

Providing Meaningful Pricing Information

Many patients today are more aware of the costs of their health care as their portion of payment responsibility increases. Yet hospitals find providing them with meaningful estimates before they receive healthcare services often proves to be a complex task due to the variety of factors that go into building a charge as well as differences in health plan coverage and variability in patient health needs. HFMA, with sponsorship from Cerner, recently brought together a group of senior healthcare finance executives to discuss hospital efforts toward providing patients with accurate and meaningful pricing information. The following is a highlight of the discussion.

Rappuhn: What does pricing for health care mean from the patient's perspective?

Rooney: I think price is a very nebulous concept to most people. For a simple service, like a lab test or an X-ray, patients ought to know what it is going to cost. But when someone has a health problem that's undiagnosed, it is more complicated for the hospital to provide the patient with a cost estimate for total care. There's a logical approach by the physician to the diagnostic process, but there's nothing in place to provide patients with a price estimate for each diagnostic procedure that they will need to receive. Service after service will be provided until the patient's physician figures out what is wrong. However, as people become more aware of payment responsibilities tied to these diagnostic services, I think they're going to start asking prior to testing, "What is this going to cost me?"

Chen: I think another important consideration is that consumers expect a lab test at one hospital to be similar in price to the same test at another hospital. So what folks really need is more education on how today's healthcare system works from a price standpoint.

Rappuhn: What can hospitals do to help educate patients on pricing and answer their questions?

Chen: Our facilities are struggling with the same thing that everybody else around this table is: How can you help consumers know what their payment responsibility will be up front? It's turning the industry upside down as we try to be more open about what a patient is potentially going to have to pay based on the insurance level carried.

It seems like the real issue is how the hospital's front line staff can best educate patients about how their insurance coverage will work for them. Often, when we as healthcare executives are reading our own benefit plans, we have to stop and think, "OK, what did that just tell me?" For individuals not in health care, understanding their plan can be an insurmountable task—even when they're communicating with their company's benefits department. So first and foremost, hospitals need to think education, education, education.

Anderson: I agree with the need to have better informed front-line staff. I would also say that we need to tailor patient education to meet the needs of our customers who are covered by some sort of insurance and also those who are self-pay.

For those patients covered by insurance, it really comes down to helping them understand their benefit design: coverage and limitations, deductible, in- and out-of-network benefits, co-insurance amounts, whether secondary coverage is available through a spouse, and how all this coverage works together.

You might be able to educate insured patients about what your hospital charges, but that may not be the actual amount that they will be paying given their specific benefit design. Patients need to be educated about their benefit design and benefit plan document so that they can ask the appropriate questions and understand how much they are going to pay. They need to know that it's not enough to

make a quick phone call and say, "How much does an MRI cost?" because that may be meaningless to someone with insurance coverage.

Rooney: What we've discovered is that when people ask about price, what they're really asking is, "How much is it going to cost me?" And because of differences in insurance plans, the answer is, "It depends." It's hard for the public to accept this response. Yet even different Blue Cross plans have different levels for the patient portion of the cost.

My hospital's managed care representative has put on a seminar for the community called "Making the Most of Your Managed Care Plan." People don't know how to maximize the benefits from their managed care plans. What's interesting is how many of our own hospital employees show up for that seminar.

Nelson: There's another element that comes into play and makes estimating cost for the patient difficult: When someone comes in with three or four plans listed on the insurance card. We can look up in all of the multiple contracts to try to figure out what the cost is, but the problem is that these insurance companies will go out and pay us the lowest rate based on the various network contracts they have signed, this is what we call "silent PPOs". So you really don't know what the patient's cost will eventually be, because the insurance company is going to get your claim and run it through all its repricers based on what the cheapest rate is, and then apply it through that contract back to the hospital.

This becomes a difficulty for our business office as well as for the admitting staff, because how do you explain to the patients that we are unsure what their plan will pay or what the patient's copayment will be? It's a big problem if I give you an estimate and the final cost ends up completely different.

Rappuhn: Is there something you can do proactively, either with your contracting or with systems or technology, to keep that from happening?

Nelson: We try to provide some control with our contracting efforts, in terms of noting that when we do a contract with a network that they can't resell to another group and so

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Paul Ziegele, CPA, CFO at Adventist LaGrange Memorial Hospital, LaGrange, Ill., a member of Adventist Midwest Health.

Representing the roundtable sponsor were **Ken Cyr,** solution consultant; **J.P. Fingado,** vice president of solutions sales operations; and **Carmen Voelz,** manager of solution consultants, from Cerner Corporation.

The moderator for the discussion was **Terry Allison Rappuhn,** CPA, project leader for the PATIENT FRIENDLY BILLING® Project, a collaborative endeavor spearheaded by HFMA to promote clear, concise, correct, and caring patient financial communications.

forth. But that doesn't really prevent it, because then you're talking about all sorts of other actions and how you're going to enforce anything. So that has been difficult for us.

Alton: We're seeing more consolidation of some of those networks. It's hard to stay away from them.

Rappuhn: What types of information would be necessary to provide patients with information about pricing in advance of the service or at the time of service?

Doyle: You need their insurance benefits. If there wasn't insurance involved, then pricing would have some meaning. What we need, effectively, is for the insurance companies to create a network that would allow people to see what their out-of-pocket is going to be, because the bulk of what they're going to pay is related to their employer's choice from among a variety of options and benefits based on how much exposure they're going to give to the individual. The hospital's charge is really almost irrelevant.

Ziegele: And even if you did have that perfect package of all of the things that the hospital would need to know to price the services out, I question how much of that activity you would want performed on your front end by scheduling staff anyway. You would make it so difficult for a patient to get access: It would be a 10-minute call just to get somebody scheduled because of all the questions the hospital would have to ask. A competing hospital might just ask for the patient's name and a few other things, and then have someone call to get more information later; some people might find that method more convenient. So it's a balancing act trying to provide the best service.

Nelson: What patients don't want to hear is, "Well, this isn't a guaranteed price." But it can't be a definite amount because of complications that may arise during a procedure. Of course, everybody expects that everything is going to go perfectly and there won't be any problems, but when you are providing pricing for customers, you have to throw in caveats. You can tell them, "Based on our general average procedure, here's how things work," but then you have to add, "if you have complications, it could be two to three times more, depending on what's going on."

Rooney: That's true. Even if you have perfect benefits information, there's still a problem of expectations. For example, a hip replacement is a pretty routine procedure, at least in our hospital where we do about 900 a year. Most of those cases are exactly three days and the costs are very similar. But if a patient has complications of some kind, it could be twice the usual cost.

Doyle: People want to know what things cost, but when you introduce the variability of the human being into the process, they don't want to hear about that. They want us to take on the risk of "package pricing."

Another question is: As a hospital in a network, do you want to be known in your market as the low-cost provider or the high-cost provider, given the nature of the product? Will patients particularly welcome the notion of having bought the cheapest care in town?

Rappuhn: Are you seeing more sensitivity from your patients to price? Are you getting more questions from patients about what something costs? If so, how do you handle that?

Nelson: We give out estimates. We will do an estimate worksheet for patients based on their insurance and what we know. But we try to make it clear that this is an average case, and does not include the costs of any major complications.

The general public just is not aware of how the pricing system became what it is today. At one time, payment was cost-based. Then everybody went to DRGs and the PPS



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(prospective payment) system, and all of a sudden payment was less than cost. Hospitals were forced to find ways to recover those costs. So we had to raise prices, but then the commercial payers wanted discounts off those prices. So now, we're in a situation where we've raised prices to a level that some people think is astronomical.

And nobody considers that the prices are not what we collect. At our hospital, on average we collect about 35 cents per dollar that we bill. That's a huge discount—I don't expect to get full charges. Yet that is the outcome when the insurance industry has pushed hospitals to attempt to cover costs. The general public doesn't understand this, and I think that's "shame on us." We probably should have been educating the public about this payment process over the years.

Rappuhn: So when you're dealing with that situation, where your charges are so different from what you're ultimately going to get paid, and the patient wants to know what the cost will be, what kind of data do you need? To what extent do you look for data to be able to make that estimate?

Nelson: We just need to know the orders from the physician—we have to have that so we know what the tests are—and basic insurance information from patients: Are they covered by Medicare? Are they covered by Medicaid? What is their commercial coverage? Are they uninsured?

We have a basic discount if someone is uninsured; so we are able to provide an upfront discount for those patients. If we have some additional information, such as the patient's income, we can advise them on whether they qualify for one of our charity care programs. We will work with our patients along those guidelines, but it's a lot of basic information they still have to provide for us on the front end.

Chen: At Hinsdale, our process is very similar. It's a very manual process. We also had a situation come up recently where a patient wanted to know what his payment responsibility would be for a procedure provided by a particular physician. We had to go back and look at average charges for the procedure over the past six months by the physician. It took some time to gather this information. Unfortunately,

the patient wanted the information right then and there. He didn't want to wait and was very upset that it was that way.

So, you may ask, what is it going to take in such a situation to be able to pull that sort of data more quickly? It is information systems that are built around looking at charges in that manner. Today, more often than not, we have to run several reports, look at them, aggregate the data, and then say, "OK, this is what we believe the charges might be."

Again, at the end of the day, we're still providing consumers information on what the charges might be. But it's not addressing what they really want to know: "How much is going to come out of my pocket?" That's where it comes to getting that other benefit information that we don't always have—up front—and then being able to calculate through.

Rappuhn: Do any of you have to go down into the clinical data to be able to get a good estimate? Or are charges and benefit plans enough to make those estimates?

Rooney: We do rely on clinical data. We have a pretty good cost accounting system, and my decision support person actually has final pricing authority. Our patient accounting people work with our decision support person. They will actually call the physician's office and get the best understanding they can of what the patient is having done, look at what has been charged for these services in the past, and come up with a price.

These requests for pricing information are almost always from people who are uninsured. We have a significant segment at our hospital who are essentially self-insured—a lot of immigrants who don't or can't afford to have insurance. They like to pay cash, and they want to know the price. So we'll look in our decision support system and work on a price that approximates what we would be paid by, say, Blue Cross. They have to pay almost all of it, but not all of it up front.

Nelson: We have a similar policy.

Rooney: It's important to note, however, that we don't say, "But there could be complications." We'll say, "That's the price." So far we have not been attempting pricing

for heart surgeries or brain surgeries; we have only been pricing services that are a little more straightforward. Still, we are taking a little bit of a risk on that.

But to follow up on someone's previous point: Health care is a highly customized service. If you are going in for an annual physical, pricing for that service might be fairly routine. But most healthcare services depend on resource utilization at the individual level. For something like a hip replacement, chances are the person would receive a certain combination of screws and plates that would be a little bit different from the patient prior. The variability in clinical needs is pretty amazing, actually.

Anderson: I think most hospitals have an adequate system in place to provide a reasonable estimate of billed charges and ultimately, if the insurance information is correct, the patient's portion of payment responsibility for the service. But I think you have to consider yet another variable to determine the patient's true out-of-pocket costs, and that's the physician professional fee component.

You have a level of complexity in health care. You have physicians involved, and you have highly complex variability in treatment that has been described. To consumers though, many think that it should be as easy as making one telephone call to receive a complete and accurate price for all the physician and hospital-based components that are involved—and unfortunately, it may not be that simple.

Ziegele: If you look at cataract surgery, a very simple procedure, our top-to-the-bottom physician charges vary by 33 percent to 50 percent. You would take on significant risk making that price quote.

And really, to get to the heart of what we're talking about, right now the people who are calling to ask for pricing tend to be the exception. For some providers, it's going to be so time-intensive for us to pursue the random individual situation that we're just going to be forced to develop more efficient processes so we have this information sitting on the shelf. Right now it's hard to make the decision to devote resources this way, even if it's the right investment of time.

Rappuhn: In the latest Patient Friendly Billing task force, we talked about this at some length. A couple of the hospital systems had been doing advanced estimates in a pretty major way for four or five years—not just a couple of estimates, but thousands. They said that as you provide pricing information more frequently, you get a lot better at it. A lot of other CFOs said, “We can't do that,” but then the ones that have been doing it said, “You'd be really surprised at how close you can get over time.”

Ziegele: What tools are they using?

Rappuhn: One of them described it as a lot of “muscle power,” and the other has built a database. The first one is looking at adding more automation now.

Rooney: If you have a good decision support system, really it isn't that hard. It takes some time. If you take that to its logical conclusion, where it's something you're doing every day, would this—over time—reduce variation in medical practice? Maybe your chief medical officer would have a whole new role, with a goal of reducing variations so that you can give a more reliable price.

O'Connor: We haven't really talked about the operational issues. We have one decision support analyst, who is very highly paid and is typically being pulled off some significant activity to help come up with these price estimates—not the best use of his time.

It also takes an enormously skilled registrar, scheduler, or customer service representative to perform these pricing tasks, and this is important to consider because these individuals are a patient's first access to the system. To train these staff to give the same, consistent information is highly resource-intensive. I'll be honest with you—it's very expensive, because you have to train them like a clinician. If the patient is having a colonoscopy, is it a level I, II, III, IV? If the patient is going to need a CT scan, is it head/head-neck, with/without infusion? These types of things all change the price of the procedure.

As a premier healthcare facility, we've been left holding the bag when costs don't go as estimated. We have a guaranteed service policy: if we provide incorrect information or something unanticipated happens, we may end

up fully waiving the charges. Our policy exacts a certain amount of financial pain on the organization, but it is in line with our mission.

We've also found the process of providing pricing estimates tends to result in patient dissatisfaction, partly because it takes a long time to explain the pricing system to patients and you're always calling them back. Also, expectations aren't met if patients get their bill and the amount due isn't what you said it was going to be—because all patients hear is the number attached to the estimate; they remember the number and not the qualifications of “complications not included” or “other physician professional fees are not included” that are attached to the estimate.

Rappuhn: So did you have to change your processes? What did you have to change?

O'Connor: When we first started getting these calls, every call went straight to a manager. Well, the managers realized that they couldn't devote four hours a day just to these types of calls. Fact-finding missions resulted in calls around the entire hospital. We then looked organization-wide to implement tools and centralize requests.

Right now, our customer service department is responsible for any quotes on prices. But, again, the patients typically come through the scheduling department. So when you're looking at a simple procedure, it's a slam dunk. The hospital charges this, pathology charges that, here are the technical and lab fees, and we're done.

But when you get into anything that might be a more nebulous procedure, we have a really tough time. We don't package—we don't write up an estimate or give them a guarantee. We haven't taken it to that step. It hasn't improved patient satisfaction, but we do whatever it takes within reason to make it right.

Rappuhn: Has anyone used this kind of conversation to segue into how the patient will pay for the anticipated amount due?

Chen: I'd say at our facility, the answer is no. We have one individual dedicated to putting together the price quote, and that's not the same individual who would be talking to the patient about scheduling or how the patient is going to pay.

But you bring up a really good point. Going forward, I think if we're going to have these conversations with the patients, optimal service delivery will entail having the whole discussion at once, from “What are you coming in for?” and “When would it be good for you to come in?” to “How will you be paying?”

But then you also would need to look at how the information needed to have these conversations can be obtained within a short time frame. The consumer is not going to want to spend half of an hour on the phone with you. And on top of that, no one wants more than one call. So how do you strike a balance between the need for accurate information and the patient's desire for a timely response?

Alton: At a past employer, we had implemented centralized scheduling and had moved most of our collection people up front in the process. When the schedulers were calling, they were verifying appointments and ability to pay and potentially getting back to the consumer on pricing.

We did ask for deposits; we had a collection policy approved by the board. If they were self-pay or uninsured/underinsured, we were looking for either deposits or payment plans—at least some commitment to pay something up front before the service was provided. And actually, once we educated the community about the program, it was relatively well accepted. We really didn't have that many complaints about it. Everything was up front and the patients knew what payment responsibility was expected. We weren't vociferous about having everything paid up front. We had terms set through board policy, so we had the backing of the board of the hospital and made sure that they would stand behind us when that first person called to complain.

O'Connor: We don't find that the patients who call about pricing are the ones we really have an issue collecting from. They're either charity care or they pay. It's everybody else, and then that tends to fragment your collection approach to the global patient population.

When someone calls for pricing, we don't ask how they're going to pay. Rather, one of the first questions that our customer service reps are supposed to ask is, “What's the reason that you need this information?” The response will then typically send the rep down one of two paths.

Either the rep is going to quote the caller information or help the caller find a way to pay for the service. Often these individuals are calling because they don't have insurance, and they are trying to estimate what the service is going to cost them.

Rooney: We will give people a payment plan. Of course, if they have a credit card we're happy to take that, but a lot of times people don't want to do that—it's a big expense. So we'll give people payment plans, even on relatively low-cost services. If they have a couple hundred dollars that is the patient portion due, they may want to pay the balance over four months or five months. We will find a way to arrange such payment plans, and we have pretty good compliance. We actually have someone on a payment plan who has been paying down his balance now for a year and a half. Payment may be slow, but at least the bill is being paid. We don't charge our patients interest, because we would rather have them pay than to try to be a bank.

We actually have been burned in the past when we have provided a quote and didn't arrange for payment. In reality, however, the patient probably couldn't pay; if we had been smarter about gathering the right information, the person probably would have qualified for charity care.

Alton: The other pricing transparency issue, certainly in this area, is what hospitals are charging the uninsured. Hospitals have been under a lot of pressure from governmental agencies in terms of justifying their not-for-profit status and tax exemption, and what they are doing to provide help to those people who can't pay. The entire

industry has been under fire because of its pricing practices, and this issue is something that is probably going to play out over the next couple of years.

Rooney: Our charity care write-offs are up about 25 percent, and our bad debt is actually down. We can't attribute this to anything that we've done aside from generating greater awareness in the community that charity care is available. Staff are giving out more applications, more people are filling out the applications, and we're granting more charity care than we ever have done in the past. Same guidelines; there's no difference in the guidelines.

O'Connor: I am wondering why is pricing an issue, and where did it come from? A lot of us have said that the uninsured are driving this interest, but I think it's also the consumerism design of health plans: increased cost-sharing, high deductibles, high co-insurance, and presence of health savings and health reimbursement accounts. The incentive for the consumer is to keep unused funds, either in their pocket or a tax-sheltered account. And the educated consumer—the person whom these plans were designed for—is going to start shopping around and looking for the cheapest CT scan or the cheapest MRI, access and quality being equal.

I see increased consumerism being the big driver of pricing. Our calls are not typically from self-insured people in the community. Ours are more, "I have insurance, but I'm more judicious and becoming proactive in its use. I want to make sure I'm going somewhere where I am going to get good care, will be seen quickly, and will not be charged excessively for service."



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