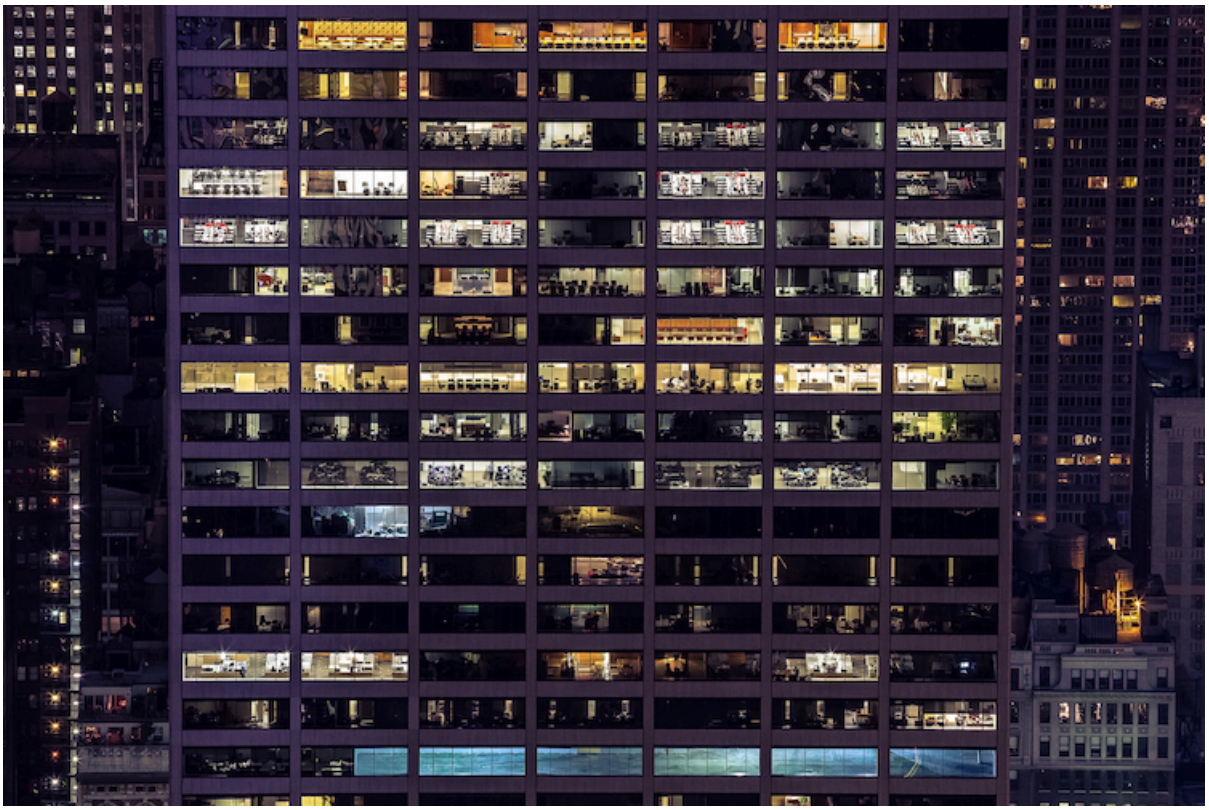
Health Care Price Transparency for Consumers Starts with Provider Action

written by Theresa Hush | March 23, 2017



“Consumer choice” is at the heart of the national health care debate. This presumes access to accurate information about costs. While consumers woke up to health care costs a few years ago as their share began to rise, they lack the necessary facts to make intelligent decisions about the quantity and quality of what they are purchasing. As costs continue skyward, this crucial information, especially price transparency, is what consumers are now demanding.

But health care pricing remains a mystery that can’t be solved by consumers, on their own. While “pricing” to consumers includes insurance premiums and payments to providers, only providers have the key to correct the problem that is largely driven by provider decisions and costs.

Without Clear Pricing on Health Services, Consumers Risk Significant Debt

The proposed American Health Care Act promotes "freedom of choice" for consumers, replacing current subsidies and plans with Health Spending Account tax incentives for consumers to purchase what they need. But how will consumers be able to make choices without clear pricing on health services? Absent that information, they risk piling up debt for unpaid medical bills.

The average contribution into Health Savings Accounts (HSAs) was $1,864 in 2015. It is clear that even consumers who are making coverage choices now are not properly estimating the costs of care, failing to set aside the basic average deductible amount for their insurance coverage, let alone the co-insurance for services. Furthermore, those consumers are the currently covered and employed. Higher risk or poorer individuals losing coverage under the ACA repeal will be less able to set aside necessary resources.

For Consumers, Health Care "Prices" Are Fake

I recently read an article that compared health care to getting a car fixed, because in the initial stages of diagnosis and treatment, the future costs are unknown. This is a big understatement of the problem for consumers.

The first issue facing consumers is not prediction, but basic pricing facts. The reality is that even though there is a "schedule of fees," those fees are not the truth. Real fees are the ones negotiated with each individual insurance company or health plan. Those prices don't create a schedule of prices for "gall bladder surgery," for instance; they only indicate what the health plan will pay Provider A for the physician charges for that service. Provider B in another network has a different negotiated fee.

Charges are what the provider puts on the bill to the health plan; *the real price is what the health plan will allow for payment*. That is why a consumer can get an initial estimated bill from a hospital for a $33,000 CT scan (that says "DO NOT PAY" on it), yet an Explanation of Benefits (EOB) from the health plan that shows the allowed charge as $5,000, and "a write-off" for the difference. The $5,000 is the price that was negotiated with the health insurance plan. But the consumer doesn't know those prices, which vary widely across carriers and markets.

In today's market, almost all prices are negotiated between providers and health plans. The only exception is that some providers refuse to participate in certain health plans, and do not accept insurance company "assignment" (willingness to accept their payment in full for

covered charges). The idea of real "fees" changed long ago during the transition to Managed Care HMOs and PPOs, when health plans realized they could take money out of payments to providers by negotiating prices.

Without confirmed prices, it is difficult or impossible for patients to know their costs in advance. As a practical matter, even if a physician, who wanted to be responsive to a consumer, could estimate his or her own fee, the figure would not reflect the consumer's total costs; there would also be hospital inpatient or outpatient charges (diagnostics or procedures), plus other physicians and services (anesthesiology, pathology, and assistants or consultants). For the consumer, making a health care purchasing decision is as risky as writing a blank check.

Consumers Face a Trap of "In and Out of Network" Costs

Even if consumers make the wisest decisions on their health coverage—meaning that they have verified that their own providers participate in the plan before purchasing—they still get caught in a pricing issue. How? Because under the same system negotiation that dictates fees that health plans will pay providers, there are usually separate negotiated agreements for physicians and hospitals. It is entirely possible—in fact frequently probable—for patients to be able to see their physicians under their plan, yet be out of network for diagnostic tests or procedures at that physician's institution.

Health plans can change or modify benefit plans, and often do, effective the first of January. However, contracts between health plans and providers are not on such a rigid schedule. Consumers can sign up for a plan believing their services will be covered but find their providers go out of network, forcing the consumers to change providers because the rules prevent them from changing coverage during the enrollment year.

Pricing Incorporates Regional Market Inefficiencies

Market negotiation of provider prices may give payers greater leverage than the previous "Usual and Customary" charge calculations, but the outcome is still simply to push existing cost problems to employers and consumers.

Higher regional costs produce higher fee negotiations, without relief for consumers. Indeed, under the latest high-deductible/high-coinsurance benefit plans being purchased, consumers are paying a larger and larger share of actual payments, in addition to a larger share of premiums. But they have no power to directly challenge prices to either health plans or providers.

Five Principles of a Consumer-Directed Price Transparency Strategy

While some believe state directives and legislation are necessary for price transparency, elaborate schemes and claims databases are really not required. Why? First, because providers already hold a centralized source of information for their own tangled web of health plan agreements and, thereby, prices. They also are in command of efforts to reduce their costs.

Second, market competition, as well as economic sense, will ensure that providers paint neither too rosy nor too harsh a price picture. The exercise should instill, rather, a reexamination of their pricing to the benefit of consumers. As the consumer share of reimbursement grows, this will be more obvious to providers because consumers will demand the truth or choose provider systems that are responsive.

This is why providers are the logical first responders to consumers' need for coherent pricing. To remain in business as it becomes heavily consumer-financed, providers will need to pivot their economics to better help patients make wise choices. We all know that the co-insurance alone for the treatment of any major disease will not easily be borne by consumers. It is in the provider's best interest to help consumers make affordable and cost-effective choices for their care.

There is another reason that action must come from providers. The health care payment system, including Medicare, Medicaid and private insurance, has insulated providers from the effects of their own internal actions that increase costs. There is an inherent immunity to the costs that patients will pay for the treatments they prescribe, compounded by the drive to purchase the latest technology and equipment, invest in new buildings, and promote growth strategies that providers assume will be covered by ever-willing insurance and consumer payments.

The fee-for-service payment system has numbed providers to the ramifications of decisions and pricing at all levels. The only way for providers to begin addressing the consumer issues is to comprehend their own pricing and costs, and to recognize the impact on their customers.

The implementation of a consumer-directed price transparency strategy will be most beneficial if it incorporates principles that address the problems for consumers:

> Develop a price transparency strategy with the input of consumers and consumer groups. This is important to both building a constituency of consumers, and receiving consumer perspectives that will vary across patient cohorts, coverage and utilization of services.

Consumer affordability issues deserve a hearing by providers.

Ensure that the whole cost is included in price transparency. Consumers should not have to ferret out what the “price” includes. It should include everything that is known in the treatment plan. This must include physician, hospital inpatient, outpatient surgical and diagnostic, and post-care, if essential. Episodic pricing is the optimal way to cover large case costs, using the bundled payment list most recently used by Medicare.

Focus on the allowed price, either on average, by category of coverage, or by price individualized to health plan. Price transparency built on charges misinforms consumers. It will be difficult competitively to reveal contracted prices, but creative combinations of health plan types, or categories of care, can cover proprietary concerns and still meet consumer needs. The process of patient communication can be carefully implemented to avoid the public “price list” that most providers fear, although providers must realize that in the future, such information will be readily available for comparisons by consumers.

Identify areas where there are excluded or uncovered services. All providers know the gray areas of coverage. They should identify these to their patients, as well as the costs associated with them.

Tie cost-related performance improvement initiatives into price transparency. Consumers should know the areas where providers are making the effort to keep costs down, so that they can be a partner in those goals. Cost performance has been undernourished in health care systems unless in response to reimbursement policies, but deserves a place in price transparency and consumer awareness.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image Credit: Vladimir Kudinov