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Journal Reports: Health Care

## How to Bring the Price of Health Care Into the Open

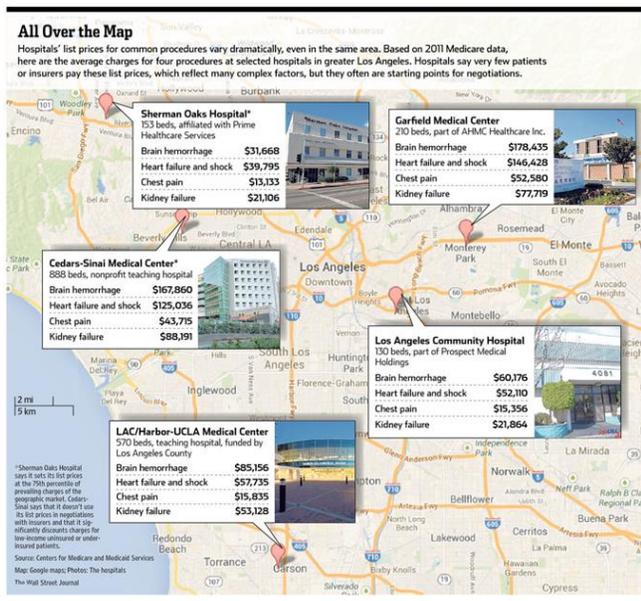
There's a Big Push to Tell Patients What They'll Pay—Before They Decide on Treatment

By Melinda Beck  
Feb. 23, 2014

It's a simple idea, but a radical one. Let people know in advance how much health care will cost them—and whether they can find a better deal somewhere else.

With outrage growing over incomprehensible medical bills and patients facing a higher share of the costs, momentum is building for efforts to do just that. Price transparency, as it is known, is common in most industries but rare in health care, where "charges," "prices," "rates" and "payments" all have different meanings and bear little relation to actual costs.

Unlike other industries, prices for health care can vary dramatically depending on who's paying. The list prices for hospital stays and doctor visits are often just opening bids that insurers negotiate down. The deals insurers and providers strike are often proprietary, making comparisons difficult. Even doctors are generally clueless about what the tests, drugs and specialists they recommend will cost patients.



Princeton economist Uwe Reinhardt likens using the U.S. health-care system to shopping in a department store blindfolded and months later being handed a statement that says, "Pay this amount."

The price-transparency movement aims to lift that veil of secrecy and empower patients and other payers to be smarter health-care consumers. Federal and state agencies are gathering reams of price information from doctors and hospitals and posting them for the public. Health plans are offering online tools that let members calculate their out-of-pocket costs. Startup companies are ferreting out and publishing the long-secret rates that providers negotiate with insurers.

When consumers can compare prices for doctor visits, hospital stays and other services, the theory goes, market competition will help keep them down.

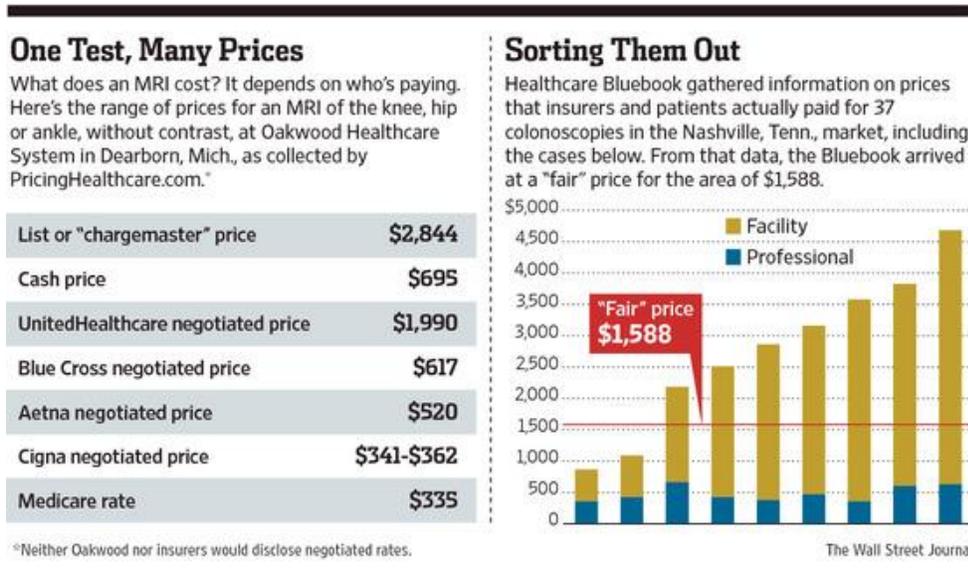
## An Incentive to Change

This is new territory for health care. Doctors and hospitals have rarely competed on cost. Third-party payers still foot the bulk of the bills, and many players in the health-care industry benefit from keeping their costs and profit margins murky.

"The time for transparency has clearly arrived—but is everybody ready to have real pricing power brought to bear in a way that could destabilize the health-care sector?" asks Susan Dentzer, a senior policy adviser at the Robert Wood Johnson Foundation. "It means upsetting a lot of apple carts."

The pressure to change is rising, however. Experts expect consumers to be much more price-sensitive as they shoulder a growing proportion of health costs themselves. Last year, 38% of Americans with employer-sponsored insurance had a deductible of \$1,000 or more—up from 10% in 2006, according to the Kaiser Family Foundation.

Silver and bronze plans created by the [Affordable Care Act](#) carry average family deductibles of \$6,000 and \$10,386, respectively. More than half of bronze plans also require patients to pay 30% of doctors' fees, according to health-information site HealthPocket.com. "Most of us still don't have much financial incentive to shop around for cheaper care," says Suzanne Delbanco, executive director of Catalyst for Payment Reform, a nonprofit that works on behalf of employers. "That's changing rapidly."



Efforts to raise transparency are coming from a number of corners, including the Obama administration. But some have mainly shown how confusing health-care pricing is.

Hoping to shine a light on the variations in hospital charges, the Centers for Medicare and Medicaid Services, or CMS, grabbed headlines last May when it released a list of the average prices 3,300 U.S. hospitals charged Medicare for the 100 most common inpatient services during 2011.

## *Huge Differences*

The variations were stunning. The average charge for joint-replacement surgery, for example, ranged from \$5,300 in Ada, Okla., to \$223,000 in Monterey Park, Calif. Even in the same city, there were huge swings. The charge for treating an episode of heart failure was \$9,000 in one hospital in Jackson, Miss., and \$51,000 in another.

A month later, CMS released a second database comparing average hospital charges for 30 common outpatient procedures, and the variations were just as great. A hospital in Pennington, N.J., charged \$3,036 for a diagnostic and screening ultrasound, while one in Bronx, N.Y., billed just \$88.

Many hospital executives dismiss those list prices—also known as chargemaster prices—as meaningless and misleading, since few patients ever pay them. Commercial insurers often use them as a starting point for negotiating big discounts. Medicare itself pays hospitals predetermined rates based on diagnoses, regardless of what they charge.

Industry experts say list prices vary so much in part because hospitals use different accounting methods and have different patient populations. List prices also reflect all the costs of running a hospital, including keeping ERs, burn units and other costly services running 24 hours a day. What's more, many hospital executives say they have to mark up charges for privately insured patients because Medicare and Medicaid reimbursements don't cover those patients' cost—a shortfall the American Hospital Association puts at \$46 billion nationwide last year.

Hospitals "are absolutely in favor of price transparency," says AHA president Rich Umbdenstock, and they support a bill in Congress that would let individual states determine price-disclosure rules. He also says hospitals would like to end the confusing chargemaster and cost-shifting practices, but they can't do it without big changes in payment practices by both the government and the insurance industry.

"If this were in our power to solve, we would have done it a long time ago," Mr. Umbdenstock says. "But it's not something we can do on our own."

## *Shining a Light*

Jonathan Blum, deputy administrator of the CMS, counters that chargemaster prices do matter, particularly to uninsured patients who sometimes get stuck with those inflated bills. He says the administration's goal was to spark discussion about price variations, and that "a tremendous number" of visitors had downloaded the data.

"We've discovered that oftentimes, even health-care providers don't fully realize the extent of those variations," he says. "Our hypothesis is that a lot of the variations aren't warranted."

The prices insurers negotiate with hospitals and doctors are more important to consumers, experts say. Traditionally, those rates have been proprietary. Neither insurers nor providers

want competitors and other business partners to know what they're willing to settle for. Some contracts include gag clauses barring disclosure.

But states are increasingly requiring payers and providers to reveal that information. A few states specifically outlaw gag clauses in health-care contracts. Sixteen states have "all-payer claims databases" designed to collect insurance claims data and use it to monitor trends and identify high- and low-price providers. And some 38 states now require hospitals to report at least some pricing information, although only two—Massachusetts and New Hampshire—rated an "A" in Catalyst for Payment Reform's annual report card for making the information accessible and usable by patients.

Meanwhile, entrepreneurs are sleuthing out negotiated rates from claims data and making them available to consumers and employers in various forms. Healthcare Bluebook aims to do for health care what the Kelley Blue Book does for used cars: It analyzes negotiated rates paid for thousands of medical services in every ZIP Code—supplied by employers and other clients—and posts what it considers a "fair" price for each so consumers can evaluate what they're being charged.

Bluebook's founder and CEO, Jeffrey Rice, says the rates insurers pay for, say, an MRI or knee surgery can vary as much as chargemaster prices do, particularly if a local hospital is dominant or prestigious.

"The difference may not be much between Nashville and Chicago—the big difference may be just down the block," he says.

Mr. Rice says the employers Healthcare Bluebook works with have saved as much as 12% on their health-care costs by making price information available to their employees, with most savings coming on imaging studies, endoscopies, cardiac testing and other outpatient procedures.

Another service, PricingHealthcare.com, asks users to anonymously supply information from their own medical bills to help it amass the list prices, cash prices and negotiated rates for common procedures. It currently shows rates for some 500 procedures in 11 states. Founder Randy Cox says some providers are furious when asked what their rates are, while others are eager to have their entire price list posted. "I get calls from hospital CEOs who know people are concerned about price and think this is an opportunity for their business," he says.

### *A Hand From Insurers*

One of the most widespread initiatives comes from insurers themselves—who say they are eager to help plan members and employers cut their health-care bills. Some 98% of health plans now offer their members some online tool that lets them calculate their out-of-pocket costs, according to a survey by Catalyst for Payment Reform. A few let users compare different providers in the same network.

UnitedHealth Group Inc. has one of the most extensive tools. More than 21 million members can log into myHealthcare Cost Estimator and compare the negotiated rates for more than

500 individual services at in-network providers across the country, as well as their individual out-of-pocket costs for each one. Hundreds of thousands of plan members have used the tool since it launched in 2012, the company says.

Nationwide, only about 2% of health-plan members who have access to such tools have used them, according to Catalyst for Payment Reform. But Ms. Delbanco expects that number to rise as more patients become aware of the tools and see their out-of-pocket costs growing.

Proponents say it is too early to tell how much impact transparency efforts will have on costs overall. California has required hospitals to make their chargemaster prices public since 2003, with little effect on prices.

But one approach called "reference pricing" has yielded some savings. Where local prices differ substantially for a service like a colonoscopy, an insurer publishes a list of providers' rates and agrees to pay a set amount. If patients choose a provider that charges more, they must pay the difference themselves.

In one pilot project, the California Public Employees' Retirement System, found prices for hip and knee replacements ranging from \$15,000 to \$110,000 in the San Francisco area. It agreed to pay up to \$30,000, and some 40 hospitals cut their prices to match. Such initiatives have helped Calpers save nearly \$3 million in the past two years, one study found.

### *What Comes Next?*

Experts say that as consumers increasingly compare prices, it's critical to provide them with information about quality of care as well—otherwise, they might assume high cost equates with high quality.

A growing body of research has found that there is no clear connection between price and outcomes such as mortality rates, blood clots, bed sores and hospital readmission. "Until you break that connection in peoples' minds, there is a perverse incentive for hospitals and health systems to continue to raise prices," Ms. Dentzer says.

Indeed, critics fear that some price-transparency efforts could backfire and spur higher prices: If providers see that insurers are paying competitors more, they might hold out for higher rates, and insurers might be less inclined to give some providers favorable deals.

Some skeptics think that without fundamental changes in how health care is priced and paid for, transparency may confuse consumers more than it empowers them.

But there's a growing consensus that while price transparency alone cannot transform the health-care system, it is necessary to help reveal which costs are excessive and let consumers make better-informed choices.

"At the end of the day, it's our money," Ms. Delbanco says. "We have a right to know what our health care is going to cost."