ability to access new therapeutic areas, new geographic areas, or obtaining a technological advantage in product development. (58) Corporations can also shore up any potential profit losses due to a product mix that may soon lose patent protection. When patents expire, a brand name drug may lose the majority of its profits to a generic rival.

Perhaps the most common industry given reason for a merger or acquisition is the new company's ability to devote more resources to R&D in a leaner, more efficient post merger environment.(153) Companies often cite the extraordinary resources that go into a pharmaceutical development, such as materials, researchers' salaries and clinical trials. The industry has at varying times pegged the average cost of developing a successful drug at more than $500 million, (174) and more recently, at more than $802 million. (49)

The accuracy of those estimates is not universally shared:

[8] This is not a misprint. Combined market capitalization for the top 50 Pharmas is $1.2 trillion.

Dr. Nelson Levy, a former head of research and development at Abbott Laboratories, who now works as a consultant for industry and the federal government on drug development, bluntly challenged the industry's oft-repeated cost of developing a drug. "That it costs $500 million to develop a drug," Dr. Levy said in a recent interview, "is a lot of bull."(93)

More recently,

Even using PhRMA's own figures for total R & D costs for the decade of the 1990s, it can be calculated that the cost per drug came to around $100 million after taxes. … So where did the $802 million figure come from? … The number was the finding of a group of economists, headed by Joseph DiMasi of the Tufts Center for the Study of Drug Development …. The Tufts Center is largely supported by the pharmaceutical industry, and this was an updating of an analysis done by the same group over a decade ago. … It was not until a year and a half later that the Tufts group actually published their analysis and became possible to see how it was done. …. one thing is clear from the paper. The $802 million figure has nothing to do with the "average cost of developing a new drug,"… It refers only to the cost of developing a tiny handful of the very most expensive drugs….(49)

More importantly, whatever the cost of drug development, the drug industry burden in those costs is considerably lightened through federal subsidies:

Dr. Levy, the former Abbott Laboratories executive, says preclinical research could account for as much as 20 to 25 percent of a company's research and development budget for a particular drug.

"N.I.H.-supported research represents a subsidy to pharmaceutical development," said Dr. Louis Lasagna, an expert in drug development at Tufts University whose studies are widely cited by the industry. "But you need a midwife, the companies, to bring it to market."

The word subsidy, not surprisingly, rankles drug industry officials, who say other businesses, including the medical device industry, also benefit from public science.

Yet it is clear that the government plays an important, and an increasing, role in drug development, both through inventions like Dr. Bito's[9] *and more basic scientific research on which the companies can build. A 1995 study by the Massachusetts Institute of Technology found that, of the 14 new drugs the industry identified as the most medically significant in the preceding 25 years, 11 had their roots in studies paid for by the government.*

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9 *On Jan. 7, 1982, in a laboratory at Columbia University, a little-known science professor, Laszlo Z. Bito, finished a nine-month experiment on the eyes of cats. In his handwritten data, carefully charted in gray hardcover notebooks, lay the origins of what every pharmaceutical company longs for: a blockbuster drug.*

The drug is Xalatan, a best-selling eyedrop for glaucoma. With $507 million in sales last year -- and the potential for billions more, most of it pure profit -- the four-year-old medicine is the equivalent of liquid gold for its manufacturer, the Pharmacia Corporation. The eyedrop earned Columbia University about $20 million in royalties last year, and it has made a millionaire of Dr. Bito as well.

"The general pattern is that industry is building enormously heavily on basic research supported by N.I.H.," said Dr. Francis Narin, president of C.H.I. Research, a consulting firm that has analyzed patents as a way of measuring the role public science plays in industry.

In a 1997 study commissioned by the National Science Foundation, C.H.I. looked at the most significant scientific research papers cited in medicine patents. It found that half the cited studies were paid for with United States public funds, primarily from government and academia; only 17 percent were paid for by industry. (The rest came from public and private foreign sources.)

And in a study with the National Eye Institute, published in 1996, C.H.I. found that 41 percent of patented eye-care technology was linked to research financed by the health institutes…(93)

However, the claim that mergers will improve the industry's success in health breakthroughs is not clear according to Dr. Sidney Wolf and Dean Baker at the CEPR. As Director of Public Citizen's Health Research Group, Dr. Wolf states,

> *There is no evidence that the economies of scale have resulted in price savings to consumers -- quite the contrary. Also, there is no evidence that more research will come out of the combined companies than the two individuals.*(40)

Others maintain that the Pharma's R&D estimates are grossly inflated and are based on confidential industry data not subject to outside review.(49;174) Furthermore, some of the costs that the industry includes as part of R&D could more accurately be described as marketing costs than research. For example, development costs often include consulting fees paid to doctors.(40) Marketing costs already outpace R&D costs. According to the Kaiser Family Foundation, in 1998, the industry spent three times as much on marketing and administrative expenses than on R&D as a percentage of sales.(40)

The American Journal of BioEthics (127) recently commented on the credibility of Pharma R&D claims:

- *The average amount of research funds the drug industry needs to recover appears to be much less than the industry's figure of $800 million per new drug approved…*
- *The $800 million figure is based on the small unrepresentative subsample of all new drugs. It excludes the majority of "new" drugs that are extensions or new administrations of existing drugs, as well as all drugs developed by NIH, universities, foundations, foreign teams, or others that have been licensed in or bought. Variations on existing drugs probably cost much less because so much of the work has already been done and*

Yet there are other, unseen, partners in the creation of Xalatan: the American taxpayers, who backed Dr. Bito's work with $4 million from the National Institutes of Health. The taxpayers have reaped no financial return on their investment; their reward, government officials say, is the eyedrop itself.

Xalatan costs patients $45 to $50 for a tiny bottle that lasts six weeks. That price -- about $1 a day for a drug that staves off blindness -- may not seem excessive. But the key ingredient in that daily dose costs Pharmacia only pennies to make, and Americans, who live in the only industrialized nation that lacks government restraints on drug prices, pay more than twice what European patients pay for the drug. (93)

trials are simpler.

- *About half of the $800 million figure consists of "opportunity costs", the money that would have been made if the R&D funds had been invested in equities, in effect a presumed profit built in and compounded every year and then called a "cost." Drug companies then expect to make a profit on this compounded profit, as well as on their actual costs. Minus the built-in profits, R&D costs would average about $108 million 93% of the time and $400 million 7% of the time.*
- *The $800 million estimate also does not include taxpayers' subsidies via deductions and credits and untaxed profits.*
- *Net R&D costs are then still lower.*
- *….. Advertising firms are now running clinical trials .*

An analysis of 22 pharmaceutical companies that merged between 1988 and 1999 shows that clinical research spending and productivity declines post merger. CenterWatch's analysis shows that after three years, clinical research projects drop nine percent, representing a decline of $15-$20 million in investigator grants.[10]

Post merger research may be deliberately squeezed. The FTC reports that the growth of formularies, which limit the number of available drugs to consumers, serves to encourage the consolidation of new drug development capacity.(125) In fact, formularies provide a disincentive for companies to develop new drugs, but rather to promote one popular drug.

Between 1990 and 2000, the FDA approved 857 new drug applications. However, 50 percent of these applications were for new versions of existing drugs, and only 36 percent were for new products.(137) This practice, called *evergreening*, allows pharmaceutical companies to apply for new patents on a modestly improved, already-existing product, thus eliminating the need for major R&D and extend the life of the original patent to prolong profitability.

The steps which Big Pharma is prepared to take in bending the demands of the scientific method to those of the accumulation process[11] are illustrated below:

> *What if Ray Romano cracked a few jokes while asking his doctor for a Viagra prescription? What if in his next movie middle-age master spy James Bond needed a dose of Lipitor to reduce cholesterol? Those fairytale plotlines just might come to fruition one*

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[10] Long term levels of pre-clinical through phase III projects dip 34 percent below the cumulative, premerger levels.(40) A therapeutic area head from Monsanto/Searle, recently acquired by Pharmacia Upjohn, states: "Portfolio pruning is very common and it can cut deep. Marginal projects, and those projects that lose their internal champions, they are the targets." In the short term post merger, merged companies slow down their rate of R&D spending substantially. After three years, the level of R&D spending returns to premerger levels, about 7.9 percent. A contract and budgets administrator from Ciba-Geigy, now Novartis, explains: "It's pretty frenetic. I've seen a flurry of activity pre-merger to help generate a high valuation and to get the projects going. Then one year after the close, there's a freeze on practically everything. A couple of years out, with a new mission and more focus, spending increases and outsourcing increases."(40)

[11] See (180) for a progressive analysis of the historical relationship between science and the market. For other commentaries germane to an analysis of the political economy of health see, (1;2;20-22;31;48;64;76;77;81;94) For exegeses on the sometimes problematic role of mathematics in the physical and social sciences see (95) and (154) respectively.

*day, now that **Pfizer** is teaming up with a Hollywood heavyweight to seek out new sorts of advertising opportunities.*

The world's largest drug maker has retained talent firm William Morris Agency to come up with entertainment-marketing ideas that could include embedding Pfizer goods in movies and television programs, developing movie tie-ins or setting up TV-show sponsorships. "We are engaging William Morris on an explorative project for six months, and can't talk about the nature of that assignment," says Michal Fishman, a spokeswoman for Pfizer.

New York-based Pfizer seems to be one of the first pharmaceutical giants to seek Hollywood's help, and its push toward Tinseltown is likely to raise eyebrows. Many pharmaceutical-ad experts say drug makers should tread lightly when dabbling in this sector so as not to anger the Food and Drug Administration, which strictly regulates pharmaceutical advertising.

"It becomes a dicey situation for drug companies that get into this entertainment arena," says Mel Sokotch, director of the consumer health-care practice at Interpublic Group's FCB. "They run the risk of upsetting watchdog groups and regulatory officials." Experts note that if a drug company actively seeks product plugs within entertainment venues, it runs the risk of violating FDA ad guidelines. Any paid media that mentions a drug by name and by what it does is required by U.S. law to disclose potential side effects as well, says Stu Klein, president of WPP Group's Quantum Group.

Pfizer -- which in addition to Viagra and Lipitor makes depression medication Zoloft, and Celebrex for arthritis pain -- joins a growing list of blue-chip marketers seeking access to writers, producers and directors to help them weave their brands into entertainment content as a way to combat the waning power of the traditional 30-second TV commercial. Like many other marketers, Pfizer has been looking to be more creative with its advertising and become less reliant on advertising on network TV.(41;184)

By the early 1990s, the companies that made competing versions of the new antacids were battling over a $7-billion-a-year market. The leading firms began pouring hundreds of millions of research dollars into clinical trials in an effort to prove that their product was better than the competition. There is little interest among elite scientists in conducting these types of studies, although many medical professionals at the nation's academic medical centers take part in order to raise money for their labs. Many times the results aren't even published in the literature, or when they are, they appear in second-tier journals that receive little notice from the mainstream of the profession.

By the end of 1994, Astra, Glaxo, and SmithKline had sponsored hundreds of studies on the relative merits of Prilosec, Zantac, and Tagamet. One reviewer counted 293 clinical trials comparing the drugs. He concluded that proton-pump inhibitors were marginally more effective at healing ulcers, with cure rates at 94 percent after four weeks for Prilosec compared to 70 to 80 percent for the H2 antagonists. The cure rate for Prilosec fell to 84 percent after eight weeks, and for some types of ulcers and conditions, the cure rates were statistically indistinguishable. Despite the similarities between the drugs, Astra and Merck used the results to launch a massive marketing push for its proton-pump inhibitor, which soon turned Prilosec into the best-selling medicine in the world. By 2000, it was racking up nearly $5 billion a year in sales in the United States alone. TAP Pharmaceuticals' me-too proton-pump inhibitor Prevacid, launched in 1995, was the third-best-selling medicine in the United States with more than $3 billion in sales.

Astra's research team wasn't through with heartburn yet. With the company's patent on Prilosec set to expire in 2001, company officials knew that generic

manufacturers would line up to manufacture the lucrative pill. As early as 1995, Astra officials launched a massive research project to come up with a successor to their wildly popular purple pill (the color became a mainstay of its advertising campaigns). It would be best if they came up with a better drug, company scientists knew. But with an 80-percent cure rate for the existing antacids, a better mousetrap would be hard to find.

The company never considered one possible approach, which had been percolating in the world of academic medicine for more than a decade. In the years since the discovery of H2 antagonists and proton-pump inhibitors, scientifically inclined academics had moved away from interfering with the mechanisms for generating stomach acid. In 1983, Barry Marshall, then working at the Royal Perth Hospital in Australia, had isolated a bacterium called helicobacter pylori that flourished in the excess stomach acids of gastritis and ulcer patients. He believed it was the root cause of ulcers. After returning to the United States to a post at the University of Virginia, he used NIH funding to establish the Center for the Study of Diseases Caused by Helicobacter Pylori. Over the course of the next decade, Marshall and other scientists showed that the bacterium, which infects about half the world's population, was the leading cause of stomach and intestinal ulcers, gastritis, and stomach cancer. The center even developed regimens of common antibiotics that could eliminate the minor infection.

Unfortunately, no pharmaceutical company championed the cure. They had no interest in eliminating the cause of ulcers with a short, cheap course of generic antibiotics when they could make billions of dollars treating their chronic recurrence with expensive prescription antacids. ***As one NIH analyst put it: "A one-time antibiotic treatment regimen to eliminate H. pylori, as opposed to long-term maintenance with H2-antagonist drugs, recurrence, and sometimes surgery as a last resort, is an obvious benefit both to the patient and to the health care insurers. However, [promoting this approach would lead to] the possible decline in sales.****" [Emphasis added].*

Instead of pursuing this potential cure for ulcers, Astra scientists launched Operation Shark Fin, an effort to find a drug to replace Prilosec after it came off patent and became generically available. At first they tried drug combinations and oral suspensions, but they didn't work any better and were less convenient. Finally, Astra scientists created a molecule that was, in essence, half of Prilosec. They dubbed it Nexium. In doing so, they used a process that by the late 1990s had become one of the drug industry's chief strategies for extending patents, a strategy that was garnering an increasing share of industry research-and-development budgets. [Emphasis added] (41)

Apart from distorting or ignoring good science for the sake of better profits, Big Pharma is not above simply raising drug prices at whatever rate it deems politically possible. Sometimes, however, its pricing acumen runs afoul of the sense of medical propriety of individual caregivers, if not the whole of the healing arts. In 1992, Johnson & Johnson raised the price of levamisole about 10,000% of its former price when it became FDA approved for other applications.

… a Minnesota physician publicly chastised Johnson & Johnson for its pricing of levamisole, which has been found to be effective in advanced colon cancer cases. What galled Charles G. Moertel, M.D., of the Mayo Comprehensive Cancer Center in Rochester, Minn., was that this drug cost $ 14 for its previously approved use -- treatment of worms in sheep. But when the drug was approved to treat cancer in humans, the company raised the price to $ 1,250 to $ 1,500 for a year's supply. (152)

Industry stated reasons for merger and acquisition activity have little empirical support. R&D spending is not as high as claimed, and mergers tend to reduce R&D expenditures. Moreover, the R&D that is being spent is not resulting in pharmaceutical breakthroughs, but rather minor improvements on existing drugs. Finally, though the industry touts the high costs of R&D, its biggest spending item is actually marketing.

There is some evidence, however, that the mergers of the last few years are associated with escalating drug costs. The greater market power engendered via mergers and acquisitions enables the industry – their protestations about price controls notwithstanding - to set their own inflated price controls on drugs.

3. Prescription Drugs and the Elderly

As many Seniors live on a modest fixed income and since they consume 28 percent of all prescription drugs,(6) and twenty percent of elderly Americans take at least five prescription medications every day, (6) the rising costs of pharmaceuticals has a disproportionate impact on the Medicare patient population:

As others have noted,

… the costs of prescription drugs (are) -- the single largest health-care expense for the elderly. (118)

As the following excerpted figures make clear, the price of those drugs is considerable, especially for those on a fixed income: (18) See also, (118)

Figure 2 Average Wholesale Price of the Top 30 Drugs Used by the Elderly[12]

Annual Average Wholesale Price[a] of the Top 30 Brand-Name Drugs Used by the Elderly

Brand-Name Drug	Strength	Dose Form	Therapeutic Category	Marketer	2001 Cost/Year	2004 Cost/Year
Lipitor	10 mg	tab	Lipid-Lowering Agent	Pfizer	$742	$943
Plavix	75 mg	tab	Antiplatelet Agent	Bristol-Myers Squibb	$1,232	$1,661
Fosamax	70 mg	tab	Osteoporosis Treatment	Merck	$802	$953
Norvasc	5 mg	tab	Calcium Channel Blocker	Pfizer	$514	$603
Celebrex	200 mg	cap	Anti-Inflammatory/Analgesic	Pfizer	$1,837	$2,273
Zocor	20 mg	tab	Lipid-Lowering Agent	Merck	$1,520	$1,747
Prevacid	30 mg	cap cr	Gastrointestinal Agent	TAP Pharmaceutical	$1,459	$1,740
Protonix	40 mg	tab	Gastrointestinal Agent	Wyeth	$1,095	$1,396
Lipitor	20 mg	tab	Lipid-Lowering Agent	Pfizer	$1,148	$1,369
Norvasc	10 mg	tab	Calcium Channel Blocker	Pfizer	$794	$827
Toprol XL	50 mg	tab cr	Beta Blocker	Astra Zeneca	$221	$286
Nexium	40 mg	cap	Gastrointestinal Agent	Astra Zeneca	nm	$1,710
Xalatan	0.005%	sol	Glaucoma Treatment	Pfizer	$573	$701
Vioxx	25 mg	tab	Anti-Inflammatory/Analgesic	Merck	$958	$1,100
Zocor	40 mg	tab	Lipid-Lowering Agent	Merck	$1,520	$1,747
Zoloft	50 mg	tab	Antidepressant	Pfizer	$882	$1,049
Evista	60 mg	tab	Osteoporosis Treatment	Eli Lilly	$807	$1,033
Cozaar	50 mg	tab	Angiotensin II Inhibitor	Merck	$497	$607
Combivent	1 mg	aerosol	Respiratory Agent	Boehringer Ingelheim	$612	$957
Toprol XL	100 mg	tab cr	Beta Blocker	Astra Zeneca	$332	$429
Zocor	10 mg	tab	Lipid Lowering Agent	Merck	$871	$1,001
Actonel	35 mg	tab	Osteoporosis Treatment	Procter & Gamble	nm	$916
Diovan	80 mg	tab	Angiotensin II Inhibitor	Novartis	nm	$640
Detrol LA	4 mg	tab	Overactive Bladder Treatment	Pfizer	$1,031	$1,220
Miacalcin	200 iu/act	spray	Calcitonin Replacement	Novartis	$765	$938
Pravachol	20 mg	tab	Lipid-Lowering Agent	Bristol-Myers Squibb	$931	$1,203
Alphagan P	0.15%	5ml	Glaucoma Treatment	Allergan	nm	$535
Aricept	10 mg	tab	Alzheimer's Disease Treatment	Pfizer	$1,637	$1,893
Pravachol	40 mg	tab	Lipid-Lowering Agent	Bristol-Myers Squibb	$1,511	$1,765
Celexa	20 mg	tab	Antidepressant	Forest	$789	$952

Note: The top 30 brand-name drugs prescribed to the elderly, listed in descending order based on 2003 claims volume from the Pennsylvania PACE program. List excludes brand-name drugs that have generic or co-marketed versions available.

nm: Not marketed during part or all of the period indicated.

[a] Cost per year is based on Average Wholesale Price (AWP) as of January 15 for 2001 and 2004 and calculated using the usual therapy dosage. This is not necessarily the retail price that seniors pay at the drugstore. However, it is the best measure available to examine base prices and the rate of price increases over time.

Source: Compiled by Families USA from data provided by the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) and data found in Medi-Span's MDDB Select published by MediSpan (First Databank, Indianapolis), April 2004.

12 Reproduced from Families USA, website, www.familiesusa.com (18)

Figure 3 Annual Percent Change in Price of Top 30 Brand-Name Drugs Used by the Elderly[13]

Annual Percent Change in Price of the Top 30 Brand-Name Drugs Used by the Elderly*

Brand-Name Drug	Strength	Dose Form	Marketer	2003-2004 % Price Change	2003-2004 Multiple of CPI
Lipitor	10 mg	tab	Pfizer	8.3%	5.5
Plavix	75 mg	tab	Bristol-Myers Squibb	7.9%	5.3
Fosamax	70 mg	tab	Merck	6.9%	4.6
Norvasc	5 mg	tab	Pfizer	9.9%	6.6
Celebrex	200 mg	cap	Pfizer	8.1%	5.4
Zocor	20 mg	tab	Merck	4.4%	2.9
Prevacid	30 mg	cap cr	TAP Pharmaceutical	3.0%	2.0
Protonix	40 mg	tab	Wyeth	8.9%	5.9
Lipitor	20 mg	tab	Pfizer	2.9%	1.9
Norvasc	10 mg	tab	Pfizer	4.2%	2.8
Toprol XL	50 mg	tab cr	Astra Zeneca	3.2%	2.1
Nexium	40 mg	cap	Astra Zeneca	6.0%	4.0
Xalatan	0.005%	sol	Pfizer	10.2%	6.8
Vioxx	25 mg	tab	Merck	4.8%	3.2
Zocor	40 mg	tab	Merck	4.4%	2.9
Zoloft	50 mg	tab	Pfizer	8.6%	5.7
Evista	60 mg	tab	Eli Lilly	15.4%	10.3
Cozaar	50 mg	tab	Merck	9.7%	6.5
Combivent	1 mg	aerosol	Boehringer Ingelheim	19.8%	13.2
Toprol XL	100 mg	tab cr	Astra Zeneca	3.1%	2.1
Zocor	10 mg	tab	Merck	4.4%	2.9
Actonel	35 mg	tab	Procter & Gamble	6.1%	4.0
Diovan	80 mg	tab	Novartis	12.9%	8.6
Detrol LA	4 mg	tab	Pfizer	12.8%	8.5
Miacalcin	200 iu/act	spray	Novartis	0.0%	0.0
Pravachol	20 mg	tab	Bristol-Myers Squibb	7.0%	4.7
Alphagan P	0.15%	5ml	Allergan	15.5%	10.3
Aricept	10 mg	tab	Pfizer	4.5%	3.0
Pravachol	40 mg	tab	Bristol-Myers Squibb	7.0%	4.7
Celexa	20 mg	tab	Forest	8.2%	5.5
Top 30 Brands, Average Weighted by Sales[a]				6.5%	4.3
CPI-All Items Less Energy, Percent Change Jan 2003-Jan 2004				1.5%	

* Excludes brand-name drugs available in generic or co-marketed versions. Excludes drugs not marketed for the entire period. Based on prices as of January 15 for each year reported. Drugs are listed in descending order of number of prescriptions in the PACE program in 2003

[a] The weighted average was calculated based on 2003 expenditures for each drug in the Pennsylvania PACE program.

Source: Compiled by Families USA from data provided by the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) and data found in Medi-Span's MDDB Select published by Medi-Span (First Databank, Indianapolis), April 2004.

13 Reproduced from Families USA, website, www.familiesusa.com (18)

Figure 4 Price Changes of the Top 30 Brand-Name Drugs Used by the Elderly[14]

Price Changes of the Top 30 Brand-Name Drugs Used by the Elderly*

Brand-Name Drug	Strength	Dose Form	2003-2004		2001-2004	
			Number of Price Changes	Cumulative % Price Change	Number of Price Changes	Cumulative % Price Change
Lipitor	10 mg	tab	2	8.3%	4	27.0%
Plavix	75 mg	tab	1	7.9%	4	34.8%
Fosamax	70 mg	tab	2	6.9%	4	18.7%
Norvasc	5 mg	tab	2	9.9%	4	17.2%
Celebrex	200 mg	cap	2	8.1%	4	23.7%
Zocor	20 mg	tab	1	4.4%	2	15.0%
Prevacid	30 mg	cap cr	1	3.0%	4	19.3%
Protonix	40 mg	tab	2	8.9%	5	27.5%
Lipitor	20 mg	tab	1	2.9%	4	19.2%
Norvasc	10 mg	tab	1	4.2%	1	4.2%
Toprol XL	50 mg	tab cr	1	3.2%	7	29.1%
Nexium	40 mg	cap	2	6.0%	nm	nm
Xalatan	0.005%	sol	2	10.2%	4	22.3%
Vioxx	25 mg	tab	1	4.8%	4	14.9%
Zocor	40 mg	tab	1	4.4%	2	15.0%
Zoloft	50 mg	tab	2	8.6%	4	18.9%
Evista	60 mg	tab	2	15.4%	4	28.0%
Cozaar	50 mg	tab	2	9.7%	4	21.9%
Combivent	1 mg	aerosol	2	19.8%	6	56.3%
Toprol XL	100 mg	tab cr	1	3.1%	5	29.1%
Zocor	10 mg	tab	1	4.4%	3	15.0%
Actonel	35 mg	tab	2	6.1%	nm	nm
Diovan	80 mg	tab	1	12.9%	nm	nm
Detrol LA	4 mg	tab	2	12.8%	3	18.3%
Miacalcin	200 iu/act	spray	0	0.0%	3	22.6%
Pravachol	20 mg	tab	1	7.0%	4	29.2%
Alphagan P	0.15%	5ml	2	15.5%	nm	nm
Aricept	10 mg	tab	1	4.5%	3	15.7%
Pravachol	40 mg	tab	1	7.0%	3	16.8%
Celexa	20 mg	tab	2	8.2%	5	20.7%
Top 30 Brands, Average Weighted by Sales*				6.5%		21.6%
CPI-All Items Less Energy, Percent Change Jan-Jan				1.5%		6.0%

nm Not marketed during part of the period indicated.

* Excludes brand-name drugs available in generic or co-marketed versions. Excludes drugs not marketed for the entire period. Based on prices as of January 15 for each year reported. Drugs are listed in descending order of number of prescriptions in the PACE program in 2003.

* The weighted average was calculated based on 2003 expenditures for each drug in the Pennsylvania PACE program.

Source: Compiled by Families USA from data provided by the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) and data found in Medi-Span's MDDB Select published by Medi-Span (First Databank, Indianapolis), April 2004.

14 Reproduced from Families USA, website, www.familiesusa.com (18)

Table 3 Leading 20 Drug Products by U.S. Sales, Moving Annual Total June 2004[15]

Rank	Product	U.S. Sales (U.S. $Billions)[16]	% Growth +/-	% Market Share
1	Lipitor	$7.2	12%	3.2%
2	Zocor	4.5	8	2.0
3	Prevacid	3.9	2	1.7
4	Nexium	3.4	35	1.5
5	Procrit	3.3	1	1.5
6	Epogen	3.1	4	1.4
7	Zyprexa	3.0	-3	1.3
8	Zoloft	3.0	12	1.3
9	Neurontin	2.7	19	1.2
10	Celebrex	2.7	5	1.2
11	Advair Diskus	2.6	38	1.2
12	Plavix	2.6	36	1.2
13	Effexor XR	2.4	36	1.1
14	Norvasc	2.3	9	1.0
15	Protonix	2.1	41	0.9
16	Pravachol	2.1	9	0.9
17	Risperdal	2.0	4	0.9
18	Singulair	2.0	36	0.9
19	Oxycontin	1.9	11	0.9
20	Fosamax	1.9	9	0.8

Medicare beneficiaries – many of whom have been deserted by the HMO industry - comprise the single largest patient group in need of expensive medications. Those beneficiaries are at particular risk to increases in drug pricing structures. The new Medicare Prescription Drug Benefit legislation may prove in the long run to be a less than ideal resolution concerning drug costs for the Medicare population. The legislation provides economic incentives to insurers to re-enter the Medicare market but at the same time is designed to weaken the Medicare program via a privatization clause and may lead to increased healthcare costs. (46)

> *The new law requires "demonstration projects" beginning in 2010, forcing traditional Medicare to "compete" with private health insurers in six different regions of the country….. these insurers will get generous incentives to enter the Medicare market ($12 billion over 10 years), which starts the "competition" on unequal footing. These insurers are likely to target their plans to younger, healthier seniors, concentrating more and more of the older and sicker into traditional Medicare, hence driving up costs for those in traditional Medicare.(165)*

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15 Reproduced from IMS Health, www.imshealth.comims/portal/front/articleC/0,2777,6599_49695983_54699423,00.html

16 Represents prescription pharmaceutical purchases at wholesale prices by retail, food stores and chains, mass merchandisers, independent pharmacies, mail services, non-federal and federal hospitals, clinics, closed-wall HMOs, long-term care pharmacies, home health care, and prisons/universities.

Part of the pharmaceutical merger and acquisition fallout for patients and the health care provider sector alike has been a steady escalation of drug prices as a percent of total health care costs since 1995.

> *The (health care merger and acquisition) binge was fueled by a Department of Justice and Federal Trade Commission 1994 ruling that impacted U.S. anti-trust law(both the Sherman and Clayton acts, and ironically, the only major change adopted by Congress in response to the Clinton administration's 1993 health care plan) that granted extraordinary latitude to merging health care corporations, reputedly to encourage competition. (69)*

In particular, hospital charges for drugs have reached new highs in part due to Pharma consolidation in recent years and the attendant rise in drug prices coupled with the 1994 ruling impacting anti-trust.

That change can in part be summarized as follows:

> *In September 1994, the Justice Department and Federal Trade Commission issued comprehensive "non-enforcement" antitrust policy statements in health care, expanding safe-harbors and areas of non-enforcement established a year earlier. Statements of Enforcement Policy and Analysis, reprinted in 4 Trade Reg. Rep. (CCH) ¶ 13, 152 at 20, 769 (Sept. 30, 1994). The stated purpose of the policies is "to provide education and instruction to the health care community in a time of tremendous change, and to resolve, as completely as possible, the problem of antitrust uncertainty that some have said may deter mergers, joint ventures, or other activities that would lower health care costs." Id.*
>
> *The statements provide antitrust "safety zones" and other relief for nine separate areas of collective activity: (1) hospital mergers; (2) joint ventures involving high technology or other expensive health care equipment; (3) joint ventures involving specialized clinical or other expensive health care services; (4) providers' collective provision of non-fee-related information to purchasers; (5) providers' collective provision of fee-related information to purchasers; (6) provider participation in exchanges of price and cost information; (7) joint purchasing arrangements among health care providers; (8) physician network joint ventures; and (9) multi-provider networks.*
>
> *For networks and ventures among health care providers who jointly market their services the multi-provider network policy rejects the historical "per se" approach to analyzing the lawfulness of price-fixing and geographic market division among competitors in favor of the "rule of reason" approach. The Department of Justice and the FTC will apply the "rule of reason" analysis to multiprovider networks if they determine that the collective activity among the network participants is "necessarily related to significant economic integration among them." Id. at 20, 793-94. "Substantial financial risk-sharing" among the network participants is evidence of such integration. Id. at 20, 794. Examples of "substantial risk sharing" include: (i) when the network agrees to provide services to a health benefit plan at capitulated rates; or (ii) when the network creates significant financial incentives for participants to "achieve specified cost containment goals." Id.*
>
> ***The initial 1993 non-enforcement policies (Antitrust Enforcement Policy Statements in the Health Care Area, reprinted in 4 Trade Reg. Rep. (CCH) ¶ 13, 151 (Sept. 30, 1994)) were limited to the first six of these "safety zones," yet were severely criticized by dissenting FTC Commissioner Deborah K. Owen:***

The risks of higher prices and reduced output or lower quality care posed to some health care consumers by the more relaxed enforcement proposed in some of these Statements far outweigh any benefits generated. Moreover, the premises implicitly underlying some of the Statements –that sufficient guidance is not available and that the agencies' past enforcement efforts have been unreasonable–are simply unsupportable.... Some of today's action effectively constitutes a special-interest antitrust exemption that should more appropriately be accomplished through legislative action, if at all....4 Trade Reg. Rep. (CCH) ¶ 13, 235, (Sept. 15, 1993) [Emphases added].

The DOJ/FTC non-enforcement policies were again revised in August 1996, providing even more relief from federal enforcement for physician and multi-provider networks. The new revisions to Statements 8 and 9 were promoted by DOJ/FTC as giving providers greater flexibility in the creation of networks in an attempt to remedy a perceived "chilling effect" of existing law on the development of new and innovative provider networks. Statements of Antitrust Enforcement Policy in Health Care, 4 Trade Reg. Rep. (CCH) ¶ 13, 153 (Sept. 5, 1996)(79)

FTC Commissioner Owen's concerns have proven prescient over the last decade.

The tables below depict the percent of health care costs expended on prescription drugs for selected years and the average hospital drug charge to cost ratio for fiscal year 2002/2003 by provider control type and the weighted national average.

Rising hospital charge to cost ratios for drugs (70) reflect increases in Pharma merger and acquisition activity and the associated increase in prescription drug costs in past years.

Table 4 Percent of Total Health Care Costs for Prescription Drugs Selected Years[17]

Year % of Total Health Care Costs for Prescription Drugs	Percent
1960	10.1%
1970	7.5%
1980	4.9%
1988	5.5%
1990	5.8%
1991	5.9%
1992	5.8%
1993	5.8%
1994	5.8%
1995	6.2%
1996	6.5%
1997	6.9%
1998	7.6%
1999	8.5%
2000	9.3%

[17] Source: Centers for Medicaid and Medicare, Table 2, National Health Expenditure Amounts and Average Annual Percent Change by Type of Expenditure: Selected Calendar Years 1990-2013

Year % of Total Health Care Costs for Prescription Drugs	Percent
2001	9.9%
2002	10.5%

Table 5 Hospital Medical Supply and Drug Charge to Cost Ratios by Control Type – 2002/2003[18] (Sorted by Drug Charge to Cost Ratios)

Provider Control Type: Hospital Medical Supply and Drug Charge to Cost Ratios by Control Type – 2002/2003	Total Charge to Cost Ratio- Medical Supplies	Total Charge to Cost Ratio- Drugs
Proprietary, Corporation	505.11%	644.11%
Proprietary, Partnership	445.35%	484.69%
Natl. Weighted Avg. by Control Type	**614.68%**	**439.10%**
Proprietary, Other	615.40%	424.94%
Proprietary, Individual	1497.24%	423.16%
Voluntary Nonprofit, Church	475.71%	404.75%
Voluntary Nonprofit, Other	428.01%	357.13%
Government (Consolidated)	335.94%	334.92%

4. Consequences of Increased Pharmaceutical Market Share

As pharmaceutical corporations consolidate and gain market power, they are more easily able to set higher drug prices:[19]

Greater market power also enables them to create demand for brand name drugs via public advertising campaigns.

As a result of "patient demand" – in good part driven by heavy industry advertising - for more specific medications, the aging population and more expensive therapies, providing prescription benefits will cost employers on average 20 percent more in 2001 than in 2000, according to a survey by the Segal Company. (7)

These trends make it more expensive for insurance plans that cover prescription benefits - although clearly recent HMO profits suggest that the plans have simply raised rates over and above any drug incurred costs (41) - employers who offer such plans and hospitals.. Rising drug costs have played a significant role with respect to higher premiums, higher co-payments, fewer benefits and more restricted access to pharmaceuticals and health care.(87)

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[18] Source: IHSP calculations of Federal Hospital Cost Reports, current as of March 31, 2004.

[19] Drugs sold in Canada and Mexico are generally half the price of the same drugs sold in the US.(5) The average American pays 50 percent more for a prescription drug than in England, 75 percent more than in France and 100 percent more than in Italy for the same drug.(164)

a) Hospital Drug Charge to Cost Ratios and Pharma Drug Prices

The IHSP year 2000 Pharma study(70) found that of the approximate 4,545 acute care only hospitals[20] whose most recent Federal Hospital Cost Report filing was in 1999 or 2000, drug costs for patients ($21,008,013,762) were only 29.3% of what hospitals charged patients for those same drugs ($71,705,455,513) which is a net difference of $50.7 billion for the time period. Our current findings for FY 2002/2003 reveal that hospital charges for drugs as a percent of drug costs stands at 398%, an increase of approximately 53 percentage points from the earlier time period. Some part of this increase may be due to the overall rise in drug prices. Concomitantly, there are indications that some Pharmas may be pushing for more stringent hospital contractual relationships as they relate to drug purchases.

> *Some critics of Pfizer say its tough style has morphed into arrogance. This January, Pfizer eliminated discounts for some hospitals that had been offered by Pharmacia, another drug company that Pfizer acquired in April 2003. In New York, hospitals are paying about $13 million this year for Pharmacia drugs now sold by Pfizer, with an average price increase of 24% for the drugs, according to GNYHA Ventures Inc. The for-profit subsidiary of the Greater New York Hospital Association contracts with a national buying co-op, Premier Inc., to pool drug purchases for more than 200 New York City area hospitals and affiliated facilities.*
>
> *The buying group estimates that the cost to those hospitals of the former Pharmacia drug Depo-Medrol, a long-acting steroid for cancer and other diseases, will rise 28% to nearly $600,000 this year. "Among the top 25 companies, Pfizer is the only one that doesn't discount to hospitals," says Lee Perlman, president of GNYHA Ventures. "Their hard and unique line puts us in a spot where we have to seek alternatives to their products."*
>
> *A Pfizer spokeswoman says that the company's policy is to offer the same price to all hospitals, and that it raised the prices of the Pharmacia drugs when that company's contract expired, in order to be consistent with Pfizer policy.(99)*

[20] Drug charges and costs analyses are limited to only acute care hospitals

C. HMOs, Hospitals, Pharmas and the Health Care War Economy

Despite the talk of a "power shift" from HMOs to hospitals, (71;88) that alleged shift has not inhibited profits from soaring within the elite top strata of the HMO sector. (4;37;55;60;162;169;170)

> *The nation's HMOs nearly doubled their net profits last year, earning $10.2 billion in 2003, up from $5.5 billion in 2002, according to a new report by financial ratings firm Weiss Ratings. California and Illinois HMOs reported the highest aggregate earnings at $773.6 million and $624.6 million, respectively. One HMO, Kaiser Permanente, Oakland, Calif., accounted for a full fifth of the industry's profit gains… Meanwhile, the nation's Blue Cross and Blue Shield plans saw their combined profits jump 63% last year, to $5.4 billion from $3.3 billion in 2002, the study found. "The industry's soaring profits continue to irk both consumers and businesses who are shouldering skyrocketing healthcare costs without any perceived improvement in benefits," Melissa Gannon, vice president of Weiss, said in a press release. "We may soon see the next wave of consumer backlash forcing HMOs to evolve their cost structures." Of the 502 HMOs reviewed by Weiss using year-end 2003 data, 24 companies were upgraded, while 14 were downgraded (41)*

Our calculations for the top 50 HMOs are consistent if not identical with *Weiss Ratings* findings. From 2000 to 2003, the top 50 HMOs increased their profits from $3.7 billion to $7.1 billion for a net gain of about 88%.

Table 6 Top 50 HMO Profits Increase – 2000 to 2003[21]

Top 50 HMOs	2000 Profits	2003 Profits	Ratio of 2003 to 2000	Percentage Increase
	$3,773,466,432.00	$7,083,508,184.00	187.72%	87.72%

Hospitals in the aggregate seem to be coping with the high cost of drugs by demanding substantial Drug Charge to Cost Ratios (DCCRs) while HMOs are simply raising rates and/or tightening up their formularies. (4;30) Hospitals, always adept at cross-subsidization, (83;84) and contingent to a large degree on their control type (See Table, *Hospital Medical Supply and Drug Charge to Cost Ratios by Control Type – 2002/2003*), either attempt to simply maintain operations or dramatically enrich the bottom line.

This battle among HMOs, Pharmas and Hospitals to enrich and/or protect their market shares, revenues and profits is one of many among the various sectors that comprise the health care industry and a conflict of great moment within the larger Health Care War Economy.[22] (27)

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[21] Source: IHSP calculations of InterStudy data. (Individual HMO profit data may be available upon request).

[22] See, Part VII, Section C, *Hospitals and the Health Care War Economy*, for more detail).

The alleged "magic of the marketplace," – which holds that the unbridled pursuit of **individual** gain "magically" brings about the collective good - is entrenched in mythic proportions in our popular culture and in most corporate boardrooms and most of Congress. It is so deeply rooted and this particular battle so intense that both tend to go unnoticed. Instead, the ***outcomes*** of this single but extraordinary battle in the global Health Care War Economy – high drug prices, increased hospital pricing structures and runaway health premium costs - are labeled as "cost drivers" in the health care inflation debacle.

Such a view is politically and economically myopic: it serves only to obscure the root cause of health care inflation - the Health Care War Economy - and at the same moment to secure the ability of the entities in this particular battle - HMOs, Pharmas and Hospitals - to continually raise prices in the pursuit of greater and greater revenues.

V. Medicare Fixed Rate Reimbursement is Impacted by Hospital Gross Charges

When pressed, the hospital industry habitually states that gross hospital discharges are irrelevant since actual payments from Medicare and other payers are reimbursed via fixed rates.

The question left unasked and unanswered is, if reimbursement rates are **absolutely** fixed, then why are not hospital gross charges – the "list prices" – fixed and indexed to the same rate? The answer is that reimbursement rates are not *a priori* **absolutely** fixed. For example, the method by which Medicare reimbursement rates are set makes use of a number of variables, *including* hospital billed or gross charges. (See Table 25) The same charge structure plays a vital role as a starting point for negotiated hospital reimbursement rates from other payers, such as HMOs.

Medicare "outlier payments" are discussed below, but the often cited Medicare fixed rate for each DRG is itself not immune from hospital charge structures. Those flat rates are impacted by a number of variables, among them a federally computed relative weighting system for each DRG.. Most critical for understanding the importance of hospital gross charges, those relative DRG weights are *themselves* heavily impacted by hospital pricing practices; that is, hospital gross charges or "list prices" for products and services. In discussing the variation in hospital margins relative to Medicare payments, the federal Medicare Payment Advisory Commission.[23] MedPAC states:

> *Adopting a patient classification system that is more sensitive to differences in severity of illness than the current DRGs might eliminate the unintended case mix contributions to margin variation across hospitals. It is also possible, however, that a portion of the problem arises from limitations in the data and methods used to calculate the national DRG relative weights.* ***The DRG weights may be biased because they are based on hospitals' service charges,****(emphasis added) and thus reflect the systematic differences in mark-ups across services that are built into hospitals' charge structures. (15;16;25;32;67)*

[23] The Medicare Payment Advisory Commission (MedPAC) is an independent federal body established by the Balanced Budget Act of 1997 (P.L. 105–33) to advise the U.S. Congress on issues affecting the Medicare program. The Commission's statutory mandate is quite broad in addition to advising the Congress on payments to health plans participating in the Medicare-Choice program and providers in Medicare's traditional fee-for-service program. (14)

Calculations of Medicare reimbursement rates – both the flat rate and outliers – therefore involve hospital gross charges, the "list price" for hospital products and services. Self-payers are often forced to pay the gross charge itself or the "list price." For other payers, the gross charge tends to be a starting point for negotiations on actual reimbursement levels.

Elsewhere, MedPAC writes:

> … *the weights (relative DRG weights) are based on the total billed service charges hospitals report on their claims for all cases in each DRG* (14)

Further,

> *Currently, the weight for each DRG is calculated by dividing the national average standardized total charge per case for all cases in the category by the overall national average standardized charge for all cases.* ***Basing the weights on the national average standardized charge per case in each DRG, however, makes them vulnerable to distortion from systematic differences among hospitals in the mark-up of charges over costs and in the level of costs****. (14)* (Emphasis added).

A. Calculating Medicare Reimbursement Rates

Gross hospital charges are utilized in determining relative DRG weights, which in turn impact the "flat rate" reimbursements under Medicare reimbursement formulae. It is also the case, as outlined below, that there is no *standard* flat rate of reimbursement per DRG that is "the same" for all hospitals. Individual hospital reimbursement rates can and do vary:

> *The DRG adjusted payment (DRG price) is the base amount multiplied by a national "weight" associated with the hospitalization's DRG. The base amount is calculated from information* ***(for the hospital)*** *found in the PPS Impact File (wage indices, disproportionate share and medical education adjustments) and a national calculation of average capital costs and operating costs with geographic adjustments for all Medicare hospitalizations found in the Federal Register.*
>
> *The costs incurred by a hospital for a case are evaluated to determine whether it is eligible for additional payments as an outlier case. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases. Any outlier payment due is added onto the DRG-adjusted base payment rate.* (100)

The principle elements in the determination of a **particular** hospital's Medicare flat rate for any given DRG are: (100)

- *The standardized amounts, which are the basic payment amounts.*
- *A wage index to account for differences in hospital labor costs.*
- *The DRG relative weights, which attempt to account for differences in the mix of patients treated across hospitals.*[24]

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[24] Basing the weights on the national average standardized charge per case in each DRG, however, makes them vulnerable to distortion from systematic differences among hospitals in the markup of charges over costs and in the level of costs. (14)

- *An add-on payment for hospitals that serve a disproportionate share of low-income patients.*
- *An add-on payment for hospitals that incur indirect costs of medical education.*

The actual reimbursement for a given case of a particular DRG in a given hospital is equal to the sum of the PPS Operating Payment and the PPS Capital Payment. Calculations take the form:

PPS Operating Payment:

> [(Standardized Labor Share x Operating Wage Index) + (Standardized Non-Labor Share x Operating COLA Adjustment for Hospitals Located in Alaska and Hawaii)] x (1 + Operating IME + Operating Disproportionate Share Adjustment Factor) x (DRG Weight)

PPS Capital Payment:

> (Standard Federal Rate) x (GAF) x (Large Urban Add-on, if applicable) x (Capital COLA Adjustment for Hospitals Located in Alaska and Hawaii) x (1+ DSH Adjustment Factor + IME Adjustment Factor) x (DRG Weight)

Hospital Specific DRG Price (Payment):

> PPS Operating Payment + PPS Capital Payment = Total Payment

The relative DRG weights are of clear import in computing the reimbursement rate for a given DRG.. Hospitals' gross charges are influential in computing those DRG relative weights even though, again,

> *The DRG weights may be biased because they are based on hospitals' service charges, and thus reflect the systematic differences in mark-ups across services that are built into* ***hospitals' charge structures.*** *(15;16;32)*

Hospital gross charges are also a principal determinant in triggering an outlier Medicare payment for a given DRG. Consequently, a hospital's gross charge structure plays an important role in the actual reimbursement that hospital can receive from Medicare for any given DRG or group of DRGs.

Some elements (126) within the hospital industry inexplicably continue to claim that "gross charges are irrelevant" because rates are "fixed" or "flat" from most payers, including Medicare. For Medicare, it is more accurate to say that the rates "float" year by year relative to the values of a number of variables in the reimbursement formulae, a principal component of which is hospitals' gross charging structure that influences the relative DRG weights.

Hospital stop-loss arrangements with HMOs and the impact of hospital charges with respect to Workers Compensation cases are discussed below.

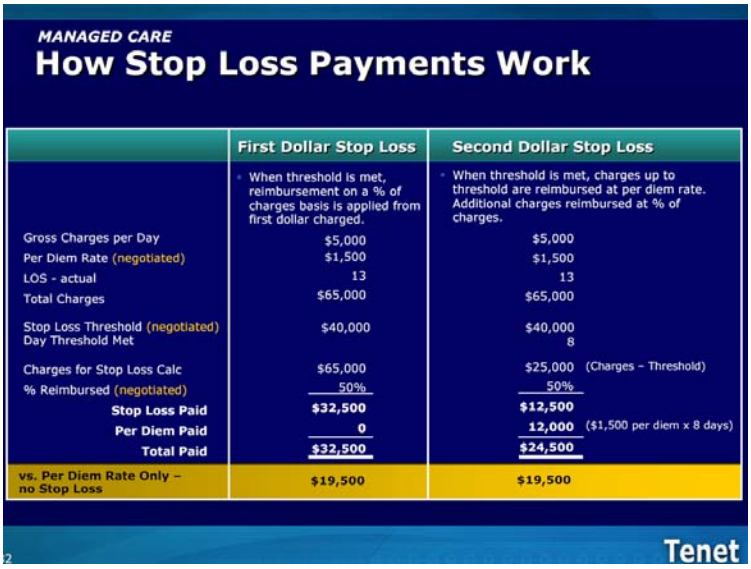
B. High Charges are a Warning Sign

Hospital charges of 20% to 25% above the statewide or national median may or may not be a cause for concern. Charges more than double the median are a clear danger sign that the uninsured; employers large and small, private and public; and government may have been subject

to inflated charges far beyond hospital actual costs, that unnecessary medical procedures may have been performed, or that hospital charges may have been submitted for services not performed at all.

Reliable data on individual hospital patient discharges that include information on actual hospital costs, gross charges and actual reimbursements per specific patient discharge by service and product for all payers are not readily available within any given state or on a state-by-state comparison. Aggregated charges and costs are available in the federal cost reports but not on a case-by-case basis, and actual reimbursements are cumbersome and time consuming to calculate. Other national data sets do have actual reimbursements on a case-by-case basis and hospital charges but apply to only one payer (Medicare), and hospital costs are not specified. In California, data on hospital charges per discharge is available from the California State Office of Statewide Health Planning and Development. But, it is not readily possible to determine if those charges are appropriate relative to actual costs, or if unnecessary procedures were performed, or if any "upcoding" (charging for services not actually rendered) occurred.

State-level hospital costs per specific patient discharge by specific service and product on a case-by-case basis are not available, since most states aggregate charges only for each patient discharge. However, reasoned health care planning at any level – local, state, or national – requires line item specific charges, costs and reimbursements at the individual patient discharge level.



C. Medicare Outliers, Worker's Compensation & HMO Stop Loss Payments

Both Medicare and worker's compensation[25] were "gameable" under statute. (12;26)

Both:

- were based on the DRG classificatory system for reimbursement purposes,
- had economic thresholds, all of which are open to public access, beyond which a given case becomes eligible for outlier consideration,
- were based on a given hospital's habitually outdated cost-to-charge ratio, and

[25] The much publicized legislation overhauling California's worker's compensation program does not seem to address the outlier issue. (11)

- were susceptible to encouraging hospitals to game the system by raising gross charges at a rapid rate to increase profits/revenue.

Medicare outlier payments, those payments above the "flat rate" set by Medicare for specific DRGs to compensate hospitals for unusually costly and complicated cases, garnered nationwide attention, even though stop-loss payments[26] from HMOs were considerably richer.

However, much of past years' news coverage surrounding Medicare outliers, where questions about unnecessary surgical procedures, inflated pricing structures and possible Medicare fraud proliferate, may inadvertently give the impression that Medicare outlier payments are per se wrong and/or illegal. That is not the case. The US Congress developed Medicare outlier payments to protect hospitals from unusually costly patient hospital stays. The outlier payments provide additional reimbursement for those unusually costly hospital stays via a complex formula indexed to the average charge for a given Diagnostic Related Group (DRG). At a specified amount above that charge, the outlier payment mechanism[27] "kicks in." (107).

At the height of the outlier debacle that captured public and government attention in 2002, the formula for calculating Medicare outlier reimbursements changed in October. (85;181) It can be expressed in the following algebraic formula:

> Outlier Payment = (.80) x [(charges x cost/charge ratio) - (DRG + IME + DSH + threshold)].
>
> Terms are defined as follows:
>
> - Charges = Hospital's actual charges for services provided to the patient
> - Cost/Charge ratio = Cost-to-charge ratio derived from most recent settled Medicare cost report

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[26] The slide, *How Stop Loss Payments Work*, is taken directly from a Tenet Online Investor Conference, December 3-6, 2002.

[27] Under the former regulatory system for inpatient outlier payments, a hospital could unilaterally affect the amount of outlier payments it received by adjusting its charges. A hospital that increased s its charges from one year to the next would also increase the outlier payments it received.

Medicare reimburses hospital inpatient services under a prospective payment system ("PPS"), paying a predetermined amount for each inpatient discharge. The amount varies according to the diagnosis-related group ("DRG") to which the patient is assigned, as well as certain characteristics of the hospital (e.g., teaching hospitals receive certain medical education payments; hospitals that admit a large percentage of low-income patients receive disproportionate share payments). When it created inpatient PPS, Congress was concerned about reimbursement of cases whose costs far exceed the costs of typical cases within that DRG. As a result, Congress created a system for "outlier" payments (in addition to the prospective payments) to defray some of the expenses in caring for the most costly cases.

Hospitals qualify for outlier payments when the hospital's charges (adjusted by the hospital's cost-to-charge ratio) exceed a certain threshold amount. The outlier payment for a given inpatient equals 80 percent of the difference between the hospital's charges, adjusted by the hospital's cost-to-charge ratio, and the sum of the DRG, IME, and DSH payments plus a threshold amount set annually by the Centers for Medicare and Medicaid Services ("CMS") (107)

- DRG = Standard DRG payment
- IME = Indirect medical education payment
- DSH = Disproportionate share payment
- Threshold = Annual threshold set by CMS ($31,000in fiscal year 2004).[28]

Table 7 CMS Outlier Thresholds, 1997 through 2005 (Source: Federal Register, 2003)

Fiscal Year	Effective Date	Effective Until	Outlier Threshold Amount
2005*	10/1/2004	9/30/2004	$35,085
2004	10/1/2003	9/30/2004	$31,000
2004^	NA	NA	$54,000
2003	10/1/2002	9/30/2003	$33,560
2002	10/1/2001	9/30/2002	$21,025
2001	4/1/2001	9/30/2001	$16,500
2001	10/1/2000	3/31/2001	$17,550
2000	10/1/1999	9/30/2000	$14,050
1999	10/1/1998	9/30/1999	$11,100
1998	10/1/1997	9/30/1998	$11,050
1997	10/1/1996	9/30/1997	$9,700
^Proposed prior to the change in outlier policy.			
*Proposed			

We would expect some hospitals to have higher than average percentages of outliers. Among them are teaching hospitals treating acutely ill Medicare patients with heart, respiratory and neurological related DRGs, and smaller public hospitals subjected to patient dumping by more powerful hospital systems that may be tempted to foist Medicare patients with potentially less lucrative DRGs onto the smaller public sector.

We believe a number of factors should be considered in explaining outlier percentage increases in past years. Following are some of the more important variables:

- A number of hospitals nationwide, but not all, may have been responding to the BBA mandated Medicare payment cuts by exploiting rather than utilizing the outlier mechanism.
- From 1993 through December of 2003, our statistical analysis of the hospital industry's merger and acquisition activity shows that the industry has engaged well in excess of 1,000 publicly announced transactions valued at about $142,100,000,000.The industry is still paying for those costs.

[28] For more detail, see (107)

- Some hospital systems may have "leveraged" outliers as a means to cope with stringent HMO contractual allowances.

Given recent CMS changes in the outlier formulation, it is probable that hospitals nationwide will find their total Medicare reimbursements substantially lowered. (104) As such, lacking a real national health care program, many hospitals could in the future be facing unprecedented fiscal uncertainties.

> *Medicare Outliers made national headlines in late October, 2002, when it was revealed that Tenet Healthcare Corporation was receiving abnormally large outlier payments by raising their charges faster than their costs.*[29] *As subsequent investigations*[30]*, and the findings presented below will indicate, it was not only Tenet Healthcare that was abusing outliers. The attention on outliers prompted the federal administrator of Medicare, the Center on Medicare and Medicaid Services (CMS), to review and change its policies on outlier determination…..*
>
> *The Outlier Methodology procedures have changed in 3 ways to transform the outlier portion of Medicare Reimbursements from prospectus to retro-active payment system. The three changes include:*
>
> 1. *Previously, in determining the Cost-to-Charge Ratio (CCR) the Financial Intermediary (FI) would use the most recent settled CCR. The problem was that the most recent CCRs would be at least two years old. The new rule requires that the FI use the most recently submitted or tentatively settled Medicare Cost Reports to determine the relevant CCR. The Medicare Cost Reports are tentatively settled within 4 months of being submitted. This will provide more timely data.*
>
> 2. *State Wide Averages for the CCR when the CCR falls below 3 standard deviations of the states' CCR are no longer used. This happens when a hospital raises its charges faster than it costs are rising. The State Wide Average will still apply to those hospitals with a CCR 3 standard deviations above the statewide average.*
>
> 3. *Outlier payments will become subject to reconciliation after the CCR are settled. Also CMS will be able to charge interest on overpayments of outliers. This change is designed to prevent gaming of the outlier payments as CMS can now inspect retrospectively a hospital's filings.*

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[29] Don Lee, "Tenet Shares Tumble 14% After Downgrade; An analyst's report raises questions about the hospital company's Medicare reimbursements and whether it can sustain its stellar." Los Angeles Times 29 October 2002. See Institute for Health and Socio-Economic Policy's Research on Outliers at http://cna.igc.org/outliers/.

[30] Mary Chris Jaklevic, "It's more than just Tenet: Analysis shows not-for-profit hospitals, including a cluster in New Jersey, also heavily rely on outliers." *Modern Healthcare*, 14 July 2003. Thomas Scully, former head of CMS, estimated that about 300 hospitals were gaming outliers. Uwe E. Reinhardt "The Medicare World From Both Sides: A Conversation With Tom Scully." *Health Affairs*, November/December 2003; 22(6): p. 169.

Closely related to the change in the procedures is the dramatic increase in the Outlier Threshold since 1997. The Outlier Threshold is the amount the hospital's costs must surpass for the hospital to be eligible for an outlier reimbursement. Medicare law establishes that Outlier Reimbursement as a percent of Total Medicare Payments (DRG Payments + OutlierPayments, ignoring Disproportionate Share Payments and Medical Education)[31] should be between 5 and 6% and CMS sets a goal of 5.1%. This is called the Outlier Percentage.

These changes potentially have a devastating impact on the amount of Medicare reimbursement that hospitals receive. The prospective payment system is set up as a zero-sum game; the amount of money for outliers and ordinary DRG reimbursements is fixed each year. If one hospital games the system, then other hospitals pay for it with lower reimbursements.

Consequently, the new reimbursement rules could hurt those hospitals that did play by the rules, making it more difficult for them to survive. Preliminary data calculated by the Institute for Health and Socioeconomic Policy (IHSP) indicates that if the new outlier methodology had been in effect from 1997 through 2001, total outlier payments to US hospitals would have been reduced by billions of dollars over the five-year period. Such a loss - projected into the future - would deal an overwhelming... blow to many U.S. hospitals. (104)

All of which highlights the unpleasant reality that market mechanisms left to their own devices are not capable of delivering accessible high quality and cost effective care.

In the past, calculations were based on cost reports that were often two to four years old. Concerning Medicare, for example,

The CCR's (Cost to Charge Ratios) used in calculation of 2003 inpatient PPS payments are based on cost reports filed in fiscal 1998 and 1999. (39)

For the sake of public oversight, <u>whatever</u> reports are used, they must be publicly available at the time of their utilization. However, even then, nothing here provides the state or the public the ability to monitor and/or audit if necessary, actual costs, charges and reimbursements to and from the various payers; i.e., Medicare, Medicaid, HMOs, self-pays (the uninsured), etc.

1. Worker's Compensation and Outlier Payments

The regulations governing the eligibility of a DRG (Diagnostic Related Group) for an increased outlier payment from workers' compensation in California are in principle similar to those that governed Medicare outlier payments. (34). The imputed cost[32] of a DRG must exceed a regulatory threshold amount. The term "imputed cost" must be taken literally. We presume that

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[31] Disproportionate Share and Medical Education, two politically charged reimbursement issues, are left out of the outlier percentage, though they are present in determining whether a discharge qualifies as an outlier.

[32] Disproportionate Share and Medical Education, two politically charged reimbursement issues, are left out of the outlier percentage, though they are present in determining whether a discharge qualifies as an outlier.

the business managers of hospital chains know their actual costs; the public does not. Included in the public is the State workers' compensation system.

The imputed cost is derived by multiplying the hospital's charge for the procedure times an estimated total cost-to-charge ratio.[33]

As a matter of simple mathematics, the higher the gross charge billed by a hospital, the higher the imputed cost, which tends to contribute to higher costs for the workers' compensation system.[34] Concomitantly, hospitals have the unfettered ability to continually raise gross charges.

This state of affairs allows imputed costs to rise and to exceed actual costs – whatever they may be – by a significantly growing fissure that directly benefits a hospital's bottom line.

VI. Charges Matter: Implications of Gross Hospital Charges – the "Sticker Price"

High hospital charges have provided ideological cover for health plans to raise once again premium rates by double digits – and to dramatically increase their profits[35] – thus increasing health care costs for large and small employers and federal, state and local government agencies. This has prompted a number of businesses to scale back on the quality of the plans available for their employees and has been a significant contributor to the growing ranks of the uninsured whose only recourse to care is the hospital emergency room – the most expensive form of care. Hospitals then cost shift that economic burden to other payers by raising charges in so far as possible, particularly drug, medical supply and operating room charges, contributing to a self-perpetuating and self-defeating Health Care War Economy of more expensive care, less care, higher premium rates, and more uninsured.

This brings us full circle and is exactly what one should expect as the necessary outcome of the ongoing but unwinnable battle within the Health Care War Economy struggles among pharmaceutical corporations, insurers and hospitals as they do their best to exploit each other in a market care-blind to the nation's health needs.

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[33] (e) "Cost-to-charge ratio" means the sum of the hospital-specific operating cost-to-charge ratio and the hospital specific capital cost-to-charge ratio. The operating cost-to-charge ratio for each hospital was published in the Payment Impact File at positions 161-168. The capital cost-to-charge ratio for each hospital was published in the Payment Impact File at positions 99-106. A table of hospital-specific capital cost-to-charge, operating cost-to-charge and total cost-to-charge ratios for each health facility in California is contained in Appendix A to Section 9792.1. (12)

[34] Furthermore, the applicable state regulations are revised at intervals of one, two, or more years, rendering them habitually out of date.

[35] See (41) and Table, *Top 50 HMO Profits Increase*….

VII. Implications for Health Care Reform: The U.S. Does Not Have A Health Care System

A. Failure of Market Led Health Care Reform

Table 8 Health Care Related Corporations – Selected Values[36]

Value of All Outstanding Stock of Top 100 Publicly Traded Health Care Related Corporations:[37] $2,641,463,000,000 **Profits of Top 100 Publicly Traded Health Care Related Corporations:** $107,200,000,000 **Net Sales of Top 100 Publicly Traded Health Care Related Corporations:** $1,274,184,000,000 **Percent of Staffed Hospital Beds Controlled by Top Ten California Hospital Systems in 2003:** 47.2% **U.S. Hospital Profits 1986 through 2002:** $230,300,000,000 **Percent of Total Number of US Chain HMO Members held by Top Fifteen HMO Chains, 2003:** 80% **Percent of Total Number of California HMO Members held by Top Ten HMO Chains, 2003:** 92.1%	**Total Number of California HMO Members, 2003:** 25,731,000 **U.S. HMO Mergers and Acquisitions: 1993 through December, 2003:** $110,800,000,000 **U.S. Hospital Mergers and Acquisitions: 1993 through December, 2003:** $142,100,000,000 **U.S. Pharmaceutical Merger and Acquisitions 1993 through December, 2003:** $554,600,000,000 **Top Fifty Pharmaceutical Corporations Combined Profits, 2003 FY:[38]** $50,100,000,000 **Top Fifty Pharmaceutical Corporations Combined Market Capitalization, 2003 FY:** $1,200,000,000,000[39] **Total Profit of US Hospitals in 2002:** $19,300,000,000 **Number of Under 65 Uninsured in the US in 2003:** 45,000,000

[36] Adapted from (27)

[37] A publicly traded health care related corporation is here stipulated as a corporation possessing at least one Standard Industrial Code (SIC), primary or secondary, in its overall operations as reported in its Securities Exchange Commission (SEC) filings that is health care related.

[38] See (67) for more detail on year 2002 Pharma profits.

[39] This is not a misprint. Combined market capitalization for the top 50 Pharmas is $1.2 trillion.

The United States does not have a health care system.

It does have a market driven – and market concentrated – health care industry.[40] The high degree of hospital market concentration in the years following the 1994 Department of Justice and Federal Trade Commission ruling that effectively relaxed anti-trust law (80), resulting in more than $142 billion in hospital merger and acquisition activity, has not issued forth in the costs savings for which many had hoped. Medical inflation is on the rise, and some hospitals and hospital chains that command large market share have overall charge to cost ratios in excess of 1,000%, some them with corresponding hefty profits.

B. Hospitals and the "Health Care War Economy"

In effect, the health care industry as a whole has itself contributed to the conditions which perpetuate a virtual Health Care War Economy among its various sectors – pharmaceuticals, HMOs, hospitals, medical device manufacturers, long term care entities, bio-tech and others. Those conditions are not, however, simply to be found ***in*** the health care market. Rather, the intrinsically antagonistic relations among the sectors collectively ***constitute*** the health care market – a market that is sustained and reproduced day-by-day and year-by-year by the industry and the sectors that comprise it.

The industry and its member sectors, dominated more and more by corporate giants, are locked in a never ceasing and irrational conflict for economic supremacy. It is a battle that is in the long term not winnable even for such behemoths as HCA, Tenet, the "Blues" or Kaiser. This same battle – and ***not*** its causal effects such as the medical arms race, drug costs, demands for "greater" access to care by the patient population, rising insurance premiums, or even the hospital costs documented in this report – is the real genesis of the current crisis in escalating health care spending, quality, and the dilemma of the un- and underinsured. The market that the industry has in good measure helped foster and currently sustains ***demands*** corporate giantism, inter and intra-sector greed and duplicity, "care containment" disguised as cost containment, and brutish disregard of human health as necessary for short-term industry survival. (24;111;113-117;130;131;149;186)

But the single-minded pursuit of market-based survival – or dominance - is not without costs for the industry. Long-term survival requires industry success in at least two fundamental strategic arenas: the first is predominantly economic and the second primarily political, but both have economic and political facets:

The industry as a whole and the sectors within it need one another – and other industries – as economic trading partners to buy and sell their various products, and their political/legislative neutrality if not support regarding pricing levels and structures.

The industry's survival as an industry is linked to its ability to be widely seen as legitimate, fair, and trustworthy by both the general public and the nation's caregivers. (69) And the health care industry needs ***other*** industries' political resources and support in promoting cut-rate care to their

[40] All figures are IHSP calculations utilizing SEC filings, Thomson Financial Data, InterStudy, and Irving Levin Associates data, American Hospital Association statistics and State of California Hospital Filings obtained from the California Office of Statewide Health Care Planning and Development (OSHPD). Unless specified otherwise, all dates are for most current year available.

employees and the general population. Even ancient monarchies did not rule without a modicum of support and consent from the ruled.

Neither of the above demands is likely achievable or sustainable in the long-term.

Part of the inevitable economic fallout of this Health Care War Economy is our finding that about 33% of the hospitals examined in this report had net losses for the time period – a statistic that is consistent for the nation's hospitals since 1983. This suggests that on average high charge to cost ratios have become a national but much unwanted norm for a healthy hospital bottom line, and that many hospitals are losing the battle with pharmaceutical corporations, HMOs, medical supply corporations, and others in trying to control costs.

A necessary condition of hospital financial success is a sometimes exorbitant overall charge to cost ratio, in which technical efficiency – such activities as throughput, "cycle time," the ratio of capital to labor (the substitution of technology for employees, or degree of mechanization), etc., is granted priority over social efficiency. Social efficiency is directly concerned with the social value of a given hospital defined in terms of both the quantity and quality of health care it makes available and the expense associated with that quantity and quality.

Stated simply, hospitals are entrapped in the nation's Health Care War Economy and are encouraged and sometimes forced to choose between their own economic survival (or in extreme cases, generating staggering profits) and making available cost effective, quality health care to as many of the nation's people as possible.

In this sense, hospitals are both victims of a market indifferent to the intent of the original Greek formulation of the Hippocratic oath[41] with its dual emphases on doing no medical harm and promoting social justice, and victimizers of patients and society at large for failing to take a leadership role to end the inter- and intra-sector struggles endemic to Health Care War Economy and provide quality health care at affordable prices. (68;130) Hospital pricing behaviors may be one of the nation's best witnesses to the futile economic thrashings of the Health Care War Economy as national health care reform is debated this political season.

No amount of market tinkering (45;56;60;62;109;110;112;121;138-148;150;160;161;171;175;181-183;188) or politically motivated flights of wishful thinking (96) that the often-cited-but-never-seen "magic of the marketplace" will resolve the health care crisis (47;59;128;187) in the foreseeable future.

Both reason and simple human compassion demand creation of a new national environment in which health care related social efficiency is ascendant. Whatever that environment is, it must obliterate the current market-generated debacle and its contradictory demands made on the hospital industry:

> *… it becomes clear why the burden is not simply on other hospitals to lower costs to achieve a greater degree of technical efficiency via a higher charge to cost ratio. In a nation with 41 million uninsured, the burden is on those hospitals with a high charge to*

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[41] I swear by... (the ancient Greek Gods).. making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant. … I will apply..(medical) measures for the benefit of the sick according to my ability and judgment; I will keep them from harm *and injustice*. (78) [Emphasis added].

cost ratio to lower their charges to increase the quantity and quality of care available to all and thereby give preference to social and not mere technical efficiency…

VIII. Stripping Away the Myth of a U.S. Health Care System: A 12 Step Program to Begin Recovery[42]

A new national health care environment for hospital survival entails at least the following twelve primary steps, (27).

1. **Single Universal Standard of Care Applied to All Patients**
2. **Uniform Benefits Package for All**
3. **Mandated and Enforced Safe Caregiver Staffing Levels Based on Patient Need**
4. **Patient and Caregiver Safety Standards Placed on Caregiver Work Redesign Programs**
5. **Patient and Caregiver Safety Standards Placed On Computer-Based Technologies**
6. **Implementation of a Single and Uniformly Applied Acute Care Hospital Acuity System**
7. **Public Regulation of Health Care Investments and Divestments**
8. **Transition Employment Program for Displaced Workers as a Direct Result of Health Care Reform Measures**
9. **Patient Sensitive Criteria (e.g., Race, Gender And Socio-Economic Status) Must be Given First Priority in all Health Care Investment and/or Divestment Proposals**
10. **Protections Against Patient Dumping and Providers Gaining a Monopoly on Healthy (Less expensive) Patients**
11. **Expansion of Traditional Funding Sources: Making Corporations Accountable[43]**
12. **Expansion of Clinical and Economic Reporting Requirements**

Each step in the 12-step program is informed by a paradigmatic break from the current industrial-like focus on static patient care outcomes and profits. In its stead is a stress on a dynamic system approach focused on long-term quality of life. The new paradigm focuses on fostering cooperative system relationships among the various health care sectors rather than the antagonistic internal profit driven conflicts inherent in the market-based industrial battles currently in place.

This approach is grounded in the basic supposition that human beings have certain inalienable rights – all of which are derived from the fact that neither human beings as such, their health nor their long-term quality of life should be enslaved to the market – or in the instance of the health care industry – be reduced to mere economic units.

The new paradigm stresses,

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[42] For further detail on the 12 Steps, see, *Stripping Away the Myth of a U.S. Health Care Industry: A 12 Step Program to Begin Recovery. An IHSP Policy Brief* (2003). Orinda: Institute for Health & Socio-Economic Policy.

[43] This includes development of a publicly funded and administered health care payer system, similar to but more expansive than some current Western European models.

> "… *maximization of public health and long-term quality of life consistent with humanity's inalienable right to health care and the indivisible, universal and intrinsic dignity that comprises the foundation of the human condition."(27)*

As the 12 Steps are informed by this paradigmatic shift, Step 1, the *Single Universal Standard of Care Applied to All Patients*, informs and is supported by the remaining steps directly or indirectly. Steps 3 through 5 offer direct support and are logically implied by the Single Universal Standard of Care. Steps 2, and 6 through 12 play vital supporting roles and are empirically essential in bringing Step 1 to fruition.

Implementation of **all** these basic steps constitutes a necessary political and economic prerequisite in eliminating in so far as possible what we have termed the Health Care War Economy – itself both the offspring and keystone of a market that is care-indifferent to the inherent health needs of the nation.

Failing implementation of these twelve steps, there is little hope that hospitals will lower charges for the sake of health care related social efficiency and a more just civil society in which human beings are no longer reduced to, demeaned, and trivialized as "covered lives" for sale in a Health Care War Economy.

IX. Tables

A note on the Top 100 Table:

Tenet Healthcare has and is undergoing a significant restructuring – both in its management ranks and its business plan. They have sold or are planning to sell a number of hospitals listed in the Top 100 in this study. Those hospitals are marked with an asterisk. Their current business plan calls for trimming the number of their hospitals down to 60 in an effort to control both costs and an escalating pricing structure. Data to assess the pricing impact of Tenet's new leadership and business plan will not be available for at least one year and perhaps longer. Even then, judging the impact of Tenet's new business plan and attempts to control prices and costs cannot be fruitfully explored for at minimum two years, when it is hoped that such changes will have been implemented for a full year.

Table 9 The Nation's Hospitals with the Highest Charges Compared to Costs: Fiscal Year 2002/2003[44]

Current Ranking	Hospital Name The Nation's Hospitals with the Highest Charges Compared to Costs: Fiscal Year 2002/2003	City	State	System Affiliation	Total Charges as a % of Total Costs 2002/2003	Net Profit or (Net Loss)	Rank from Previous Report 2000/2001	Total Charges as a % of Total Costs 2000/2001
1.	Doctors Medical Center Of Modesto	Modesto	CA	Tenet Healthcare Corporation	1185.66%	$165,804,779	1	1092%
2.	Doctors Hospital Of Manteca	Manteca	CA	Tenet Healthcare Corporation	1092.34%	$15,788,250	2	920%
3.	Temple University Hospital	Philadelphia	PA	Temple University Health	1090.28%	$92,942,000	52	485%

[44] In the column labeled 'Rank from Previous Report 2001/2002' the designation 'NA' means that the hospital was not on last year's Top 100 List.

Current Ranking	Hospital Name The Nation's Hospitals with the Highest Charges Compared to Costs: Fiscal Year 2002/2003	City	State	System Affiliation	Total Charges as a % of Total Costs 2002/2003	Net Profit or (Net Loss)	Rank from Previous Report 2000/2001	Total Charges as a % of Total Costs 2000/2001
				Syst				
4.	Midway Hospital Medical Center*	Los Angeles	CA	Tenet Healthcare Corporation[45]	945.32%	$9,345,339	3	794%
5.	Warminster Hospital	Warminster	PA	Tenet Healthcare Corporation	926.09%	($2,511,481)	39	526%
6.	Temple East Hospital	Philadelphia	PA	Temple University Health Syst	906.23%	$5,171,623	NA	347%
7.	Brownsville Medical Center*	Brownsville	TX	Tenet Healthcare Corporation	902.53%	$63,875,236	8	706%
8.	Graduate Hospital	Philadelphia	PA	Tenet Healthcare Corporation	885.46%	$7,718,051	16	594%
9.	Garfield Medical Ctr.*	Monterey Park	CA	Tenet Healthcare Corporation	860.53%	$31,252,690	Medicare data not available at time of previous study. CCR was 807%, which would have been third in last	807%

[45] Tenet hospitals recently sold or currently for sale are marked with an asterisk (*).

Current Ranking	Hospital Name The Nation's Hospitals with the Highest Charges Compared to Costs: Fiscal Year 2002/2003	City	State	System Affiliation	Total Charges as a % of Total Costs 2002/2003	Net Profit or (Net Loss)	Rank from Previous Report 2000/2001	Total Charges as a % of Total Costs 2000/2001
							study	
10.	Jeanes Hospital	Philadelphia	PA	Temple University Health Syst	855.72%	($1,348,000)	NA	398%
11.	Christ Hospital	Jersey City	NJ	No Affiliation Listed	830.83%	$17,080,259	NA	266%
12.	Hahnemann University Hospital	Philadelphia	PA	Tenet Healthcare Corporation	813.89%	$45,823,295	59	474%
13.	Twin Cities Community Hospital	Templeton	CA	Tenet Healthcare Corporation	813.87%	$20,294,486	4	761%
14.	Monterey Park Hospital*	Monterey Park	CA	Tenet Healthcare Corporation	796.76%	$7,915,411	7	711%
15.	Los Alamitos Medical Ctr.	Los Alamitos	CA	Tenet Healthcare Corporation	796.14%	$25,539,246	11	658%
16.	Columbus Hospital	Newark	NJ	Cathedral Healthcare Syst, Inc	793.11%	$10,890,230	NA	356%

Current Ranking	Hospital Name The Nation's Hospitals with the Highest Charges Compared to Costs: Fiscal Year 2002/2003	City	State	System Affiliation	Total Charges as a % of Total Costs 2002/2003	Net Profit or (Net Loss)	Rank from Previous Report 2000/2001	Total Charges as a % of Total Costs 2000/2001
17.	Redding Medical Center*	Redding	CA	Tenet Healthcare Corporation	790.78%	$49,328,532	Medicare data not available at time of previous study. CCR was 744%, which would have been sixth in last study	744%
18.	Brookwood Medical Center	Birmingham	AL	Tenet Healthcare Corporation	785.49%	($11,643,072)	89	433%
19.	Medical College Of Pennsylvania*	Philadelphia	PA	Tenet Healthcare Corporation	778.79%	($7,880,111)	64	468%
20.	Bayonne Medical Center	Bayonne	NJ	No Affiliation Listed	766.64%	$2,439,350	NA	352%
21.	Sierra Vista Regional Med Ctr	San Luis Obispo	CA	Tenet Healthcare Corporation	756.35%	$12,942,277	5	758%
22.	Centinela Hospital Medical Center*	Inglewood	CA	Tenet Healthcare Corporation	755.60%	$31,976,866	20	585%
23.	Abington Memorial Hospital	Abington	PA	No Affiliation Listed	749.31%	$17,333,000	34	541%
24.	Encino Tarzana Medical Center*	Encino	CA	Tenet Healthcare	747.70%	$13,312,020	14	625%

Current Ranking	Hospital Name The Nation's Hospitals with the Highest Charges Compared to Costs: Fiscal Year 2002/2003	City	State	System Affiliation	Total Charges as a % of Total Costs 2002/2003	Net Profit or (Net Loss)	Rank from Previous Report 2000/2001	Total Charges as a % of Total Costs 2000/2001
				Corporation				
25.	Brotman Medical Center*	Culver City	CA	Tenet Healthcare Corporation	746.76%	$16,293,198	21	584%
26.	Whittier Hospital Medical Center*	Whittier	CA	Tenet Healthcare Corporation	740.91%	($4,627,656)	Medicare data not available at time of previous study. CCR was 700%, which would have been 10th in last study	700%
27.	Tarzana Encino Regional Med Ctr*	Tarzana	CA	Tenet Healthcare Corporation	739.23%	$24,982,604	10	680%
28.	Meadowlands Hospital Medical Center	Secaucus	NJ	Libertyhealth	738.59%	$1,884,304	97	421%
29.	Memorial Hospital Modesto	Modesto	CA	Sutter Health	733.19%	$46,839,494	15	597%
30.	Temple Lower Bucks Hospital	Bristol	PA	No Affiliation Listed	722.42%	$2,765,340	NA	327%
31.	Lakewood Regional Med. Ctr.	Lakewood	CA	Tenet Healthcare Corporation	722.38%	$18,692,746	12	651%
32.	Barnert Hospital	Paterson	NJ	No Affiliation Listed	701.44%	$10,501,777	NA	258%

Current Ranking	Hospital Name The Nation's Hospitals with the Highest Charges Compared to Costs: Fiscal Year 2002/2003	City	State	System Affiliation	Total Charges as a % of Total Costs 2002/2003	Net Profit or (Net Loss)	Rank from Previous Report 2000/2001	Total Charges as a % of Total Costs 2000/2001
33.	Raritan Bay Medical Center	Perth Amboy	NJ	No Affiliation Listed	701.05%	$5,714,016	48	496%
34.	Parkway Hospital	Forest Hills	NY	No Affiliation Listed	698.54%	$19,739	NA	306%
35.	San Dimas Community Hospital	San Dimas	CA	Tenet Healthcare Corporation	696.91%	$5,863,579	6	743%
36.	Desert Hospital	Palm Springs	CA	Tenet Healthcare Corporation	694.98%	$85,259,063	30	547%
37.	Daniel Freeman Memorial*	Inglewood	CA	Tenet Healthcare Corporation	690.92%	($8,689,708)	NA (Not owned by Tenet in 2000/2001)	329%
38.	Hialeah Hospital	Hialeah	FL	Tenet Healthcare Corporation	669.09%	$25,188,088	46	511%
39.	John.F. Kennedy Memorial Hosp.	Indio	CA	Tenet Healthcare Corporation	668.37%	$3,785,621	13	632%
40.	Sierra Medical Center	El Paso	TX	Tenet Healthcare Corporation	666.56%	$84,919,684	18	592%
41.	Warren Hospital	Phillipsburg	NJ	No Affiliation Listed	665.97%	$3,211,135	NA	339%
42.	Usc University Hospital	Los Angeles	CA	Tenet Healthcare Corporation	662.71%	$74,587,173	19	590%
43.	Delaware County Memorial Hospital	Drexel Hill	PA	Crozer-Keystone Health System	662.51%	$3,364,289	17	594%

Current Ranking	Hospital Name The Nation's Hospitals with the Highest Charges Compared to Costs: Fiscal Year 2002/2003	City	State	System Affiliation	Total Charges as a % of Total Costs 2002/2003	Net Profit or (Net Loss)	Rank from Previous Report 2000/2001	Total Charges as a % of Total Costs 2000/2001
44.	Providence Memorial Hospital	El Paso	TX	Tenet Healthcare Corporation	656.94%	$124,921,647	37	535%
45.	Century City Hosp*	Los Angeles	CA	Tenet Healthcare Corporation	653.36%	$2,217,911	22	581%
46.	Suburban Medical Center*	Paramount	CA	Tenet Healthcare Corporation	650.72%	$1,968,198	24	580%
47.	Doctors Medical Center-San Pablo*	San Pablo	CA	Tenet Healthcare Corporation	649.61%	($4,309,739)	Medicare data not available at time of previous study. CCR was 653%, would have been 12th in last study	653%
48.	Palmetto General Hospital	Hialeah	FL	Tenet Healthcare Corporation	644.90%	$40,506,916	31	546%
49.	Meadowcrest Hospital	Gretna	LA	Tenet Healthcare Corporation	644.87%	$7,047,952	36	538%
50.	Queen Of Angels/Hollywood Pres Mc*	Los Angeles	CA	Tenet Healthcare Corporation	633.08%	($10,547,546)	47	498%

Current Ranking	Hospital Name The Nation's Hospitals with the Highest Charges Compared to Costs: Fiscal Year 2002/2003	City	State	System Affiliation	Total Charges as a % of Total Costs 2002/2003	Net Profit or (Net Loss)	Rank from Previous Report 2000/2001	Total Charges as a % of Total Costs 2000/2001
51.	Heart Of Florida Reg L Medical Ctr.	Haines City	FL	Health Management Associates	628.32%	$17,788,323	Medicare data not available at time of previous study. CCR was 471%, which would have been 60th in last study	471%
52.	Wmc Santa Ana	Santa Ana	CA	Tenet Healthcare Corporation	627.15%	$24,049,333	33	544%
53.	Delray Medical Center	Delray Beach	FL	Tenet Healthcare Corporation	625.94%	$54,927,334	41	520%
54.	Crozer Chester Medical Center	Upland	PA	Crozer-Keystone Health System	622.35%	$2,614,037	25	575%
55.	Northshore Reg. Medical Center	Slidell	LA	Tenet Healthcare Corporation	618.56%	$6,598,848	27	572%
56.	Nazareth Hospital-Phila Pa	Philadelphia	PA	Catholic Health East	616.23%	$2,567,236	94	425%
57.	St. Michaels Medical Center	Newark	NJ	Cathedral Healthcare Syst, Inc	615.94%	$44,929,806	NA	206%
58.	Irvington General Hospital	Irvington	NJ	Saint Barnabas	611.80%	$313,000	23	581%

Current Ranking	Hospital Name The Nation's Hospitals with the Highest Charges Compared to Costs: Fiscal Year 2002/2003	City	State	System Affiliation	Total Charges as a % of Total Costs 2002/2003	Net Profit or (Net Loss)	Rank from Previous Report 2000/2001	Total Charges as a % of Total Costs 2000/2001
				Health System				
59.	Stringfellow Memorial Hospital	Anniston	AL	Health Management Associates	605.28%	$8,218,265	Medicare data not available at time of previous study. CCR was 452%, which would have been 71st in last study	452%
60.	Ft. Walton Beach Medical Center	Fort Walton	FL	HCA	603.15%	$45,940,762	Medicare data not available at time of previous study. CCR was 579%, which would have been 25th in last study	579%

Current Ranking	Hospital Name The Nation's Hospitals with the Highest Charges Compared to Costs: Fiscal Year 2002/2003	City	State	System Affiliation	Total Charges as a % of Total Costs 2002/2003	Net Profit or (Net Loss)	Rank from Previous Report 2000/2001	Total Charges as a % of Total Costs 2000/2001
61.	Greater El Monte Community Hospital*	South El Monte	CA	Tenet Healthcare Corporation	601.42%	$436,450	26	573%
62.	Twin Cities Hospital	Niceville	FL	HCA	601.26%	$6,579,346	38	531%
63.	Hospital Center @ Orange	Orange	NJ	Cathedral Healthcare Syst, Inc	598.34%	$2,011,711	NA	223%
64.	Elkins Park*	Elkins Park	PA	Tenet Healthcare Corporation	597.68%	($32,113,591)	Medicare data not available at time of previous study. CCR was 422%, which would have been 97th in last study	422%
65.	Florida Medical Center	Lauderdale Lakes	FL	Tenet Healthcare Corporation	592.86%	$18,098,855	28	572%
66.	Coral Gables Hospital	Coral Gables	FL	Tenet Healthcare Corporation	590.40%	$4,312,673	45	511%

Current Ranking	Hospital Name The Nation's Hospitals with the Highest Charges Compared to Costs: Fiscal Year 2002/2003	City	State	System Affiliation	Total Charges as a % of Total Costs 2002/2003	Net Profit or (Net Loss)	Rank from Previous Report 2000/2001	Total Charges as a % of Total Costs 2000/2001
67.	Orange Park Medical Center	Orange Park	FL	HCA	584.75%	$34,738,139	Medicare data not available at time of previous study. CCR was 511%, which would have been 45th in last study	511%
68.	Irvine Medical Center	Irvine	CA	Tenet Healthcare Corporation	583.67%	$4,856,285	72	450%
69.	Alvarado Community Hospital	San Diego	CA	Tenet Healthcare Corporation	582.63%	$20,440,292	29	552%
70.	Saint Vincent Health Center	Erie	PA	St Vincent Health System	582.50%	$5,328,320	NA	313%
71.	Placentia Linda Community Hospital	Placentia	CA	Tenet Healthcare Corporation	579.16%	$7,464,231	44	512%
72.	Brooksville Regional Hospital	Brooksville	FL	Health Management Associates	574.00%	$16,620,921	NA	414%

Current Ranking	Hospital Name The Nation's Hospitals with the Highest Charges Compared to Costs: Fiscal Year 2002/2003	City	State	System Affiliation	Total Charges as a % of Total Costs 2002/2003	Net Profit or (Net Loss)	Rank from Previous Report 2000/2001	Total Charges as a % of Total Costs 2000/2001
73.	St. Petersburg General	Saint Petersburg	FL	HCA	571.70%	$11,313,481	Medicare data not available at time of previous study. CCR was 476%, which would have been 57th in last study	476%
74.	San Ramon Reg. Medical Center	San Ramon	CA	Tenet Healthcare Corporation	571.07%	$16,242,845	43	513%
75.	Frankford Hospital	Philadelphia	PA	Jefferson Health System	570.02%	($9,610,111)	32	546%

Current Ranking	Hospital Name The Nation's Hospitals with the Highest Charges Compared to Costs: Fiscal Year 2002/2003	City	State	System Affiliation	Total Charges as a % of Total Costs 2002/2003	Net Profit or (Net Loss)	Rank from Previous Report 2000/2001	Total Charges as a % of Total Costs 2000/2001
76.	Riverview Reg L Medical Center	Gadsden	AL	Health Management Associates	568.97%	$17,935,242	Medicare data not available at time of previous study. CCR was 518%, which would have been 43th in last study	518%
77.	Our Lady Of Lourdes Med. Ctr.	Camden	NJ	Catholic Health East	568.93%	$19,187,996	NA	245%
78.	Coastal Communities Hospital*	Santa Ana	CA	Tenet Healthcare Corporation	564.23%	$9,958,772	Medicare data not available at time of previous study. CCR was 428%, which would have been 92nd in last study	428%

Current Ranking	Hospital Name The Nation's Hospitals with the Highest Charges Compared to Costs: Fiscal Year 2002/2003	City	State	System Affiliation	Total Charges as a % of Total Costs 2002/2003	Net Profit or (Net Loss)	Rank from Previous Report 2000/2001	Total Charges as a % of Total Costs 2000/2001
79.	St. Charles General Hospital*	New Orleans	LA	Tenet Healthcare Corporation	562.36%	$5,715,344	74	449%
80.	Community Medical Center	Toms River	NJ	Saint Barnabas Health System	560.95%	$43,697,415	40	523%
81.	Memorial Medical Center	New Orleans	LA	Tenet Healthcare Corporation	560.68%	$43,716,429	78	445%
82.	St. Mary Hospital	Hoboken	NJ	Bon Secours Health System, Inc	560.62%	($10,406,168)	NA	254%
83.	St. James Hospital	Newark	NJ	Cathedral Healthcare Syst, Inc	559.57%	$5,488,199	NA	231%
84.	French Hosp Med Ctr	San Luis Obispo	CA	No Affiliation Listed	558.08%	($2,907,689)	Medicare data not available at time of previous study. CCR was 436%, which would have been 86th in last study	436%
85.	North Ridge Medical Center	Fort	FL	Tenet Healthcare	558.05%	$28,387,768	51	490%

Current Ranking	Hospital Name The Nation's Hospitals with the Highest Charges Compared to Costs: Fiscal Year 2002/2003	City	State	System Affiliation	Total Charges as a % of Total Costs 2002/2003	Net Profit or (Net Loss)	Rank from Previous Report 2000/2001	Total Charges as a % of Total Costs 2000/2001
		Lauderdale		Corporation				
86.	Fountain Valley Reg Medical Center	Fountain Valley	CA	Tenet Healthcare Corporation	557.22%	$24,577,863	75	446%
87.	Rahway Hospital	Rahway	NJ	No Affiliation Listed	556.18%	($6,238,425)	NA	305%
88.	North Okaloosa Medical Center	Crestview	FL	Community Health Systems, Inc	553.74%	$8,865,913	66	466%
89.	Gulf Coast Medical Center	Panama City	FL	HCA	552.31%	$27,348,882	60	470%
90.	Jersey City Medical Center	Jersey City	NJ	Libertyhealth	551.90%	$9,826,361	NA	361%
91.	Doctors Hospital Of Jefferson*	Metairie	LA	Tenet Healthcare Corporation	551.79%	$4,148,230	NA	394%
92.	Parkview Hospital*	Philadelphia	PA	Tenet Healthcare Corporation	551.79%	($5,959,132)	NA	290%
93.	Kentucky River Medical Center	Jackson	KY	Community Health Systems, Inc	550.15%	$4,211,306	NA	405%
94.	Byrd Regional Hospital	Leesville	LA	Community Health Systems, Inc	547.24%	$6,375,242	NA	379%
95.	Brandywine Hospital	Coatesville	PA	Community Health Systems, Inc	546.42%	$6,227,107	NA	282%

Current Ranking	Hospital Name The Nation's Hospitals with the Highest Charges Compared to Costs: Fiscal Year 2002/2003	City	State	System Affiliation	Total Charges as a % of Total Costs 2002/2003	Net Profit or (Net Loss)	Rank from Previous Report 2000/2001	Total Charges as a % of Total Costs 2000/2001
96.	Kimball Medical Center	Lakewood	NJ	Saint Barnabas Health System	545.74%	$6,560,948	35	539%
97.	Spalding Regional Hospital	Griffin	GA	Tenet Healthcare Corporation	545.68%	$28,092,097	NA	376%
98.	St. Francis Trenton Nj	Trenton	NJ	Catholic Health East	539.98%	($1,640,926)	93	428%
99.	Houston Northwest Medical Center	Houston	TX	Tenet Healthcare Corporation	538.84%	$90,362,953	68	463%
100.	Bmc Princeton	Birmingham	AL	Baptist Health System	538.72%	$1,298,899	NA	389%
	Averages for Top 100				**672.88%**	**$18,652,475**		

Table 10 The Nation's Hospitals with the Lowest Charges Compared to Costs: Fiscal Year 2002/2003

Rank	Hospital Name The Nation's Hospitals with the Lowest Charges Compared to Costs: Fiscal Year 2002/2003	City	State	System Affiliation	Total Charges as a % of Total Costs	Net Profit or Net Loss
1.	Metropolitan Hospital Center	New York	NY	New York City Hlth & Hosp Corp	100.00%	$63,260,875
2.	Johnson County Healthcare Center	Buffalo	WY	No Affiliation Listed	100.13%	$142,084
3.	First Care Health Center	Park River	ND	No Affiliation Listed	100.21%	$70,078
4.	Haskell County Hospital	Stigler	OK	No Affiliation Listed	100.27%	($489,061)
5.	Pioneer Memorial Hospital And Health	Viborg	SD	Sioux Valley Hosp & Hlth Syst	100.27%	($44,304)
6.	Pecos County Memorial Hospital	Fort Stockton	TX	No Affiliation Listed	100.50%	($1,909,059)
7.	Garfield Memorial Hospital	Panguitch	UT	Intermountain Health Care, Inc	100.61%	($7,374)
8.	Kearney County Health Services	Minden	NE	No Affiliation Listed	100.67%	($83,784)
9.	Morton General Hospital	Morton	WA	No Affiliation Listed	100.70%	($19,066)
10.	Weston County Health Svcs	Newcastle	WY	No Affiliation Listed	100.82%	$264,122
11.	Sparta Hospital	Sparta	WI	Mayo Foundation	100.85%	$9,250,582
12.	Genoa Community Hospital	Genoa	NE	No Affiliation Listed	100.98%	($250,802)
13.	Tyler Healthcare Center	Tyler	MN	Avera Health	101.10%	$79,546
14.	San Mateo Medical Center	San Mateo	CA	No Affiliation Listed	101.36%	$493,727
15.	Johnson Memorial Hospital	Dawson	MN	No Affiliation Listed	101.48%	($29,534)
16.	Bayside Community Hospital	Anahuac	TX	No Affiliation Listed	101.51%	$1,066,172
17.	Deuel County Memorial	Clear Lake	SD	Sioux Valley Hosp & Hlth Syst	101.66%	$162,749
18.	Logan County Hospital	Oakley	KS	No Affiliation Listed	101.72%	($6,209)
19.	Sleepy Eye Municipal Hospital	Sleepy Eye	MN	No Affiliation Listed	101.76%	$148,746
20.	Memorial Health Center	Medford	WI	No Affiliation Listed	101.79%	$1,865,472
21.	District Medical Center	Andrews	NC	No Affiliation Listed	101.85%	($3,580,561)
22.	Dells Area Health Ctr/Avera Healt	Dell Rapids	SD	Avera Health	101.87%	($291,211)
23.	Chillicothe Hospital District	Chillicothe	TX	No Affiliation Listed	102.11%	$259,045
24.	Coulee Community Hospital	Grand Coulee	WA	No Affiliation Listed	102.30%	$345,680

Rank	Hospital Name The Nation's Hospitals with the Lowest Charges Compared to Costs: Fiscal Year 2002/2003	City	State	System Affiliation	Total Charges as a % of Total Costs	Net Profit or Net Loss
25.	Sacred Heart Hospital	Cumberland	MD	Ascension Health	102.31%	$714,396
26.	St. Joseph Hospital	Polson	MT	Providence Services	102.31%	($1,069,397)
27.	Humboldt County Memorial Hospital	Humboldt	IA	Iowa Health System	102.35%	$772,209
28.	Community Medical Center Of Izard Co	Calico Rock	AR	No Affiliation Listed	102.55%	$144,342
29.	Wishek Community Hospital	Wishek	ND	No Affiliation Listed	102.67%	($219,245)
30.	Sakakawea Medical Center	Hazen	ND	No Affiliation Listed	102.69%	($377,049)
31.	Forks Community Hospital	Forks	WA	No Affiliation Listed	102.76%	($3,905,979)
32.	Cooperstown Medical Center	Cooperstown	ND	Benedictine Health System	103.03%	($249,677)
33.	Beaver Valley Hospital	Beaver	UT	No Affiliation Listed	103.26%	($49,582)
34.	St Joseph Memorial Hospital	Larned	KS	Catholic Health Initiatives	103.44%	($888,205)
35.	Clark Fork Valley Hospital	Plains	MT	No Affiliation Listed	103.51%	($160,801)
36.	Community Memorial Hospital	Redfield	SD	No Affiliation Listed	103.60%	$82,773
37.	Cimarron Memorial Hospital	100 South Ellis	OK	No Affiliation Listed	103.74%	($338,977)
38.	Memorial Community Hospital	Blair	NE	Alegent Health	103.87%	($354,679)
39.	Great Plains Of Sabetha Inc.	Sabetha	KS	Great Plains Health Alliance	103.97%	$375,872
40.	Pembina County Memorial Hospital	Cavalier	ND	No Affiliation Listed	104.06%	($82,475)
41.	Ochsner Clinic Foundation	New Orleans	LA	No Affiliation Listed	104.14%	($1,814,052)
42.	Washington County Hospital	Hagerstown	MD	No Affiliation Listed	104.18%	($6,174,226)
43.	Ashley Medical Center	Ashley	ND	No Affiliation Listed	104.32%	$8,891
44.	Johns Hopkins Bayview Med. Ctr.	Baltimore	MD	Johns Hopkins Health System	104.41%	$4,615,092
45.	North Sunflower County Hospital	Ruleville	MS	No Affiliation Listed	104.46%	$200,670
46.	Charleston Memorial Hospital	Charleston	SC	Musc Med Ctr Of Med Univ Of Sc	104.46%	$1
47.	Holton Community Hospital	Holton	KS	No Affiliation Listed	104.61%	($192,072)
48.	Aspen Valley Hospital	Aspen	CO	No Affiliation Listed	104.72%	$829,072
49.	Medicine Lodge Memorial Hospital	Medicine Lodge	KS	Great Plains Health Alliance	105.04%	$318,267
50.	Phoebe Worth Medical Center	Sylvester	GA	No Affiliation Listed	105.13%	($311,426)

Rank	Hospital Name The Nation's Hospitals with the Lowest Charges Compared to Costs: Fiscal Year 2002/2003	City	State	System Affiliation	Total Charges as a % of Total Costs	Net Profit or Net Loss
51.	Hamlin Memorial Hospital	Hamlin	TX	No Affiliation Listed	105.13%	($225,759)
52.	Sanpete Valley Hospital	Mt. Pleasant	UT	Intermountain Health Care, Inc	105.17%	$361,620
53.	Kiowa District Hospital	Kiowa	KS	No Affiliation Listed	105.26%	$40,003
54.	Endless Mountains Health Systems	Montrose	PA	No Affiliation Listed	105.32%	($394,903)
55.	Lincoln County Hospital	Lincoln	KS	No Affiliation Listed	105.36%	($603,046)
56.	W.J. Mangold Memorial Hospital	Lockney	TX	No Affiliation Listed	105.40%	$33,441
57.	Benewah Community Hospital	St. Maries	ID	No Affiliation Listed	105.41%	$192,995
58.	Wild Rose Community Mem. Hospital	Wild Rose	WI	No Affiliation Listed	105.51%	($332,009)
59.	Schoolcraft Memorial Hospital	Manistique	MI	No Affiliation Listed	105.56%	$1,272,062
60.	Callaway Hospital District	Callaway	NE	No Affiliation Listed	105.56%	$121,142
61.	Mcgehee Desha County Hospital	Mcgehee	AR	No Affiliation Listed	105.65%	$482,249
62.	Sioux Valley Memorial Hosp-Cherokee	Cherokee	IA	No Affiliation Listed	105.72%	$144,224
63.	Pemiscot Memorial Hospital	Hayti	MO	No Affiliation Listed	105.75%	$1,226,639
64.	Wamego City Hospital	Wamego	KS	No Affiliation Listed	105.90%	($240,769)
65.	So. Lyon Comm. Hospita	Yerington	NV	No Affiliation Listed	105.98%	$428,395
66.	Kit Carson County Memorial Hospital	Burlington	CO	No Affiliation Listed	106.00%	$317,726
67.	Platte Health Center Inc.	Platte	SD	Avera Health	106.01%	$60,663
68.	Laguna Honda Hospital	San Francisco	CA	No Affiliation Listed	106.13%	$18,902,114
69.	Casey County Hospital	Liberty	KY	No Affiliation Listed	106.13%	$498,847
70.	Refugio Memorial Hospital	Refugio	TX	No Affiliation Listed	106.21%	$409,706
71.	Emory Parkway Medical Center	Lithia Springs	GA	No Affiliation Listed	106.51%	($1,535,480)
72.	Our Lady Of The Lk Assump. Comm Hos	Napoleonville	LA	Franciscan Missionaries	106.69%	($256,365)
73.	Gove County Medical Center	Quinter	KS	No Affiliation Listed	106.71%	($722,983)
74.	Willapa Harbor Hospital	South Bend	WA	No Affiliation Listed	106.73%	($164,615)
75.	Greater Baltimore Medical Center	Baltimore	MD	No Affiliation Listed	106.74%	$5,680,603
76.	Mineral Community Hospital	Superior	MT	Brim Healthcare, Inc	106.80%	($296,735)

Rank	Hospital Name The Nation's Hospitals with the Lowest Charges Compared to Costs: Fiscal Year 2002/2003	City	State	System Affiliation	Total Charges as a % of Total Costs	Net Profit or Net Loss
77.	Bibb Medical Center	Centreville	AL	No Affiliation Listed	107.12%	$31,381
78.	St. Mary S Hospital	Leonardtown	MD	No Affiliation Listed	107.20%	$1,486,550
79.	Tenton Valley Hospital	Driggs	ID	No Affiliation Listed	107.24%	$344,010
80.	Teton Valley Hospital	Driggs	ID	No Affiliation Listed	107.24%	$344,010
81.	St. Agnes Hospital	Baltimore	MD	Ascension Health	107.30%	($871,365)
82.	Humboldt General Hospital	Winnemucca	NV	No Affiliation Listed	107.34%	($749,841)
83.	Southeast Colorado Hospital	Springfield	CO	No Affiliation Listed	107.38%	$198,409
84.	Harbor Hospital Center	Baltimore	MD	Medstar Health	107.42%	($2,068,964)
85.	Hancock County Memorial Hospital	Britt	IA	Trinity Health	107.42%	$428,963
86.	South Peninsula Hospital	Homer	AK	No Affiliation Listed	107.44%	$901,469
87.	Alegent Health Memorial Hospital	Schuyler	NE	Alegent Health	107.75%	$57,186
88.	Miami Jewish Hm & Hospt./Aged Inc.	Miami	FL	No Affiliation Listed	107.77%	($3,957,902)
89.	District Memorial Hospital	Andrews	NC	No Affiliation Listed	107.83%	($1,174,828)
90.	St. James Health Services	St. James	MN	Mayo Foundation	107.88%	($95,507)
91.	Lakewood Health System	Staples	MN	No Affiliation Listed	107.95%	($2,288)
92.	St Aloisius Medical Center	Harvey	ND	Sisters Of Mary	108.11%	($179,400)
93.	Hill Hospital Of Sumter County	York	AL	No Affiliation Listed	108.28%	($192,343)
94.	East Adams Rural Hospital	Ritzville	WA	No Affiliation Listed	108.56%	$526,243
95.	Mckenzie County Hospital	Watford City	ND	No Affiliation Listed	108.61%	$204,870
96.	Sioux Center Community Hospital	Sioux Center	IA	Avera Health	108.62%	($223,778)
97.	Saint Francis Memorial Hospital	West Point	NE	Franciscan Srs Of Christian	108.73%	$1,205,282
98.	Lindsborg Community Hospital	Lindsborg	KS	No Affiliation Listed	108.77%	$146,133
99.	Montgomery General Hospital	Olney	MD	No Affiliation Listed	108.85%	($541,791)
10(	St Aloisius Medical Center	Harvey	ND	No Affiliation Listed	108.86%	$247,116
	Average				**104.65%**	**$840,350**

Table 11 State Location of the Top 100 Hospitals, 2002/2003

State: State Location of the Top 100 Hospitals: 2002/2003	Frequency
CA	34
NJ	18
PA	17
FL	14
LA	6
AL	4
TX	4
GA	1
KY	1
NY	1

Table 12 System Affiliation of the Top 100: 2002/2003

System: System Affiliation of the Top 100: 2002/2003	Frequency
Tenet Healthcare Corporation	55
No Affiliation Listed	10
HCA	5
Cathedral Healthcare Syst, Inc	4
Community Health Systems, Inc	4
Health Management Associates	4
Catholic Health East	3
Saint Barnabas Health System	3
Temple University Health Syst	3
Crozer-Keystone Health System	2
Libertyhealth	2
Baptist Health System	1
Bon Secours Health System, Inc	1
Jefferson Health System	1
St Vincent Health System	1
Sutter Health	1

Table 13 System Affiliation of the Lowest 100: 2002/2003

System: System Affiliation of Lowest 100	Frequency
No Affiliation Listed	71
Avera Health	4
Alegent Health	2
Ascension Health	2
Great Plains Health Alliance	2
Intermountain Health Care, Inc	2
Mayo Foundation	2
Sioux Valley Hosp & Hlth Syst	2
Benedictine Health System	1
Brim Healthcare, Inc	1
Catholic Health Initiatives	1
Franciscan Missionaries	1
Franciscan Srs Of Christian	1
Iowa Health System	1
Johns Hopkins Health System	1
Medstar Health	1
Musc Med Ctr Of Med Univ Of Sc	1
New York City Hlth & Hosp Corp	1
Providence Services	1
Sisters Of Mary	1
Trinity Health	1

Table 14 Hospital Average Profits by Decile of Total Charge to Cost Ratios: 2002/2003

	Avg. Hospial Profits by Charge to Cost Decile. 2002-2003 Fiscal Year	
Decile	**Decile Values (Percent)**	**Avg. Net Profit or Net Loss**
1.	<= 129.51	($159,043.65)
2.	129.52 - 151.49	$1,391,640.76
3.	151.50 – 168.57	$1,264,288.74
4.	168.58 - 1.8613	$1,711,863.99
5.	186.14 - 203.13	$2,913,758.17
6.	203.14 - 224.13	$2,113,538.90
7.	224.14 - 251.79	$4,095,810.34
8.	251.80 - 292.08	$5,575,358.64
9.	292.09 - 372.92	$6,867,834.28
10.	372.93+	$14,864,609.20

Table 15 Average Hospital Profits by Average Charge Per Individual Inpatient Discharge: 2002/2003[46]

Decile	Average Hospital Profits by Charge Per Individual Inpatient Patient Discharge Decile Value	Avg. Net Profit or Net Loss
1	<= $5,808.07	($1,193,499.06)
2	$5,808.08 - $7,337.09	$478,838.39
3	$7,337.10 - $8,701.44	$742,391.56
4	$8,701.45 - $10,198.26	$712,028.18
5	$10,198.27 - $11,932.18	$1,338,407.44
6	$11,932.19 - $14,050.98	$3,420,163.04
7	$14,050.99 - $16,649.03	$4,987,318.64
8	$16,649.04 - $20,827.97	$4,083,036.47
9	$20,827.98 - $26,941.78	$7,025,400.19
10	$26,941.79+	$15,054,981.09

[46] Some readers expressed confusion over the "Charge Per Discharge" table. We have therefore amended the table to reflect inpatient charges only.

Table 16 Average Total Charge to Cost Ratio of the Top 100 Hospitals by State: 2002/2003

Hospital Name Average Total Charge to Cost Ratio for the Top 100 Hospitals by State	City	State	System Affiliation	Total Charges as a % of Total Costs
Brookwood Medical Center	Birmingham	AL	Tenet Healthcare Corporation	785.49%
Stringfellow Memorial Hospital	Anniston	AL	Health Management Associates	605.28%
Riverview Reg L Medical Center	Gadsden	AL	Health Management Associates	568.97%
Bmc Princeton	Birmingham	AL	Baptist Health System	538.72%
		AL Average for Top 100 Members		**624.62%**
Doctors Medical Center Of Modesto	Modesto	CA	Tenet Healthcare Corporation	1185.66%
Doctors Hospital Of Manteca	Manteca	CA	Tenet Healthcare Corporation	1092.34%
Midway Hospital Medical Center	Los Angeles	CA	Tenet Healthcare Corporation	945.32%
Garfield Medical Ctr.	Monterey Park	CA	Tenet Healthcare Corporation	860.53%
Twin Cities Community Hospital	Templeton	CA	Tenet Healthcare Corporation	813.87%
Monterey Park Hospital	Monterey Park	CA	Tenet Healthcare Corporation	796.76%
Los Alamitos Medical Ctr.	Los Alamitos	CA	Tenet Healthcare Corporation	796.14%
Redding Medical Center	Redding	CA	Tenet Healthcare Corporation	790.78%
Sierra Vista Regional Med Ctr	San Luis Obispo	CA	Tenet Healthcare Corporation	756.35%
Centinela Hospital Medical Center	Inglewood	CA	Tenet Healthcare Corporation	755.60%
Encino Tarzana Medical Center	Encino	CA	Tenet Healthcare Corporation	747.70%
Brotman Medical Center	Culver City	CA	Tenet Healthcare Corporation	746.76%
Whittier Hospital Medical Center	Whittier	CA	Tenet Healthcare Corporation	740.91%
Tarzana Encino Regional Med Ctr	Tarzana	CA	Tenet Healthcare Corporation	739.23%
Memorial Hospital Modesto	Modesto	CA	Sutter Health	733.19%
Lakewood Regional Med. Ctr.	Lakewood	CA	Tenet Healthcare Corporation	722.38%
San Dimas Community Hospital	San Dimas	CA	Tenet Healthcare Corporation	696.91%
Desert Hospital	Palm Springs	CA	Tenet Healthcare Corporation	694.98%
Daniel Freeman Memorial	Inglewood	CA	Tenet Healthcare Corporation	690.92%
John.F. Kennedy Memorial Hosp.	Indio	CA	Tenet Healthcare Corporation	668.37%

Hospital Name Average Total Charge to Cost Ratio for the Top 100 Hospitals by State	City	State	System Affiliation	Total Charges as a % of Total Costs
Usc University Hospital	Los Angeles	CA	Tenet Healthcare Corporation	662.71%
Century City Hosp	Los Angeles	CA	Tenet Healthcare Corporation	653.36%
Suburban Medical Center	Paramount	CA	Tenet Healthcare Corporation	650.72%
Doctors Medical Center-San Pablo	San Pablo	CA	Tenet Healthcare Corporation	649.61%
Queen Of Angels/Hollywood Pres Mc	Los Angeles	CA	Tenet Healthcare Corporation	633.08%
Wmc Santa Ana	Santa Ana	CA	Tenet Healthcare Corporation	627.15%
Greater El Monte Community Hospital	South El Monte	CA	Tenet Healthcare Corporation	601.42%
Irvine Medical Center	Irvine	CA	Tenet Healthcare Corporation	583.67%
Alvarado Community Hospital	San Diego	CA	Tenet Healthcare Corporation	582.63%
Placentia Linda Community Hospital	Placentia	CA	Tenet Healthcare Corporation	579.16%
San Ramon Reg. Medical Center	San Ramon	CA	Tenet Healthcare Corporation	571.07%
Coastal Communities Hospital	Santa Ana	CA	Tenet Healthcare Corporation	564.23%
French Hosp Med Ctr	San Luis Obispo	CA	No Affiliation Listed	558.08%
Fountain Valley Reg Medical Center	Fountain Valley	CA	Tenet Healthcare Corporation	557.22%
		CA Average for Top 100 Members		**719.08%**
Hialeah Hospital	Hialeah	FL	Tenet Healthcare Corporation	669.09%
Palmetto General Hospital	Hialeah	FL	Tenet Healthcare Corporation	644.90%
Heart Of Florida Reg L Medical Ctr.	Haines City	FL	Health Management Associates	628.32%
Delray Medical Center	Delray Beach	FL	Tenet Healthcare Corporation	625.94%
Ft. Walton Beach Medical Center	Fort Walton	FL	HCA	603.15%
Twin Cities Hospital	Niceville	FL	HCA	601.26%
Florida Medical Center	Lauderdale Lakes	FL	Tenet Healthcare Corporation	592.86%
Coral Gables Hospital	Coral Gables	FL	Tenet Healthcare Corporation	590.40%
Orange Park Medical Center	Orange Park	FL	HCA	584.75%
Brooksville Regional Hospital	Brooksville	FL	Health Management Associates	574.00%
St. Petersburg General	Saint Petersburg	FL	HCA	571.70%

Hospital Name Average Total Charge to Cost Ratio for the Top 100 Hospitals by State	City	State	System Affiliation	Total Charges as a % of Total Costs
North Ridge Medical Center	Fort Lauderdale	FL	Tenet Healthcare Corporation	558.05%
North Okaloosa Medical Center	Crestview	FL	Community Health Systems, Inc	553.74%
Gulf Coast Medical Center	Panama City	FL	HCA	552.31%
		FL Average for Top 100 Members		**596.46%**
Spalding Regional Hospital	Griffin	GA	Tenet Healthcare Corporation	545.68%
		GA Average for Top 100 Members		**545.68%**
Kentucky River Medical Center	Jackson	KY	Community Health Systems, Inc	550.15%
		KY Average for Top 100 Members		**550.15%**
Meadowcrest Hospital	Gretna	LA	Tenet Healthcare Corporation	644.87%
Northshore Reg. Medical Center	Slidell	LA	Tenet Healthcare Corporation	618.56%
St. Charles General Hospital	New Orleans	LA	Tenet Healthcare Corporation	562.36%
Memorial Medical Center	New Orleans	LA	Tenet Healthcare Corporation	560.68%
Doctors Hospital Of Jefferson	Metairie	LA	Tenet Healthcare Corporation	551.79%
Byrd Regional Hospital	Leesville	LA	Community Health Systems, Inc	547.24%
		LA Average for Top 100 Members		**580.92%**
Christ Hospital	Jersey City	NJ	No Affiliation Listed	830.83%
Columbus Hospital	Newark	NJ	Cathedral Healthcare Syst, Inc	793.11%
Bayonne Medical Center	Bayonne	NJ	No Affiliation Listed	766.64%
Meadowlands Hospital Medical Center	Secaucus	NJ	Libertyhealth	738.59%
Barnert Hospital	Paterson	NJ	No Affiliation Listed	701.44%
Raritan Bay Medical Center	Perth Amboy	NJ	No Affiliation Listed	701.05%
Warren Hospital	Phillipsburg	NJ	No Affiliation Listed	665.97%
St. Michaels Medical Center	Newark	NJ	Cathedral Healthcare Syst, Inc	615.94%
Irvington General Hospital	Irvington	NJ	Saint Barnabas Health System	611.80%
Hospital Center @ Orange	Orange	NJ	Cathedral Healthcare Syst, Inc	598.34%
Our Lady Of Lourdes Med. Ctr.	Camden	NJ	Catholic Health East	568.93%

Hospital Name Average Total Charge to Cost Ratio for the Top 100 Hospitals by State	City	State	System Affiliation	Total Charges as a % of Total Costs
Community Medical Center	Toms River	NJ	Saint Barnabas Health System	560.95%
St. Mary Hospital	Hoboken	NJ	Bon Secours Health System, Inc	560.62%
St. James Hospital	Newark	NJ	Cathedral Healthcare Syst, Inc	559.57%
Rahway Hospital	Rahway	NJ	No Affiliation Listed	556.18%
Jersey City Medical Center	Jersey City	NJ	Libertyhealth	551.90%
Kimball Medical Center	Lakewood	NJ	Saint Barnabas Health System	545.74%
St. Francis Trenton Nj	Trenton	NJ	Catholic Health East	539.98%
		NJ Average for Top 100 Members		**637.09%**
Parkway Hospital	Forest Hills	NY	No Affiliation Listed	698.54%
		NY Average for Top 100 Members		**698.54%**
Temple University Hospital	Philadelphia	PA	Temple University Health Syst	1090.28%
Warminster Hospital	Warminster	PA	Tenet Healthcare Corporation	926.09%
Temple East Hospital	Philadelpha	PA	Temple University Health Syst	906.23%
Graduate Hospital	Philadelphia	PA	Tenet Healthcare Corporation	885.46%
Jeanes Hospital	Philadelphia	PA	Temple University Health Syst	855.72%
Hahnemann University Hospital	Philadelphia	PA	Tenet Healthcare Corporation	813.89%
Medical College Of Pennsylvania	Philadelphia	PA	Tenet Healthcare Corporation	778.79%
Abington Memorial Hospital	Abington	PA	No Affiliation Listed	749.31%
Temple Lower Bucks Hospital	Bristol	PA	No Affiliation Listed	722.42%
Delaware County Memorial Hospital	Drexel Hill	PA	Crozer-Keystone Health System	662.51%
Crozer Chester Medical Center	Upland	PA	Crozer-Keystone Health System	622.35%
Nazareth Hospital-Phila Pa	Philadelphia	PA	Catholic Health East	616.23%
Elkins Park	Elkins Park	PA	Tenet Healthcare Corporation	597.68%
Saint Vincent Health Center	Erie	PA	St Vincent Health System	582.50%
Frankford Hospital	Philadelphia	PA	Jefferson Health System	570.02%
Parkview Hospital	Philadelphia	PA	Tenet Healthcare Corporation	551.79%

Hospital Name Average Total Charge to Cost Ratio for the Top 100 Hospitals by State	City	State	System Affiliation	Total Charges as a % of Total Costs
Brandywine Hospital	Coatesville	PA	Community Health Systems, Inc	546.42%
		PA Average for Top 100 Members		**733.98%**
Brownsville Medical Center	Brownsville	TX	Tenet Healthcare Corporation	902.53%
Sierra Medical Center	El Paso	TX	Tenet Healthcare Corporation	666.56%
Providence Memorial Hospital	El Paso	TX	Tenet Healthcare Corporation	656.94%
Houston Northwest Medical Center	Houston	TX	Tenet Healthcare Corporation	538.84%
		TX Average for Top 100 Members		**691.22%**

Table 17 Average Total Charge to Cost Ratios by Hospital System, Sorted by Average Charge to Cost Ratio, Fiscal Year 2002/2003

Rank	Hospital System Charges as a Percent of Costs by Hospital System	Charges as a % of Costs
1.	Temple University Health Syst	950.74%
2.	Crozer-Keystone Health System	642.43%
3.	Cathedral Healthcare Syst, Inc	641.74%
4.	LibertyHealth	607.68%
5.	Tenet Healthcare Corporation	558.45%
6.	Jefferson Health System	486.44%
7.	Robert Wood Johnson Hlth Syst	464.24%
8.	Saint Barnabas Health System	447.60%
9.	NorthBay Healthcare System	416.04%
10.	St Vincent Health System	413.99%
11.	Albert Einstein Healthcare	413.03%
12.	Sun Health Corporation	408.27%
13.	Meridian Health System	406.98%
14.	St Joseph's Healthcare System	401.54%
15.	Health Management Associates	391.86%
16.	North Broward Hospital Dist	385.78%
17.	Pacific Health Corporation	382.83%
18.	Univ of Pennsylvania Hlth Syst	377.76%
19.	Citrus Valley Health Partners	376.65%
20.	John C Lincoln Health Network	374.98%
21.	Daughters of Charity Hlth Syst	374.08%
22.	Catholic Healthcare West	368.64%
23.	Baptist Health System	366.31%
24.	HCA	358.30%
25.	Solaris Health System	356.38%
26.	Vanguard Health System	355.25%

Rank	Hospital System Charges as a Percent of Costs by Hospital System	Charges as a % of Costs
27.	St Joseph Health System	347.53%
28.	Sutter Health	346.89%
29.	Catholic Health East	344.11%
30.	Community Health Systems, Inc	343.02%
31.	Virtua Health	337.01%
32.	Southern California Hlth Syst	334.72%
33.	Universal Health Services, Inc	334.46%
34.	Sharp Healthcare	332.65%
35.	Exempla Healthcare, Inc	325.32%
36.	Scripps Health	324.52%
37.	Coffee Health Group	323.33%
38.	IASIS Healthcare	322.22%
39.	University Community Health	317.63%
40.	Univ of CA-Systemwide Adm	317.00%
41.	Resurrection Health Care Corp	315.43%
42.	Scottsdale Healthcare	313.88%
43.	Stanford Health Care	313.80%
44.	Orlando Regional Healthcare	313.73%
45.	Memorial Healthcare System	313.48%
46.	Cottage Health System	310.23%
47.	Alexian Brothers Health System	309.66%
48.	Alta Healthcare System	309.59%
49.	West Penn Allegheny Hlth Syst	306.78%
50.	Baptist Health Care Corp	306.40%
51.	Geisinger Health System	304.42%
52.	DCH Health System	304.05%
53.	Triad Hospitals, Inc	302.00%
54.	Palomar Pomerado Health	299.26%
55.	Baptist Health South Florida	298.46%

Rank	Hospital System Charges as a Percent of Costs by Hospital System	Charges as a % of Costs
56.	Mountain States Hlth Alliance	298.23%
57.	Eastern Health System, Inc	293.54%
58.	Willis-Knighton Health System	293.01%
59.	Adventist Health	291.73%
60.	Loma Linda University Health	291.50%
61.	Memorial Hermann Hlthcare Syst	287.83%
62.	College Health Enterprises	286.24%
63.	Greater Hudson Valley Health	284.42%
64.	Atlantic Health System	282.26%
65.	Covenant Health	281.51%
66.	UAB Health System	281.13%
67.	UPMC Health System	279.76%
68.	Rush University Medical Center	278.01%
69.	Methodist Health Care System	276.34%
70.	Advocate Health Care	276.29%
71.	Memorial Health Services	275.62%
72.	Bon Secours Health System, Inc	275.18%
73.	HealthEast Care System	274.79%
74.	Continuum Health Partners	274.36%
75.	Riverside Health System	273.01%
76.	American MedTrust	272.78%
77.	Baptist Health	271.77%
78.	WellStar Health System	270.24%
79.	LifePoint Hospitals, Inc	269.06%
80.	Province Healthcare Corp	269.00%
81.	William Beaumont Hospitals	267.60%
82.	Henry Ford Health System	267.50%
83.	Shands HealthCare	267.19%
84.	East Texas Med Ctr Reg Syst	267.05%

Rank	Hospital System Charges as a Percent of Costs by Hospital System	Charges as a % of Costs
85.	Adventist Hlth System Sunbelt	266.87%
86.	Queen's Health Systems	266.00%
87.	McLaren Health Care Corp	265.12%
88.	HEALTHSOUTH Corporation	263.12%
89.	MultiCare Health System	262.85%
90.	Christus Health	262.03%
91.	Community Medical Centers	261.29%
92.	Wuesthoff Health System	261.28%
93.	Kettering Med Center-Network	260.08%
94.	BJC HealthCare	259.96%
95.	Forum Health	259.42%
96.	Baptist Hlth System of TN	259.13%
97.	Halifax-Fish Community Health	257.35%
98.	Marshall County Hlth Care Auth	256.14%
99.	Detroit Medical Center	252.54%
100.	Provena Health	252.45%
101.	Appalachian Reg Healthcare	251.48%
102.	Cumberland Cnty Hosp System	251.24%
103.	SSM Health Care	248.08%
104.	Greater Hazleton Hlth Alliance	246.62%
105.	Norton Healthcare	246.21%
106.	Texas Health Resources	245.98%
107.	Sisters of Charity	245.67%
108.	North Shore-Long Island Hlth	245.24%
109.	Valley Health System	244.83%
110.	Little Company of Mary SRS	244.42%
111.	Cleveland Clinic Health System	243.88%
112.	United Medical Corporation	243.34%
113.	Jewish Hosp HealthCare Serv	242.91%

Rank	Hospital System Charges as a Percent of Costs by Hospital System	Charges as a % of Costs
114.	Southern Illinois Hosp Servs	242.27%
115.	Baylor Health Care System	240.12%
116.	Ardent Health Services	240.04%
117.	Banner Health	239.10%
118.	Sentara Healthcare	238.20%
119.	Covenant Health Systems, Inc	237.56%
120.	KALEIDA Health	237.56%
121.	Lifespan Corporation	237.32%
122.	Saint Luke's Health System	236.98%
123.	Westmoreland Health System	236.16%
124.	Catholic Healthcare Partners	235.46%
125.	WakeMed	234.08%
126.	Wheaton Franciscan Servs, Inc	232.68%
127.	Sunlink Healthcare	232.54%
128.	**National Average**	**232.40%**
129.	Inova Health System	232.32%
130.	Memorial Health System	231.62%
131.	Oakwood Healthcare, Inc	231.02%
132.	Catholic Health Services of LI	230.59%
133.	Methodist Healthcare	229.73%
134.	National Surgical Hospitals	229.05%
135.	Greenville Hospital System	228.76%
136.	Health Alliance of Cincinnati	228.61%
137.	Novant Health	228.55%
138.	Carolinas HealthCare System	228.39%
139.	Partners HealthCare System	227.45%
140.	Wellmont Health System	227.34%
141.	Ohio Valley Health Services	227.00%
142.	MedCath, Inc	224.73%

Rank	Hospital System Charges as a Percent of Costs by Hospital System	Charges as a % of Costs
143.	Via Christi Health System	224.62%
144.	Northern Arizona Healthcare	224.40%
145.	LSU Health Sciences Center	223.57%
146.	Hawaii Pacific Health System	223.38%
147.	Eastern Connecticut Hlth Netwk	222.99%
148.	Doctors Community Healthcare	221.78%
149.	Yale New Haven Health System	221.57%
150.	Franciscan Services Corp	221.26%
151.	Providence Health System	221.23%
152.	FirstHealth of the Carolinas	220.71%
153.	Aurora Health Care	219.51%
154.	New York Presby Hlthcare Syst	217.29%
155.	Fremont-Rideout Health Group	216.58%
156.	Kindred Healthcare	215.71%
157.	ProMedica Health System	215.33%
158.	UMass Health System	215.29%
159.	St Paul & Zale Lipshy Univ Hsp	215.00%
160.	MidMichigan Health	214.31%
161.	Park Nicollet Health Services	214.10%
162.	Ascension Health	213.90%
163.	West Tennessee Healthcare	212.72%
164.	Rush Health Systems	212.60%
165.	Summit Health	212.15%
166.	Baptist Healthcare System	212.11%
167.	Palmetto Health Alliance	210.68%
168.	Kishwaukee Health System	210.63%
169.	Allina Hospitals & Clinics	210.15%
170.	Baptist Mem Health Care Corp	209.61%
171.	Sisters of Mercy	209.61%

Rank	Hospital System Charges as a Percent of Costs by Hospital System	Charges as a % of Costs
172.	Caritas Christi Health Care	209.50%
173.	Spartanburg Reg Hlthcare Syst	207.57%
174.	Univ of South Alabama Hosps	207.52%
175.	Catholic Health Initiatives	207.38%
176.	Jackson Health System	206.80%
177.	Columbus Regional Hlth System	206.79%
178.	Ohio State Univ Med Center	206.79%
179.	Saint Vincent Cath Med Ctrs	206.48%
180.	Baystate Health System, Inc	205.52%
181.	OhioHealth	205.26%
182.	Duke University Health System	204.79%
183.	Fairview Health Services	204.48%
184.	INTEGRIS Health	203.42%
185.	WellSpan Health	203.10%
186.	University of MO Health Care	202.96%
187.	Hospital Sisters Health System	201.96%
188.	Our Lady of Mercy Healthcare	200.87%
189.	Carilion Health System	199.23%
190.	Southeast Georgia Health Syst	199.08%
191.	Blue Water Health Servs Corp	198.79%
192.	Hawaii Health Systems Corp	197.89%
193.	Emory Hospitals	197.50%
194.	Trinity Health	197.14%
195.	Nebraska Meth Hlth System, Inc	196.69%
196.	Cardinal Health System	195.00%
197.	Eastern Maine Healthcare	194.91%
198.	Clarian Health Partners	194.73%
199.	Care New England Health System	194.71%
200.	No Affiliation Listed	193.75%

Rank	Hospital System Charges as a Percent of Costs by Hospital System	Charges as a % of Costs
201.	Legacy Health System	193.36%
202.	Infirmary Health System, Inc	193.28%
203.	Franciscan Missionaries	193.19%
204.	Sisters of St Francis	192.96%
205.	New Hanover Health Network	192.69%
206.	Empire Health Services	191.65%
207.	Cancer Treatment Centers	191.52%
208.	Sisters of 3rd Franciscan	191.47%
209.	North Mississippi Hlth Servs	191.17%
210.	Akron General Health System	190.58%
211.	ViaHealth	189.90%
212.	OSF Healthcare System	188.79%
213.	ProHealth Care	188.52%
214.	Guthrie Healthcare System	188.10%
215.	West Virginia United Hlth Syst	188.02%
216.	Covenant Health System	187.93%
217.	Catholic Health System	187.46%
218.	Mid Atlantic Health Management	187.46%
219.	Quorum Health Resources	186.76%
220.	Saint Francis Health System	185.98%
221.	Freeman Health System	185.81%
222.	Marian Health System	185.65%
223.	Hillcrest HealthCare System	185.34%
224.	Ty Cobb Healthcare System, Inc	185.07%
225.	Alegent Health	184.87%
226.	Bronson Healthcare Group, Inc	184.12%
227.	Associated Healthcare Systems	183.82%
228.	Brim Healthcare, Inc	182.69%
229.	Asante Health System	182.40%

Rank	Hospital System Charges as a Percent of Costs by Hospital System	Charges as a % of Costs
230.	Parkview Health	181.89%
231.	Community Healthcare System	181.60%
232.	St Mary's/Duluth Clinic Health	180.72%
233.	Accord Health Care Corporation	180.03%
234.	University Hospitals Hlth Syst	179.58%
235.	Symphony Healthcare	179.51%
236.	Archbold Medical Center	179.32%
237.	Essent Healthcare	178.47%
238.	Charleston Area Med Ctr System	178.31%
239.	Presbyterian Healthcare Servs	177.87%
240.	Strong Memorial Hospital	177.84%
241.	Adventist Healthcare	176.87%
242.	Berkshire Health Systems, Inc	176.70%
243.	Cape Cod Healthcare, Inc	176.05%
244.	Preferred Management Corp	175.25%
245.	Alameda Medical Center	172.13%
246.	University Health Systems	169.67%
247.	Healthcorp of Tennessee, Inc	169.60%
248.	HealthMont, Inc	169.02%
249.	DasSee Community Hlth System	167.41%
250.	Tarrant County Hosp District	166.30%
251.	CoxHealth	166.11%
252.	ThedaCare, Inc	165.21%
253.	Providence Services	162.51%
254.	Samaritan Health Services	161.25%
255.	Spectrum Health	160.97%
256.	Munson Healthcare	158.63%
257.	MedStar Health	155.35%
258.	Puerto Rico Department of Hlth	154.72%

Rank	Hospital System Charges as a Percent of Costs by Hospital System	Charges as a % of Costs
259.	CentraCare Health System	154.15%
260.	Iowa Health System	151.90%
261.	Intermountain Health Care, Inc	150.57%
262.	University of MD Medical Syst	149.78%
263.	Ancilla Systems Inc	148.74%
264.	Rapid City Regional Hospital	147.78%
265.	Mayo Foundation	145.79%
266.	Christiana Care Health System	145.04%
267.	Missionary Benedictine Sisters	144.47%
268.	LA Cnty-Dept of Health Servs	143.44%
269.	Moses Cone Health System	142.82%
270.	Benedictine Health System	141.67%
271.	University of Texas System	141.50%
272.	PeaceHealth	140.75%
273.	MUSC Med Ctr of Med Univ of SC	140.28%
274.	Sioux Valley Hosp & Hlth Syst	135.86%
275.	Cascade Health Services	134.32%
276.	Avera Health	131.31%
277.	Benedictine Sisters	130.59%
278.	Sisters of Mary	130.04%
279.	Franciscan SRS of Christian	128.62%
280.	Great Plains Health Alliance	126.61%
281.	Rural Health Management Corp	124.55%
282.	Truman Medical Centers	122.10%
283.	North Carolina Baptist Hosp	121.99%
284.	LifeBridge Health	119.07%
285.	Cook Cnty Bureau of Hlth Serv	118.58%
286.	Dimensions Healthcare System	116.18%
287.	Upper Chesapeake Health System	115.35%

Rank	Hospital System Charges as a Percent of Costs by Hospital System	Charges as a % of Costs
288.	Johns Hopkins Health System	111.72%
289.	New York City Hlth & Hosp Corp	100.00%

Table 18 Average Charge to Cost Ratio, Beds, Profits and Charge Per Discharge by Hospital Bed Deciles, 2002/2003

Decile	Avg. Range of Beds in Decile	Avg. Total Charge to Cost Ratio	Avg. Number of Beds in Decile	Avg. Net income (or loss)	Avg. Charge Per Discharge
1	<= 23	151.98%	16	$320,889.93	$29,122.99
2	24 - 31	152.20%	26	$299,095.83	$22,204.12
3	32 - 45	177.44%	39	$173,947.17	$21,292.61
4	46 - 61	204.10%	52	$685,019.93	$22,064.35
5	62 - 97	223.10%	78	$1,762,413.01	$23,710.62
6	98 - 123	266.12%	109	$682,763.16	$26,533.32
7	124 - 166	270.08%	143	$3,766,217.88	$27,940.64
8	167 - 231	285.49%	195	$6,271,034.36	$29,943.56
9	232 - 330	285.91%	277	$7,555,753.13	$31,652.53
10	331+	282.12%	492	$15,831,414.65	$35,052.87
	National Average	**232.39%**	**142**	**$3,697,428.63**	**$26,948.83**

Table 19 Average Total Charge to Cost Ratio by Hospital Control Type: 2002/2003

Charge to Cost Ratios by Hospital Control Type Hospital Control Type	N	Total Charges as a % of Total Costs
Proprietary, Corporation	654	350.5760%
Proprietary, Partnership	30	255.0341%
Proprietary, Individual	9	251.4381%
Voluntary Nonprofit, Church	590	241.3037%
National Average		**232.39%**
Proprietary, Other	49	229.8908%
Voluntary Nonprofit, Other	1960	216.0500%
Govt. (Federal, City-County, County, State, District, City, Other)	892	184.5866%

Table 20 Average Total Charge to Cost Ratio by State: 2002/2003

State: Total Charges as a % of Total Costs by State: 2002/2003		
Rank	**State**	**Total Charges as a % of Total Costs**
1.	NJ	414.75%
2.	CA	355.04%
3.	FL	354.72%
4.	PA	308.15%
5.	AL	283.61%
6.	NV	276.48%
7.	AZ	276.06%
8.	TX	261.53%
9.	LA	255.06%
10.	TN	253.17%
11.	SC	247.92%
12.	VA	237.21%
13.	IL	227.15%
14.	KY	220.78%
15.	MO	215.20%
16.	DC	215.10%
17.	AR	213.06%
18.	MS	212.92%
19.	NY	212.84%
20.	GA	211.60%
21.	CO	210.32%
22.	RI	209.74%
23.	HI	205.48%
24.	PR	205.36%
25.	MA	203.49%
26.	NM	202.08%
27.	NC	199.58%

State: Total Charges as a % of Total Costs by State: 2002/2003		
Rank	**State**	**Total Charges as a % of Total Costs**
28.	OK	198.10%
29.	OH	197.96%
30.	CT	196.68%
31.	MI	195.29%
32.	DE	189.99%
33.	WV	186.59%
34.	IN	183.85%
35.	NH	181.87%
36.	ME	179.33%
37.	UT	178.53%
38.	KS	175.10%
39.	WA	172.04%
40.	WI	171.07%
41.	OR	164.34%
42.	MN	156.04%
43.	WY	151.77%
44.	NE	150.51%
45.	VT	148.58%
46.	IA	148.39%
47.	SD	147.72%
48.	AK	146.39%
49.	ID	140.07%
50.	MT	137.41%
51.	ND	127.01%
52.	MD	120.24%
53.	VI	111.63%
National Average	**Total**	**232.40%**

Table 21 Top 40 Hospitals: Total Operating Room Charges as a Percent of Total Operating Room Costs by State

Rank	Hospital Name Top 40 Hospitals: Operating Room Charges as a % of Operating Room Costs: 2002/2003	City	State	System Affiliation	OR Charges as a % of Total OR Costs
1.	Doctors Hospital Of Manteca	Manteca	CA	Tenet Healthcare Corporation	1694.69%
2.	Palmetto General Hospital	Hialeah	FL	Tenet Healthcare Corporation	1472.78%
3.	Clifton-Fine Hospital	Star Lake	NY	No Affiliation Listed	1369.22%
4.	Fletcher Allen Health Care	Burlington	VT	No Affiliation Listed	1350.37%
5.	Hahnemann University Hospital	Philadelphia	PA	Tenet Healthcare Corporation	1336.74%
6.	Los Alamitos Medical Ctr.	Los Alamitos	CA	Tenet Healthcare Corporation	1238.69%
7.	Desert Hospital	Palm Springs	CA	Tenet Healthcare Corporation	1211.96%
8.	Garfield Medical Ctr.	Monterey Park	CA	Tenet Healthcare Corporation	1188.90%
9.	San Dimas Community Hospital	San Dimas	CA	Tenet Healthcare Corporation	1167.51%
10.	Doctors Medical Center Of Modesto	Modesto	CA	Tenet Healthcare Corporation	1153.03%
11.	Harris Hospital	Newport	AR	Community Health Systems, Inc	1152.13%
12.	Our Lady Of Lourdes Med. Ctr.	Camden	NJ	Catholic Health East	1141.42%
13.	Graduate Hospital	Philadelphia	PA	Tenet Healthcare Corporation	1126.53%
14.	Northridge Medical Center - Roscoe	Northridge	CA	Catholic Healthcare West	1125.34%
15.	Suburban Medical Center	Paramount	CA	Tenet Healthcare Corporation	1112.45%
16.	Hialeah Hospital	Hialeah	FL	Tenet Healthcare Corporation	1039.34%
17.	Parkway Hospital	Forest Hills	NY	No Affiliation Listed	1027.94%
18.	Temple University Hospital	Philadelphia	PA	Temple University Health Syst	1026.51%
19.	Tops Surgical Specialty Hospital	Houston	TX	No Affiliation Listed	1021.65%
20.	Grand View Hospital	Sellersville	PA	No Affiliation Listed	1017.67%
21.	John.F. Kennedy Memorial Hosp.	Indio	CA	Tenet Healthcare Corporation	1016.63%
22.	Regional Medical Center Southwest Fl	Fort Myers	FL	HCA	1001.97%
23.	Ft. Walton Beach Medical Center	Fort Walton	FL	HCA	995.85%

Rank	Hospital Name Top 40 Hospitals: Operating Room Charges as a % of Operating Room Costs: 2002/2003	City	State	System Affiliation	OR Charges as a % of Total OR Costs
24.	Orange Coast Memorial Medical Center	Fountain Valley	CA	Memorial Health Services	984.00%
25.	Centinela Hospital Medical Center	Inglewood	CA	Tenet Healthcare Corporation	978.52%
26.	Lakewood Regional Med. Ctr.	Lakewood	CA	Tenet Healthcare Corporation	973.32%
27.	Three Rivers Healthcare	Poplar Bluff	MO	Tenet Healthcare Corporation	972.96%
28.	Queen Of Angels/Hollywood Pres Mc	Los Angeles	CA	Tenet Healthcare Corporation	964.84%
29.	Selma Community	Selma	CA	Adventist Health	960.04%
30.	Kendall Regional Medical Center	Miami	FL	HCA	946.74%
31.	Kansas Heart Hospital	Wichita	KS	No Affiliation Listed	941.18%
32.	Easton Hospital	Easton	PA	Community Health Systems, Inc	939.93%
33.	Orange Park Medical Center	Orange Park	FL	HCA	939.14%
34.	Riddle Memorial Hospital	Media	PA	No Affiliation Listed	927.49%
35.	Med. Ctr. Of Southeastern Oklahoma	Durant	OK	Health Management Associates	926.81%
36.	Northridge Hospital - Sherman Way	Van Nuys	CA	Catholic Healthcare West	915.32%
37.	Century City Hosp	Los Angeles	CA	Tenet Healthcare Corporation	904.23%
38.	Fawcett Memorial Hospital	Port Charlotte	FL	HCA	891.09%
39.	St. Anne Mercy Hospital	Toledo	OH	No Affiliation Listed	891.07%
40.	Usc University Hospital	Los Angeles	CA	Tenet Healthcare Corporation	891.00%

Table 22 Top 40 Hospitals: Total Drug Charges as a Percent of Total Drug Costs

Rank	Hospital Name Top 40 Hospitals: Total Drug Charges as a % of Total Drug Costs: 2002/2003	City	State	System Affiliation	Total Drug Charges as a % of Total Drug Costs
1.	The Brooklyn Hospital Center	Brooklyn	NY	New York Presby Hlthcare Syst	6796.47%
2.	Charlotte Hungerford Hospital	Torrington	CT	No Affiliation Listed	5225.94%
3.	Davis Memorial Hospital	Elkins	WV	No Affiliation Listed	4014.70%
4.	Doctors Medical Center Of Modesto	Modesto	CA	Tenet Healthcare Corporation	2655.10%
5.	Centinela Hospital Medical Center	Inglewood	CA	Tenet Healthcare Corporation	2466.53%
6.	Doctors Hospital Of Manteca	Manteca	CA	Tenet Healthcare Corporation	2263.15%
7.	Suburban Medical Center	Paramount	CA	Tenet Healthcare Corporation	1964.78%
8.	Doctors Medical Center-San Pablo	San Pablo	CA	Tenet Healthcare Corporation	1895.32%
9.	Sierra Vista Regional Med Ctr	San Luis Obispo	CA	Tenet Healthcare Corporation	1895.19%
10.	Etmc - Athens	Athens	TX	East Texas Med Ctr Reg Syst	1871.63%
11.	Pennsylvania Hospital Of Uphs	Philadelphia	PA	Univ Of Pennsylvania Hlth Syst	1843.64%
12.	Midway Hospital Medical Center	Los Angeles	CA	Tenet Healthcare Corporation	1828.50%
13.	Hospital	Meadowbrook	PA	No Affiliation Listed	1818.34%
14.	Ny Community Hospital Of Brooklyn	Brooklyn	NY	New York Presby Hlthcare Syst	1767.23%
15.	Redding Medical Center	Redding	CA	Tenet Healthcare Corporation	1756.48%
16.	Renaissance Womens Ctr. Of Edmond	Edmond	OK	No Affiliation Listed	1704.28%
17.	Desert Hospital	Palm Springs	CA	Tenet Healthcare Corporation	1657.97%
18.	Christian Hospital Northwest	Florissant	MO	No Affiliation Listed	1639.42%
19.	Irvine Medical Center	Irvine	CA	Tenet Healthcare Corporation	1637.81%
20.	Memorial Hospital Modesto	Modesto	CA	Sutter Health	1633.66%
21.	John.F. Kennedy Memorial Hosp.	Indio	CA	Tenet Healthcare Corporation	1606.82%
22.	Pacific Hospital Of Long Beach	Long Beach	CA	No Affiliation Listed	1595.20%
23.	Brotman Medical Center	Culver City	CA	Tenet Healthcare Corporation	1549.71%
24.	Med. Ctr. Of Southeastern Oklahoma	Durant	OK	Health Management Associates	1546.94%

Rank	Hospital Name Top 40 Hospitals: Total Drug Charges as a % of Total Drug Costs: 2002/2003	City	State	System Affiliation	Total Drug Charges as a % of Total Drug Costs
25.	Mercy Hosp - Community	Merced	CA	Catholic Healthcare West	1539.45%
26.	Warminster Hospital	Warminster	PA	Tenet Healthcare Corporation	1538.70%
27.	The Good Samaritan Hospital	Lebanon	PA	No Affiliation Listed	1529.69%
28.	Monterey Park Hospital	Monterey Park	CA	Tenet Healthcare Corporation	1501.49%
29.	Garfield Medical Ctr.	Monterey Park	CA	Tenet Healthcare Corporation	1483.53%
30.	Hospital De La Concepcion	San German	PR	No Affiliation Listed	1479.81%
31.	Santa Barbara Cottage Hospital	Santa Barbara	CA	Cottage Health System	1468.99%
32.	Brownsville Medical Center	Brownsville	TX	Tenet Healthcare Corporation	1460.70%
33.	Biloxi Regional Medical Center	Biloxi	MS	Health Management Associates	1458.08%
34.	Coastal Communities Hospital	Santa Ana	CA	Tenet Healthcare Corporation	1424.64%
35.	Helene Fuld Medical Center	Trenton	NJ	No Affiliation Listed	1421.93%
36.	Lawnwood Regional Medical Center	Ft. Pierce	FL	HCA	1419.46%
37.	Brookwood Medical Center	Birmingham	AL	Tenet Healthcare Corporation	1418.77%
38.	Twin Cities Community Hospital	Templeton	CA	Tenet Healthcare Corporation	1409.47%
39.	Queen Of Angels/Hollywood Pres Mc	Los Angeles	CA	Tenet Healthcare Corporation	1405.82%
40.	Community Hospital Of San Bernardino	San Bernardino	CA	Catholic Healthcare West	1394.47%

Table 23 Top 40 Hospitals: Total Medical Supplies Charges as a Percent of Total Medical Supplies Costs

Rank	Hospital Name Top 40 Hospitals: Medical Supplies Charges as a % of Total Medical Supplies Costs	City	State	System Affiliation	Total Medical Supplies Charges as a % of Total Medical Supplies Costs
1.	Kindred Hospital - Delaware County	Darby	PA	No Affiliation Listed	9592.80%
2.	Smh - Chula Vista	Chula Vista	CA	Scripps Health	9565.11%
3.	St. Francis Hospital-Wilmington De	Wilmington	DE	Catholic Health East	9376.34%
4.	St. Francis Medical Center	Honolulu	HI	Sisters Of 3Rd Franciscan	8822.40%
5.	St. Bernard Hospital	Chicago	IL	No Affiliation Listed	8035.81%
6.	Baylor Medical Center At Garland	Garland	TX	Baylor Health Care System	7584.49%
7.	Prattville Baptist Hospital	Prattville	AL	Baptist Health	7555.02%
8.	New York Methodist Hospital	Brooklyn	NY	New York Presby Hlthcare Syst	7183.07%
9.	Crestwood Medical Center	Huntsville	AL	Triad Hospitals, Inc	7117.66%
10.	Southeastern Oh Reg Med Ctr	Cambridge	OH	No Affiliation Listed	7046.71%
11.	Woodland Memorial Hospital	Woodland	CA	Catholic Healthcare West	6997.10%
12.	Franklin Square Hospital Center	Baltimore	MD	Medstar Health	6943.00%
13.	Upmc Bedford Memorial	Everett	PA	Upmc Health System	6655.36%
14.	Camden Medical Center	St. Marys	GA	Southeast Georgia Health Syst	6310.55%
15.	St. Mary S Hospital	Rogers	AR	Sisters Of Mercy	6238.34%
16.	Seton Edgar B. Davis	Luling	TX	Ascension Health	5452.96%
17.	Fort Atkinson Memorial Health Servic	Fort Atkinson	WI	No Affiliation Listed	5434.69%
18.	Hayward Area Memorial Hospital	Hayward	WI	No Affiliation Listed	5320.80%
19.	Delaware County Memorial Hospital	Drexel Hill	PA	Crozer-Keystone Health System	4997.75%
20.	Upland Hills Health Inc.	Dodgeville	WI	No Affiliation Listed	4972.75%

Rank	Hospital Name Top 40 Hospitals: Medical Supplies Charges as a % of Total Medical Supplies Costs	City	State	System Affiliation	Total Medical Supplies Charges as a % of Total Medical Supplies Costs
21.	Trinitas Hospital	Elizabeth	NJ	No Affiliation Listed	4823.37%
22.	North Shore Univ Hosp At Plainview	Plainview	NY	North Shore-Long Island Hlth	4766.20%
23.	Good Samaritan Hospital	Downers Grove	IL	Advocate Health Care	4108.93%
24.	E. Liverpool City Hospital	East Liverpool	OH	No Affiliation Listed	4016.80%
25.	St. Lukes Roosevelt Hospital Center	New York	NY	Continuum Health Partners	4011.72%
26.	Scottsdale Healthcare - Shea	Scottsdale	AZ	Scottsdale Healthcare	3772.46%
27.	Torrance Memorial Medical Center	Torrance	CA	No Affiliation Listed	3666.64%
28.	Valley Lutheran	Mesa	AZ	Banner Health	3557.22%
29.	Nazareth Hospital-Phila Pa	Philadelphia	PA	Catholic Health East	3271.93%
30.	Doctor S Community Hospital	San Juan	PR	No Affiliation Listed	3199.64%
31.	Mineral Area Regional Medical Center	Farmington	MO	No Affiliation Listed	3186.50%
32.	The Mount Vernon Hospital	Mount Vernon	NY	No Affiliation Listed	3166.38%
33.	Noxubee County Hospital	Macon	MS	No Affiliation Listed	3098.78%
34.	St. Lukes Cornwall Hospital	70 Dubois St Newburgh	NY	No Affiliation Listed	3055.18%
35.	Madison County Hospital	Canton	MS	Health Management Associates	3054.30%
36.	St. Anthonys Hospital	St. Petersburg	FL	Catholic Health East	3036.04%
37.	Pinnacle Health Hospitals	Harrisburg	PA	No Affiliation Listed	2990.71%
38.	Springs Memorial Hospital	Lancaster	SC	Community Health Systems, Inc	2953.99%
39.	St. Elizabeths Medical Center	Boston	MA	Caritas Christi Health Care	2902.60%
40.	Margaret Mary Community Hospital	Batesville	IN	No Affiliation Listed	2896.98%

X. The IHSP Hospital 500: Top Ten Hospitals by State by Total Charge to Cost Ratio

We present below the Top Ten Hospitals with the Most Expensive Total Charge to Cost Ratios on a state by state basis.

We believe that such a presentation may help to clarify a principal analytical goal of this study; the demystification of the relationship among hospital billing practices, costs, profits and the access to – or lack thereof – of quality care at affordable levels.

Lacking such an understanding, the nation is analytically blind and politically impoverished as it faces ever increasing pressures regarding policy decisions in its attempt to transform the current failing bottom-line-oriented health care industry into a successful, just and humane health care system.

The first step in guiding those policy decisions and the subsequent transformation to follow is first to deepen as best we can our understanding of the health care industry. This is of particular urgency as it pertains to such absolutely fundamental elements as hospital charges, costs, reimbursements and their relation to hospital fiscal health.

Table 24 Top Ten Hospital Total Charge to Costs Ratios by State

Rank	Hospital Name Top Ten Hospitals in Each State: Total Charges as a % of Total Costs	System	State	Total Charges as a % of Total Costs
1	Brookwood Medical Center	Tenet Healthcare Corporation	AL	785.49%
2	Stringfellow Memorial Hospital	Health Management Associates	AL	605.28%
3	Riverview Reg L Medical Center	Health Management Associates	AL	568.97%
4	Bmc Princeton	Baptist Health System	AL	538.72%
5	Gadsden Regional Medical Center	Triad Hospitals, Inc	AL	511.19%
6	Parkway Medical Center	Community Health Systems, Inc	AL	490.78%
7	Bmc - Montclair	Baptist Health System	AL	489.50%
8	Woodland Medical Center	Community Health Systems, Inc	AL	481.67%
9	Crestwood Medical Center	Triad Hospitals, Inc	AL	481.61%
10	Walker - Baptist Medical Center	Baptist Health System	AL	467.79%
1	Alaska Regional Hospital	HCA	AK	227.14%
2	Providence Alaska Medical Center	Providence Health System	AK	200.36%
3	Fairbanks Memorial Hospital	Banner Health	AK	150.69%
4	Valley Hospital Association		AK	145.24%
5	Central Peninsula General Hospital		AK	140.03%
6	Ketchikan General Hospital	PeaceHealth	AK	132.02%
7	Prov. Kodiak Island Med Ctr	Providence Health System	AK	127.61%
8	Wrangell Medical Center		AK	119.47%
9	Bartlett Regional Hospital	Quorum Health Resources	AK	113.94%
10	South Peninsula Hospital		AK	107.44%

Rank	Hospital Name Top Ten Hospitals in Each State: Total Charges as a % of Total Costs	System	State	Total Charges as a % of Total Costs
1	Walter O. Boswell Memorial Hospital	Sun Health Corporation	AZ	427.98%
2	Valley Lutheran	Banner Health	AZ	423.92%
3	Arrowhead Community Hospital	Vanguard Health System	AZ	404.29%
4	Chandler Regional Hospital	Catholic Healthcare West	AZ	403.01%
5	Western Arizona Regional Medical Cen		AZ	392.42%
6	Del E Webb Memorial Hospital	Sun Health Corporation	AZ	388.56%
7	Thunderbird Samaritan Medical Cnt	Banner Health	AZ	380.56%
8	Lutheran Heart Hospital		AZ	380.37%
9	Jcl North Mountain	John C Lincoln Health Network	AZ	375.66%
10	Jcl Hospital - Deer Valley	John C Lincoln Health Network	AZ	374.30%
1	Harris Hospital	Community Health Systems, Inc	AR	480.13%
2	National Park Medical Center	Tenet Healthcare Corporation	AR	477.40%
3	Southwest Regional Medical Center	Health Management Associates	AR	416.43%
4	Crawford Memorial Hospital	Health Management Associates	AR	394.02%
5	St. Joseph S Mercy Health Center	Sisters of Mercy	AR	390.21%
6	St. Mary S Regional Med Ctr	Tenet Healthcare Corporation	AR	388.96%
7	Regional Medical Center Of Nea	Tenet Healthcare Corporation	AR	373.98%
8	Central Arkansas Hospital	Tenet Healthcare Corporation	AR	335.34%
9	Medical Center Of South Arkansas	Triad Hospitals, Inc	AR	281.31%
10	Baptist Health Medical Center - Lr	Baptist Health	AR	273.28%
1	Doctors Medical Center Of Modesto	Tenet Healthcare Corporation	CA	1185.66%
2	Doctors Hospital Of Manteca	Tenet Healthcare Corporation	CA	1092.34%

Rank	Hospital Name Top Ten Hospitals in Each State: Total Charges as a % of Total Costs	System	State	Total Charges as a % of Total Costs
3	Midway Hospital Medical Center	Tenet Healthcare Corporation	CA	945.32%
4	Garfield Medical Ctr.	Tenet Healthcare Corporation	CA	860.53%
5	Twin Cities Community Hospital	Tenet Healthcare Corporation	CA	813.87%
6	Monterey Park Hospital	Tenet Healthcare Corporation	CA	796.76%
7	Los Alamitos Medical Ctr.	Tenet Healthcare Corporation	CA	796.14%
8	Redding Medical Center	Tenet Healthcare Corporation	CA	790.78%
9	Sierra Vista Regional Med Ctr	Tenet Healthcare Corporation	CA	756.35%
10	Centinela Hospital Medical Center	Tenet Healthcare Corporation	CA	755.60%
1	St. Anthony North	Catholic Health Initiatives	CO	389.96%
2	Rose Medical Center	HCA	CO	350.05%
3	Medical Center Of Aurora	HCA	CO	345.43%
4	Exempla St. Joseph Hospital	Exempla Healthcare, Inc	CO	339.98%
5	North Suburban Medical Center	HCA	CO	336.94%
6	St. Anthony Central	Catholic Health Initiatives	CO	332.98%
7	Swedish Medical Center	HCA	CO	326.59%
8	St. Mary Corwin Medical Center	Catholic Health Initiatives	CO	317.47%
9	Exempla Lutheran Medical Center	Exempla Healthcare, Inc	CO	310.66%
10	Penrose/St. Francis Healthcare	Catholic Health Initiatives	CO	303.30%
1	The Griffin Hospital		CT	272.24%
2	Hospital Of Saint Raphael		CT	253.07%
3	Johnson Memorial Hospital		CT	248.31%
4	Milford Hospital Inc.		CT	244.37%
5	Yale-New Haven Hospital	Yale New Haven Health System	CT	231.34%

Rank	Hospital Name Top Ten Hospitals in Each State: Total Charges as a % of Total Costs	System	State	Total Charges as a % of Total Costs
6	Bridgeport Hospital	Yale New Haven Health System	CT	231.00%
7	St. Marys Hospital		CT	229.42%
8	Rockville General Hospital Inc.	Eastern Connecticut Hlth Netwk	CT	226.85%
9	Manchester Memorial Hospital	Eastern Connecticut Hlth Netwk	CT	219.13%
10	Bristol Hospital Inc.		CT	215.91%
1	St. Francis Hospital-Wilmington De	Catholic Health East	DE	240.24%
2	Milford Memorial Hospital		DE	194.72%
3	Beebe Medical Center		DE	190.18%
4	Kent General Hospital		DE	186.14%
5	Nanticoke Memorial Hospital		DE	183.64%
6	Christiana Care Health Services	Christiana Care Health System	DE	145.04%
1	George Washington Univ. Hospt.	Universal Health Services, Inc	DC	266.96%
2	Greater Southeast Comm. Hosp	Doctors Community Healthcare	DC	240.25%
3	Georgetown University Hospital	MedStar Health	DC	228.46%
4	Washington Hospital Center	MedStar Health	DC	226.08%
5	Providence Hospital	Ascension Health	DC	222.51%
6	Howard University Hospital		DC	175.76%
7	Hadley Memorial Hospital	Doctors Community Healthcare	DC	145.68%
1	Hialeah Hospital	Tenet Healthcare Corporation	FL	669.09%
2	Palmetto General Hospital	Tenet Healthcare Corporation	FL	644.90%
3	Heart Of Florida Reg L Medical Ctr.	Health Management Associates	FL	628.32%
4	Delray Medical Center	Tenet Healthcare Corporation	FL	625.94%

Rank	Hospital Name Top Ten Hospitals in Each State: Total Charges as a % of Total Costs	System	State	Total Charges as a % of Total Costs
5	Ft. Walton Beach Medical Center	HCA	FL	603.15%
6	Twin Cities Hospital	HCA	FL	601.26%
7	Florida Medical Center	Tenet Healthcare Corporation	FL	592.86%
8	Coral Gables Hospital	Tenet Healthcare Corporation	FL	590.40%
9	Orange Park Medical Center	HCA	FL	584.75%
10	Brooksville Regional Hospital	Health Management Associates	FL	574.00%
1	Spalding Regional Hospital	Tenet Healthcare Corporation	GA	545.68%
2	Atlanta Medical Center	Tenet Healthcare Corporation	GA	439.84%
3	Cartersville Medical Center	HCA	GA	398.96%
4	South Fulton Medical Center	Tenet Healthcare Corporation	GA	397.04%
5	Doctors Of Augusta Hospital	HCA	GA	394.69%
6	East Georgia Regional Medical Ctr	Health Management Associates	GA	358.71%
7	Doctors Hospital Of Columbus	HCA	GA	348.58%
8	Redmond Regional Medical Center	HCA	GA	347.51%
9	Fairview Park Hospital	HCA	GA	337.29%
10	Douglas Hospital	WellStar Health System	GA	312.19%
1	Kapiolani Medical Ctr @ Pali Momi	Hawaii Pacific Health System	HI	279.87%
2	The Queen S Medical Center	Queen's Health Systems	HI	266.00%
3	Maui Memorial Medical Center	Hawaii Health Systems Corp	HI	243.06%
4	Straub Clinic & Hospital	Hawaii Pacific Health System	HI	217.82%
5	St Francis Medical Center West	Sisters of 3rd Franciscan	HI	213.44%
6	Castle Medical Center	Adventist Health	HI	205.83%
7	Kuakini Medical Center		HI	199.24%

Rank	Hospital Name Top Ten Hospitals in Each State: Total Charges as a % of Total Costs	System	State	Total Charges as a % of Total Costs
8	St. Francis Medical Center	Sisters of 3rd Franciscan	HI	193.83%
9	Kona Community Hospital	Hawaii Health Systems Corp	HI	175.40%
10	Hilo Medical Center	Hawaii Health Systems Corp	HI	175.20%
1	West Valley Medical Center	HCA	ID	234.49%
2	Mercy Medical Center	Catholic Health Initiatives	ID	183.10%
3	Kootenai Medical Center		ID	181.17%
4	Magic Valley Regional Medical Cente		ID	173.85%
5	Treasure Valley Hospital		ID	170.45%
6	St. Joseph Regional Medical Center	Ascension Health	ID	164.41%
7	Saint Alphonsus Regional Med Center	Trinity Health	ID	160.40%
8	Bannock Regional Medical Center		ID	158.61%
9	Cassia Regional Med. Center	Intermountain Health Care, Inc	ID	157.43%
10	Walter Knox Memorial Hospital		ID	154.17%
1	Our Lady Of The Resurrection	Resurrection Health Care Corp	IL	427.50%
2	Gottlieb Memorial Hospital		IL	426.33%
3	West Suburban Hospt. Med. Ctr.		IL	384.72%
4	Macneal Hospital	Vanguard Health System	IL	377.64%
5	Northside Health System		IL	368.62%
6	Holy Cross Hospital		IL	361.03%
7	Swedish Covenant Hospital		IL	354.32%
8	Alton Memorial Hospital	BJC HealthCare	IL	348.85%
9	Saint Anthonys Health Center		IL	347.27%
10	Resurrection Medical Center	Resurrection Health Care Corp	IL	343.14%

Rank	Hospital Name Top Ten Hospitals in Each State: Total Charges as a % of Total Costs	System	State	Total Charges as a % of Total Costs
1	Terre Haute Regional Hospital	HCA	IN	342.13%
2	Lutheran Hospital Of Indiana	Triad Hospitals, Inc	IN	266.15%
3	Community Hospital South		IN	255.05%
4	Clark Memorial Hospital	Jewish Hosp HealthCare Serv	IN	249.79%
5	Union Hospital Inc.		IN	247.25%
6	Bedford Regional Medical Center	Clarian Health Partners	IN	244.75%
7	Memorial Hospt. Of South Bend Inc.		IN	236.01%
8	St Joseph Reg Med Ctr - Sb Campus	Trinity Health	IN	235.97%
9	Womens Hospital Of Indianapolis	Ascension Health	IN	233.30%
10	St. Elizabeth Medical Center		IN	232.04%
1	Mercy Hospital Council Bluffs	Alegent Health	IA	259.22%
2	Covenant Medical Center	Wheaton Franciscan Servs, Inc	IA	250.54%
3	Mercy Medical Center-Des Moines	Catholic Health Initiatives	IA	237.68%
4	Trinity Regional Medical Center	Iowa Health System	IA	209.59%
5	Iowa Methodist Medical Center	Iowa Health System	IA	203.13%
6	Sartori Memorial Hospital	Wheaton Franciscan Servs, Inc	IA	200.15%
7	Mercy Medical Center	Trinity Health	IA	193.36%
8	Great River Medical Center		IA	192.91%
9	Mercy Medical Center		IA	191.39%
10	Jennie Edmundson Memorial	Nebraska Meth Hlth System, Inc	IA	189.68%
1	Overland Park Regl Med. Center	HCA	KS	366.58%
2	Wesley Medical Center	HCA	KS	354.17%

Rank	Hospital Name Top Ten Hospitals in Each State: Total Charges as a % of Total Costs	System	State	Total Charges as a % of Total Costs
3	Shawnee Mission Medical Center Inc.	Adventist Hlth System Sunbelt	KS	343.87%
4	Kansas Heart Hospital		KS	329.38%
5	Providence Medical Center	Sisters of Charity	KS	306.07%
6	Menorah Medical Center	HCA	KS	290.87%
7	Salina Surgical Hospital		KS	289.02%
8	Saint Lukes South Hospital Inc.	Saint Luke's Health System	KS	274.98%
9	Olathe Medical Center		KS	273.12%
10	Cushing Memorial Hospital	Saint Luke's Health System	KS	272.20%
1	Kentucky River Medical Center	Community Health Systems, Inc	KY	550.15%
2	Paul B. Hall Regl Medical Center	Health Management Associates	KY	530.29%
3	Three Rivers Medical Center	Community Health Systems, Inc	KY	380.62%
4	Lake Cumberland Regional Hospital	LifePoint Hospitals, Inc	KY	326.17%
5	Hazard Arh	Appalachian Reg Healthcare	KY	317.48%
6	Jewish Hospital Shelbyville	Jewish Hosp HealthCare Serv	KY	308.65%
7	Greenview Regional Hospital	HCA	KY	308.14%
8	University Of Louisville Hospital		KY	302.82%
9	Frankfort Regional Medical Center	HCA	KY	295.91%
10	Williamson Arh	Appalachian Reg Healthcare	KY	292.59%
1	Meadowcrest Hospital	Tenet Healthcare Corporation	LA	644.87%
2	Northshore Reg. Medical Center	Tenet Healthcare Corporation	LA	618.56%
3	St. Charles General Hospital	Tenet Healthcare Corporation	LA	562.36%
4	Memorial Medical Center	Tenet Healthcare Corporation	LA	560.68%
5	Doctors Hospital Of Jefferson	Tenet Healthcare Corporation	LA	551.79%

Rank	Hospital Name Top Ten Hospitals in Each State: Total Charges as a % of Total Costs	System	State	Total Charges as a % of Total Costs
6	Byrd Regional Hospital	Community Health Systems, Inc	LA	547.24%
7	Kenner Regional Medical Center	Tenet Healthcare Corporation	LA	495.88%
8	North Monroe Hospital	HCA	LA	406.11%
9	Medical Center Of Southwest Louisian	HCA	LA	398.33%
10	Lakeview Regional Medical Center	HCA	LA	391.91%
1	St. Marys Regional Medical Center	Covenant Health Systems, Inc	ME	241.20%
2	Redington-Fairview General Hospital		ME	218.36%
3	The Aroostook Medical Center	Eastern Maine Healthcare	ME	215.05%
4	Bridgton Hospital		ME	211.33%
5	Central Maine Medical Center		ME	204.56%
6	Parkview Memorial Hospital		ME	202.71%
7	Cary Medical Center (Aroostook	Quorum Health Resources	ME	202.47%
8	Maine Coast Memorial Hospital	Quorum Health Resources	ME	199.68%
9	Mainegeneral Medical Center		ME	196.76%
10	Penobscot Bay Medical Center		ME	195.68%
1	Kernan	University of MD Medical Syst	MD	219.08%
2	Southern Maryland Hospital		MD	146.06%
3	Univ. Of Maryland Medical System	University of MD Medical Syst	MD	138.07%
4	Union Memorial Hospital	MedStar Health	MD	129.92%
5	Chester River Hospital		MD	128.67%
6	Calvert Memorial Hospital		MD	126.87%
7	Maryland General Hospital	University of MD Medical Syst	MD	126.23%
8	Washington Adventist Hospital	Adventist Healthcare	MD	125.20%

Rank	Hospital Name Top Ten Hospitals in Each State: Total Charges as a % of Total Costs	System	State	Total Charges as a % of Total Costs
9	Mem Hospital At Easton Md. Inc.		MD	123.17%
10	Garrett County Memorial Hospital		MD	122.47%
1	Metrowest Medical Center	Tenet Healthcare Corporation	MA	306.22%
2	Faulkner Hospital	Partners HealthCare System	MA	304.39%
3	Saint Vincent Hospital	Tenet Healthcare Corporation	MA	276.01%
4	Emerson Hospital		MA	270.27%
5	Heywood Hospital		MA	265.12%
6	Marlborough Hospital	UMass Health System	MA	259.28%
7	Deaconess Glover Hospital		MA	250.35%
8	Milford-Whitinsville Reg. Hospt.		MA	245.76%
9	Athol Memorial Hospital		MA	238.35%
10	Ummhc~Clinton Hospital	UMass Health System	MA	237.86%
1	St. John Macomb Hospital	Ascension Health	MI	319.57%
2	St. John Hospital And Medical Center	Ascension Health	MI	309.22%
3	Kindred Hospital - Metro Detroit		MI	305.11%
4	Crittenton Hospital		MI	300.76%
5	Huron Valley-Sinai Hospital	Detroit Medical Center	MI	298.59%
6	Lapeer Regional Hospital	McLaren Health Care Corp	MI	295.98%
7	Saline Community Hospital	Trinity Health	MI	287.05%
8	William Beaumont Hospital	William Beaumont Hospitals	MI	277.60%
9	St. John Northeast Community Hosp	Ascension Health	MI	276.57%
10	Mclaren Regional Medical Center	McLaren Health Care Corp	MI	271.61%

Rank	Hospital Name Top Ten Hospitals in Each State: Total Charges as a % of Total Costs	System	State	Total Charges as a % of Total Costs
1	Healtheast St John S Hospital	HealthEast Care System	MN	320.16%
2	St Joseph S Hospital	HealthEast Care System	MN	274.40%
3	Abbott Northwestern Hospital	Allina Hospitals & Clinics	MN	266.03%
4	Fairview Ridges Hospital	Fairview Health Services	MN	263.64%
5	Unity Hospital	Allina Hospitals & Clinics	MN	258.22%
6	Methodist Hospital	Park Nicollet Health Services	MN	252.56%
7	Fairview Southdale Hospital	Fairview Health Services	MN	250.08%
8	Cambridge Medical Center	Allina Hospitals & Clinics	MN	248.58%
9	North Memorial Health Care		MN	231.79%
10	Healtheast Woodwinds Health Campus	HealthEast Care System	MN	229.81%
1	Natchez Community Hospital	Health Management Associates	MS	472.76%
2	Biloxi Regional Medical Center	Health Management Associates	MS	452.69%
3	Gulf Coast Medical Center	Tenet Healthcare Corporation	MS	450.88%
4	Central Mississippi Med. Ctr.	Health Management Associates	MS	363.28%
5	Garden Park Community Hospital	HCA	MS	355.45%
6	Northwest Ms Reg. Med. Center	Health Management Associates	MS	343.51%
7	Riley Memorial Hospital	Health Management Associates	MS	324.72%
8	River Region Medical Corp	Triad Hospitals, Inc	MS	322.91%
9	River Oaks Hospital	Health Management Associates	MS	318.02%
10	Womans Hospital At River Oaks	Health Management Associates	MS	304.96%
1	Des Peres Medical Center	Tenet Healthcare Corporation	MO	478.79%
2	Moberly Regional Medical Center	Community Health Systems, Inc	MO	391.44%
3	Saint Louis University Hospital	Tenet Healthcare Corporation	MO	383.85%

Rank	Hospital Name Top Ten Hospitals in Each State: Total Charges as a % of Total Costs	System	State	Total Charges as a % of Total Costs
4	St Alexius Hospital	Tenet Healthcare Corporation	MO	373.60%
5	Forest Park Hospital	Tenet Healthcare Corporation	MO	369.53%
6	Research Medical Center	HCA	MO	351.67%
7	St. Joseph Hospital - West	SSM Health Care	MO	350.09%
8	Christian Hospital Northeast	BJC HealthCare	MO	330.24%
9	Three Rivers Healthcare	Tenet Healthcare Corporation	MO	326.22%
10	Medical Center Of Independence	HCA	MO	323.52%
1	Holy Rosary Healthcare	Sisters of Charity	MT	190.11%
2	St. Patrick Hospital	Providence Services	MT	186.17%
3	Kalispell Regional Medical Center		MT	180.67%
4	St Peters Hospital		MT	179.75%
5	St. Vincent Healthcare	Sisters of Charity	MT	176.12%
6	Deaconess Billings Clinic		MT	175.95%
7	St. James Healthcare	Sisters of Charity	MT	162.99%
8	Glendive Medical Center		MT	156.09%
9	Northern Montana Hospital		MT	155.09%
10	Bozeman Deaconess Health Services		MT	147.66%
1	Creighton University Medical Center	Tenet Healthcare Corporation	NE	516.30%
2	Immanuel Medical Center	Alegent Health	NE	256.50%
3	Midlands Community Hospital	Alegent Health	NE	253.80%
4	Bergan Mercy Medical Center	Alegent Health	NE	253.69%
5	Nebraska Health System		NE	245.55%
6	St. Elizabeth Reg. Med. Ctr.	Catholic Health Initiatives	NE	211.94%

Rank	Hospital Name Top Ten Hospitals in Each State: Total Charges as a % of Total Costs	System	State	Total Charges as a % of Total Costs
7	Nebraska Methodist Hospital	Nebraska Meth Hlth System, Inc	NE	203.70%
8	Good Samaritan Hosptial	Catholic Health Initiatives	NE	202.57%
9	Bryanlgh Medical Center East		NE	192.69%
10	Great Plains Regional Medical Center	Quorum Health Resources	NE	182.53%
1	Lake Mead Medical Center	Tenet Healthcare Corporation	NV	525.52%
2	Valley Hospital Medical Center	Universal Health Services, Inc	NV	456.62%
3	Summerlin Hospital Medical Center	Universal Health Services, Inc	NV	439.36%
4	Desert Springs Hospital	Universal Health Services, Inc	NV	437.27%
5	Mountainview	HCA	NV	416.59%
6	Sunrise Hospital	HCA	NV	410.72%
7	St Rose Dominican - Siena	Catholic Healthcare West	NV	378.00%
8	St Rose Dominican - Delima	Catholic Healthcare West	NV	328.25%
9	Washoe Medical Center Inc.		NV	327.71%
10	Northern Nevada Medical Center	Universal Health Services, Inc	NV	318.64%
1	Portsmouth Regional Hospital	HCA	NH	257.00%
2	Parkland Medical Center	HCA	NH	244.10%
3	St. Josephs Hospital	Covenant Health Systems, Inc	NH	233.92%
4	Catholic Medical Center		NH	231.20%
5	Elliot Hospital		NH	210.33%
6	Exeter Hospital Inc.		NH	209.85%
7	Wentworth-Douglass Hospital		NH	208.10%
8	Southern Nh Medical Center		NH	203.13%
9	Frisbie Memorial Hospital		NH	203.00%

Rank	Hospital Name Top Ten Hospitals in Each State: Total Charges as a % of Total Costs	System	State	Total Charges as a % of Total Costs
10	Concord Hospital Inc.		NH	200.82%
1	Christ Hospital		NJ	830.83%
2	Columbus Hospital	Cathedral Healthcare Syst, Inc	NJ	793.11%
3	Bayonne Medical Center		NJ	766.64%
4	Meadowlands Hospital Medical Center	LibertyHealth	NJ	738.59%
5	Barnert Hospital		NJ	701.44%
6	Raritan Bay Medical Center		NJ	701.05%
7	Warren Hospital		NJ	665.97%
8	St. Michaels Medical Center	Cathedral Healthcare Syst, Inc	NJ	615.94%
9	Irvington General Hospital	Saint Barnabas Health System	NJ	611.80%
10	Hospital Center @ Orange	Cathedral Healthcare Syst, Inc	NJ	598.34%
1	Eastern New Mexico Medical Center	Community Health Systems, Inc	NM	401.64%
2	N.E. Regional Hospital	Community Health Systems, Inc	NM	311.87%
3	Carlsbad Medical Center	Triad Hospitals, Inc	NM	263.24%
4	Albuquerque Regional Med Ctr	Ardent Health Services	NM	262.36%
5	Northeast Heights Medical Center	Ardent Health Services	NM	261.07%
6	Kaseman Presbyterian Hospital	Presbyterian Healthcare Servs	NM	244.87%
7	West Mesa Hospital	Ardent Health Services	NM	229.09%
8	Rehoboth Mckinley Christian Hospital		NM	225.74%
9	Heart Hospital Of New Mexico	MedCath, Inc	NM	220.97%
10	Memorial Medical Center		NM	217.03%
1	Parkway Hospital		NY	698.54%

Rank	Hospital Name Top Ten Hospitals in Each State: Total Charges as a % of Total Costs	System	State	Total Charges as a % of Total Costs
2	Lenox Hill Hospital		NY	452.37%
3	Brookhaven Memorial Hospital M C		NY	447.51%
4	Long Beach Medical Center		NY	377.24%
5	Victory Memorial Hospital		NY	370.25%
6	Vassar Brothers Medical Center		NY	354.00%
7	Nyack Hospital		NY	348.59%
8	Interfaith Medical Center		NY	342.39%
9	St. Lukes Hospital	Greater Hudson Valley Health	NY	322.85%
10	Long Island College Hospital	Continuum Health Partners	NY	321.64%
1	Central Carolina Hospital	Tenet Healthcare Corporation	NC	483.28%
2	Frye Regional Medical Center	Tenet Healthcare Corporation	NC	406.52%
3	Sandhills Regional Medical Center	Health Management Associates	NC	397.17%
4	Lake Norman Reg L Medical Center	Health Management Associates	NC	372.23%
5	Davis Regional Medical Center	Health Management Associates	NC	324.69%
6	Franklin Regl Medical Center	Health Management Associates	NC	315.97%
7	Martin General Hospital	Community Health Systems, Inc	NC	288.68%
8	Carolinas Medical Center-Mercy	Carolinas HealthCare System	NC	281.43%
9	Presbyterian Orthopaedic Hospital	Novant Health	NC	276.02%
10	Presbyterian Hospital Matthews	Novant Health	NC	264.86%
1	Altru Health System-Altru Hospital		ND	203.48%
2	Mercy Hospital	Catholic Health Initiatives	ND	202.31%
3	Meritcare Hospital		ND	175.74%
4	St. Joseph S Hospital & Health Ctr	Catholic Health Initiatives	ND	159.39%

Rank	Hospital Name Top Ten Hospitals in Each State: Total Charges as a % of Total Costs	System	State	Total Charges as a % of Total Costs
5	Oakes Community Hospital	Catholic Health Initiatives	ND	157.12%
6	Mercy Medical Center	Catholic Health Initiatives	ND	156.33%
7	Presentation Medical Center	Sisters of Mary	ND	141.59%
8	St Alexius Medical Center	Benedictine Sisters	ND	139.23%
9	Trinity Hospitals		ND	132.03%
10	Carrington Health Center	Catholic Health Initiatives	ND	129.21%
1	Mount Carmel Health	Trinity Health	OH	321.98%
2	Jewish Hospital Of Cincinnati		OH	310.47%
3	Marymount Hospital	Cleveland Clinic Health System	OH	301.18%
4	St. Elizabeth Health Center	Catholic Healthcare Partners	OH	300.33%
5	St. Ann S Hospital	Trinity Health	OH	299.83%
6	St. John West Shore	Sisters of Charity	OH	291.88%
7	The Toledo Hospital	ProMedica Health System	OH	291.66%
8	Sycamore Hospital	Kettering Med Center-Network	OH	290.86%
9	Flower Hospital	ProMedica Health System	OH	289.84%
10	Lakewood Hospital	Cleveland Clinic Health System	OH	289.13%
1	Med. Ctr. Of Southeastern Oklahoma	Health Management Associates	OK	525.12%
2	Midwest Regional Medical Center	Health Management Associates	OK	477.44%
3	Oklahoma Spine Hospital		OK	374.26%
4	St. Mary Reg L Medical Center	Universal Health Services, Inc	OK	354.82%
5	Ou Medical Center	HCA	OK	324.23%
6	Integris Baptist Medical Center	INTEGRIS Health	OK	320.29%
7	Integris Southwest Medical Center	INTEGRIS Health	OK	310.29%

Rank	Hospital Name Top Ten Hospitals in Each State: Total Charges as a % of Total Costs	System	State	Total Charges as a % of Total Costs
8	Hillcrest Medical Center	Hillcrest HealthCare System	OK	295.63%
9	Southwestern Medical Center	HCA	OK	291.80%
10	Southcrest Hospital	Triad Hospitals, Inc	OK	287.86%
1	Willamatte Valley Medical Center	Triad Hospitals, Inc	OR	248.80%
2	St. Anthony Hospital	Catholic Health Initiatives	OR	239.29%
3	Mercy Medical Center	Catholic Health Initiatives	OR	225.33%
4	Legacy Meridian Park Hospital	Legacy Health System	OR	212.25%
5	St. Vincent Hospital Med Ctr	Providence Health System	OR	203.89%
6	Ashland Community Hospital		OR	200.52%
7	Ohsu Hospital And Clinics		OR	196.76%
8	Mid-Columbia Medical Center		OR	195.34%
9	Legacy Mount Hood Medical Center	Legacy Health System	OR	194.74%
10	Providence Portland Medical Center	Providence Health System	OR	192.28%
1	Temple University Hospital	Temple University Health Syst	PA	1090.28%
2	Warminster Hospital	Tenet Healthcare Corporation	PA	926.09%
3	Temple East Hospital	Temple University Health Syst	PA	906.23%
4	Graduate Hospital	Tenet Healthcare Corporation	PA	885.46%
5	Jeanes Hospital	Temple University Health Syst	PA	855.72%
6	Hahnemann University Hospital	Tenet Healthcare Corporation	PA	813.89%
7	Medical College Of Pennsylvania	Tenet Healthcare Corporation	PA	778.79%
8	Abington Memorial Hospital		PA	749.31%
9	Temple Lower Bucks Hospital		PA	722.42%
10	Delaware County Memorial Hospital	Crozer-Keystone Health System	PA	662.51%

Rank	Hospital Name Top Ten Hospitals in Each State: Total Charges as a % of Total Costs	System	State	Total Charges as a % of Total Costs
1	Hospital Dr. Susoni Inc.		PR	494.30%
2	Cayetano Coll Y Toste		PR	389.35%
3	Doctor S Community Hospital		PR	331.79%
4	Hospital Pavia	United Medical Corporation	PR	283.56%
5	Hospital I. Gonzalez Martinez		PR	265.96%
6	Hospital Hermanos Melendez		PR	249.77%
7	Hospital Matilde Brenes		PR	238.42%
8	Hospital Episcopal San Lucas		PR	234.60%
9	Hospital San Carlos Borromeo		PR	227.18%
10	Hospital Bella Vista		PR	225.85%
1	The Miriam Hospital	Lifespan Corporation	RI	256.51%
2	Rhode Island Hospital	Lifespan Corporation	RI	255.80%
3	St. Joseph Health Services Of Ri		RI	247.06%
4	The Westerly Hospital		RI	200.37%
5	Newport Hospital	Lifespan Corporation	RI	199.65%
6	Kent County Memorial Hospital	Care New England Health System	RI	194.71%
7	Memorial Hospital Of Rhode Island		RI	186.15%
8	South County Hospital		RI	179.96%
9	Roger Williams Hospital		RI	167.42%
1	Carolina Pines Reg L Med. Ctr.	Health Management Associates	SC	418.50%
2	Springs Memorial Hospital	Community Health Systems, Inc	SC	414.35%

Rank	Hospital Name Top Ten Hospitals in Each State: Total Charges as a % of Total Costs	System	State	Total Charges as a % of Total Costs
3	East Cooper	Tenet Healthcare Corporation	SC	410.33%
4	Marlboro Park Hospital	Community Health Systems, Inc	SC	390.13%
5	Trident Regional Medical Center	HCA	SC	373.34%
6	Piedmont Medical Center	Tenet Healthcare Corporation	SC	368.78%
7	Hilton Head Hospital	Tenet Healthcare Corporation	SC	361.40%
8	Upstate Carolina Medical Center	Health Management Associates	SC	360.38%
9	Grand Strand Reg Med Ctr	HCA	SC	335.99%
10	Chesterfield General	Community Health Systems, Inc	SC	324.76%
1	Black Hills Surgery Center Llp		SD	241.36%
2	Sioux Falls Surgical Center		SD	227.44%
3	Dakota Plains Surgical Center Llp		SD	220.99%
4	Siouxland Surgery Center		SD	216.05%
5	Rapid City Regional Hospital	Rapid City Regional Hospital	SD	204.45%
6	Sioux Valley Hospital	Sioux Valley Hosp & Hlth Syst	SD	196.86%
7	Heart Hospital Of South Dakota	MedCath, Inc	SD	186.49%
8	Same Day Surgery Center		SD	175.40%
9	Huron Regional Medical Center	Quorum Health Resources	SD	169.12%
10	Avera Queen Of Peace	Avera Health	SD	166.69%
1	University Medical Center	Tenet Healthcare Corporation	TN	445.50%
2	Scott County Hospital	Community Health Systems, Inc	TN	440.26%
3	St. Francis Hospital	Tenet Healthcare Corporation	TN	436.56%
4	White County Community Hospital	Community Health Systems, Inc	TN	430.98%
5	Medical Center Of Manchester		TN	417.43%

Rank	Hospital Name Top Ten Hospitals in Each State: Total Charges as a % of Total Costs	System	State	Total Charges as a % of Total Costs
6	John W. Harton Reg. Med. Ctr.	Tenet Healthcare Corporation	TN	396.56%
7	Cleveland Community	Community Health Systems, Inc	TN	395.66%
8	Lakeway Regional Hospital	Community Health Systems, Inc	TN	381.38%
9	Summit Medical Center	HCA	TN	352.67%
10	Fort Sanders Parkwest Medical Center	Covenant Health	TN	350.21%
1	Brownsville Medical Center	Tenet Healthcare Corporation	TX	902.53%
2	Sierra Medical Center	Tenet Healthcare Corporation	TX	666.56%
3	Providence Memorial Hospital	Tenet Healthcare Corporation	TX	656.94%
4	Houston Northwest Medical Center	Tenet Healthcare Corporation	TX	538.84%
5	Del Sol Medical Center	HCA	TX	533.85%
6	Nacogdoches Medical Center	Tenet Healthcare Corporation	TX	529.43%
7	Cleveland Regional Medical Center	Community Health Systems, Inc	TX	511.64%
8	Park Plaza Hospital	Tenet Healthcare Corporation	TX	496.88%
9	Vista Medical Center Hospital		TX	494.88%
10	Doctors Hospital Of Dallas	Tenet Healthcare Corporation	TX	473.00%
1	Jordan Valley Hospital	IASIS Healthcare	UT	310.11%
2	Pioneer Valley Hospital	IASIS Healthcare	UT	287.15%
3	Davis Hospital & Medical Ctr	IASIS Healthcare	UT	284.44%
4	St. Mark S Hospital	HCA	UT	260.51%
5	Salt Lake Regional Medical Center	IASIS Healthcare	UT	260.02%
6	Mountain View Hospital	HCA	UT	240.01%
7	Ogden Reg Med Ctr	HCA	UT	229.12%
8	Lakeview Hospital	HCA	UT	225.80%

Rank	Hospital Name Top Ten Hospitals in Each State: Total Charges as a % of Total Costs	System	State	Total Charges as a % of Total Costs
9	Castleview Hospital	LifePoint Hospitals, Inc	UT	224.04%
10	Ashley Valley Medical Center	LifePoint Hospitals, Inc	UT	206.74%
1	Southwestern Vermont Medical Center		VT	160.72%
2	Central Vermont Hospital		VT	159.94%
3	Northwestern Medical Center	Quorum Health Resources	VT	159.77%
4	Northeastern Vt Regional Hospital		VT	157.65%
5	Porter Hospital		VT	157.49%
6	North Country Hospital & Health Ctr		VT	156.08%
7	Copley Hospital Inc.		VT	146.75%
8	Gifford Medical Center		VT	146.62%
9	Brattleboro Memorial Hospital		VT	141.70%
10	Mt Ascutney Hospital Cah		VT	134.85%
1	Gov. Juan F. Luis Hospital		VI	111.63%
1	Cjw Medical Center	HCA	VA	490.68%
2	Henrico Doctors Hospital	HCA	VA	470.82%
3	Retreat Hospital	HCA	VA	412.31%
4	John Randolph Medical Ctr	HCA	VA	398.18%
5	Clinch Valley Medical Center	HCA	VA	390.01%
6	St. Mary S Hospital	Bon Secours Health System, Inc	VA	369.33%
7	Russell County Medical Center	Community Health Systems, Inc	VA	336.78%
8	Greensville Memorial	Community Health Systems, Inc	VA	334.81%
9	Memorial Regional Medical Center	Bon Secours Health System, Inc	VA	330.27%

Rank	Hospital Name Top Ten Hospitals in Each State: Total Charges as a % of Total Costs	System	State	Total Charges as a % of Total Costs
10	Riverside Regional Medical Center	Riverside Health System	VA	310.89%
1	St Clare Hospital	Catholic Health Initiatives	WA	326.11%
2	St Francis Hospital	Catholic Health Initiatives	WA	274.61%
3	Tacoma General Allenmore Hospital	MultiCare Health System	WA	262.85%
4	St. Joseph Medical Center	Catholic Health Initiatives	WA	255.78%
5	Capital Medical Center	HCA	WA	253.09%
6	Auburn Regional Medical Centet	Universal Health Services, Inc	WA	244.34%
7	Sacred Heart Medical Center	Providence Services	WA	238.74%
8	Providence Toppenish Hospital	Health Management Associates	WA	237.53%
9	Swedish Medical Center		WA	235.61%
10	Walla Walla General Hospital	Adventist Health	WA	226.92%
1	Williamson Memorial Hospital	Health Management Associates	WV	278.37%
2	Wetzel County Hospital		WV	254.93%
3	Raleigh General Hospital	HCA	WV	246.34%
4	St Francis Hospital	HCA	WV	240.68%
5	Greenbrier Valley Medical Center	Triad Hospitals, Inc	WV	238.34%
6	Ohio Valley General Hospital	Ohio Valley Health Services	WV	228.52%
7	Putnam General Hospital	HCA	WV	227.68%
8	Boone Memorial Hospital		WV	223.01%
9	Bluefield Regional Medical Center		WV	221.00%
10	Beckley Arh	Appalachian Reg Healthcare	WV	215.65%
1	Elmbrook Mem L Hospt.	Wheaton Franciscan Servs, Inc	WI	290.74%

Rank	Hospital Name Top Ten Hospitals in Each State: Total Charges as a % of Total Costs	System	State	Total Charges as a % of Total Costs
2	West Allis Memorial Hospital	Aurora Health Care	WI	287.32%
3	St. Francis Hospital	Wheaton Franciscan Servs, Inc	WI	273.34%
4	St. Joseph S Hospital	Wheaton Franciscan Servs, Inc	WI	269.67%
5	St. Lukes Medical Center	Aurora Health Care	WI	252.08%
6	St. Mary S Hospital-Ozaukee	Ascension Health	WI	242.33%
7	Lakeland Medical Center	Aurora Health Care	WI	239.20%
8	Aurora Sinai Medical Center	Aurora Health Care	WI	238.20%
9	St. Michael Hospital	Wheaton Franciscan Servs, Inc	WI	231.34%
10	Aurora Medical Center Kenosha	Aurora Health Care	WI	230.70%
1	Evanston Regional Hospital	Community Health Systems, Inc	WY	236.44%
2	United Medical Center		WY	208.31%
3	Lander Medical Center	LifePoint Hospitals, Inc	WY	202.53%
4	Wyoming Medical Center		WY	178.95%
5	Memorial Hospital Of Sheridan County		WY	163.63%
6	Ivinson Memorial Hospital		WY	162.30%
7	Washakie Medical Center	Banner Health	WY	161.68%
8	Memorial Hospital Of Carbon County		WY	136.97%
9	Mem. Hospt. Of Sweetwater County		WY	136.01%
10	Campbell County Memorial Hospital		WY	135.71%

Table 25 Medicare Payment System Description for Acute Care Hospitals, adapted from Table A-1, Summary of Medicare's Current Payment Systems by Setting (15)

Payment System Description Category	Payment System Description Category Source
Fiscal Year Began	1984
Basis Of Payment	Prospective
Product Definition	
Unit Of Payment	Discharge
Product Classification System	509 DRGs
Policies Defining Product	72-Hour Rule
Boundaries	Short-Stay
	Transfers; High-
	Cost Outliers
Product Relative Values	
Components Of Relative Values	Single Value For Each DRG
Source Of Relative Values	**Hospitals' Billed Charges (Emphasis added).**
Base Payment Rate/Conversion Factor	
Components Of Base Amount	Labor-Related;
Components of Base Amount	Nonlabor; Capital
Source Of Base Amount	Updated Providers' 1982 Costs
Adjustments For Local Market Conditions	
Labor Input Prices	Hospital Wage Index
Other Input Prices	Cola
Other Payment Adjustments	Low Income Patients (DSH), GME Programs
Payment Update Method	Rise In Hospital Market Basket Index
Payments For Capital Costs	Separate Prospective Rates
Other Policies	Higher Rates In Large Urban Areas; Policies For Rural

Payment System Description Category	Payment System Description Category Source
	Providers

Table 23, *Hospital Financial Categories/Centers*, is a listing of the federal hospital cost report financial categories/centers utilized in this study in calculating hospital charge to cost ratios. The hospital cost report forms have provisions for subcategories for each category/center which can range from 1 to 99 in number. Hence, the 99 categories enumerated in Table 72 represent a good deal more categories than those listed.

Table 26 Hospital Financial Categories/Centers

Hospital Financial Categories/Centers
1. Acupuncture
2. Adults & Pediatrics (General Routine Care)
3. All Other Outpatient Cost Centers
4. Ambulance Services
5. Anesthesiology
6. Angiocardiography
7. Asc (Non Distinct Part)
8. Audiology
9. Bacteriology & Microbiology
10. Biopsy
11. Birthing Center
12. Blood Clotting For Hemophiliacs
13. Blood Storing, Processing, & Transfusing
14. Burn Intensive Care Unit
15. Cardiac Catheterization Laboratory
16. Cardiology
17. Cardiopulmonary
18. Cat Scan
19. Chemistry
20. Chemotherapy
21. Circumcision
22. Clinic
23. Coronary Care Unit
24. Cytology
25. Delivery Room & Labor Room
26. Dental Services
27. Detoxification Icu
28. Drugs Charged To Patients
29. Durable Medical Equipment Rented
30. Durable Medical Equipment Sold
31. Echocardiography
32. Ekg And Eeg
33. Electrocardiology
34. Electroencephalograpy
35. Electromyography

Hospital Financial Categories/Centers
36. Electroshock Therapy
37. Emergency
38. Endoscopy
39. Family Practice
40. Federally Qualified Health Center
41. Gastro Intestinal Service
42. Hematology
43. Histology
44. Holter Monitor
45. Home Program Dialysis
46. Icf/Mr
47. Immunology
48. Intensive Care Unit
49. Intravenous Therapy
50. Laboratory
51. Laboratory Clinical
52. Laboratory Pathological
53. Mammography
54. Medical Supplies Charged To Patients
55. Mri
56. Neonatal Icu
57. Nuclear Medicine Diagnostic
58. Nuclear Medicine Therapeutic
59. Nursery
60. Nursing Facility
61. Observation Beds (Distinct Part)
62. Observation Beds (Non Distinct Part)
63. Occupational Therapy
64. Oncology
65. Operating Room
66. Ophthalmology
67. Osteopathic Therapy
68. Other Ancillary Cost Centers
69. Other Long Term Care
70. Other Reimbursable Cost Centers (Excl. Hha & Corf)
71. Pbp Clinical Lab Service Program Only
72. Pediatric Icu
73. Physical Therapy
74. Premature Icu
75. Prosthetic Devices
76. Psychiatric / Psychological Services
77. Psychiatric Icu

Hospital Financial Categories/Centers
78. Pulmonary Function Testing
79. Radioisotope
80. Radiology - Diagnostic
81. Radiology Therapeutic
82. Recovery Room
83. Recreational Therapy
84. Renal Dialysis
85. Respiratory Therapy
86. Rural Health Clinic
87. Skilled Nursing Facility
88. Speech Pathology
89. Stress Test
90. Subprovider
91. Support Surfaces Sold
92. Support Surfaces Rented
93. Surgical Intensive Care Unit
94. Telemedicine
95. Trauma Icu
96. Ultra Sound
97. Urology
98. Vascular Lab
99. Whole Blood & Packed Red Blood Cells

Table 27 Average Total Medical Supplies Charges as a % of Total Medical Supplies Costs by State

Rank	State	Medical Supplies: Average Total Charges as a % of Total Medical Supplies Costs by State
1.	DE	2238.03%
2.	HI	976.01%
3.	AL	699.32%
4.	PA	631.20%
5.	CA	607.67%
6.	IL	592.17%
7.	AZ	556.80%
8.	MS	556.11%
9.	FL	514.31%
10	WI	487.84%
11	NY	482.52%
12	AR	474.56%
13	SC	467.49%
14	NJ	459.46%
15	NV	457.26%
16	LA	455.28%
17	MO	443.56%
18	GA	438.20%
19	TX	412.75%
20	PR	409.75%
21	TN	405.07%
22	ME	396.30%
23	CO	390.25%
24	IN	379.18%
25	DC	377.53%
26	VA	373.72%
27	KS	372.74%
28	OH	365.93%
29	MI	359.30%
30	NC	352.09%
31	MA	351.28%
32	WV	325.99%
33	NH	319.76%
34	MD	313.33%
35	MN	312.75%
36	OK	311.63%
37	NM	309.74%
38	KY	307.33%
39	NE	285.49%

Rank	State	Medical Supplies: Average Total Charges as a % of Total Medical Supplies Costs by State
40	IA	285.49%
41	CT	280.33%
42	SD	276.09%
43	MT	273.53%
44	VT	252.26%
45	WA	250.43%
46	UT	249.18%
47	WY	241.64%
48	AK	237.93%
49	ND	230.59%
50	OR	228.51%
51	ID	225.51%
52	RI	215.91%
53	VI	147.38%
	Wtd. Avg.	**432.96%**

Table 28 Average Total Drug Charges as a % of Total Drug Costs by State

Rank	State	Drugs: Average Total Charges as a % of Total Drug Costs
1.	CA	710.59%
2.	FL	612.96%
3.	NV	558.91%
4.	AL	543.93%
5.	SC	528.30%
6.	LA	497.23%
7.	GA	466.18%
8.	AZ	458.70%
9.	CT	457.25%
10.	TX	452.27%
11.	MS	447.14%
12.	PA	445.42%
13.	TN	423.79%
14.	AR	419.01%
15.	OK	415.91%
16.	NC	405.10%
17.	IL	393.58%
18.	MO	391.89%
19.	NJ	387.55%
20.	CO	383.52%
21.	NM	355.56%
22.	VA	355.42%
23.	WV	343.78%
24.	KY	328.96%
25.	DC	328.47%
26.	KS	307.79%
27.	ME	307.39%
28.	IN	306.33%
29.	NY	303.46%
30.	NH	296.69%
31.	OH	292.80%
32.	SD	290.64%
33.	PR	290.01%
34.	MI	285.77%
35.	NE	284.23%
36.	IA	283.81%
37.	WI	281.87%
38.	WY	279.08%
39.	OR	276.68%

Rank	State	Drugs: Average Total Charges as a % of Total Drug Costs
40.	WA	264.38%
41.	RI	263.00%
42.	MT	261.22%
43.	UT	260.09%
44.	MN	259.15%
45.	MA	257.05%
46.	HI	255.90%
47.	ND	245.01%
48.	ID	235.43%
49.	AK	235.42%
50.	DE	233.49%
51.	VI	204.13%
52.	VT	187.31%
53.	MD	133.85%
	Wtd. Avg.	**398.65%**

Table 29 Average Total Operating Room Charges as a % of Total Operating Room Costs by State

Rank	State	Operating Room: Average Total Charges as a % of Total Operating Room Costs
1.	CA	446.01%
2.	FL	441.42%
3.	NV	355.06%
4.	VT	343.27%
5.	PA	338.32%
6.	AZ	337.46%
7.	AL	330.70%
8.	LA	317.65%
9.	DE	305.64%
10.	TX	300.33%
11.	SC	292.75%
12.	NJ	290.01%
13.	CO	288.54%
14.	AR	281.32%
15.	GA	280.67%
16.	OK	279.88%
17.	RI	279.07%
18.	KY	279.02%
19.	VA	274.40%
20.	MS	273.71%
21.	TN	268.36%
22.	MO	261.16%
23.	OH	260.19%
24.	DC	259.73%
25.	ME	259.46%
26.	KS	258.48%
27.	NM	257.24%
28.	NH	249.40%
29.	WA	248.08%
30.	SD	247.82%
31.	MA	247.65%
32.	IL	245.16%
33.	MI	242.01%
34.	IN	240.17%
35.	NC	240.11%
36.	ND	236.52%
37.	NY	234.03%
38.	WI	233.46%
39.	WY	232.03%

Rank	State	Operating Room: Average Total Charges as a % of Total Operating Room Costs
40.	IA	226.09%
41.	MN	225.36%
42.	CT	224.68%
43.	OR	219.87%
44.	HI	217.71%
45.	PR	215.86%
46.	UT	213.53%
47.	WV	201.04%
48.	ID	200.98%
49.	MT	198.63%
50.	NE	188.79%
51.	AK	148.11%
52.	MD	133.69%
53.	VI	122.48%
	Wtd. Avg.	**284.00%**

XI. Addendum

A. Background on Hospital Charges

This is the second annual ISHP Hospital 200 report detailing the total gross charge to cost ratios of the U.S. hospital industry. Our first report on hospital pricing, issued in the Summer of 2003, (28) generated considerable criticism from hospital industry quarters to the effect that hospital pricing practices are 'irrelevant' (see the discussion below) while some others (89) agreed that hospital pricing practices are a matter of urgent concern.

Prior to our 2003 study (and currently) public interest and the majority of inquiries into hospital pricing practices were largely limited in scope, save in their concern with the financial plight of the uninsured.[47] (23;50;53;57;102;124;133;135;163;172).

Unlike the vast majority of past studies into hospital pricing, our study findings suggest that:

- Higher hospital charge to cost ratios tend to be strongly associated with higher hospital profits.
- Higher charges per inpatient discharge **alone** are also strongly associated with higher hospital profits.
- Larger hospitals tend to have a richer pricing structure than smaller facilities.

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[47] *Scott Ferguson, a retired artist without health insurance, was billed $66,900 for treatment of a heart condition at St. Anthony Central Hospital in Denver last December. If he had had insurance, his attorneys claim, the tab would have been about $10,000*. (38)

- System-affiliated hospital pricing is on average greater than unaffiliated hospital pricing; that is, the anticipated reduction in charges from building economies of scale has not occurred. (69;73-75;80)
- Market mechanisms – embodied in what may be termed the "Health Care War Economy" (27) – are the "drivers" behind hospital and medical price inflation generally.(99) Drug prices, premium rates, medical equipment costs, etc., are the consequent **symptoms** or **results** of the subjugation of health care to anachronistic market ideals, not **causes** of medical inflation. It is the mistreatment of health care as a commodity that strongly encourages higher hospital charges.

Only one earlier research project of which we are aware involving hospital charges found that higher pricing was often associated with higher profits. (167). In contrast to our 2003 analysis and our current 2004 hospital pricing study, which encompasses more than 4,000 hospitals and 30,000,000 inpatient and outpatient discharges, that study was relatively modest and examined a limited number of cases:

> *An assessment of data on the average charges of hospitals in the area showed that Menorah Medical Center had the highest charges in 1988 for five of 17 of the most frequently performed procedures. North Kansas City Hospital and Research Medical Center had the highest average charges in four categories each.*
>
> *Menorah, however, lost $1.8 million during the corresponding fiscal year while North Kansas City made $17.9 million and was one of the state's most profitable hospitals. Research made $9.4 million that year.*
>
> *That assessment is based on average charges by Kansas City-area hospitals and their profits. The analysis by the Kansas City Business Journal also compared the increase in average charges for the most common inpatient procedures.*
>
> *The analysis is based on a just-released 1988 voluntary charge study by the Missouri Hospital Association. That data was compared to average charges in 1987, released by the hospital association last year. (167)*

Concentrating on ratios of reimbursement to cost rather than charge to cost ratios, a 1974 study of 32 San Francisco Bay area hospitals' drug reimbursement ratio found that the average reimbursement to cost ratio was 261%, with a low of 165% to a high of 491%. (172)

Employing 1980 data, an examination of South Carolina hospitals found that the average charge to cost ratio for hospital pharmaceuticals was 199%. (105) Data employed in the IHSP current study indicates that South Carolina's charge to cost ratio for hospital drugs has increased to 528%. In marked contrast to

the South Carolina study, which found no relationship between the magnitude of charge to cost ratios and multi-hospital affiliation, our study demonstrates a strong correlation (Tables 9, 10 and 15). Of 289 systems scrutinized in our study (see Table 17 especially), non-affiliated hospitals ranked number 200; that is, considered **as** a "system," two-thirds of all other hospital systems have a greater charge to cost ratio.

In part, the inquiry into South Carolina hospitals found:

> *The relationship between pharmacy pricing policies and overall hospital objectives was analyzed for 64 South Carolina hospitals in 1980. ….. The level of hospital use by Medicare and Medicaid patients had the greatest influence on variation in markup, indicating that hospitals were responding to cost-based payer reimbursement practices by raising charges in areas with a high cost base, such as pharmacy. Nonoperating revenue and operating revenue of departments other than pharmacy also were significantly related to the charge-to-cost ratio….. The hospitals studied set pharmacy revenues to contribute to overall target income, but pharmacy prices were not set to achieve maximum profits by responding to changes in demand.* (105)

In 1989, a little known survey by the Florida Health Care Cost Containment Board monitored charges for 215 hospitals. Then, as is presently the case, lawsuits followed:

> *Orlando hospital administrators, their attorneys and the Florida Hospital Association are carefully monitoring a series of class-action lawsuits that threaten to forever change the way state health care facilities price their services.*
>
> *Fourteen class-action lawsuits have been filed against separate hospitals throughout the state in the last three months, each claiming that some pricing practices are exorbitant.*
>
> *The suits have been filed against hospitals in Daytona Beach, Delray Beach, Gainesville, Jacksonville, Palm Beach, Tampa and several other communities.*
>
> *In a suit against Humana Hospital in Brandon, attorneys cite a $9.23 charge for four Tylenol tablets. A suit against Palm Beach Gardens Memorial Center alleges a $54.30 bill for a sponge. Other examples include $5.80 for two multiple vitamins and $37 for a bandage.*
>
> *Delray Beach attorney Richard Collins says that while such pricing strategies may be "customary," that doesn't make them fair. Collins is one of three lawyers helping to spearhead the lawsuits.*
>
> *Collins says his clients feel many high-priced, everyday items are unreasonable, "nothing short of blatant price gouging, symptomatic of a system out of control."* (151)

Other studies have been concerned with:

- Higher charge to cost ratios as a function of cross-subsidizing hospital losses in "cost centers" as distinct from "revenue centers;"(52;63;83;98;108;129;155)
- The relation of hospital charges to various Diagnostic Related Groups (19).
- The impact of charges imposed on the poor by multi-hospital systems (82).

Mass media coverage of potential and filed lawsuits on behalf of the insured, legislative hearings, and investigations by government bodies – as distinct from more formal academic studies – have for years been sources of much information on hospital pricing practices. (23;43;44;44;50;51); (3;17;29;55;57;90-92;103;119;120;122;123;133;135;151;156-158;168;173;179)

Congress has held two recent hearings focusing on hospital pricing practices. The first hearing was on June 22, 2004 before the Subcommittee on Oversight of the Energy and Commerce Committee.

> *The indications are that—at least in some cases—Greenwood is not yet at the point of urging policy solutions as hard-nosed as his hearings.(17)*

In 1991, the House Energy and Commerce Committee's Subcommittee on Oversight held hearings into pricing in Humana's then 77 hospitals (which was spun off to become Galen, which in turn was purchased by Columbia/HCA). (29) John Dingell, then chairman of the subcommittee, stated the following:

> *The now-famous $640 Pentagon toilet seat pales in the face of some these hospital charges*. (86)

In the months following our first IHSP Hospital 200 report on charge to cost ratios, many people have become aware that high hospital pricing structures are a national problem. Few, however, are aware of its magnitude. From very small systems to the some of the largest and most prestigious of independents, high charges are not uncommon.

B. Study History

In a previous national investigation of hospital charges and costs, the IHSP documented the Nation's Top 100 Hospitals with the highest Operating Room charges compared to costs (101) for the 1999/2000 federal fiscal year.

That report found that investor-owned hospitals and large hospital systems dominated the top 100 highest charging operating rooms in the U.S. The average charge to cost ratio in their operating rooms was about 227%.

Nationally, for-profit hospitals comprised 61 of the Top 100, of which 44 were owned by large investor-owned systems. For-profit hospitals accounted for 9 of the top 10. Multi-hospital systems made up 79 of the Top 100, suggesting a strong correlation between both for-profit and large hospital chains with enhanced market share and high operating room charges. (See Table 21 for 2002/2003 data on operating room charges as a percent of operating room costs).

That report prompted criticism from some quarters, notably hospital executives, to the effect that although the report's charge to cost calculations were probably accurate, operating room charges are only one line item in the reports that hospitals must file with the federal government and they do not give a complete picture of a hospital's "… entire scope of the stay(s)…" (159)

> *"They've taken a piece of the cost report which every hospital files with Medicare, with the government, and they've taken one line which is the relation of cost to charges for the operating room." Busatti added.*
> *In other words, Wesley says the study only looked at what it costs to be on the operating table, not what it costs for everything else.*
> *"If our pharmacy charges are less, if our radiology charges are less, that's the entire scope of the stay. It's not just your operating time." (159)*

Later in 2003, the IHSP released a much more comprehensive charge to cost study, encompassing more than 4,000 hospitals nationwide and tens of millions of inpatient and outpatient discharges. (28) That report prompted similarly severe criticisms from some hospitals, which maintained that they did not receive as payment all that they charge and consequently charges are irrelevant, particularly since, they stated, reimbursement rates are fixed by payers such as Medicare, HMOs and others. Further, critics claimed, their high charge to cost ratios are simply a reflection of their greater efficiency and they should not be publicly censured on that basis.

Typical of that criticism was the following:

> *Gregory Duick, chief executive of the Kansas Heart Hospital and one of its founders, said the hospital's charges are "very similar" to the amounts charged for the same procedures at Wichita's major hospitals, Wesley and Via Christi Regional Medical Center.*
> *But, he said, Kansas Heart Hospital's costs are lower, resulting in a greater cost-to-charges ratio.*
> *Asked why the hospital doesn't simply charge less, Duick said, "Why would we penalize ourselves for our own efficiency? The real question is why can't the other hospitals lower their costs?"*
> *Wesley's chief financial officer, David Busatti, called the numbers in the report "irrelevant."*
> *"We establish a charge based on the cost of the procedure plus a small mark-up," he said. "We charge the same to everybody. But that's not what we get paid. Ninety percent of our patients are either Medicare or covered by contract payers."*
> *He said the cost-to-charge ratios were taken from reports filed by Wesley with the federal government, and he did not dispute their validity.*
> *"I'm sure the numbers are correct," he said. "But again, the charges are irrelevant because that's not what we get paid." (97)*

It should be noted that, contrary to hospital industry straw-man allegations, the IHSP did not then – and does not now – maintain that hospitals habitually receive 100% of gross charges as reimbursement, only that gross charges are a crucial variable – a starting point in the reimbursement negotiations process - in determining actual reimbursements from a number of payers, including Medicare, Medicaid, HMO contractual agreements, and workers compensation programs. This fact, in contrast to the initial publication of our first IHSP Hospital 200 report, is now widely accepted. However, recent accounts have focused on the uninsured and the fact that they *are* often billed at full charges. (42-44;50)

Paul Ginsberg, president of the Center for Studying Health System Change, also conveyed his concern about hospital gross charges or “list prices:”

> *Gross charges are important to payer issues beyond Medicare outlier reimbursements, said Paul Ginsburg…*
>
> *Among federal policymakers, Ginsburg said, there "is a belated recognition of the fact that there are some categories of services that have long been more profitable than others. The source of this has to be in the charge system." These profitability distortions, amplified by rapid increases in gross charges, have resulted because of productivity improvements in some clinical areas, such as cardiovascular and orthopedic services, he said. Fewer such gains have been made in treating medical admissions, he added, so these DRGs tend to be money-losers.*
>
> *General hospitals–not to mention specialty hospitals and surgery centers–have followed those incentives and have invested in the profitable services and downplayed the unprofitable services or, in other words, skewed their case mix to favor the lucrative services, Ginsburg said. That has thrown the overall fairness of the Medicare reimbursement system out of whack, he said.* (89)

Our previous IHSP Hospital 200 report (28) and the current study both address and refute those criticisms and employ data sets that only recently became available. They do so by first calculating aggregated inpatient and outpatient total charges to total costs for the major hospital financial categories/centers commonly found in federal hospital cost report filings. These include 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.

Secondly, our reports demonstrate the relationship of gross charges and costs to average hospital profits. Such an examination is particularly useful in understanding why and how it is that at the national level, on average, the greater a given hospital decile total charge to cost ratio, the greater its net income benefit. Perhaps even more tellingly, the report also shows that on average, **the greater the charge per inpatient discharge alone, the greater the net income**. Tables 14 and 15 in this report examining profits in relation to total charge to cost ratios and profits by individual inpatient patient discharges alone for 4,184 hospitals and more than 30 million patient discharges in fiscal year 2002/2003 clearly articulate the exceptionally positive correlations among a) high charge to cost ratios, b) charges per patient discharge alone and c) average hospital profits.

Finally, the pedantic neo-classical economic conceptualization of “efficiency” employed by some hospital executives when referring to their lower costs and/or subsequent overall charge to cost ratios should be clarified.

> *Asked why the hospital doesn't simply charge less, Duick said, "Why would we penalize ourselves for our own efficiency? The real question is why can't the other hospitals lower their costs?" (97)*

What can be termed “technical efficiency” in any given business enterprise has absolutely no necessary relation to the “social efficiency” the product of that enterprise may engender.

Technical efficiency refers to such activities as throughput, “cycle time,” the ratio of capital to labor (the substitution of technology for employees, or degree of mechanization), etc.

Social efficiency, by contrast, is directly concerned with the social value of a given firm’s product, in this instance, both the quantity and quality of health care made available by a given hospital and the expense associated with that quantity and quality.

Viewed from this perspective, it becomes clear why the burden is not simply on other hospitals to lower costs and achieve a greater degree of technical efficiency via a higher charge to cost ratio. In a nation with nearly 44 million uninsured, the burden is on those hospitals with a high charge to cost ratio to lower their charges, increase the quantity and quality of care available to all, and thereby give preference to social and not mere technical efficiency, simultaneously lowering overall medical inflation.

C. General Observations on Scientific Method

Subsequent to the initial release of last year’s study (28), some hospital systems, particularly those found to have charge to cost ratios well above the national average, have been critical of the study findings. However, none have spoken to the methodology employed, while continuing to claim that gross hospital charges are irrelevant because actual reimbursement rates are “fixed.”

Elements within the industry that had significant higher than average charge to cost ratios displayed a marked unwillingness to address either the applicability of the data sources (federal hospital cost reports)

or the study design and methodology. (61;89;126) Exemplifying such unwillingness, hospitals with higher than average charge to cost ratios simply

> … *decline(d) to make specific comments on the validity of the methodology used* (89)

By contrast, those individual hospitals or chains found to be at, below, or only slightly above the national average were, while also on the whole silent about the study methodology; quick to claim that the IHSP study demonstrated they deliver quality care at affordable rates. (72;132;134) Given all this, we believe it is appropriate to clarify in relatively simple terms those design criteria that we feel are common to all sound research programs.

We present below a very brief enumeration of design criteria to which we believe any social science study should adhere. Other criteria are germane, too; however, they tend to be derivatives of these basic principles. For example, if sampling is employed in the study design, it should be representative (a derivative of the Integrity of Data Sets criterion) and the sampling method should be clearly articulated (a derivative of the Transparency of Design criterion).

All adequate study designs adhere to sound and widely accepted principles of scientific practice. Among them are:

1. **Replicability of findings**

The findings of any given scientific study must be able to be replicated by other analysts employing the same methodology and the same data. This is a crucial component of validity testing in any study design and is related to the Transparency of Design criterion.

2. **Transparency of design**

Transparency is a necessary condition of any good design. In the present instance, it is particularly necessary for future studies on the relation between hospital charges, costs, reimbursements and public access to care.

3. **Open data architecture, format and structure**

Clearly stated methodology
Non-proprietary data sets

4. **Consistency of data format and structure across study period**

Without a consistent data format and structure across the study period, no comparative analysis is possible within the study period or with future studies.

5. **Demonstrable mechanism of action, i.e., relevance between antecedent conditions and study object**

Both the selection and relevance of variables logically and formally precede statistical manipulation and examination of them. However, there is apparent widespread confusion in the literature on this basic research criterion. Many researchers have designed models with insufficient attention to the relevance of the variables to be initially included. Those designs proceed as though variable relevance **reduces** to a product of mathematical and/or statistical examination. If that were so, a model design whose object was to determine the cause of the sun rising **could** include the crowing of roosters.

6. **Integrity of data sets**

Original data sets must not only have an open architecture but must in so far as possible accurately reflect the phenomena they purport to describe.

7. Design model must take into account both the possible confirmation and disconfirmation of principal findings/hypotheses

A given design model must not fall victim to a *self-fulfilling prophecy* flaw; that is, the model **itself** must provide a mechanism by which its hypotheses could be subject to disconfirmation. Common occurrences of this flaw take the following forms:

- Only data which can confirm hypotheses are selected for inclusion in the model; all other data are excluded,
- the hypotheses to be tested are so trivial that confirmation is guaranteed,
- the confirmation and disconfirmation mechanisms within the model – statistical, observational, or otherwise – are constructed to **improve** the likelihood of confirming hypotheses confirmation and to **decrease** the likelihood of disconfirming them.

Strict adherence to these general canons of scientific practice is reflected in this report.

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