

## ***Modern Healthcare Opinions-Commentary***

*Written by William Cox*

# **No simple answers on pricing**

Comprehensive reform of chargemasters requires a single national policy

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Hospital pricing is at center stage in the national debate over controlling healthcare costs, particularly with regard to President Bush's support for consumer-driven healthcare plans.

The administration believes that the success of such plans depends on consumers' ability to make rational choices about seeking care based on how much it will cost. But administration officials don't seem to appreciate that there are steep barriers to fundamental pricing reform that will require one group to take the lead in establishing a national policy that eliminates them.

Hospital charges are the result of more than half a century of incremental development; they emerged from the expansion of private health insurance in the 1940s and were reinforced by the enactment of Medicare and Medicaid in 1965, required by ever-changing government regulations and shaped by the transformation of the healthcare marketplace. While each change seemed necessary at the time, the result is less than optimal for patients, insurers and hospitals.

Hospital administrators have long regarded hospital charges and chargemasters as necessary evils. For lack of an acceptable alternative, they have become deeply embedded in our nation's public and private payment systems. All parts of the system, including hospital care for the uninsured, depend on them.

In acknowledging that hospital charge structures are in need of fundamental reform or replacement, we need to recognize that there is much at stake not only for hospitals, but also for the entire healthcare system. If hospital care is reduced to a price-driven commodity, hospitals may be forced to focus and specialize on the most profitable patients, and provide fewer and less-intensive services to those who pay less, a possibility posed by the authors of a recent article in *Health Affairs*. Will hospitals be able to continue the cost-shifting to private payers that underwrites below-cost payments by Medicare and Medicaid and services to the uninsured? Will hospitals have enough capital to obtain the latest life-saving technologies and improve quality and patient safety?

Currently, changes to charge systems are being adopted in the same patchwork fashion that characterized the systems' evolution. The federal government has issued clarifications that address parts of the problem. Hospitals are revising their billing policies to mitigate the impact of charge-based billing practices on the uninsured. Some state governments (such as California's) have passed legislation requiring hospitals to publicly disclose their chargemasters in an effort to increase scrutiny of individual hospitals' charges. However, these measures fall far short of eliminating the systemic barriers that impede fundamental reform of the hospital charge-based system of pricing.

Developing a comprehensive reform plan would require several demanding steps:

\* Analyzing the various uses of a charge system by hospitals, government programs and private insurers, including how they interact and affect patients and other system participants.

\* Analyzing federal and state laws, regulations and payment systems that require or otherwise

rely on hospitals' maintaining charge-based systems.

- \* Determining how the cost of uninsured hospital patients and shortfalls in Medicare and Medicaid hospital payments would be covered.

- \* Developing one or more alternatives that could replace current charge systems and meet the various needs of patients, hospitals, payers and other healthcare system stakeholders. (For example, eliminating gross charges for the apportionment of costs would require adopting an alternative methodology by Medicare and state Medicaid programs.)

- \* Estimating the costs to hospitals and insurers of converting to the new system, and designing a fair method of paying for it.

Finally, comprehensive reform would require a well-articulated, well-tested plan to achieve a smooth transition from the current system to a new one. The current charge-based system is entrenched in hospital-insurer contracts, state and federal payment systems and in hospitals' internal accounting systems.

Neither individual hospitals nor their associations are in a position to undertake such an effort alone. To be credible and to fairly reflect the needs of all stakeholders, any reform proposal should be the product of a disinterested organization rather than the hospital community itself.

Moreover, significant antitrust issues would surface if hospitals were to join together without government sanction to develop and adopt a new pricing methodology to replace charges. Antitrust laws prohibit not only agreements on specific prices, but also agreements to use specific methods for setting prices.

There is only one institution that has the stature and capacity to address it fairly and effectively: the Institute of Medicine of the National Academy of Sciences. It is the one organization that is capable of engaging the best minds in healthcare-including the hospital community-and doing so in a nonideological, nonpartisan and fair fashion. It has the confidence of Congress and the executive branch, as well as the public and principal stakeholders in the healthcare system.

Hospitals-and all of us, whether patient, provider or insurer-have an immediate interest in ensuring that the hospital pricing debate occurs in a dispassionate and balanced forum that can produce solutions that will be effective and command respect. Without such a forum, we may end up with a healthcare system even less fair, efficient and effective than the one we have today.

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