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Price Transparency Begins at Home

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WHEN IT COMES to reforming their price structure, it is to be hoped that hospitals will do the right thing for the wrong reason. They certainly show no signs of doing the right thing for the right reason.

The right thing is to develop a coherent strategy for setting a structure of prices that combines an external, market-facing perspective on the value of particular services to particular customers with an internal, organization-facing perspective on the cost of offering those services to those customers. The right thing means leaving behind the framework of cost-based pricing and moving to value-based pricing. It requires the pricing of a meaningful unit of service—the same unit that is meaningful from a clinical, operational, and marketing perspective. The right thing means acknowledging that some services cannot be sold at the prices that the market is willing to pay, and so should not be produced unless they are explicitly designated as charitable or otherwise mission related.

The right reason to do the right thing is that developing a coherent pricing strategy supports all the hospital's goals, including its financial survival, organizational growth, community contribution, and quality enhancement goals. A coherent pricing strategy not only provides the hospital with the greatest possible revenue from its services (revenue that can be used to finance charity care, clinical research, and other worthwhile projects) but, of greater importance, helps the institution decide which services it should be offering, where, when, and to whom. The contemporary confusion in pricing mirrors a larger confusion in organizational strategy, with almost all hospitals trying to be almost all things to almost all people and then shrinking in fear of specialty facilities, ambulatory surgical and diagnostic chains, and the technology-enabled offices of their own medical staff.

The wrong reason to do the right thing in hospital pricing is to act because the contemporary pricing incoherence is garnering unfavorable

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Hospital management needs to know the true cost of each service. This is very different from the price at which each service can be sold.

publicity and creating financial liabilities. Billing uninsured patients full chargemaster-based retail prices is not only unethical, it exposes the mindlessness of chargemasters that confuse internal cost-accounting functions with external revenue-generating functions. Using charges

to calculate when particular patients have tripped past contractual (stop-loss) thresholds invites markups to maximize outlier payments from Medicare and the reversing of private payments from per diem to discounted fee-for-service.

Offering patients who face deductible and coinsurance provisions a menu with tens of thousands of prices is an insult to the principles of consumer-driven healthcare, which, when last checked, had the support of the employers, the insurers, and the president of the United States.

PRINCIPLES OF VALUE-BASED PRICING

Hospitals are multiproduct, multimarket, multichannel firms. They offer numerous distinct services in distinct facilities in distinct communities to distinct sets of payers and patients. The wrong way to develop a structure of prices across all these contexts is to measure the cost of each service and then set price equal to that cost, plus a uniform percentage markup. Cost-based pricing of this sort ignores what the payers are willing to pay (i.e., more than cost plus markup in some contexts, less in others). It leaves the firms with unsold services in contexts where the price exceeds the customers' willingness to pay and constitutes a charitable donation (i.e., to the shareholders of a for-profit insurer) in contexts where price falls below

willingness to pay. Good information on costs, by service, facility, market, and customer, is an essential component of pricing strategy (and of organizational strategy more broadly), but it is only one component. Cost information provides the minimum rate at which a particular service should be priced, while the customer's willingness to pay provides the maximum rate. The correct rate is a point within the feasible range that accommodates the organization's larger objectives (e.g., public image, capital accumulation for future growth, historical commitment to particular constituencies) and will vary across services.

Cost-based pricing approximates value-based pricing in the rare circumstance where services and markets are not changing rapidly, overhead expenses are limited, innovation is incremental, quality is easily measured, products are easily compared, numbers of competing buyers and sellers are large, consumers are sophisticated, and the world is at peace. In other circumstances, cost-based and value-based pricing diverge.

It goes without saying that Medicare and Medicaid place strong constraints on the allowable structure of prices for hospital services. Even here, however, a value orientation is important to undergird the organization's range of options, which include which services to offer, in which quantities, in which contexts (e.g., ambulatory, inpatient), with which inputs (e.g., which implantable devices and other clinical technologies). Moreover, Medicare and many Medicaid programs are seeking to outsource the provider payment function to private insurers (Medicare Advantage and Medicaid managed care), where prices are negotiated rather than dictated.

CHARGEMASTER PATHOLOGY

Much ink has been spilt bemoaning that incomprehensible foundation of hospital cost accounting and prices, the redoubtable chargemaster. Hospital charges are opaque, inconsistent, and exorbitant. Much of the worry derives from the misperception that prices should be based on costs, and that the chargemaster is a poor measure of costs, and hence a poor foundation for prices. The truth is that prices should not be based (merely) on costs, and hence, that the chargemaster should be redesigned as either a good measure of costs or a good basis for prices, but not as a measure of both.

It is imperative that the hospital have a valid internal measure of its costs, including fixed and variable, overhead and incremental, and by service line, facility, market, and payer. This analytic structure needs to be built from the bottom up, based on the thousands of components of the hospital's wide range of services, and the criticism that somewhere thousands of cost items are combined in different ways to measure the true cost of particular services is not valid. The fundamental principle of cost accounting should be truth. Hospital management needs to know the true cost of each service. This is very different from the price at which each service can be sold. The most important reason for divorcing prices from costs, and hospital prices from the chargemaster, is to reduce the pressure for distortions to enter the chargemaster based on someone's perception of what a particular service can be sold for rather than what it really costs to produce. The attempt to use the chargemaster as both a set of prices and a measure of costs contami-

nates both uses, leaving the hospital with neither a valid cost tool nor a coherent pricing structure.

A few of the many pathologies of the chargemaster include:

- Hospitals have negotiated discounted charges as the price structure for many private insurers, giving hospitals the clear incentive to raise charges as fast as possible. This leads to the excessive prices charged to individuals and organizations who do not have contractual discounts, including the uninsured but also out-of-town insurers and insured individuals going out of network for care.
- Hospitals often contract with private insurers on a per diem basis subject to a stop-loss threshold, after which a particular patient's case reverts to discounted charges. Again, the hospital has the incentive to raise charges as fast as possible. Not only are overall charges inflated, but markups can be especially high for those services most likely to bring patients across the stop-loss threshold.
- Hospitals paid on a prospective per diem or per case basis are at risk from the rising cost of medical devices (e.g., cardiac stents, orthopedic implants) and are seeking to carve them out of the prospective rate and be paid on a fee-for-service basis. Since invoices for medical devices are difficult to match to particular patients, the fee charged for the carved-out device is based on the chargemaster. This creates an incentive for aggressive markups on these "physician preference items," turning the hospital into a sort of device wholesaler (buy as low as possible

from the device vendors, sell as high as possible to the insurer).

EPISODE PRICING

The contemporary emphasis on consumer cost sharing and information has highlighted the absurdity of the individual chargemaster unit as the basis for pricing, as individuals obviously cannot make choices based on this sort of "information." That the state of California

The meaningful unit of pricing should be the episode of care.

requires hospitals to post their chargemasters on the Internet makes a mockery of the principles of price-conscious choice. The meaningful unit of pricing should be the episode of care, approximated not too poorly by Medicare's diagnosis-related group system (except that the DRG payment excludes the physicians' contribution). It strains the imagination to demand that consumers shop among hospitals based on an obligation to pay 20 percent coinsurance, but at least if prices are enumerated in terms of episodes they have a fighting chance. Not only is the episode potentially understandable to the consumer as a unit of pricing, it is potentially understandable to the hospital staff as a meaningful unit for cost analysis, process improvement, and marketing. In short, customers want

to buy automobiles, not thousands of individual auto parts.

Episode pricing would involve numerous challenges of measurement and contracting, and may prove to be more difficult than it is worth compared to, say, per diem contracting. Either way, the debate over the appropriate unit of pricing should not obscure the deeper principles of hospital pricing. Prices should be based on value, not merely cost. Value will vary across services and customers and needs to be measured systematically and accurately. Cost will vary across services and customers and needs to be measured systematically and accurately. No one system can measure both value and costs. Prices must take into account both, not just one or the other.

Pricing strategy is a component of organizational strategy. The importance of price strategy in the hospital sector is not primarily that consumers will understand their financial obligations and make informed choices or that uninsured patients will not pay more than their insured compatriots. Rather, coherent internal cost accounting and value-based pricing are imperative in order that hospitals understand their own processes, clearly distinguish costs from prices, and make informed decisions as to which services to offer and to whom. Price transparency begins at home.

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