Healthcare Pricing Strategies In A World Of Price Transparency

What You Need To Do To Win

Daniel Weinbach | Richard Klass | Justin Irizarry

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Report Focus

This report focuses on price transparency for healthcare providers, including hospitals and health systems, ambulatory care providers, diagnostic and imaging providers, physicians, and other care providers within the context of "healthcare." It does not address the issues of insurance premium costs, pharmaceutical pricing, durable medical equipment, or skilled nursing and assisted living costs. The findings and recommendations presented in this report are based on market research, published literature on the subject, and the personal experience of the authors, who are seasoned healthcare executives and consultants.

This report will provide readers with insight regarding:

- What's driving price transparency and its adoption
- Why patients currently don't shop for healthcare services based on price
- The anticipated transformation of patient passivity to active pursuit of healthcare cost reduction
- Considerations for price strategy; notably, the importance of value in price strategy development and positioning in the context of price strategy

Who Is This Report For?

Price transparency will impact professionals across multiple areas within provider organizations, and implementation of successful policies, strategies, and tactics will require a knowledgeable, cross-functional team. Members of the team will need to contemplate legal/regulatory compliance, patient satisfaction and the patient experience, brand fidelity, cost for delivery of care, and market position.

With these topics in mind, this report will benefit Chief Executive Officers, Chief Operating Officers, Chief Financial Officers and their teams, as well as marketing and public relations professionals, compliance departments, strategic planning staff, boards of directors, consultants, advertising agencies, market research firms, healthcare provider association management, and educators.

About The Authors

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Prior to his role at OrthoNOW, Justin was a Wall Street investment banker at Scott-Macon, Ltd. He earned a B.A. in Economics from Cornell University, where he was a 4-year varsity baseball letter winner, and a M.B.A. from The Wharton School, where he was a Joseph Wharton Fellow. At Wharton, Justin taught corporate finance, accounting, and statistics to his fellow classmates and undergraduates at the University of Pennsylvania. Prior to business school, he earned the Chartered Financial Analyst® (CFA) designation, the most respected and recognized investment designation in the world.

Justin has been invited to present at Columbia Business School, The Society for Healthcare Strategy & Market Development (SHSMD), the South Florida Business Journal Roundtable series, the South Florida Executive Roundtable, and the American Academy of Orthopedic Executives.

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Richard is a co-founder of KCI Partners, Inc. He also served as Senior Vice President and Chief Strategy Officer for the Jackson Health System, and Worldwide Director for Market Research for Cordis Corporation, a Johnson and Johnson subsidiary. He previously worked for Price Waterhouse where he led the Medical Practice Management consulting team.

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Daniel has more than two decades of experience delivering marketing communications, advertising, and public relations programs to healthcare clients in nearly every aspect of the healthcare industry. He is president and CEO of The Weinbach Group, a Miami, Florida-based healthcare marketing firm. Under his leadership, the agency has served Jackson Health System, the nation's largest public health system; the University of Miami Health System and its related hospitals and physician groups, as well as Hospital Corporation of America (HCA), SSM Health, and Health First.

In addition to his experience working with provider organizations, Daniel has far-reaching knowledge of healthcare reimbursement models, with expertise in managed care and Medicare Advantage marketing.

He is regarded as a healthcare marketing expert, and his work has been published in numerous journals including the American Marketing Association's *Marketing Healthcare Services, Strategic Health Care Marketing, HealthLeaders* and *Healthcare Marketing Report*.

Daniel earned his Master of Fine Arts degree at the University of Southern California School of Cinema-Television and his Bachelor's degree in Organizational Management at the University of Michigan.

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Executive Summary

Healthcare pricing is a complex and opaque component of healthcare delivery. Wide variances in pricing for the same service, along with huge discrepancies between billed charges and actual reimbursement leave patients and those responsible for their healthcare costs confused about how healthcare prices are calculated. As a result, many consumers harbor dissatisfaction toward the healthcare provider organizations that deliver their care.

In addition to overall frustration, patients bear a greater share of their healthcare costs than ever before – in the form of higher premium payments, higher deductibles, and higher co-insurances. This greater cost burden, along with dissatisfaction, pressure from patient advocacy groups, government, and employer-sponsored insurance plans are driving the industry toward greater price transparency.

Those advocating for price transparency explain that patients need to better understand their financial obligation for the services they're consuming; and greater understanding of this financial obligation can eliminate surprise expenses. Further, price transparency has the potential to allow patients to shop for their healthcare using price as a criterion for selection – something that has historically been absent from healthcare purchase decision making. However, to date, few consumers have demonstrated great concern for price when selecting healthcare providers, even in those circumstances when price information is made available to them.

As healthcare pricing transparency becomes the norm, patients will likely use price in their decision-making only for "shoppable" services, which are those services that are available from multiple providers in the same market, non-emergent, and where price information is readily available.

Healthcare leaders will need to respond to price transparency by developing strategies that incorporate price into their organization's positioning. Most importantly, these organizations will need to establish a price/value model for shoppable services and clearly identify which attributes of their organization contribute to the value proposition – recognizing that each organization is different. Those organizations that approach price transparency as an opportunity to compete solely on price will likely fail, unless they have a long term cost advantage that their competitors cannot replicate.

Successful healthcare organizations will also approach price transparency holistically, integrating market research, advertising and public relations, finance, analytics, and IT into the process. Perhaps most importantly, healthcare organizations will need to develop well-crafted, robust public communications programs to explain their positioning and value proposition to their audiences in the context of price transparency.

The State of Price Transparency

II

The Charge Master

The charge master is a comprehensive listing of a provider's billable services, and it contains the "list price" for those services; i.e., the maximum billable amount invoiced to patients and third-party payers. Healthcare policy makers and pundits opine that the charge master is the root cause of all evil. Yet, the charge master rarely impacts the cost patients or their insurance companies pay.

To the contrary, charge master prices are simply the starting point for negotiating the actual price. For example, managed care companies often reimburse providers at a negotiated discounted rate to their charge master; Medicare and Medicaid may reimburse providers based on patient diagnoses or a fee schedule completely separate from the provider's charge master; and patients who pay privately usually have access to their own set of discounted pricing. Ironically, patients without insurance are among those most likely to be billed at the charge master rates.

Critics of the charge master point out that the prices listed are not publically available and do not provide advance price transparency. Charge masters are often classified as a trade secret, and providers are free to set their rates at any level. Most providers use a multiple (3-6x) of Medicare rates to determine their charge master prices. However, despite this convention, there are virtually no regulations governing how much a provider can charge for a private consumer for a specific service. Further, charge masters:

- Do not base rates on the cost of delivering care.
- Do not base rates on the value provided by the provider.
- Are widely different from provider to provider, even within the same geographic market.
- Rarely mirror an amount most frequently collected by the provider.
- Are exhaustive in scope. *The Essentials of Managed Healthy Care* reports a typical (hospital) charge master may include 20,000 to 50,000 price definitions.[1]

States may enact legislation making hospital charge masters publically available. Michigan did exactly this in 2016.[2] However, since the amount a provider charges has little to do with the amount a provider collects or gets reimbursed by an insurance company, comparing gross charges between providers doesn't accomplish much. Publically available databases report charges, not reimbursement.

1 P. Kongstvedt (2012), *Essentials of Managed Health Care*, Jones & Bartlett Learning, p. 114–115.

2 L. Vanhulle (March 2016), *Michigan Law would require hospitals to post list of fees for services*, Crain's Detroit Business.

Healthcare: It's Complicated

Healthcare is one of the few industries that cannot tell its customers how much vendors charge for a specific service. Indeed, even providers may not know how much they will be paid for a patient encounter at the time service is rendered. For a paradigm shift to take place and for price transparency to accomplish the goals its advocates want, patients must have:

- Easy-to-find price information so they can shop for healthcare service in advance.
- Access to multiple providers for the same service in their geographic area, i.e. there must be competition.
- A clear understanding of all the services (and associated charges) they are consuming during a particular encounter. Most providers do not issue a single unified patient bill showing facility fees, all physician charges, and the cost for all ancillary services.

Lack of pricing information is only one issue. Patients shop for elective services, not emergent care. This limits the opportunity for price transparency to reduce overall healthcare costs. Further, providers in a particular health insurance company's network may not include the most cost-effective options, thereby eliminating the opportunity for a patient to consume the least expensive option.

Comparison Shopping

Finding or *creating* apples-to-apples healthcare pricing comparisons or comparisons of healthcare providers is a difficult task. Assessments of healthcare providers are affected by different patient value perceptions; e.g., physician skill and experience, physician reviews, brand associations, ease of access, etc.

Commodity-like services – or those services perceived as commodities – offer the best opportunity for comparison shopping based on prices. Commodity-like services include: radiology/imaging, physical therapy, biopsies, pathology, most urgent care, colonoscopies, endoscopies, vaccinations, dialysis, and even medication management of chronic diseases such as diabetes and hypertension.

Pushing Against & Fighting For Price Transparency

Advocates for price transparency assume patients will seek lower cost options when they have price information available to them and are responsible for their healthcare bill. They contend the veil of secrecy that surrounds healthcare price information leads to unanticipated charges. These surprise bills anger consumers, and sympathetic legislators are pushing to make policy changes to rectify the situation. These changes are intended to allow healthcare consumers to easily determine their financial responsibility for the healthcare services they purchase.

However, political action groups create formidable barriers to effective implementation of price transparency initiatives. These groups include the American Hospital Association (AHA) and other provider associations. To illustrate, the Ohio AHA, Ohio State Medical Association, the Ohio Psychological Association, the Ohio Physical Therapy Association, and the Ohio chapters of the American Academy of Pediatrics, the American College of Surgeons, and the American Osteopathic Association *all opposed state transparency legislation*.[3] However, some of these organizations disseminated communications – perhaps to address public perception – that varied greatly from their lobbying efforts. For example, consider the following public positions:

- The AHA's official position is "patients and families deserve meaningful information about the price of their hospital care, and America's hospitals and the AHA are committed to providing it. But more can, and should, be done to share health information with the public, including, but not limited to, hospital pricing information. The AHA and its members stand ready to work with policymakers on innovative ways to build on efforts already occurring at the state and hospital level and share information that helps consumers make better choices about their healthcare."[4]

- The American Medical Association (AMA) addressed price transparency with two policies in June 2015. The AMA "supports price transparency and recognizes that achieving meaningful price transparency may help control healthcare costs by empowering patients to choose low-cost, high-quality care."[5]

Despite the majority of trade associations working against price transparency, a few powerful trade organizations have come out forcefully in favor of price transparency, including the American College of Physicians, the Business Group on Health, and the Healthcare Financial Management Association.

Court rulings are not always price-transparency friendly either. In 2015, the Supreme Court (Gobeille v. Liberty Mutual) ruled that self-insured companies do not have to turn over their healthcare payment information. This ruling shoots a "huge hole in APCDs [All-Payer Claims Databases]," which seek to provide essential insight into what private health insurers pay for healthcare – something that has long been shrouded in secrecy. Because more than 60% of workers are covered by self-insured plans, the absence of those claims diminishes the overall value of any APCDs. They're no longer "all-payer," but rather "a few payers."[6]

3 R. Bluth (July 2017), Price Transparency In Medicine Faces Stiff Opposition — From Hospitals And Doctors, Kaiser Health News. Found at: https://khn.org/news/price-transparency-in-medicine-faces-stiff-opposition-from-hospitals-and-doctors/

4 American Hospital Association. Found at: http://www.aha.org/advocacy-issues/transparency/index.shtml

5 American Medical Association (2015), Strategies to increase health care price transparency. Found at: https://www.ama-assn.org/sites/default/files/media-browser/public/about-ama/ councils/ Council%20Reports/council-on-medical-service/issue-brief-strategies-increase-health-care-price-transparency.pdf

6 Y. Feyman and A. Frakt (March 2016), Found at: https://www.statnews.com/2016/03/04/health-care-cost-transparency/

Drivers For Healthcare Price Transparency

III

State Initiatives

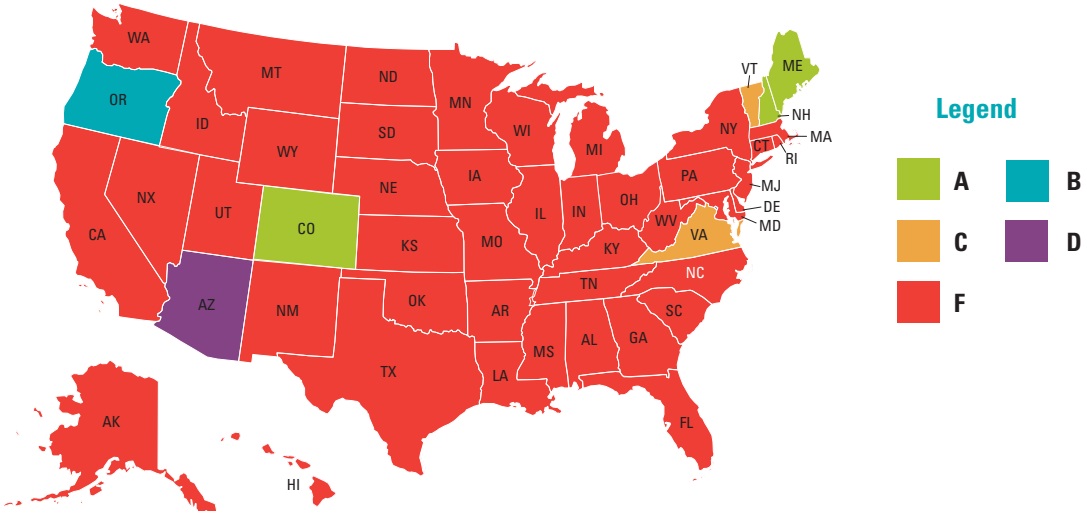
The Catalyst for Payment Reform and the Health Care Incentives Improvement Institute ("the Institute") distinguishes between states with effective and non-effective price transparency initiatives. The Institute states "real healthcare price transparency relies on a rich data source and supplies meaningful price information on a wide range of procedures and services, and is presented on an accessible, publicly available web site."[7]

States want healthcare price transparency. But their definition of price transparency differs, and each state's level of effort to attain transparency varies greatly.

As a result, most legislative efforts to advance price transparency have been ineffective. Collecting data is not sufficient; it must be publically reported over time, easily digested by consumers, and comparable between different providers.

- While most states address pricing transparency, the majority are not performing well when measured against the standards established by the Institute. Ineffectiveness emanates from the "weaknesses in the design and implementation" of state "laws, earning them each a D or F" in the report card.[8]

Price Transparency Grades By State



7 F. Brantes and S. Delbanco (July 2016), Report Card on State Price Transparency Laws, p.5 Found at: https://www.catalyze.org/wp-content/uploads/woocommerce_uploads/2017/04/2016-Report-Card-on-State-Price-Transparency-Laws.pdf

8 Ibid.

State Initiatives *continued*

Fortunately, state laws can quickly change. To illustrate, Florida received an F from the Institute. Yet, soon after the report was published, Florida "enacted one of the strongest state laws protecting consumers."[9, 10] The law was enacted in April 2016.

- Even before this law, Florida passed *The Healthcare Price Transparency Act* (effective July 2011). Under this act, certain medical offices, urgent care centers, and healthcare clinics must publish and post charges for medical services.

- In Florida, urgent care companies post the prices of many of their most frequent services.

Price transparency laws are not effective, according to the Catalyst for Payment Reform and the Health Care Incentives Improvement Institute.

Health Insurance Companies

Health insurance companies often seek to incentivize health plan members to shop for lower prices. They implement direct steerage programs using financial incentives or design benefit plans that get patients to price shop.

Most healthcare insurance companies have created tools for their subscribers to better control healthcare costs. For example, United HealthGroup launched the tool *myHealthcare Cost Estimator*.[11] The tool "allows users to search through an alphabetical list for a particular procedure or problem such as knee pain and provides different treatment paths. Several estimates are offered and are color coordinated by price with red being above the cost of the local average and green being under the cost."[12]

9 H. Meyer, (April 2016), *New price transparency law puts Florida in the consumer vanguard*, Blog: Vital Signs, Modern Healthcare. Found at: http://www.modernhealthcare.com/article/20160419/blog/160419918

10 H. Meyer (April 2016), Florida governor signs law shielding patients from surprise medical bills: Found at: http://www.modernhealthcare.com/article/20160414/NEWS/160419946

11 United HealthGroup, myHealthcare Cost Estimator Now Offers Quality and Cost Information for Inpatient Services. Found at: http://www.unitedhealthgroup.com/newsroom/ articles/feed/unitedhealthcare/2013/1120myhealthcareestimator.aspx

12 S. Baumi (May 2012), Healthcare transparency tool from UnitedHealthcare to be rolled out. Found at: https://medcitynews.com/2012/05/healthcare-transparency-tool-from-unitedhealthcare-to-be-rolled-out/

Patients

Patients are generally confused about their healthcare costs because they a) don't understand all the ways in which they are financially responsible and b) have, in part, providers that do not render a single, unified statement. Instead, patients often receive charges from radiologists, anesthesiologists, pathologists, laboratories, etc., and these invoices may arrive months after services are rendered.

Understandably patients want to know their financial obligation, which is typically comprised of their:

1. **Insurance Premium**: The money paid to a third-party payer (insurance company) for a healthcare insurance policy. Patients in employer-sponsored plans often pay only a portion of their premium, as little as 10%, or as much as 90%.

2. **Deductible**: The patient's financial obligation before the patient's insurance kicks in to pay a claim.

3. **Copayment**: The money paid to a provider at the time a medical service is rendered.

4. **Co-insurance**: A percentage of the healthcare cost that the patient pays after his or her deductible has been met.

5. **Out-of-network exposure**: Cash payments to providers not included in the insurance plan network of providers.

6. **Non-covered healthcare services exposure**: Cash payments to providers for services not covered by the insured's insurance plan.

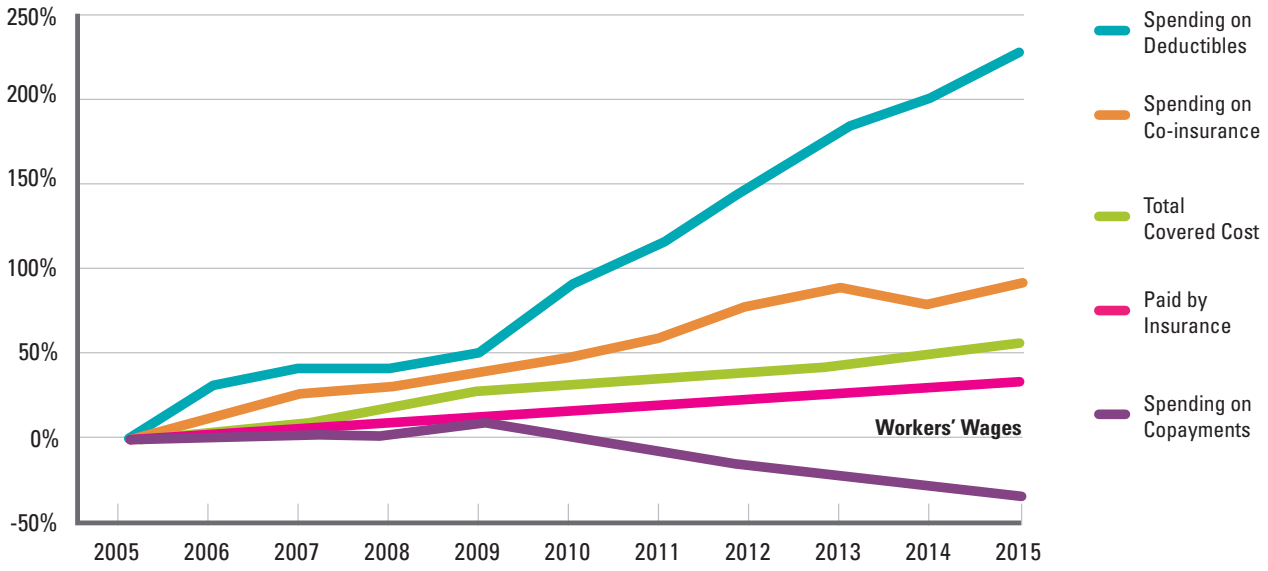
Patients pay more out-of-pocket for healthcare services now than historically. "A new Kaiser Family Foundation analysis finds about one in four people (24%) covered by large employer plans spent more than $1,000 out-of-pocket on healthcare in 2015, an increase of seven percentage points from 17% in 2005. About 1 in 10 people in such plans (12%) paid more than $2,000 out-of-pocket in 2015." [13]

13 Kaiser Family Foundation (October 2017), New Analysis Finds High Out-of-Pocket Spending Increased for People Covered by Large Employer Plans, Updated Brief Tracks Rise in Workers' Out-of-Pocket Insurance Costs
Found at: https://www.kff.org/health-costs/press-release/new-analysis-finds-high-out-of-pocket-spending-increased-for-people-covered-by-large-employer-plans/

Patients *continued*

An analysis of Truven MarketScan Commercial Claims and Encounters Database shows "between 2005 and 2015, average payments for deductibles and co-insurance rose considerably faster than the overall cost for covered benefits, while the average payments for copayments fell." The graph below shows "over this time period, patient cost-sharing rose substantially faster than payments for care by health plans as insurance coverage became less generous." [14]

Cumulative Increases in Health Costs, Amounts Paid by Insurance, Amounts Paid for Cost Sharing and Workers' Wages 2005 – 2015



Source: Kaiser Family Foundation analysis of Truven Health Analytics MarketScan Commercial Claims and Encounters Database, 2005-2015; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2005-2015 (April to April).

14 G. Claxton, L Levitt, M. Long, & E. Blumenkranz, Kaiser Family Foundation, Peterson-Kaiser, Health System Tracker. Found at: https://www.healthsystemtracker.org/brief/increases-in-cost-sharing-payments-have-far-outpaced-wage-growth/?utm_campaign=KFF-2017-October-Health-Costs-Out-Of-Pocket&utm_source=hs_email&utm_medium=email&utm_content=2&_hsenc=p2ANqtz--

When Does Price Matter?

IV

Shoppable Services

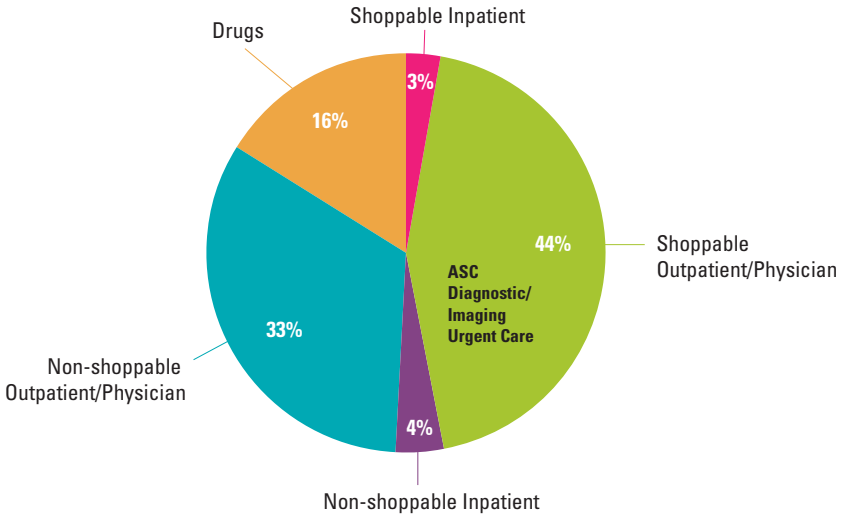
In theory, the higher the out-of-pocket cost to a patient, the more likely shopping (price comparison) behavior will occur. Shoppable healthcare services are:

- **Elective, not emergent**: Patients have a choice to access services or not. For example, a patient can choose where to have a knee or hip replacement; however, a trauma or heart attack victim has no choice where the ambulance takes him or her.
- **Commodities**. For example, the quality of radiology/ imaging services have no meaningful differentiation from one provider to another (from the perspective of the patient).
- **Available from multiple providers in geographically convenient locations.**

A study of insureds in employer-sponsored plans shows:

- **44%** of all out-of-pocket expenses are attributed to shoppable, outpatient services; e.g., procedures performed in ambulatory surgery centers (ASCs), diagnostic imaging centers, urgent care centers, etc.
- **16%** of all out-of-pocket expenses are for drugs/pharmaceuticals. Entities taking risk for a patient population should consider incentivizing such options as generic over brand therapies.
- **3%** of all out-of-pocket expenses are shoppable inpatient services.

Out -Of-Pocket Spending



Source: HCCI, 2016. Claims data from employer-sponsored insurance population. < 65 years old for 2011, data weighted for national representation.

The Conundrum Of Finding Better Deals

Despite increasing financial responsibility for healthcare costs, and despite the advent of some cost-containment tools, most patients have yet to demonstrate a proclivity to apply price comparisons to their selection of healthcare service. Consider:

- Only 20% of patients use cost calculators when given the chance.[15]
- Price transparency – when available – has not reduced patient spending.[16]
- Only 2% of health plan users refer to pricing information.[17]
- In New Hampshire, only 1% of residents used the state's price comparison website. [18]

Even among patients with high deductibles, we have yet to see increased shopping for low price. Take, for example people who have a bronze plan sold through Healthcare.gov, where the average deductible is $12,393. These consumers have responded to higher costs not by seeking better deals, but rather by purchasing less healthcare overall. They've reduced consumption: postponing inpatient (elective) care, visiting fewer specialists, and utilizing less preventive care.

So, if patients are bearing a greater cost for their healthcare utilization, why are they not taking advantage of cost-saving opportunities? There are many reasons, including:

- The consumer cost burden is still tolerable. The average family deductible for an employer-sponsored health plan is $1,478. These families will likely meet their deductible regardless of how frugal they may be in selecting healthcare services based on price.
- Many services are not shoppable.
- Physicians' recommendations remain a more important selection criterion than price.
- Consumers use many attributes to select a healthcare provider beyond price and their physicians' recommendations, including brand perception.
- Healthcare pricing remains opaque, even with the modicum of transparency initiatives underway.
- Patients rarely know all the services required for their treatment or the cost for those services until after services are rendered. For example, they may shop physicians' fees, but they fail to contemplate hospital or facility fees.
- Some people equate higher price with better outcomes, and are willing to pay for it.

15 JAMA. 2016;315(17):1874-1881. doi:10.1001/jama.2016.4288

16 Ibid

17 A. Frakt (December 2016), *Price Transparency Is Nice. Just Don't Expect It To Cut Health Costs*, New York Times. Found at: https://www.nytimes.com/2016/12/19/upshot/price-transparency-is-nice-just-dont-expect-it-to-cut-health-costs.html

18 A. Mehrotra, T. Brannen, & A. Sinaiko (2014), *Use patterns of a state health care price transparency web site: what do patients shop for?*, The Journal of Health Care Organization, Provision, and Financing.

Succeeding In A World Of Price Transparency

V

Pricing and Value

Patients' criteria for selecting a provider are multi-variate; and price has historically not been a determining factor. Patients consider availability/access, geographic proximity, insurance coverage (in network), quality/brand perceptions, physician referrals, recommendations from family and friends, operational efficiency, and potentially many other factors.

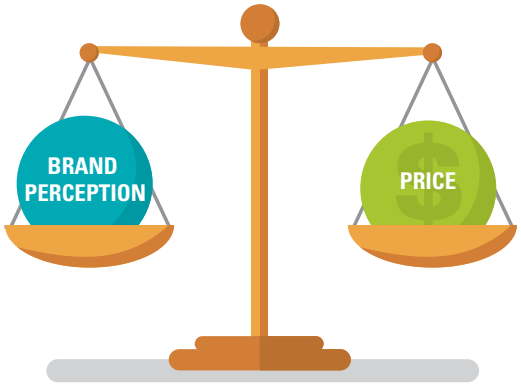
- All of these factors result in a patient value perception.
- The greater the value perception, the more patients are willing to pay, at least when it comes to shoppable services.

More precisely, when it comes to shoppable services, patients will pay more for value. To illustrate: What is a desired healthcare outcome worth? What is the value of a three hour wait versus 20 minutes? Would a patient pay more to go to a physician or urgent care center affiliated with a hospital versus an unknown brand entity?

Positioning In The Context Of Price

Through positioning, healthcare organizations can create the consumer perceptions they desire, e.g. they can determine how their audiences see their brand. "Positioning is not what you do to a product [or service]. Positioning is what you do to the mind of the prospect."[19] Accordingly, healthcare organizations' pricing strategies should align with their positioning. For example, charging a higher price or facility fee when brand perception is superlative aligns with a positioning that prioritizes high quality.

A highly-regarded hospital or health system with a good brand reputation would be in error if it were to set prices at its urgent care centers at the same levels as privately-owned, single-location UCCs, ("doc-in-the-box"). Such a pricing strategy is antithetical to high-quality positioning.



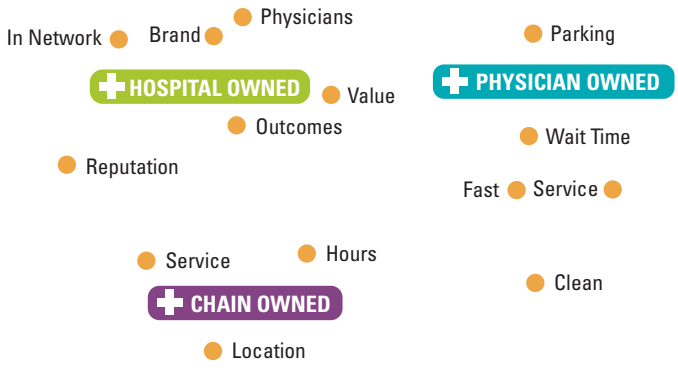
19 A. Ries and J. Trout, (1986), Positioning: The Battle for Your Mind, New York, Warner Books, Inc.

Measuring Your Organization's Brand

Brand power for a healthcare organization is typically synonymous with dominant market share for a given service area. And perceptual maps help understand how a healthcare organization's brand is positioned relative to its competitors. "Perceptual maps allow strategists to visualize products or services associated with multiple market segments. Perceptual maps take several different forms. The most frequently employed forms are correspondence maps, brand maps, and vector maps."[20]

Data for developing perceptual maps typically emanates from market surveys, but can also come from other sources. The following correspondence analysis map shows the positioning of different types of urgent care centers:

Attribute Positioning by UCC Ownership



In this perceptual map:

- Hospital-owned UCCs are seen as having the best physicians, have the most recognizable brand, covered by most insurance networks, and providing the best outcomes.
- Chain-owned UCCs are associated with the most convenient hours, best service, and most convenient locations.
- Physician-owned UCCs are seen as having the easiest parking, shortest wait times, fastest service, and best overall service.
- A good reputation is associated more with hospital and chain-owned UCCs than physician owned UCCs.

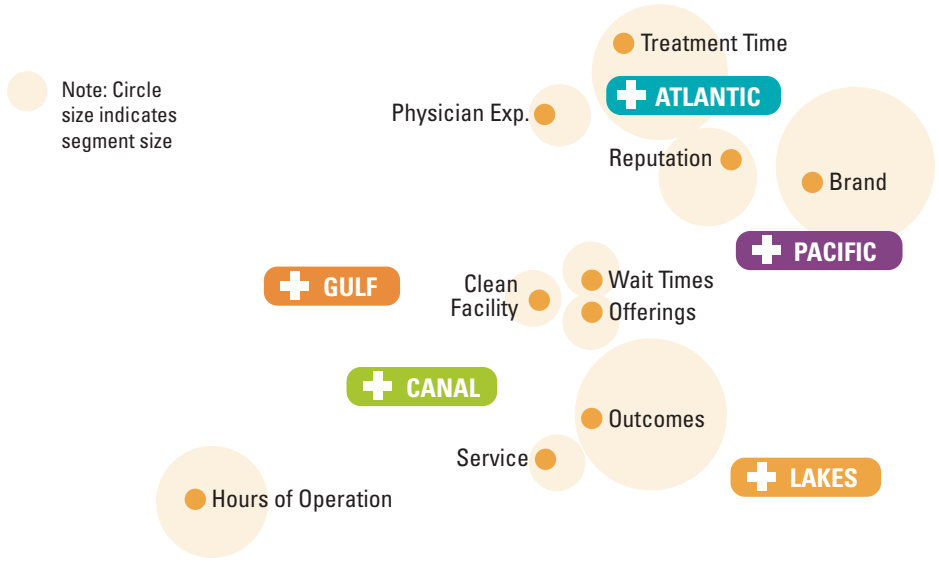
In this perceptual map hospital-owned UCCs enjoyed an attributional advantage compared to chain- and physician-owned UCCs. It informs the hospital-owned UCC to price its service like other hospital-owned facilities. Further, it discourages hospital-owned UCCs from expecting increased volume based on lower pricing.

20 R. Klass (2017), *Strategic Planning in the Real World*, InPrint Publishing, Weston, FL, p 71.

Measuring Your Organization's Brand *continued*

The following correspondence map shows the positioning of different UCC brands; the proximity of each attribute shows patient perceptions. A value-add to correspondence mapping is overlaying market segment size (the larger the circle the larger the segment).

Attribute Positioning and Segmentation by UCC Brand



If you were the Gulf or Canal Brand:

- *How would you change your advertising initiatives, given your relative disadvantage with regard to the market's perception about your UCC?*
- *What value arguments would you make given the market's perception of your best attributes?*
- *Where is the opportunity for a shoppable service pricing strategy?*

Strategic Options & Questions

As hospital and health systems contemplate how to address price transparency and pricing in their strategy, they have distinct options:

- Ignore price transparency in their strategic thinking.
- Use price transparency to differentiate their organization from competition. This means implementing initiatives ranging from broadly communicating the availability of price information to focusing on specific service lines for price/value marketing.
- Establish a competitive pricing/value model, where pricing is on par with competitors.
- Establish an aggressive pricing/value model, where pricing is less than competitors. In this scenario, robust public communication is necessary.

Market research and analytics supports fact-based pricing strategies and helps healthcare executives determine opportunities and identify market segments, document competitive activities, and establish an organization's current market position (preferably using a brand mapping exercise).

Healthcare organizations are best serviced by developing a price strategy. However, before commencing with the formation of such a strategy, ask these questions:

1. ***What do you want to accomplish with your overall pricing strategy?***

- **Make more money?** Your organization may be able to charge a higher price for higher perceived value.
- **Drive more volume?** Recognize for most healthcare services there is little to no price elasticity of demand, i.e., price and volume are not highly correlated.
- **Make competitors meet your price?** Competitors with a higher cost for delivering care may not be able to lower their price (and still earn a profit). To successfully compete primarily or solely on low price, providers must have the lowest costs in the market for care delivery, e.g. lower rent, lower employee salaries, lower utilities, etc.

2. ***Does price transparency mean you have to set a low price?***

   No. In fact, competing on price alone is not a good idea. Competing on value is a more sustainable approach. Patients want to know their total financial commitment and the related value they receive. You can promote price transparency and value, even if your prices are not the lowest, or low at all.

   If the goal is attracting price-sensitive patients through low pricing, choosing the right services for low pricing becomes essential – preferably, those with low operational/overhead costs. Also, keep in mind, price reductions across-the-board are not necessary or advisable.

Price strategy affects shoppable services, and most shoppable services are outpatient services. Still, price transparency as a *differentiator* can be applied across an entire enterprise.

However, when applying price strategy to specific service lines, choose service lines with larger

Strategic Options & Questions *continued*

out-of-pocket costs relative to the total cost, e.g. the out-of-pocket costs for an MRI may be half or all of the total cost, while the out-of-pocket costs for a heart transplant represent only a tiny fraction of the total cost.

Services that can be bundled and promoted to out-of-market audiences, such as international patients can also be appropriate for price positioning.

In addition, service lines that are easily understood and where the audience is easily identified and reached make good sense as targets for pricing strategy consideration.

3. ***Can charging extra fees or high price cause a public relations issue?***

   Yes. However, such issues may not be consequential and may not last long. Further, high prices can be mitigated by high perceived value.

- A high price and/or facility fee may be essential.
- Financial viability may depend on pricing.

4. ***Who should take the lead on establishing pricing strategies?***

   Pricing is a marketing function. Depending on the organization, this function could be found in the strategic planning department, the advertising and public relations department, or the business development department. In addition, finance executives must partner on any pricing initiative, and all collaborators need to keep in mind the following:

- Focus pricing strategies only on shoppable services, pursuant to your payer mix.
- Target services with large patient volumes, high patient demand, and patients that are price-sensitive.
- Avoid service lines with significant collections challenges.
- Determine current contribution margins of specific services, and forecast how changes to pricing for these services will impact financial performance.
- Recognize the importance of "place" in pricing strategy. For example, services provided in a hospital environment have higher associated overhead costs to the provider, and therefore, the price needs to reflect the higher "production costs." Conversely, services provided in a pharmacy-based clinic have low overhead cost and can be priced accordingly. Further, healthcare organizations benefit from actively directing patients to less-costly sites of care, such as an urgent care center instead of an emergency room.

Conclusion

VI

The healthcare industry is slowly pulling back the curtain to reveal the complex and secretive world of healthcare pricing. The reveal has been expedited by a variety of forces including government regulation, consumer advocacy groups, and some consumers who have been "bitten" by surprise charges they didn't expect. Progress toward price transparency has been slow, in part because of the arcane and esoteric nature of healthcare pricing, and also because of the powerful efforts by industry organizations that benefit from the current opaque nature of healthcare pricing.

Surprisingly, patients – by and large – have not been early adopters of healthcare pricing information when it has been made available to them. They remain habitually averse to shopping for their healthcare services based on price. That won't likely change until the majority of healthcare consumers feel the financial sting of healthcare costs (as a result of less generous insurance coverage). Additionally, the methods by which healthcare pricing is communicated to patients needs to improve and become more understandable.

Ultimately, pricing will play an important role in patients' selection of healthcare providers. However that role will be balanced by other purchasing factors, all of which will help consumers to measure value, which is the most important criteria for choosing a provider.

As healthcare organizations incorporate pricing strategy into their marketing, they need to recognize that price – as a selection criteria – only applies to shoppable services, which are elective, non-emergent, readily available in the market, and commodities (in the consumer's mind). In addition, they need to remain cognizant that their challenge as marketers is to demonstrate value, not simply to advertise the lowest price.

Those healthcare organizations that leverage their most appealing attributes and integrate price into their positioning will be most prepared for increasing price transparency and consumerism.

Additional Resources

For more information about price transparency and pricing strategy, contact the authors:

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