PRICING THE SERVICES OF HOSPITALS IN THE AGE OF "CONSUMER-DIRECTED" HEALTH CARE

Uwe E. Reinhardt, Ph. D.

Woodrow Wilson School of Public and International Affairs

Princeton University

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Beyond the $10 Aspirin: How well Does Our Hospital Financing Work?

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I. THE CURRENT HOSPITAL PRICING SYSTEM

A. American fiction: the "chargemaster"

OVERARCHING IT ALL IS THE HOSPITAL'S "CHARGE MASTER"

That charge master shows a list price for every minute procedure that might possibly be delivered by the hospital, along with a price for every conceivable supply-item that might be used in the process of treatment, like this:

$\{ P_1, P_2, P_3, \ldots P_{587}, P_{588}, P_{589}, \ldots P_{5088}, P_{5089}, \ldots$

$P_{9389}, P_{9390}, P_{9391}, \ldots P_{12361}, P_{12362}, P_{12363}, \ldots$ etc., etc., all the way to $\ldots, P_{19336}, P_{19337}, P_{19338} \}$

P_{7658}, for example, might be the list price for a ***"Cath Porta Cath Venous B"***, which, according to Stuart Altman, is a, like, popularly known medical procedure, supply item, or "stuff like that."

EXCERPT FROM CALIFORNIA'S SAMPLE CHARGEMASTER

3043442	CATH MAHURKAR	510.00
3043445	CATH MRI SINGLE	1,642.00
3043446	CATH MRI DUAL	2,181.00
3043448	CATH PERITONEAL TENCHOFF	396.00
3043449	CATH PORTA CATH ARTERIAL	2,842.00
3043450	CATH PORTA CATH INTRO 9FR	198.00
3043451	CATH PORTA CATH PERIT	1,878.00
3043452	CATH PORTA CATH TITANIUM	2,875.00
3043453	CATH PORTA CATH VENOUS A	2,842.00 *
3043454	CATH PORTA CATH VENOUS B	1,416.00
3043455	CATH ROUND 6FR	76.00
3043456	CATH TPN	99.00
3043459	CLIP APPLIER	420.00
3043462	CLIP WECK	180.00

The chargemaster is updated annually by each hospitals in a process that is a great mystery to the outside world. As one hospital recently explained it to *The Wall Street Journal:*

"There is no method to this madness. As we went through the years, we had these cockamamie formulas. We multiplied our costs to set our charges."

William McGowan, CFO of UC Davis Health System, 30-year veteran of hospital financing, quoted in *The Wall Street Journal*, December 27, 2004.

The list prices in the chargemasters of hospitals can vary enormously across hospitals – reportedly by a factor of up to 17 – even within a single state.

LIST PRICES FOR SELECTED ITEMS FOR SELECTED CALIFORNIA HOSPITALS

How Much Is That Chest X-Ray?

A new California law allows patients to look up the retail prices of many goods and services at hospitals. A survey of several hospital price lists shows dramatic differences in price.

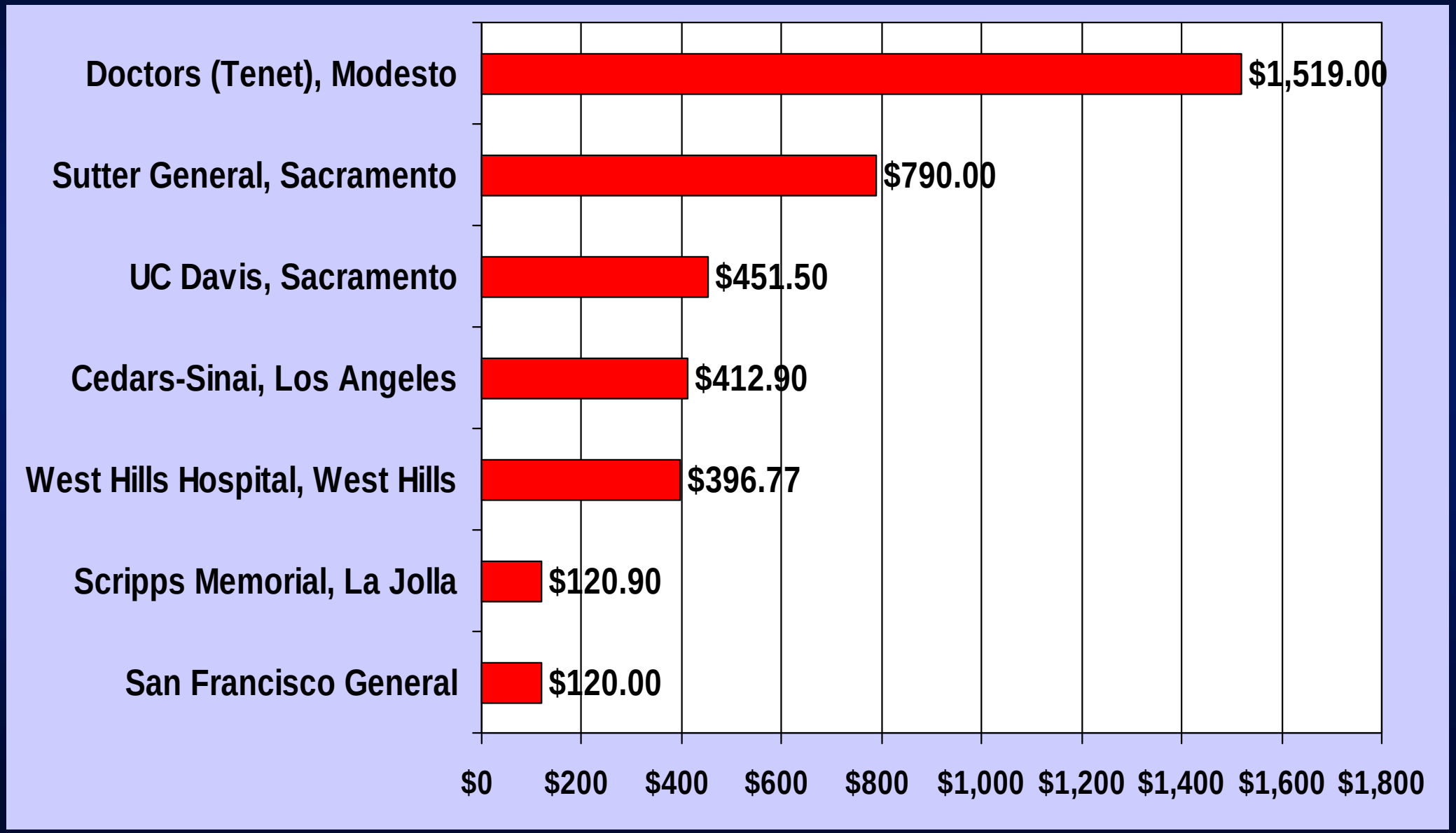
	SCRIPPS MEMORIAL LA JOLLA, San Diego	SUTTER GENERAL, Sacramento	UC DAVIS, Sacramento	SAN FRANCISCO GENERAL, San Francisco	DOCTORS, Modesto	CEDARS-SINAI, Los Angeles	WEST HILLS HOSPITAL, West Hills
Chest X-ray (two views, basic)	$120.90	$790	$451.50	$120	$1,519	$412.90	$396.77
Complete blood count	$47	$234	$166	$50	$547.30	$165.80	$172.42
Comprehensive metabolic panel	$196.60	$743	$451**	$97	$1,732.95	$576	$387.18
CT-scan, head/brain (without contrast)	$881.90	$2,807	$2,868	$950	$6,599	$4,037.61	$2,474.95
Percocet* (or Oxycodone hydrochloride and acetaminophen) one tablet, 5-325 mg	$11.44	$26.79	$15	$6.68	$35.50	$6.50	$27.86
Tylenol* (or acetaminophen) one tablet, 325 mg	$7.06	No charge	$1	$5.50	No charge	12 cents	$3.28

*Hospitals carry either generic version, name brand, or both **Represents the added total of 14 tests that make up the comprehensive metabolic panel

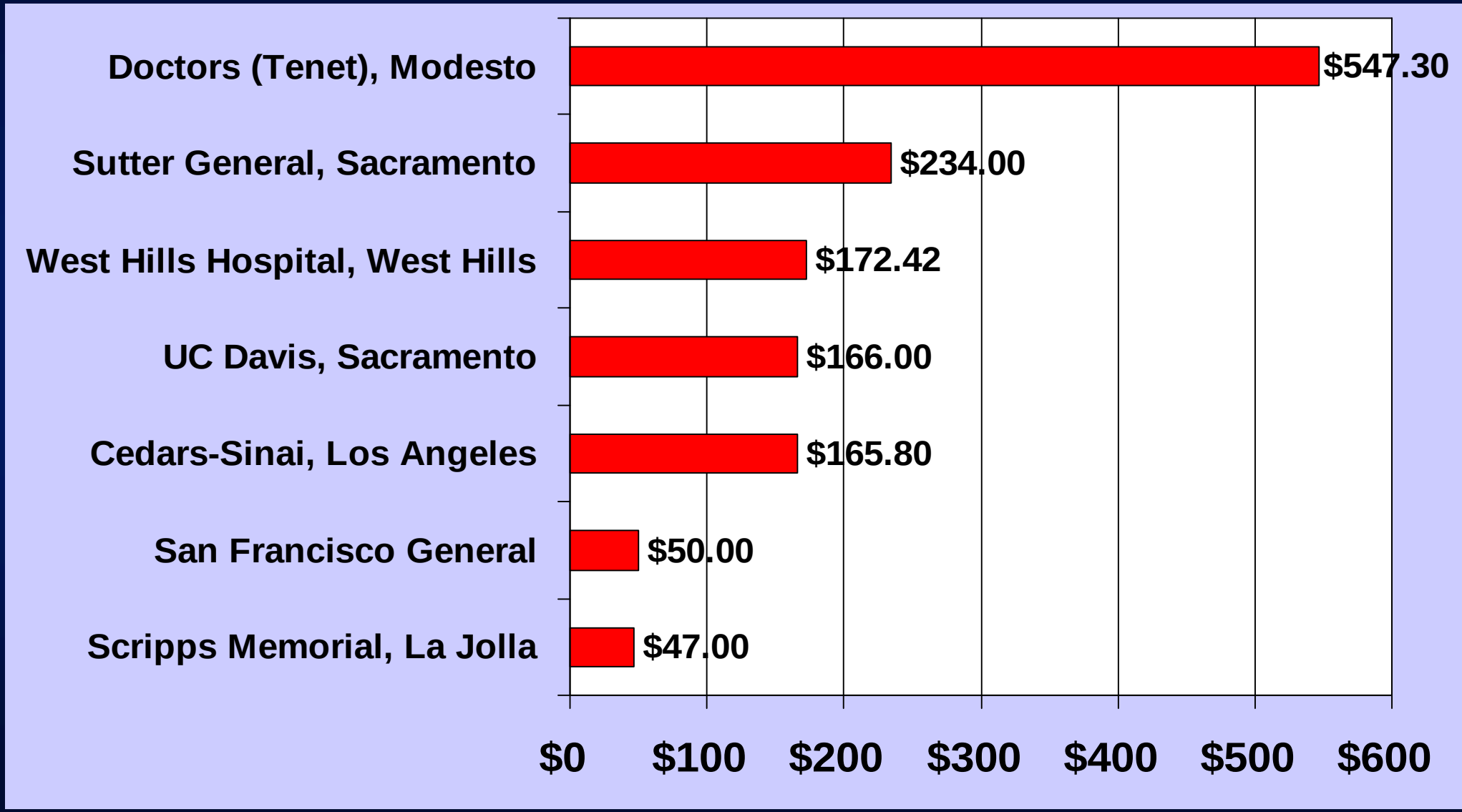
Sources: Scripps Memorial La Jolla; Sutter General; UC Davis Health System; San Francisco General; Doctors Medical Center; Cedars-Sinai Health System; West Hills Hospital and Medical Center

SOURCE: Lucette Lagnado, "California Hospitals Open Books, Showing Huge Price Differences, *The Wall Street Journal*, December 27, 2004: A1.

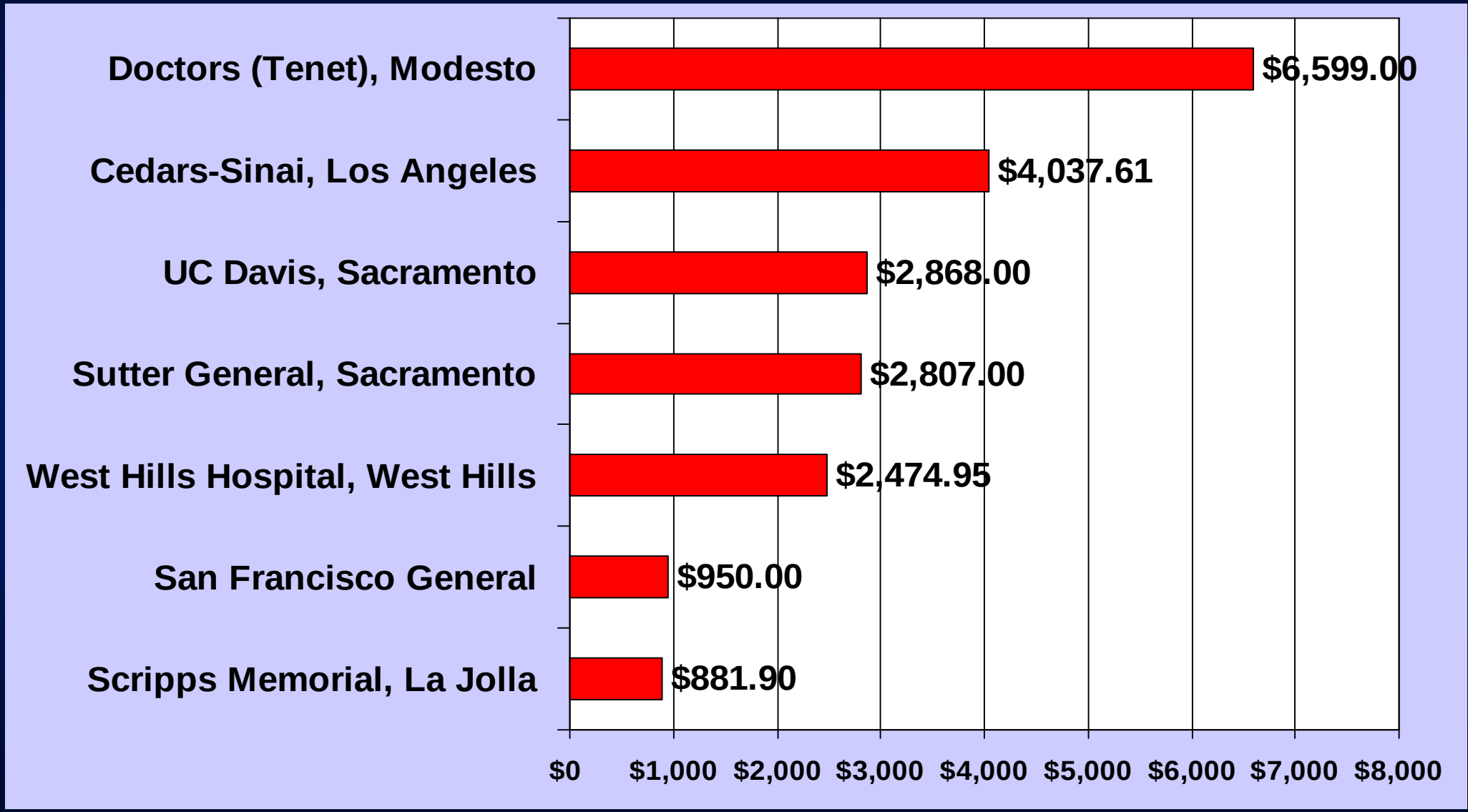
2004 “CHARGES” (LIST PRICES) FOR CHEST X-RAYS IN SELECTED CALIFORNIA HOSPITALS



2004 "CHARGES" (LIST PRICES) FOR COMPLETE BLOOD COUNT IN SELECTED CALIFORNIA HOSPITALS



2004 "CHARGES" (LIST PRICES) FOR CT SCAN HEAD/BRAIN (W/O CONTRAST) IN SELECTED CALIFORNIA HOSPITALS



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I. THE CURRENT HOSPITAL PRICING SYSTEM

A. American fiction: the "chargemaster"

B. The chaos of actual, multi-payer prices

Actually, though, very few patients are billed the list prices in the charge-masters, and even fewer pay them. Instead, all manner of systems are used actually to pay hospitals:

$$\{ P_1, P_2, P_3, \ldots P_{587}, P_{588}, P_{589}, \ldots P_{5088}, P_{5089}, \ldots P_{18389}, P_{18390}, P_{18391} \}$$

1. **MEDICARE:** fees per diagnosis-related (DRG) case, set by the federal central government for the whole country, and "OUTLIER PAYMENTS" based on "Charges" that are calculated with "charge-to-cost" ratios;
2. **MEDICAID:** per diems or DRGs, set by the state governments;
3. **COMMERCIAL INSURERS:** discounted charges or negotiated per diems separately with each of several dozens of third-party payers;
4. **THE SELF- PAYING (UNINSURED):** full charges, or means-tested discounts

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I. THE CURRENT HOSPITAL PRICING SYSTEM

II. HOSPITAL PRICING AND "CONSUMER DIRECTED" HEALTH CARE (CDHC)

"*Consumer Directed" Health Care (CDHC)* is a code term for "*High-Deductible Health Insurance*" *(HDHI)* coupled with tax-preferred "*Health Savings Accounts*" *(HSAs)* which, even more so than current employment-based, tax-favored health insurance , makes health care cheaper on an after-tax basis for high-income patients than it does for low-income patients.

The "consumer directedness" in this construct lies in the hope – and a mere hope it has been thus far – that consumers somehow can be empowered to "shop around" smartly for cost effective health care and will have an economic interest in doing so.

A distinction must be made between two forms of HDHI-HSA products:

1. Those offered by employers among the various health-insurance options, and
2. Those offered in the market for individual health insurance.

The advantage of employment based HDHI+HSAs are:

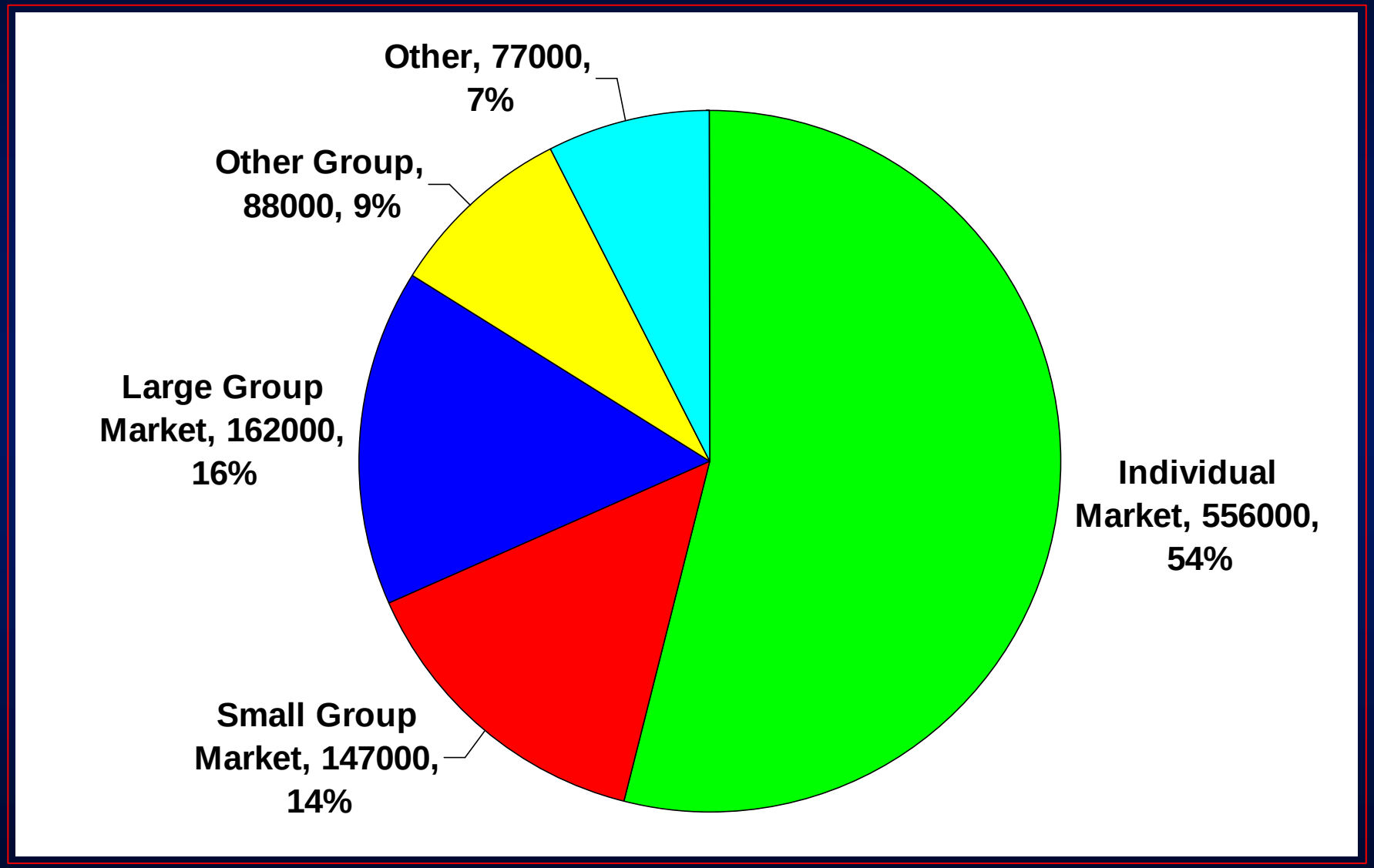
1. The individual is part of a large risk pool;
2. In conjunction with large health insurers, employers can provide individuals with a sophisticated information base on quality and prices of providers (although that these data bases are still in their infancy);
3. The insured's maximum out of pocket spending tends to be manageable and can be linked to ability to pay.

In this regard, insurance products offered in the individual markets are much more problematic.

Yet, so far the bulk of the HDHI+HAS products appear to have been sold in the individual market.

AHIP CENSUS OF HSA MEMBERSHIP AS OF MARCH ,2005

Total enrollment: 1,030,000 members



SOURCE: AHIP HSA SURVEY, Quoted in *PULSE*, Sherlock & Co. June 2005: Figure 1.b

A good feel for the individual market can be had by exploring the following website:

It is a user friendly, Internet-based farmers market, so to speak, for individually sold health insurance policies, including HSA-based policies.

In the following examples, I pretended to be a single woman, like this lady, in her mid 30s with three children under age 10 living in Dallas, Texas (Zip code 75202).

"I just work week to week"

Family Profile:	Ellen is a single mom with three daughters at home
Employment:	Ellen works in a print shop
Location:	Baltimore, MD
Annual Income:	$24,960 (136% of the federal poverty level)
Health Insurance:	Parent: Uninsured Children: Medicaid/SCHIP

Monthly Budget - $1,736

Insurance Plan Benefit Details and Comparison

<< Back to previous page

1 Quote 2 Compare

Insurance Plan Summary

	UNICARE Life & Health Insurance Company	UNICARE Life & Health Insurance Company	Golden Rule Insurance Company	Golden Rule Insurance Company
Company	UNICARE.	UNICARE.	Golden Rule Insurance Company	Golden Rule Insurance Company
Plan Name	HSA Compatible Plan 3 (Family)	HSA Compatible Plan 2 (Family)	Family HSA Saver	Family HSA Saver
Policy Form Number	TXIHDHPWP0304/TXIAPL1203	TXIHDHPWP0304/TXIAPL1203	C-006.3-42	C-006.3-42
Plan Type	PPO	PPO	Network	Network
Estimated Monthly Cost	$148.00	$187.00	$195.26	$322.83
Deductible	$10,000	$5,200	$10,000 for entire family	$3,550 for entire family
Coinsurance	0%	20%	0% after deductible	0% after deductible
Out-of-Pocket Limit	$10,000	$10,000	$10,000	$3,550
Lifetime Maximum	$5 Million	$5 Million	$3 Million per covered person	$3 Million per covered person
HSA Eligible	YES	YES	YES	YES
HSA Administrators	View Options	View Options	View Options	View Options
Online				

Company	Time Insurance	HUMANA.	Time Insurance
Plan Name	One Deductible	HumanaOne HSA	One Deductible
Policy Form Number	236.001.TX,B060-TX,2843-TX,2846,GAN 2348	TX_46073_HH	236.001.TX,B060-TX,2843-TX,2846,GAN 2348
Plan Type	PPO	PPO	PPO
Estimated Monthly Cost	$430.54	$516.46	$611.08
Deductible	$2,600 individual / $5,200 family. The deductible for family coverage is integrated. If applying for more than individual coverage, the family deductible will apply.	$1500 Single/$3000 Family	$1,600 individual / $3,200 family. The deductible for family coverage is integrated. If applying for more than individual coverage, the family deductible will apply.
Coinsurance	0% after deductible	Covered in full after deductible	20%
Out-of-Pocket Limit	$2,600 individual / $5,200 family (includes annual deductible)	$0 Single / $0 Family (deductible separate)	$2,000 individual / $4,000 family. (annual deductible is not included)

Clearly, a family facing these kinds of out-of-pocket payments needs to have access to user friendly and reliable information on differences in the prices hospitals charge in the relevant market area.

Making charge masters public, as California has done, will not be helpful at all toward that end.

EXCERPT FROM CALIFORNIA'S SAMPLE CHARGEMASTER

2982446	SWS-CPSP-GROUP	39.00
3038402	SCISSOR TIP ENDOCUT	351.00
3038407	PUMP PAIN MEDTRONIC SYNII	56,710.00
3038409	CATH MEDTRONICS SYNMED	3,570.00
3038419	PATCH KUGEL LG 19X24	34,058.00
3038420	PATCH KUGEL 13X17	11,533.00
3038421	STENT SET BILARY FARELLI	13,091.00
3038422	SET EXPLORE COMMON BILE	13,642.00
3039395	SURGERY LEVEL 1 GEN	3,089.00
3039396	SURGERY LEVEL 2 GEN	3,718.00
3039397	SURGERY LEVEL 3 GEN	4,463.00
3039398	SURGERY LEVEL 4 GEN	5,368.00
3039399	SURGERY LEVEL 5 GEN	6,435.00
3039400	SURGERY LEVEL 6 GEN	7,736.00

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III. POTENTIAL SOLUTIONS TO THE PROBLEM

A. A common DRG-based relative value scale for all patients

SIMPLIFYING HOSPITAL PRICING IN THE U.S.

1. Expand the DRG system to include all health care given by hospitals to all patients, young and old.
2. Convert the estimated DRGs into equivalent relative value scales (really, relative cost scales) and mandate that every hospital must use this common scale to price its services.
3. Allow each hospital competitively to set and publicly announce its own monetary conversion factor, which converts the common, industry-wide relative value scale into hospital-specific price schedules.

SOME OPEN QUESTIONS:

1. Should hospitals be forced to charge every payer the same monetary conversion factor (the Porter-Treisberg approach), or should these conversion factors be negotiated separately with each third-party payer?
2. If price-discrimination were no longer allowed (Porter-Treisberg), should the Soviet-style pricing approaches of Medicare and Medicaid continue to exist?
3. Should every hospital be mandated to post its own means-tested conversion factors for the uninsured?

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B. Give patients estimates of their out-of-pocket payments only

This approach is now being attempted by large private health insurers – Aetna, Cigna, Wellpoint, Humana, etc.

Rather than revealing to the insured the prices these insurers have negotiated with providers, the insurer uses claims data to estimate what the total out-of-pocket payments would be for patients at various health care providers.

It is the most relevant information from the patient's perspective. The question is how easily this can be done and how reliable the information will be.

To my knowledge, this type of information base is as yet in the early stages of development.

THE END