

Are You Ready for Pricing Transparency?

Pricing transparency is a key element in the move toward consumer-driven health care. Yet the proposition poses a number of challenges for hospitals, none the least of which includes how best to impose rationality on a patchwork system of prices and charges that is patently confusing to the layperson—and difficult even for hospitals themselves to explain. In the following article, HFMA, with sponsorship from MedAssets, asks four prominent industry professionals to share their candid views, experience, and advice about how to turn some of these challenges into opportunities.

How will hospitals be affected by the move toward increased price transparency?

Robert Bonney: In the long term, price transparency is going to drive us back to billed charges: You post your charges on the Internet and you let people go out and shop. You don't give any discounts, so that insurance companies have to position their product based on the services they provide. This will allow more insurance companies, the small plans, to enter the marketplace. Price transparency also will require hospitals to retool their pricing policies for those services that patients are likely to shop for, and to look more at package pricing, particularly for outpatient services. They will have to price these more competitively and then, on the other end, raise prices for products that are less price-sensitive, such as neonatal care or heart surgery, where consumers know they're going to hit their out-of-pocket maximums.

Right now, the insurance companies are all trying to standardize their contracts so they will be easier and cheaper to administer. That's what hospitals will need to do, too.

Kevin Brennan: I think we will gradually move to a more simplified system for common activities, such as outpatient lab tests. We've already done so in plastic surgery, which is a very competitive, price-sensitive service. We don't charge you for operating room time and sterile gauze for plastic surgery. We charge a fixed price, and we guarantee it. Setting things up this way is useful because what consumers really want to know isn't costs or charge practices, it's how

much they're going to have to pay out of pocket. I envision the industry as a whole might migrate in this direction, but it's not going to happen overnight and it's not going to change the way emergency department services are handled for the most part. Most people don't have the luxury of price shopping when they have a car accident or a heart attack.

There's nothing revolutionary about this, really—as an industry, we came from a 100 percent self-pay system. But when you look at where most of our healthcare dollars are spent—on the 15 percent of patients who are severely, chronically ill, and on the last six months of life—price transparency isn't an answer. I think it will focus our attention on some of the public policy issues we've inherited having to do with lifestyle, with health maintenance, and compliance.

Kate Banks: Hospitals must move toward a completely defensible pricing strategy that not only is understandable to the consumer, but covers costs with sufficient margin to continue to serve and invest in their communities. Additionally, service line management of some kind must evolve to provide information about the charges, cost, and profitability of various case types at the proper time and in the proper format to make it actionable.

What are the biggest challenges hospitals face as a result of this shift?

Kate Banks: Hospitals will be challenged to explain to consumers how the prices on their chargemaster relate to the

total charges for any given service as well as the difference between charges and payments. This information is extremely confusing for the ordinary consumer. He or she wants to know how much a hip replacement will cost, and it's hard for a hospital to answer that question because charges are based on utilization of services, which can be influenced by an individual physician.

Consumers also will be surprised by the markup percentages that are commonly found on hospital services, supplies, and devices. Suddenly the Internet is making it possible to know the approximate cost of an individual item, and consumers are not thinking about all of the overhead involved in the consumption of that supply or device. I expect hospitals will find a need to either effectively communicate this complexity or provide a flat rate for services that includes a method for explaining variation.

Robert Bonney: The issue that has to be addressed first is how to pay for indigent care and teaching costs. The hospital that provides a lot of indigent care or the teaching hospital is not likely to be able to compete on price in a price-transparent world. One solution is to have each state hospital association develop a provider tax structure, a formula that everyone will agree to, whereby all hospitals share these costs. We can't wait for the government here; providers need to take the lead.

Price transparency also has the disadvantage of doing away with the premium currently being paid by health plans to hospitals with excellent reputations to get them to participate in their networks.

Kevin Brennan: We will need to work with the payers to understand benefit structures so we can better educate

ourselves as well as the consumer. Many hospitals have found it difficult just to verify insurance upfront, and now we're going to have to verify the level of individual benefit as it relates to the particular services a person needs at a particular time—not just what someone's benefit design is, but whether they've met their deductible for that benefit this year. We'll need to engage patients before they walk in our front door and identify what they will be personally responsible for. This is going to require more robust and extensive training programs for our employees, who will have to become more skilled in communicating with consumers.

We also have to shift the focus away from individual units of service. As an integrated delivery system that has an insurance component as well as hospital and physician components, we're concerned with per-member-per-month costs over time. I try to get employers who call and are concerned about price to think in terms of the big picture.

Bill Bertschinger: We believe that price transparency alone is not enough to satisfy the patient, we also need to simplify the billing process and create a more patient-centered revenue cycle. If the information you provide is not understandable, comparable, or consistent for patients, you just raise the level of frustration. Right now, hospitals send out bills with a lot of detailed information, much of it in Latin or medical jargon that is meaningless to the patient. So we're talking with payers about finding a different way of billing.

It's really more of a cultural and process issue than a systems issue. The technology exists today to provide real-time estimating services, including not just charges but also the expected payments from insurers and expected patient out-of-pocket costs. We could even do what-if modeling and get real-time adjudication from the payers—but we all have to work together to come up with a vision for the future. If we don't, the government will eventually come forward to do it for us.

What are the potential benefits to making price information more available?

Kate Banks: I think it could drive the industry toward a more rational system in which hospitals and payers and physicians can really have aligned incentives. As more patients move into a position to pay for their own care, they will become much more interested in costs and more informed about the working of hospital finance. Right now, some patients don't question the actual cost of care. Rather, they are concerned with their out-of-pocket expense. This insensitivity to price has caused a callousness in use of the healthcare dollar. Increasing awareness

PARTICIPANTS

Kevin Brennan, FHFMA, CPA, is executive vice president, finance, and CFO at Geisinger Health System, a physician-led healthcare system serving 2.5 million people in 40 counties. Geisinger is located in Danville, Pa.

Robert S. Bonney, JD, FACHE, is senior vice president for business development at Saint Luke's Health System in Kansas City, Mo. The system's nine hospitals and many physician practices provide a wide range of primary, acute, tertiary, and chronic care services.

William Bertschinger is division chair, patient financial services, at Mayo Clinic in Rochester, Minn.

Kate Banks is senior vice president for MedAssets Net Revenue Systems. MedAssets, headquartered in Atlanta, is an organization dedicated to improving healthcare providers' margin and cash flow through revenue cycle and supply chain initiatives, as well as decision support technology and services.

of the cost of care at the consumer level will benefit hospitals, employers, and patients—especially the uninsured—who are, unfortunately, absorbing rising costs. A more educated healthcare consumer will likely be a more responsible consumer of the healthcare dollar. This will help benefit the entire U.S. economy.

An additional benefit will be to expose the extremely high prices of implantable medical devices and help drive price competition to these categories. These products are outrageously priced and consume the majority of the case cost, and in some cases, the majority of Medicare payment on many orthopedic, cardiac, and spinal cases. The prices are rising at rates exceeding inflation. With new DRG Medicare payment reductions proposed on supplies-intensive cases such as cardiac care, the device pricing exposure is badly needed.

Robert Bonney: When discounting first came into play, most markets had surplus capacity, which they don't today. There was a promise that hospitals would get prompt payment from insurers without hassles; that's all going away. There were narrow networks; now, everybody is in everybody's network. Now that the circumstances have changed, there's no reason to have inflated prices and offer discounts. We can lower our prices down to a rational level and compete based on price and quality.

Bill Bertschinger: We hope that it will help drive down our costs. We think it's possible to reduce our administrative costs in the long term if we can get the right information upfront about patients' coverage, so that we're not sending out bad data to a payer and having to rework it on the back end of the process. We believe that in an open market, we would be able to sell our services based on quality.

It will also be good to have more consistency in the industry. Right now, we all have different charging arrangements. Some of us mark-up more for pharmaceuticals, others for surgery. These things don't necessarily make any sense, they've simply evolved over time.

How will price transparency change hospitals' relationships with patients, vendors, and third-party payers?

Kevin Brennan: If the theory is that we can increase price competition and drive down unit prices by forcing medical suppliers to disclose their variations in price, I'm not convinced. It might work this way on one item, but if the manufacturer is a publicly owned company accountable to investors, they'll make it up somewhere else—the same way we have to make it up somewhere else if we become

more competitive on outpatient lab tests; I still have to make a 2 percent margin.

I'm also concerned about confidentiality issues. Many of us, when we purchase goods or enter into payment arrangements with insurers, obligate each other not to disclose that information. If payment information was open to everyone, it could tempt vendors to collude with each other.

Kate Banks: Hospitals will have a stronger position in negotiations with supply vendors in a transparent environment, but they must also continue to adhere to consistent purchasing practices for all transactions—whether for a commodity supply item or a high cost medical device, such as a pacemaker or hip implant. Similarly, hospitals will benefit in relationships with payers as pricing transparency improves. As healthcare consumers gain an increased understanding of the prices being paid by the various parties and the notable differences between the amounts owed by patients versus payers, they will likely be less tolerant of the discrepancies and demand price adjustments.

Bill Bertschinger: We will have to collaborate more with payers. We saw with HIPAA that when payers and providers act independently, without agreeing on common definitions, the results will fall short of the intended ideal. Some people say that payers will never want to pay hospitals on a real-time basis. But we think they will. We think they can sell more insurance policies by pleasing the patient than by hanging on to the cash for 30 or 90 days.

We have anecdotal evidence from other industries suggesting that if you give patients an upfront estimate of what they'll have to pay-out-of-pocket, they'll have more of a feeling of responsibility for that amount. Naysayers insist that this kind of system isn't going to be perfect. Well, maybe not, but it's better than what we have today.



June 2006
HFMA Executive Roundtable
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The consumer has been able to handle this kind of situation elsewhere—in making online airline reservations, for example—and I think they'll be able to handle it here as well.

What should hospital financial managers be doing now to prepare their organizations for increased price transparency?

Kate Banks: Hospitals need to be sure that they have good upfront processes in place to identify charity cases, and they need to come up with some discounting so that people with a health savings account don't have to pay the full share. The first thing to do, however, is to go over their chargemasters carefully to make sure that they don't have any unpleasant surprises lurking about—for example, the cotton swab that's described as a tip applicator and priced at \$23. When you have 10,000 items, it's easy to lose track of one or two, and hospitals need to be comfortable defending each and every price.

Robert Bonney: I'd take a two-pronged approach. I'd be trying to work with my state hospital association to come to agreement on some kind of provider tax, so that everyone will be on a relatively level playing field. This will take years to get enacted. At the same time, I'd be retooling my pricing structure to come up with competitive pricing on products like outpatient surgery, radiology tests, and maybe obstetrics—the things that people shop for.

I would also work on getting most of the cost profile down as low as possible. There was a *Wall Street Journal* online survey done on March 28 indicating that many Americans favor having health insurance plans pay more to hospitals and medical groups that have been shown to provide better care. On the other hand, the same survey suggested that few people are actually willing to personally pay more for such care. To me, that implies that price is going to be largely driving competition.

Kevin Brennan: The most important thing right now is for hospitals to make sure that they are investing in front-end processes, such as verifying insurance. I also think we need to be working with the IT vendors to help make more automated tools available to us and to our payer partners.

Bill Bertschinger: We're working to try to gain agreement within our organization on what pricing transparency actually means. Some people think it means that providers share their chargemasters and estimated charges for services. Others think it means being transparent about not just charges but also about what providers get paid by each company on each contract. Still others think it includes both of these, plus what a patient will ultimately pay out of pocket for services. These are very different things, so it is important for people to understand what we mean when we discuss pricing transparency.



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