CENTER *for* STUDYING HEALTH SYSTEM CHANGE

Providing Insights that Contribute to Better Health Policy

STATEMENT OF

Paul B. Ginsburg, Ph.D.

President

Center for Studying Health System Change

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U.S. House of Representatives

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Mr. Chairman, Representative Pomeroy and members of the Subcommittee, thank you for the invitation to testify before you today about hospital pricing issues. My name is Paul B. Ginsburg, and I am an economist and president of the Center for Studying Health System Change (HSC). HSC is an independent, nonpartisan health policy research organization funded principally by The Robert Wood Johnson Foundation and affiliated with Mathematica Policy Research.

We conduct nationally representative surveys of households and physicians and site visits to monitor ongoing changes in the local health systems of 12 U.S. communities. We also monitor secondary data and general health system trends. Our goal is to provide members of Congress and other policy makers with unique and timely insights on developments in health care markets and their impacts on people. Our various research and communication activities may be found on our Web site at *www.hschange.org.*

Rising Health Costs

After a respite in the mid-1990s, health care cost trends are rising rapidly again, leading to growing health insurance affordability problems for employers and consumers. At the moment, rising prices for hospital care are an important factor in spending increases for health care covered by private insurance.[1] Although rising input prices, especially for labor, are a factor in rising hospital prices, increased hospital consolidation and consumers' desire for broad hospital choice have enhanced hospital bargaining power with health plans. Engaging consumers through market forces to make more cost-conscious choices about hospital care offers the potential to slow this trend.

In recent years, employers' main strategy to slow cost growth has been to give consumers financial incentives to use less health care and to be sensitive to prices for services. The most important changes for the health care system have involved changes in the benefit structure—primarily increased patient cost sharing—for the health maintenance organization (HMO) and preferred provider organization (PPO) products that most privately insured people have, but consumer driven health plans (CDHP) and health savings account (HSA) plans, which push this approach further, have received more attention. Choosing hospitals on the basis of price, quality and amenities is potentially an important component of this approach. My testimony today focuses on the first—helping consumers incorporate price considerations into their choice of hospitals.

[1] Strunk, Bradley C., and Paul B. Ginsburg, "Tracking Health Care Costs: Trends Turn Downward In 2003, *Health Affairs*, Web exclusive (June 9, 2004).

Because of the bewildering complexity of hospital pricing and the uncertainty of what services a patient will need, health plan network designs offer more effective opportunities to engage consumer-driven market forces than extensive publication of hospital price lists.

Putting Price Into the Consumer-Hospital Equation: Theory vs. Reality

In theory, empowered consumers armed with precise information about what care they need would compare information about each hospital's quality, amenities and costs in relation to the benefit structure of their insurance. Their physician, who understands what services they will need, would advise them about what those services will cost at each hospital and quality differences among hospitals.

The reality involved in these choices today is far from the theory. Information on what hospital care will cost is available only in forms that are so complex that even the most sophisticated consumers would be overwhelmed. Hospitals charge on a fee-for-service basis that is highly detailed—down to charges for each aspirin. Patients all have different needs, so developing an estimate of what the charge would be for any patient is something that hospitals have not been willing to do. Indeed, many patients are hospitalized to determine what is wrong with them and to determine what treatment is needed.

A number of practical impediments concern the role of physicians. Doctors today know very little about either their patients' insurance coverage or hospital prices. They may have some sense of hospital quality, but this tends to be based on perceptions rather than objective data. Of course, if more of their patients had substantial financial incentives to choose lower-cost hospitals and if information technology were able to put the patient's insurance benefit structure at their fingertips, doctors might become better advisers on these issues.

But doctors often do not practice in all of the hospitals that might be viable options for the consumer. This not only introduces a conflict of interest into the relationship of the physician acting as the patient's agent, but also poses to the patient the reality that choosing certain hospitals will require a change in physician. Indeed, with the increasing presence of physician-owned specialty hospitals, these conflicts are becoming more significant.

Consumer Choice Under Managed Care

Under managed care, health plans serve as an intermediary between the consumer and hospitals to negotiate lower prices for hospital care. This is done not by providing the consumer with a great deal of price information, but instead by forming a network of hospitals that have agreed to a price schedule with the plan. So all managed care enrollees need to do concerning costs is decide whether to limit themselves to hospitals in the network. If consumers use a network hospital, they will in most cases know exactly what it will cost—often a fixed-dollar amount (sometimes zero)—for the hospital stay.

In the 1990s, when most managed care plans had relatively restricted networks of hospitals and physicians, plans were successful in negotiating prices that were substantially lower than they would have been in the absence of managed care. But the lack of provider choice and suspicion that plans placed too heavy an emphasis on cost in developing networks contributed to a powerful backlash against managed care. Employers and consumers demanded broader provider networks, and managed care plans, which are essentially agents of employers, responded by broadening their provider networks. The mechanism of a network remained the same, except that consumers—and their doctors—were happier about the broader choice and plans lost bargaining clout with hospitals because they could no longer credibly threaten to exclude hospitals from plan networks because hospital prices were too high. Tighter hospital capacity and increased hospital consolidation also contributed to declining plan leverage with hospitals. Nevertheless, managed care plans still maintain substantial discounts from what hospitals charge patients with traditional indemnity insurance or those without insurance.

The managed care backlash and the loss of bargaining clout with hospitals from broader networks has led health plans to search for mechanisms that rely more on using financial incentives to steer consumers to lower-cost hospitals. The most important product that has evolved to date is the tiered-hospital network. Within their broad networks, health plans label some hospitals as "preferred." Patients pay less if they choose a preferred hospital but their payments are still relatively modest if they choose nonpreferred hospitals in the network. This provides more bargaining leverage to health plans because hospitals that are not in the preferred tier will lose some volume.

What is attractive about this development is that it can accommodate both consumers who will not accept restrictions on their choice of provider as well as those who are willing to make trade-offs between choice and out-of-pocket expense. Tiered networks are consistent with the newest directions in the use of patient financial incentives, which involve targeting incentives on care decisions where patients have alternatives.[2] For a number of reasons, these tiered-network products have developed slowly,[3] but they eventually may become significant.

Hospital Choice and Consumer-Directed Health Plans

The large deductible that is a defining characteristic of CDHPs may serve to discourage some hospitalizations, but once a patient is admitted, the deductible will almost always be exceeded. So having a large deductible does not provide much of an incentive to choose a less expensive hospital. Once the deductible has been satisfied, CDHPs typically function like a PPO, with similar incentives to use network hospitals. When there is cost sharing beyond the deductible, it can take the form of a fixed-dollar amount per admission or per day (copayment) or a percentage of the amount that the health plan pays the hospital (coinsurance). It is too early to get a sense of what benefit structures will prove most popular for health savings accounts linked to high-deductible policies, but I would expect them to also function like PPOs so that enrollees can take

[2]Trude, Sally, and Joy M. Grossman, *Patient Cost Sharing: Promises and Pitfalls*, Issue Brief No. 75, Center for Studying Health System Change, Washington, D.C. (January 2004).
[3] Mays, Glen, Gary Claxton and Bradley Strunk, *Tiered-Provider Networks: Patients Face Cost-Choice Trade-offs*, Issue Brief No. 71, Center for Studying Health System Change, Washington, D.C. (November 2003).

advantage of health plans' ability to analyze complex hospital price data and negotiate favorable discounts.

Getting hospital price data to the consumer is most important in insurance products that use coinsurance (patient pays a fixed percentage of the bill). If the patient is paying 20 or 30 percent of the bill, prices are relevant, although price differences are diluted by 80 or 70 percent. Blue Cross of California has many products with substantial coinsurance and provides enrollees with hospital cost information using a rating system—from "$" to "$$$$$"—to give patients an idea of how much they will have to pay out of pocket. Such information, which is based on what the plan pays per episode of care, can be a major asset to consumers faced with these types of financial incentives.

Price Transparency vs. Lower Prices

When managed care plans negotiate prices with hospitals, both parties typically agree to keep prices secret. Each side is aware of the possibility that they can get a better deal if their counterpart can keep it secret from others in the marketplace. Whether this leads to higher or lower hospital prices on average in a community depends on whether the health plan or hospital side of the market is more concentrated. Transparency can benefit the more concentrated side of the market because it facilitates taking into account how competitors will respond to prices and aids any collusion. Since hospitals are often more concentrated than health plans at the market level, then transparency would tend to lead to higher prices for hospital care and thus higher health insurance premiums.

The combination of the complexity of dealing with hospital prices and the pitfalls of making negotiated prices public argues for consumers depending on their health plans to negotiate contracts with hospitals and present them with information as to which hospitals will cost them more. This can be conveyed to consumers through differences in copayments (e.g. you will have to pay $300 more to be admitted to hospitals in group A than to hospitals in group B) or communicating which hospitals will result in larger amounts of coinsurance.

A potentially even more powerful tool would be a return to hospital networks that provide less choice, such as the step that the California Public Employees Retirement System (CalPERS) announced on June 16. Some consumers—but not all—would be willing to sacrifice some provider choice to keep their out-of-pocket costs lower. My organization's surveys of consumers have shown a consistent result over time that a majority of consumers are willing to make these trade-offs.

Déjà vu All Over Again

In closing, I would be remiss in not pointing out that today's insurance benefit structures increasingly are returning to coinsurance models similar to traditional indemnity insurance structures. The failure of that insurance model to control costs led to the wide adoption of managed care practices, including restricted choice of providers and tighter administrative

oversight of care use. There's no reason to believe that increased patient cost sharing will be substantially more successful this time around in significantly slowing health care cost trends, even if consumers miraculously had understandable price and quality information to help guide their decisions.

Over the long haul, advancements in medical technology are far and away the biggest factor in rising costs. And our current financing system facilitates the rapid diffusion of expensive new technologies by paying most of their cost—even in the absence of careful consideration of their clinical effectiveness relative to existing treatments. Fundamental change in this dynamic would require support for improved and more frequent evaluation of new technologies prior to decisions about coverage, as well as carefully differentiated incentives built into the financing system that encourage both providers and patients to evaluate the clinical effectiveness of a given course of treatment against its cost.