Hospital Pricing Transparency
by Amy Gooch

Introduction
Fueled by a number of unsatisfactory outcomes, many advocates, academics, and healthcare professionals propose price transparency as a strategy to curb hospital pricing system problems. Price transparency is anticipated as an important step to improving the ailing healthcare system in the United States, but is only one component to healthcare reform. It is thought that transparency will reduce price distortion[1] and discrimination[2], leading to improved market efficiency. Although many stakeholders are already supportive of transparency initiatives, developing a system of price transparency will not be easy, as the healthcare system is extremely complex.

Background and History
“In its purest form, pricing transparency is simply providing the consumer with useful information about the cost of services,” (Clarke 2007, 8). Demand for such hospital price transparency has grown considerably in recent years. Nichols et al. (2006, 82) state that “demand for payment reform arises when trust in the efficiency and fairness of the existing payment system breaks down.” The cause of this distrust is largely thought to be price distortion and consumer disconnectedness[3] (Clarke 2007).

Price distortion has evolved over time and has been largely driven by the diverse payment systems used in healthcare. For example, hospital underpayment by government has caused price distortion. To make up for low reimbursement by government, hospitals shift costs to self-pay patients. Additionally, hospitals are incentivized to keep charges high, even though most consumers pay a discounted rate. This is because Medicare outlier reimbursement and some managed care payments are based on charges, rather than negotiated rates (Clarke 2007).

Presently, every hospital has discretion to determine the prices listed on its chargemaster, the undiscounted price list for all the hospitals services. A number of justifications have been established by hospitals for choosing to charge high prices, including that patients are responsible to negotiate price discounts before the time of service, uninsured pay only 10% of charges, making up for underpayment by Medicaid and Medicare, and incentivizing health plans to sign contracts to procure lower rates (Anderson 2007). These strategies cause further price distortion, making price comparison difficult for consumers.

As noted by Anderson (2007), hospitals have been under scrutiny because of the ever increasing number of uninsured who are charged, on average, 2.5 times more than private and public insurers. Other patients pay this rate also, including visitors from abroad, those with health savings accounts, those covered by auto insurance, and those covered by workers compensation. Together they make up the group known as “self-pay” patients. The uninsured represent the majority of this group, by far (Anderson 2007).

Another measure demonstrates this same pattern. A charge-to-cost ratio measures hospital charges relative to allowable costs as determined by the Center for Medicare and Medicaid Services (CMS). In 2004, this ratio was 3.07 for all U.S. hospitals, meaning they charged $307 for every $100 in CMS allowable costs. Interestingly, the ratio was higher at proprietary hospitals (4.10) than at public hospitals (2.49). Hospitals would have experienced 200 percent profit margins if this had been collected. In reality, profit margins averaged 5.7 percent. Another ratio, called the gross-to-net revenue, was 2.57 in 2004. This means for every $257 charged by hospitals, $100 was actually collected (Anderson 2007).

Historically, the gap between charges and costs was much narrower. In 1984 the charge-to-cost ratio and gross to net revenue were 1.35 and 1.25, respectively. Over the years, hospital charges increased much faster than costs increased, widening the gap. Meanwhile, revenue increased parallel to costs, not charges. A reason for this is that as hospitals increase charges, private insurers negotiate lower rates, leaving only self-pay patients to pay the higher charges (Anderson 2007).

Current Impact
The variability of hospital charges and the distortion of those charges over time have led to the current
hospital pricing structure. It is hoped that transparency initiatives will reduce price distortion and variability, possibly even lowering prices (Congressional Research Service 2008). California, a state early to adopt transparency laws, has demonstrated the price disparity among hospitals and types of payers. Figure 1 demonstrates pricing variability for specific items between hospitals. Table 1 shows the disparate prices charged by type of payer. Interestingly, the California initiative has had little effect on hospital prices (CRS 2008).

Figure 1. Hospital Charges for Selected Diagnostic Tests, 2004

Currently, over 30 states mandate hospitals provide pricing information to the public (NCSL 2008). In Utah, transparency projects are underway. The Utah PricePoint system, modeled after other successful state systems, allows consumers to compare charges and other information for a number of procedures at Utah hospitals. Additionally, hospital comparison reports have been published for several procedures. Also, funding has been provided for a Health Data Committee to collect information on health care costs.

Table 1. Average Costs and Charges for Selected Hospitals by Type of Payer, 2002

<table>
<thead>
<tr>
<th></th>
<th>O'Connor Hospital San Jose, CA</th>
<th>St. Louise Regional (Catholic) West Gilroy, CA</th>
<th>Palm Beach Gardens Community Hospital (Tenet Healthcare) Palm Beach Gardens, CA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg. Operating Cost per Patient per Day</td>
<td>$1,631</td>
<td>$1,376</td>
<td>$1,501</td>
</tr>
<tr>
<td>Collected from Managed Care</td>
<td>$1,940</td>
<td>$1,773</td>
<td>$1,774</td>
</tr>
<tr>
<td>Billed the Uninsured</td>
<td>$5,951</td>
<td>$5,508</td>
<td>$7,414</td>
</tr>
<tr>
<td>Cost-to-Charge Ratio</td>
<td>.258</td>
<td>.289</td>
<td>.205</td>
</tr>
<tr>
<td>Collection Rate from the Uninsured</td>
<td>97%</td>
<td>96%</td>
<td>32%</td>
</tr>
</tbody>
</table>

Source: CRS 2008
Current Status and Solutions

If hospital pricing transparency is to be successful in the future, several problems will need to be examined. First, the average chargemaster contains around 25,000 items, so only collecting data on a few dozen items, as California does, lends itself to price manipulation by the hospital. Second, patients cannot comparison shop beforehand if they are unaware of the services they need (Clarke 2007). Third, chargemaster items are usually written in code, impossible for a lay person to interpret. Fourth, since hospitals may change prices at any time, comparison shopping will not be helpful unless prices are guaranteed (Clarke 2007). Fifth, though transparency initiatives evolved out a desire to assist those least able to pay, posting prices will likely not improve the uninsured’s position to bargain with hospitals for discounted rates (Anderson 2007).

To successfully implement price transparency, important considerations must be made to ensure information is presented to consumers in an understandable and useful way. This will require hospitals to create common terms and explanations (AHA 2006). Regulation to deter price discrimination and require posting prices in an accessible form may also be necessary (CRS 2008).

Additionally, most consumers only want information on what they will be expected to pay out-of-pocket, that is, after third party payment, adjustments, and discounts (Anderson 2007). At a minimum, Clarke et al. (2006) suggests hospitals provide an estimate of treatment cost tailored to the patient before the time of service. Employers may require different information to make decisions. Having great market power to effect transparency model development (employer sponsored health plans account for 30 percent of hospital revenue, equal to Medicare), the ideal system for this group requires a limited number of negotiable prices and allows payers to access information necessary to compare quality, services, and prices across hospitals (Nichols et. al 2006). As noted by the American Hospital Association (AHA) in a 2006 policy statement, other consumers will likely be interested in different information, though it is not fully known what consumers want to know (AHA 2006).

The process of developing a useful, comprehensive, transparent price system will be costly and lengthy. It is thought that price transparency in healthcare will lower prices, as has been the result in other markets. However, due to the unavoidable complexity of third party payers, intermediate agents, and complicated products, it is unknown whether the healthcare market will behave this same way (CRS 2008). It should be noted that price transparency should not been seen as simply a way to gain cost savings, since those savings may not be realized (Anderson 2007).

Though the process to achieve pricing transparency will be difficult, some important parties have expressed support of the initiative. In a 2006 editorial, Secretary of Health and Human Services, Michael Leavitt, said “people deserve to know, indeed they have a right to know, what their healthcare costs and how good it is” (Leavitt 2006). Further, the American Hospital Association has endorsed pricing transparency initiatives, stating that “more can, and should be done to share hospital pricing information with consumers.” Also, over 30 states have mandated accessibility of hospital charge information for consumers. More states will likely follow suit (NCSL 2008). Lastly, President Bush has made transparency a priority of the administration (Clarke 2007), and in fact, Congress has had several hearings on the issue and several bills have been introduced (Anderson 2007).

Conclusion

Efforts to further hospital price transparency are certain to continue. The process will be slow since many of the proposed solutions have drawbacks and leave no easy answers. It is hoped that transparency may improve healthcare market efficiency and prevent pricing discrimination, but the complexities of the healthcare system ensure that perfecting price transparency will be a difficult process. However, with so many critical allies in place, it is unlikely that transparency initiatives will lose momentum anytime soon.

References

www.aha.org/aha/content/2006/pdf/5_1_06_sb_transparency.pdf (accessed May 2, 2008).


Note: Amy Gooch is enrolled in the MPH/MHA Program at the University of Utah, and is pursuing a career in healthcare administration. This policy brief was originally written for her Health Policy course in June 2008.

[1] Price distortion refers to a disparity between price and cost. Price distortion may be created by charging a higher price to one buyer in order to afford charging a lower price to another buyer.

[2] Price discrimination refers to the practice of charging unequal prices to different buyers for the same product. Buyers of healthcare are often health plans, uninsured patients, government (Medicaid, Medicare), etc.

[3] Consumer disconnectedness refers to the lack of consumer participation in the healthcare payment process, largely due to third party payers and complex billing practices.