The price–cost disconnect in healthcare: Negative consequences and recommended remedies

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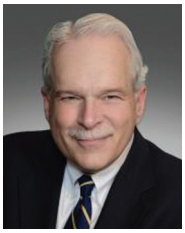

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Abstract Payers and providers have been forced to scrutinise costs more over the last five to ten years of vigorous healthcare reform; however, this increased attention to costs has not been reflected in pricing, and a price–cost disconnect leads to many deleterious consequences. This paper outlines the negative results of this disconnect and recommends several ways in which this gap can be corrected to create a more cost-efficient healthcare economy, one of the goals of the so-called Triple Aim of healthcare reform.[1]

KEYWORDS: price–cost disconnect, consumer-driven cost efficiencies, bundled payments, value-based reimbursement, cost accounting, provider management, preservation of margins

INTRODUCTION

In most free market economies, price and cost are intimately related. For instance, in the manufacturing sector, pricing usually starts with determining the cost of goods sold (or COGS) and then adding on other indirect costs, such as corporate overhead, and an anticipated margin to set a price that is likely to result in a profit.

Market demand also plays a huge role in the setting of prices, and where demand varies, price elasticity must exist to match price with demand and create an efficient marketplace.[2] Nevertheless, underlying costs of production (of goods or services) must be inextricably linked to the ultimate price for a viable microeconomy to exist.

In healthcare, there is little or no connection between the costs of producing services and the subsequent price charged to the consumer who buys these services. This, in part, has to do with the many intangible

non-cost factors, such as accessibility and reputation, that contribute to pricing models in healthcare.[3] This disconnect leads to several negative consequences within the healthcare industry that must be remedied for effective reform of this sector of the American economy to occur.

Many consumers have had the unfortunate experience of receiving a hospital bill with itemised prices for supplies or services that are way above retail prices familiar to most consumers. The notorious US$50 Tylenol is a perfect example of this phenomenon, and while most hospital CFOs claim that these high costs are nothing to worry about since 'no one really pays full price', the advent of consumer-directed health plans, with higher deductibles and co-pays, has made it harder for patients to ignore these episodes of sticker shock.[4]

Even if individual patients can be persuaded to disregard the underlying costs of healthcare services, politicians and policymakers are finding it harder and harder to do so. Healthcare expenses are rapidly approaching 20 per cent of the US gross domestic product (GDP), and while the recent recession has brought about somewhat of a plateau in the healthcare inflation curve, it is now picking up again as the economy has recovered. This paper outlines the negative results of the healthcare price–cost disconnect and recommends several ways in which this gap can be corrected to create a more cost-efficient healthcare economy.

NEGATIVE CONSEQUENCES RELATED TO THE PRICE–COST DISCONNECT

Cost shifting

Costs are commonly shifted in the current healthcare economy, eventually ending up as a responsibility of the end-consumer of services.[5] For instance, with the advent of the Affordable Care Act, many activities prevalent in the health insurance industry, for example, denial of coverage to high-risk individuals, were no longer allowed. This factor resulted in extra costs to commercial insurers, and these costs were then shifted onto consumers, in the form of higher deductibles and co-pays for individuals covered by employer-sponsored plans.[6]

Non-transparency of pricing

Costs are not only shifted in the healthcare economy but are also often hidden within prices that bear no relationship to the true costs of service delivery.[7] As an example, most hospitals rely on complex data systems, known as charge master systems (CMS), to match charges to contractual agreements with third-party payers, and often these charges (prices) are set 'strategically' to match demand and to drive patient volumes to those most highly profitable service areas within the hospital. Although underlying costs of care delivery may have once been the basis for the charges listed in the CMS, these costs may ultimately be hard to find as they become hidden within the many other items that must be factored into strategic pricing activities.[8]

Many hospitals now employ physicians, and they charge hospital outpatient department rates for the ancillary services provided in the physician practices. For instance, cardiologists often perform annual nuclear stress scans on patients with known or suspected heart disease. It is not uncommon for this testing (which entails exactly the same direct costs whether billed out through the hospital or the physician practice) to go up fivefold to tenfold in price when the hospital rates are applied. This can lead to great consternation when patients are presented with a much larger bill for their annual stress test, only to be told that the higher price reflects larger hospital overhead costs. Again, these costs are difficult to identify or justify in a price that may not have been related to true costs in the first place.

This disconnect leads to a lack of transparency with regard to true healthcare costs and thwarts efforts, such as health savings accounts or high-deductible health

plans that are being used to bring about consumer-driven cost efficiencies in the healthcare marketplace.

Hiding true costs within strategically set prices also leads to consumer backlash once the true costs are revealed, often within the line items of a bill issued by a provider to an unsuspecting consumer. This backlash is also now more challenging to defend when the consumer is responsible for high upfront deductibles or co-pays.

Price inflation

The lack of connection between price and costs leads to healthcare providers paying little attention to actual costs and more attention to negotiating agreements with third-party payers regarding fee schedules (pricing). As noted, while CMS in many hospitals or fee schedules in many physician practices may have once been built upon true costs, over time these charges are adjusted, and, ultimately, the line item charges in a CMS bear little or no relationship to underlying costs.

As one hospital CFO put it, 'We don't negotiate rates with payers line by line; that would be way too cumbersome'. Instead, rates are increased or decreased across all services included in a specific contract, with each payer, usually on an annual basis. These negotiated adjustments then accumulate in the CMS like barnacles on a ship, and they eventually obscure what little connection there originally may have been between price and cost.

Furthermore, lowering or raising fees to providers can have different effects on the consumer. Raising fees may lead to payers simply passing these increased costs on to the consumer through higher premiums. Lowering fees to providers does not necessarily lead to lowered costs to the consumer, but instead, may only result in higher profits to the payers, which when not passed on to the consumer do nothing to slow the rate of healthcare inflation.

Waste, inefficiency and poor quality

The lack of attention by providers to true costs in the healthcare sector leads to ongoing waste, inefficiency and poor quality of care. It is important to remember that quality and cost are often inversely related in the healthcare industry. This is especially true in the inpatient setting, where prolonged lengths of stay, due to hospital-acquired conditions (HACs), such as falls, infections, medication errors, post-op complications, etc., lead to higher costs and lower quality. Medicare is now penalising those hospitals with large numbers of HACs and other quality-related cost drivers, such as readmissions.

Disregard for the consumer

Adding to the problem is the healthcare market's price inelasticity. Although there is significant variability, many healthcare prices do not follow the classic laws of supply and demand. This is partly because the demand for certain healthcare services, such as emergency care or oncological care, is so high that the consumer accepts almost any price. Secondly, costs are often not considered when front-line providers order services or refer patients to other providers. Next, consumers are often unable to consider prices owing to the lack of price transparency in the market, and, finally, patients are often reluctant to go against the advice of their trusted provider. As consumerism becomes a stronger force in the healthcare economy, however, this reluctance may diminish.

SOLUTIONS AND REMEDIES FOR THE PRICE–COST DISCONNECT

Payer solutions

1. Bundled payments are emerging as one of the most commonly used types of value-based reimbursement in the newly reformed healthcare economy. This type of payment model, which involves

the consolidation of services around a procedure or episode of care for a chronic condition for which a single bill is invoiced, and a single payment is received and then distributed out to all participating providers, will undoubtedly focus more on underlying costs of care delivery. In particular, costing out bundled payments using methods, such as the Prometheus payment system[9] in which budgeted expenses for evidence-based, value-added steps in the bundled process are used as the basis for the bundled price, will lead to less of a price–cost gap in care delivery.
2. Payers should discontinue the relentless cost shifting that goes on in the marketplace, leading to the end-consumer bearing more and more of the overall cost of care delivery. This circumstance is especially true where payers serve primarily to administer claims and do not truly insure the public against healthcare costs. Remember, cost shifting does not result in true cost efficiencies and, for this to occur, true costs must be identified and permanently removed from the system.

Provider solutions

1. Although several methods of cost accounting are used now within healthcare organisations, most of these use notoriously inaccurate proxies for true costs, such as charge to cost ratios (CCRs) or labour resource value units (RVUs). More accurate methods, such as time-driven, activity-based, cost accounting (TDABC)[10] will be necessary going forward to ensure that all costs included in a service, especially where many services are bundled together, are captured accurately and used as a basis for pricing. In the end, this will allow the price to reflect the underlying costs and promote competition for services and market share, which will then drive down actual costs in the system.
2. Providers should target Medicare rates as the price ceiling for services. This factor also has to do with the propensity for cost shifting, which is a widespread practice within the commercial sector of the healthcare industry. Although commercial payers have been able to shift costs onto the consumer and will likely continue to do so until consumer backlash prevents this activity, government payers cannot follow suit without suffering significant pushback from the taxpayers/voters to whom they are beholden. Therefore, Medicare rates, which are at least nominally related to underlying costs gleaned from annual cost reports that all hospitals and some other providers must report to Medicare, should be seen as the ultimate target within which providers must operate and operate profitably. While many providers take the view that profitability under Medicare rates is not possible, there are likely equally many who believe that the elimination of waste and inefficiency within the healthcare economy will allow most providers to operate and operate profitably within these limits. Also, note that preservation of margins should be the goal in healthcare pricing, not preservation of current pricing. Further, preservation of margins in a market where reimbursement rates are falling is possible only through a lowering of costs. Thus, again, cost accounting and systematic elimination of non-value-added costs should be the goal of most healthcare providers. The aforementioned solutions will also sync provider efforts with those of government payers, who are signalling not only that Medicare and Medicaid rates will prevail across the system, but that those rates will be tied to quality and cost outcomes through value-based reimbursement models.
3. More and more healthcare providers should develop payer capabilities

and begin to negotiate directly with consumers (individuals and employers). This bypassing of third-party payers will allow for more efficient sharing of cost savings between providers and consumers and will eliminate some payer costs, which are non-value-add. Particular examples of costs that should be targeted for elimination within the current system include those related to network development, network credentialing and most third-party payer profits, which while contributing to the inherent cost inflation within the system, are not scrutinised as closely as other more obvious cost drivers. Having providers manage both the clinical and financial risks related to healthcare delivery also will allow for decisions related to cost elimination and cost-based pricing to be made directly by those best qualified to make such determinations and to do so in a way that does not jeopardise quality and patient safety. In the end, this provider management will result in cost efficiency and cost effectiveness, both of which will serve to improve a system that, unfortunately, is now operating far from its optimal potential along both of these parameters.

Patient/consumer solutions

1. Patients should demand that true costs are transparently and accurately communicated through pricing. Consumers will then be able to realise the benefits of consumer-directed healthcare spending and be able to choose wisely with regard to buying of healthcare services. Undoubtedly, price transparency will not fully eliminate the inelasticity of market demand for healthcare services, but it should mitigate this problem and allow consumer-directed healthcare dollars to be more efficiently allocated within the system.
2. Consumers should also demand that price transparency within the system is coupled with the transparent publication of quality outcomes, because knowing both cost and quality outcomes will allow true value-based purchasing to occur, where value is defined as quality per unit of cost.

CONCLUSION

One of the main deficiencies in the current healthcare economy is a fundamental disconnect between price and cost in the system. Prices should reflect true costs of care delivery and should be transparent to the consumer, who is bearing more and more of the ultimate responsibility for these expenses through cost shifting activities systematically performed by payers and providers. Lowering of both price and cost can also lead to the preservation of margins and sustainability of the healthcare system that can ill afford to curtail services, especially in rural and other underserved areas. Provider organisations should adopt sophisticated cost accounting methodologies and develop other capabilities that until now have been primarily under the purview of third-party payers, who themselves contribute significantly to the waste and inefficiency in the system. Medicare rates should be used as a price ceiling within which providers must learn to operate. Medicare rates are built on actual costs as gleaned through a hospital's annual cost reports; and, at least until price points can be more directly connected to true costs, these rates may be the closest the system can get to cost-based pricing. Over time, true costs within the system must be identified; and those that provide no value added must be reduced or eliminated. When the waste is removed, prices can be set in such a way as to reflect not only true costs but also necessary costs, and the Triple Aim components of high quality, population health and cost efficiency can be achieved.

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