

Ineffective Price Transparency

Patients need meaningful information about out-of-pocket costs

Proponents of price transparency in the healthcare industry aspire to provide patients with meaningful information that empowers them as consumers to make decisions about their treatments. However, the effort so far has simply provided patients with information about basic hospital or clinic charges, expecting patients somehow to do something useful with it. This approach adds little understanding from a patient's perspective. Instead, it has the potential to confuse and mislead them.

True price transparency depends upon a patient's thorough understanding of hospital or clinic charges; but, from a cost perspective, patients are concerned only with a medical procedure's impact on their pocketbooks. Basic charges generally don't affect a patient's out-of-pocket liability, and the information will do little more than increase frustration and decrease satisfaction.

For example, the figure below represents the actual average charges calculated over a year's worth of data for an in-patient procedure for a hip- or knee-replacement:

HIP OR KNEE JOINT REPLACEMENT (DRG 544 – MAJOR JOINT REPLACEMENT OF LOWER EXTREMITY)						
	Hospital 1	Hospital 2	Hospital 3	Hospital 4	Hospital 5	5 All five Hospitals
Number of Procedures	106	393	349	163	612	1623
Average Length of Stay	4.73	3.59	3.86	3.89	3.68	3.78
Average Charge	\$54,981.22	\$48,966.08	\$42,572.62	\$60,730.04	\$50,729.54	\$49,830.56
			LOW	HIGH		

For the same procedure at five different hospitals, the average charges range from a low of \$42,572.62 at Hospital 3 to a high of \$60,730.04 at Hospital 4. The difference between the high and low is \$18,157.42, with a five-hospital average of \$49,830.56. Given the price information above, a patient could reasonably conclude that the most expensive place to undergo the procedure is Hospital 4 and the least expensive is Hospital 3. That is not necessarily true. The industry's transparency efforts are clouded by the contractual relationships between healthcare insurance companies (payors) and healthcare providers (physicians, surgery centers and hospitals). The contracts define payments from the payors and patients to the providers; however, the contracts are neither easy to understand nor publicly accessible. Healthcare providers and insurance companies craft complicated agreements that define the reimbursement (contract allowable) on a procedure-by-procedure basis. These agreements calculate the reimbursement thresholds using variables such as case rates, per diems, and percentage of charges, just to name a few.

- Case rates, or "flat rates," are fixed amounts at which a procedure is reimbursed, regardless of provider's general charges or the length of stay in the hospital
- Per diems are fixed amounts per day at which a procedure is reimbursed, regardless of provider's general charges; but total reimbursement varies on how long the patient is in the hospital
- Percentage of charges, exactly as it sounds, is a negotiated percentage of the patient's total charges – consisting of room types, length of stay, medicines, implants, etc.

Therefore, if a patient has health insurance with reimbursement based on a case rate or per diem basis, provider's charges do not matter. It is not meaningful. The Healthcare Financial Management Association (HFMA) assembled a task force called the Patient Friendly Billing Project™ to examine transparency. The task force's most important recommendation is that patients should be provided with meaningful information specific to the procedure

**HIP OR KNEE JOINT REPLACEMENT
(DRG 544 – MAJOR JOINT REPLACEMENT OF LOWER EXTREMITY)**

		Insurance 1	Insurance 2	Insurance 3	Insurance 4	No Insurance (Self Pay Discount)	
		Case Rate \$9,750	Per Diem \$1,500	Per Diem \$2,500	Percent of Charge 30%	Percent of Charge 68%	
Patient Benefits							
Patient Deductible	\$1,000	Contract Allowable Hospital 3	\$9,750	\$6,000	\$10,000	\$12,772	\$28,949
Patient Deductible Met	\$-	Patient Out-of- pocket Hospital 3	\$2,100	\$1,725	\$2,125	\$2,402	\$9,26
Patient Co-Pay	\$250						
Patient Coinsurance	10%	Contract Allowable Hospital 4	\$9,750	\$6,000	\$10,000	\$18,219	\$41,296
Out-of-pocket Maximum	\$5,000	Patient Out-of- pocket Hospital 4	\$2,100	\$1,725	\$2,125	\$2,947	\$13,215
		Out-of-pocket difference between Hospital 3 and 4	\$0	\$0	\$0	\$545	\$3,951

and hospital that incorporates the patient's unique benefits (deductibles, co-pays, co-insurance, and out-of-pocket maximums).

Referencing the average joint-replacement charge information from before, the lowest charge was from Hospital 3 and the highest charge was from Hospital 4. Above is an example of five different insurance situations that illustrate the impact on a patient's specific out-of-pocket responsibility.

In the first four cases where a patient has the exact same deductible, co-pay, coinsurance and out-of-pocket maximum, notice the difference in the patient's out-of-pocket liability due to any of the hospitals. The difference is primarily attributed to the contractual relationship between the hospitals and the health insurance companies. The other contribution was the difference in charges. This example illustrates the impact of the contract on the patient's out-of-pocket liability.

Now let's examine the question, "Do charges matter?" Recall that Hospital 3 had the lowest average charge for the procedure while Hospital 4 had the highest. In comparing insurance plans between both hospitals, the patient's out-of-pocket liability was the same in three out of the five scenarios. Only two of five were affected by the difference in charges. So, for a patient with Insurance 2, they would pay \$1,725 at either hospital. In looking only at charges, the patient could erroneously conclude that an \$18,157.42 difference in charges would translate into a difference in their out-of-pocket liability. For a patient with Insurance 4, the \$18,157.42 difference in charges translates only into a disproportionate \$545 difference in their out-of-pocket liability.

Patients clearly need better and more meaningful information that is relevant to their specific insurance, healthcare provider, and medical condition. Patients want someone to explain their out-of-pocket responsibility. At the same time, healthcare providers need the tools to provide that information. Those tools are now available in the form of sophisticated software packages that help them understand the complexities of contracts, the specifics of benefits, and patients' out-of-pocket responsibility. But simply to prescribe publication of basic charges as the cure for the issue of price transparency is at best naïve and possibly even bordering on malpractice. □

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