The Powers Report Podcast

Episode 16

Price Transparency, Part I: Ways to Improve Provider Pricing

Welcome to The Powers Report Podcast. I am your host, Janis Powers. The show brings you candid, unique and data-driven perspectives on the health care industry. I believe that any solution that is going to positively impact the American health care system has to satisfy two major criteria: financial viability and behavioral incentive alignment. In other words, access to high quality care can only be achieved if we can afford it, and if we behave in ways that optimize our health. Please subscribe to our show on iTunes or on your preferred podcasting platform and connect with us on social media. Again, this is Janis Powers, and welcome to The Powers Report Podcast.

Americans have become increasingly frustrated with the health care system, and pricing is a big part of the problem. We're upset about drug pricing and we're upset about those pesky nonsensical hospital bills that no one understands. Over a half a million people who file for bankruptcy each year do so because of medical bills (1). They're un or under-insured and probably are sitting on a pile of statements that make absolutely no sense to them. It's outrageous.

The price transparency movement is taking hold as a means to address this problem. Legislators, patient advocates, pundits and even I have been pushing for more price transparency. In this show I am going to talk about the different ways to achieve it because I don't think the initiatives being undertaken right now are going to get us where we need to be.

This show is the first in a two-part series about price transparency. In this episode, I will focus on price transparency as it relates to hospitals and other providers. In Part II, I will address drug pricing. I think drug pricing gets more media play, but the dollars associated with it are about a third of what is spent by hospitals. From an order of magnitude perspective, dealing with price transparency in the provider system can positively impact more patients and more dollars.

Price transparency has become an increasingly important issue because health care costs have been going up and health insurance is covering a lot less. Some Americans (9% of the population in 2017) don't even have health insurance (2). For those who do have it, about half of those covered by their employer have a high deductible health plan (3). That means that they have to pay, typically, several thousand dollars out of pocket before their insurance will cover their costs. More and more patients are getting slapped with charges that they didn't expect, that they don't understand and that they cannot pay. Hence the bankruptcy problem.

The prevailing approach to this – and one embraced by the Trump administration – has been to try to force providers and drug companies to explain their pricing better. This should then allow consumers to understand what is going on and enable them to shop around or bargain more.

In January of 2019, a new regulation required hospitals to post their chargemaster prices online (4). Apparently, this requirement was part of the Affordable Care Act and it never got enforced. Isn't that crazy? Nine years after the legislation was approved and we're still rolling out parts of the law.

Anyway, chargemaster prices are like rack rates at a hotel. It's the highest price that a guest might pay because the hotel cuts deals with companies and offers ad hoc discounts that are much lower than the rack rate. Hospitals use the chargemaster pricing as a starting point with insurers. That means that if you have insurance, you're not paying the rack rate. Your insurer is paying a negotiated figure that is less than the rack rate. As a consumer, you may be responsible for a percent of charges. That percentage will be on a number that is lower than the chargemaster price. But since you don't know the price your insurer negotiated with the hospital, it's almost completely useless to see the chargemaster price.

Unfortunately, those paying out of pocket either to satisfy deductibles or because they are uninsured may get a bill with the full chargemaster price. Hospitals and patient advocates will tell you the price is negotiable, but good luck with that. You'd probably have better luck getting the IRS to reconsider your tax bill.

Incidentally, it makes no sense that people who are going to pay in cash pay the highest price. They should pay a much lower price because the hospital doesn't have to pay the administrative fees necessary to negotiate pricing with insurers or to collect their portion of the payment from them. With cash-paying customers, hospitals just get the money directly.

What should really be happening is that patients who are paying cash should be charged the average of all the prices that the hospital has negotiated with its insurers. If an MRI costs $1,000 on the chargemaster, but the hospital has a rate of $500 with Insurer A and $700 with Insurer B then the cash-paying patient should be charged the average price, or $600. A version of this concept was baked into the ACA with regard to patients who were in financial distress. But all patients, regardless of their financial status, should have access to a reasonable charge for services. Chargemaster pricing is definitely not reasonable.

As a follow on, the Trump administration has proposed that hospitals begin posting their negotiated rates with insurers (5). If the proposal goes through, the rule will go into effect in January 2020. This is a much more aggressive step than the chargemaster rule because it forces the hospitals and insurers to disclose what have long been closely held secrets. It's understandable that both hospitals and insurers would be upset about this. But the public has had enough with the pricing lunacy, and something's got to give. This is not finalized yet, so we'll see if it happens.

There is an important issue for consumers that relates to both chargemaster and negotiated rate prices. What we're seeing with the publicly-available chargemaster pricing is that it is extraordinarily difficult to interpret. I'm not sure how the negotiated rates will be presented to consumers, but I have to imagine they, too, will be convoluted at the outset.

With the chargemaster ruling, pricing is shown for individual costs for different procedures. Hospitals are not presenting so-called global rates. It would be like posting the supply costs for Ford or General Motors. Imagine that all the parts to make all of their vehicles are on one giant list. We're talking brake pads, pistons, tires, glass, windshield wipers, leather, antennae, speakers, axels…no ordinary person would be able to look at a list like that and figure out how much a car costs.

And no ordinary person can look at a chargemaster and figure out how much their open heart surgery will cost.

Even if you could, the chargemaster doesn't have a key piece of data: professional fees. In the car analogy, that would be somewhat akin to labor costs. Professional fees are the physician charges that can come in addition to everything else. And there may also be fees from the anesthesiologist. Yet, anesthesiologists are physicians too but today, they bill separately.

Nonetheless, I was always in favor of having chargemaster pricing made public because my hope is that some patient advocacy groups would be skilled enough to analyze the data and glean some useful insights. It hasn't been a year yet, but there's still time for something good will come out of it.

Alas, why wait for someone else to look at the chargemaster data when I can do it myself? Now, I am by no means an expert in this area, but I am more educated on the topic than the average American. So buckle in as I describe my experience trying to make heads or tails out of this mess.

I live in Austin, Texas. We have two major health systems in town. The most well-known is Seton, which is part of Ascension. Ascension is a huge national not-for-profit Catholic hospital network. All I had to do was go to the home page of the Seton system. They have a link at the bottom of the page called Hospital Pricing (6). Very easy to find.

When I am there, I have to select the hospital where I want to learn about the pricing. There's a massive disclaimer, which I don't read. I come back later and read it because it pops up on every Ascension hospital site. It basically says that they're complying with laws and that professional fees aren't included and three times they list a number to call if I have any questions. Anyway, I have to select an area. I pick Cardiac Cath Lab. Then the prices come up.

First is "ANS SUP G CATHLAB." That costs $146.73. Next is "ARTGRM AO ABD S&I CL." That costs $441.11. The list goes on and all of it is indecipherable. Aside from the words being abbreviated so that a normal person cannot understand them, there are no associated codes. I know that

this is what these abbreviated words relate to. And you can easily look up codes online and see what they mean. Alas, no codes are here to help.

Then I figure I'll look across other Ascension hospitals not in Texas. I know that other areas have different cost structures and their pricing may not be the same. All kinds of market forces from staffing to supply costs can moderately impact pricing differences on a regional level. But out of curiosity, I pick a hospital in Pensacola, Florida. I select Cardiac Cath Lab again. And oh my goodness – the list of services is totally different from the Austin sites. I cannot find ANS SUP G CATHLAB. Darn. Guess I'm not going to be able to compare system prices within Ascension.

Here's what I do find. "CATH TRANSLUMIN NON-LASE." In fact, it's on the site 47 times. It's the same thing over and over. And get this…there are eight different prices for it. What the…insert your favored exclamation of profanity/frustration.

This is almost insulting. These people can't be serious.

So I figure I'll go to the other big Austin provider, St. David's. They're affiliated with HCA, one of the nation's largest for-profit hospital chains.

I go to the HCA site and then I have to select a specific hospital in Austin. So I do that. There's no handy dandy hospital pricing link like they have for Seton. The best I can find is to look under the tab Patients & Visitors and work my way to Patient Pricing. I have to pick the facility again. And this is where it gets good.

The page that shows up has a splash image of some elderly folks smiling (7). This is exactly what I think of when I want to understand my medical bills. Surrounding the image is a bunch of text located in what I presume would be different boxes on the page for different subjects. The font is basic. Times New Roman. It looks like someone started working on the page and just didn't bother to finish it. So I randomly click things hoping that maybe my computer didn't load the page properly. And low and behold I get to my final destination: a 404 error. Page not found. I go back and click other stuff. Same deal. 404 error. Page not found.

This *is* insulting. And these people *are* serious.

Come to find out that there's no penalty for non-compliance with this rule. Hospitals clearly don't want to participate and they are thumbing their noses not only at CMS, but also, more importantly, at the patients they're supposed to be serving.

Interestingly, the proposal on the table now that would require hospitals and insurers to disclose their negotiated rates *does* have a penalty for non-compliance. Every day that the hospital doesn't post prices will be a $300 penalty. No wonder the hospital and insurance lobbyists are going nuts.

I still think it's a good idea to list prices. Some things can be listed at a global rate because there are surgery centers and other outpatient providers that offer this one-stop-pricing for care.

More organizations need to pick up the mantle and do the same thing. For commoditized stuff – like MRIs and X-rays – we ought to be able to price compare more than we can today.

But we have to accept the limitations that average people have in their ability to decipher this mess of online data so they can shop around in a meaningful way. I think that as more and more people have to buy things out of pocket, they are going to flock to places where the pricing is simple to understand. Hospitals do not seem to realize this and my hope is that other independent providers will siphon off business because they will do a better job catering to cash-paying patients than hospitals are doing right now.

In fact, the more I think about this, the more I realize that the problem isn't that people don't understand pricing. It's that they know they're getting ripped off. We can explain the structure and give people access to charts and tables all day long but that doesn't change the fact that the prices are just too high. People do not see the value in what they're paying for versus what they're getting.

Some economists and free market supporters believe that if we just give people the prices to everything, providers and drug makers will have to compete with each other on price and quality. The free market will take care of things and pricing will come down to the right levels. I love the idea of the power of the free market, but it has its limits. It is important to understand how people behave and how the health care industry works before we rely on economic theory alone to save the day.

What we really need to get to are prices that "feel" right. People have to trust that they're getting a fair price. Anyone can tell you that a box of Kleenex shouldn't cost $50. Hospitals have lost the trust of patients and pricing is just way too high. So how do we deal with this?

Let's take a giant leap of faith and assume that a patient can compare the cost of a cardiac cath procedure between two hospitals in her community. She learns that the cost of the cardiac cath is below her deductible, so she's going to have to pay for it out of pocket.

Hospital A's price is $200 higher than Hospital B's. Quality is the same. One would expect that over time, Hospital A's price would drop – and maybe Hospital B's price might go up a little bit, but the two facilities should reach some sort of equilibrium that results in an overall lower average price in the market. That is the theory.

Here's the part missing from the argument. The cost for a cardiac cath shouldn't be $200 less at one facility. It should be much, much lower. Why? Because the hospital industry has an absurdly high fixed cost structure that is partially responsible for the high prices we have. Pricing has to cover not only the variable costs to do the procedure but also the cost of the hospital and system's physical and human resources infrastructure.

Neither hospital, in this example, is incented to attack their fixed cost issue. Each may lower prices at a variable level. They'll cut out $100 or so on the price, but they won't push their prices down much further because they both have too much to lose in doing so. Until we

address that problem, we can't have reasonable prices for health care services. In other words, competition can only do so much. We're going to need – dare I say it – legislative action to fix this.

Here are a couple of ideas.

More and more health care is being delivered on an outpatient basis. As I discussed in an earlier podcast, "Let's Find Out About the Hospital," well over half the revenue that hospitals earn is from outpatient care (8). About two thirds of surgeries performed at a hospital are outpatient cases. The physical plant of a hospital is anachronistic. Because more and more care can be delivered safely on an outpatient basis, more and more of it should be done closer to patients, out in the community and out of the hospital. Hospital systems need to take a hard look at shutting down, repurposing and even demolishing parts of their sprawling campuses. If they did that, their fixed costs should come down considerably. And that should help pricing.

How could we use legislators to help with that? I think we should prohibit hospital donations from being used for inpatient campus facility construction. Think about your local hospital. How many wings and atriums and reflecting pools are named after donors? That money should be used to build sites out in the community or – heaven forbid – to help patients pay their bills.

Next.

I think we should revoke not-for-profit status for hospitals. Hospitals maintain their not-for-profit status by demonstrating that what they'd have to pay in taxes is actually spent in their communities on things like education and charity care. Historically, there have been concerns over the value of the services that not-for-profits deliver (i.e. they're not providing enough of it to warrant the tax break), so questioning their status is not a new idea (9). However, it gained a bit more traction in 2017 when the IRS revoked the non-profit status of a hospital for failing to meet required standards (10).

We should consider revoking not-for-profit status across the board for two reasons and neither of them has to do the fact that the government will collect more in taxes. Although that would be a nice benefit.

The first has to do with ramping up operational efficiency. As I noted in my hospital podcast, about one in four hospitals in the U.S. is part of a for-profit health system. Many of these hospitals generate a profit for shareholders and pay taxes. Not-for-profit hospitals are somehow incapable of generating a profit. A lot of this has to do with the culture of not-for-profits. They don't think about maximizing their bottom line because they're not supposed to have one.

As costs have ballooned in health care, hospitals in every sector – for-profit, rural, faith-based, etc. – have been engaging in almost predatory billing practices. I'm not espousing a for-profit hospital sector so hospitals can up the ante by plying more and more dollars out of consumers

and employers and taxpayers. In fact, I think hospitals have maximized their ability to raise revenues through this mechanism.

What they need to do is focus more on cutting costs. For-profit hospitals can make money in the same markets that not-for-profits don't. When they're in the same market, they have basically the same patient base and a similar payer mix. There's nothing radically different that one hospital can do over another because they all have to accept Medicare and Medicaid, and they're the primary payers for hospitals. Medicare and Medicaid underpay providers. For-profits must be making up at least some of the difference by holding down their costs better. The other 75% of hospitals need to do the same.

But here's the most important reason why we need to rescind the not-for-profit status of hospitals. It has to do with the raison d'etre of a hospital. What is its purpose? To take care of the sick? Or to provide service to the community? It's to treat the sick. A hospital's main function should be to perfect their caregiving abilities. Of course treating the whole patient requires the promotion of wellness, but that's not what the emergency room is for. It's not what having open heart surgery is about. These are high-cost activities that treat people at their sickest and most desperate. That business model is completely different from looking for food desserts in a community so the hospital can help direct people to better sources of fresh fruits and vegetables.

From an operational perspective, it is much more straightforward to determine the profitability of delivering health care services when reimbursement is matched against the cost of delivering the care. Right now, hospitals are overpricing care because baked into all of the costs for, say, a hernia operation, are the costs associated with delivering community service. Like helping the underserved find transportation home from the hospital. Or from paying a consultant to run a seminar about community weight loss. These things have nothing to do with the hernia operation. Yet we're all paying for these and other services through the higher costs that get transferred into today's hospital business model.

I'm not saying that we don't need community education. We need to study population health management and get a better handle on managing the external determinants of health that are impacting health outcomes. But that is not the job of the hospital. It's the job of the local government. We'd have a lot more transparency on how community funds were spent if the money were to be given to an accountable governmental agency instead of a to not-for-profit organization that can be somewhat opaque with how it spends its money because it has fewer reporting requirements. With the limited funds we have, we must make sure they're spent as efficiently as possible.

The health care industry has a long way to go before it is able to offer consumers the price transparency they deserve. Hospitals can do more to provide better access to prices to the members of their communities, especially as pressure ramps up from CMS to do so. But free market competition isn't enough. We have to think about different ways that acknowledge how

the delivery of care has changed and force hospitals to keep up. We also need to prioritize a hospital's purpose as care delivery site over that as an educator. That way we can redirect funds to local organizations so they can create the tools they need to help their community members be as healthy as they can be.

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