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Health & Life Sciences

GETTING READY FOR PRICE TRANSPARENCY

Price transparency will change not just what healthcare providers charge, but which services they offer and how they compete. Here's what you need to understand about transparency – and the steps you need to take immediately.

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Is this the year when price transparency hits a tipping point for US healthcare providers?

Certainly the movement has been gaining momentum for several years, urged on by employers, consumers, and risk-bearing physician groups—each group for its own reasons. Employers are increasingly using transparency vendors such as Castlight to help their employees find lower-cost care options. Some are implementing reference-based benefit designs that require members to pay the difference when they choose a higher-priced provider. Consumers, especially those covered by high-deductible or consumer-directed plans, need pricing information to manage their resources, and even those covered by conventional insurance want to know their out-of-pocket costs before receiving treatment. Finally, physician groups in risk-bearing contracts are actively shopping for lower-cost hospitals, imaging facilities, and other services as a straightforward way to cut their costs and meet their financial targets.

And the pace is picking up. In April, for the first time in 35 years, the Centers for Medicare and Medicaid Services (CMS) released a dataset showing what it had paid individual physicians for specific procedures. (Hospital data for 100 procedures have been published since 2013.) In May, the Health Care Cost Institute announced an agreement with Aetna, Humana, and UnitedHealthcare to create a free online consumer-facing platform that will provide cost and quality information starting in 2015. And multiple states (including Massachusetts, Arizona, and most recently California) have announced or launched statewide initiatives.

In the long run, a mature system of price-quality transparency will almost certainly benefit the healthcare industry by forcing providers to eliminate waste and inefficiency and rewarding innovation. In the short run, however, it is extremely dangerous to provider organizations, and especially to hospitals, which could lose volume to ambulatory facilities and clinics in vital "bread and butter" services. Providers need to understand which services are at risk, how they can respond to low-cost competition, and how to maintain premium pricing in areas where they truly provide superior quality and outcomes. They need a strategy that tells them when to compete, when to retreat, when to re-engineer processes, and when to restructure the organization.

THE ART OF PRICING

In other industries, prices have always been transparent, and pricing is a well-developed science. Companies understand their competitive landscape and use analytics to determine purchasing drivers, price sensitivities, and "stickiness" of key customer segments. With the help of complex models, they can predict what happens to volume, margin, and total revenue as prices are adjusted up and down. And they test, adjust, and test again.

Healthcare providers have never needed a similar approach—at least until now. In large part this is because the prices for most healthcare services in the U.S. are the rates negotiated between health plans and providers. As long as the provider offered a low enough unit price to stay in the health plan's network, price historically had almost no impact on volume.

And both sides have strong incentives to keep them confidential—to avoid revealing their competitive positioning and market power. List prices exist mostly as a starting point for negotiations. That helps explain the nearly incredible price variations found in healthcare. (In one recent study in California, researchers discovered that the price for a standard blood test—a lipid panel—ranged from $10 to more than $10,000.)

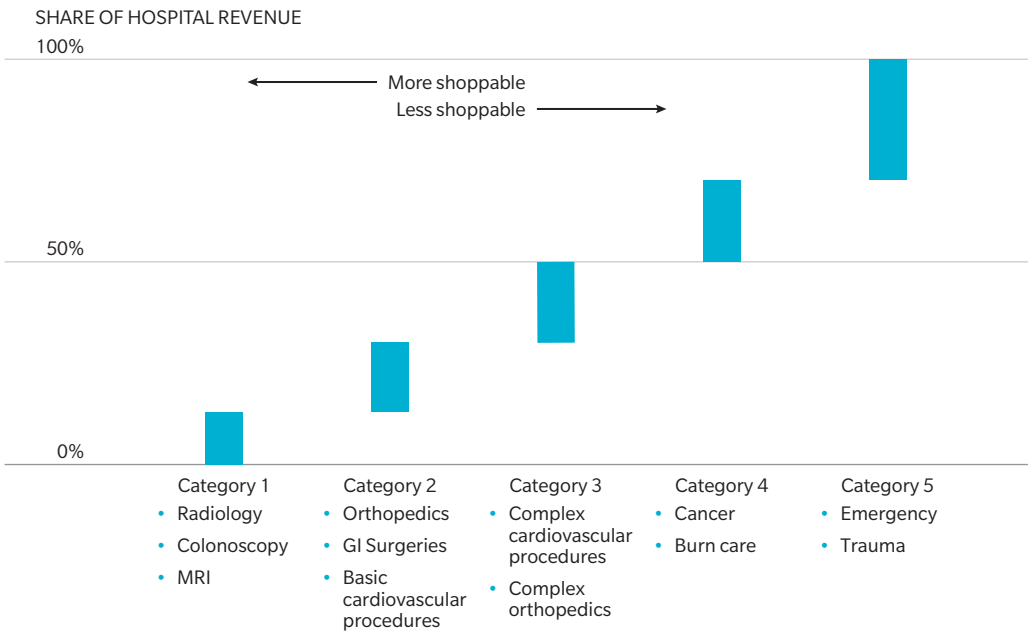
But over the next few years, pricing strategy will become a key element in maintaining profitability. The change won't come all at once, but we believe that institutions that begin analyzing and rationalizing their prices today will see short-term improvements in revenue and profitability and will lay the groundwork for their long-term survival and prosperity.

WHEN PRICE MATTERS

In thinking about the pricing of care, it is crucial to distinguish between what we might call "shoppable" and "non-shoppable" services. And it is crucial to understand the difference between competitors whose price you can match and competitors whose underlying cost structure makes their pricing unanswerable.

Identifying shoppable services is not a simple task. There are degrees of shoppability, and different customers will respond differently to issues of price and quality. (In what follows, we will focus on short episodes and hospital services. A similar process could be applied to chronic care bundles, though in practice we believe that shoppability based on value as well as price is a few years off for them.) We see at least five significant points on the continuum from fully shoppable to non-shoppable (see Exhibit 1):

Exhibit 1: Shoppability of services and share of hospital revenue



1. **Commoditized services:** This category includes services in which there is no significant level of perceived quality and no reason not to use the lowest-cost provider. Today the category is dominated by basic diagnostic procedures—radiology, MRI, colonoscopy, etc. But over the next few years, as detailed quality measures become more and more available, we would expect to see many simple surgical procedures become commoditized. Risk-bearing providers will steer patients to low-cost options, while consumers will optimize on cost, convenience, and patient experience.
2. **Elective services where quality is actually just a threshold:** This could be hip and knee replacements and perhaps other, relatively simple surgeries especially for non-life-threatening conditions. Today it is common to see providers charge a premium for services in this category based on a supposed superiority in quality that cannot actually be documented. Some payers and individual patients may buy in. Upstream risk-bearing physicians will not.
3. **Non-emergent services where there's a real value equation:** This category includes easy-to-price services where the stakes are high (for example, open-heart surgery with its high risk of mortality, or back surgery with its issues about the impact of treatment on downstream costs). Institutions that can quantify outcomes and present them as a story about mortality, back-to-work time, and readmission rates will be able to make these services shoppable on a cost/quality basis.
4. **Hard-to-price non-emergent services where perceived quality carries the day:** Cancer treatment is the classic example. Today reputation is often enough to maintain premium pricing in this category, but institutions should beware of increasing levels of quality transparency and of specialized service providers that will attempt to carve out parts of the package for themselves.
5. **Emergent services:** The patient who arrives in an ambulance usually has no choice of where he's treated. Neither, usually, does his insurance company or risk-bearing health system.

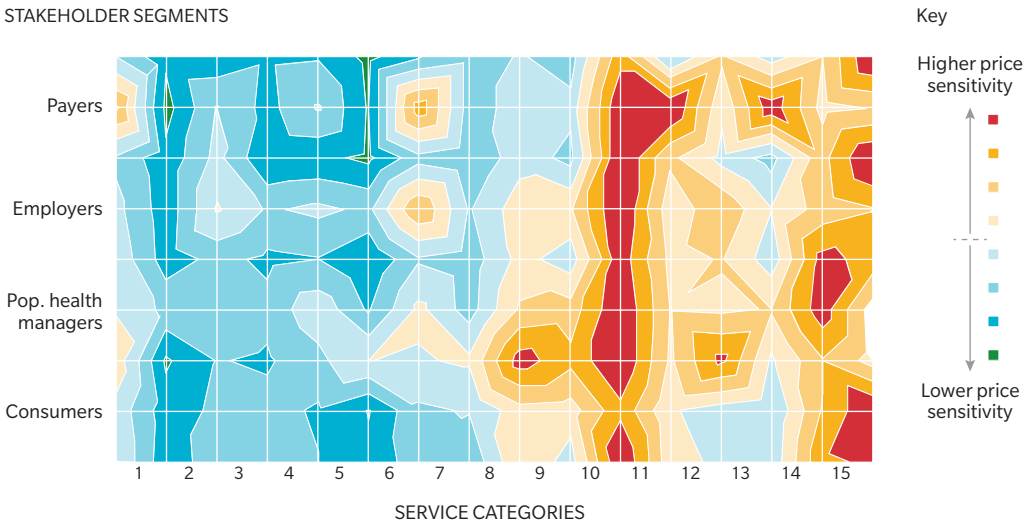
We estimate that between 20 and 35 percent of medical costs are for services that fall into categories one and two. They are the area a transparent market will shine its light on first. Prices for these services vary enormously, sometimes by a factor of five or more, and transparency should lead to rapid rationalization. Providers that cannot make money or at least break even at the new market rate will lose volume and share as customers migrate to the lowest-cost care setting that can deliver the service.

Hospitals will be at significant risk of losing volume to ambulatory surgical centers – and to other hospitals that simply can afford to offer lower prices. Emergency departments-will find themselves in competition with low-cost retail-based clinics. In some cases, it will be possible increase efficiency and reduce costs. But many institutions—especially campus-based hospitals—will discover they cannot compete on certain services. Some may need to discontinue certain service lines. The analysis of pricing should trigger an additional, deeper discussion of how the institution should invest, how it should structure itself, and what services it should offer.

With less shoppable services, providers have some latitude. There will still be price sensitivity, but other factors such as reputation and quality will also play a role. Here the key is to understand how much price counts to each of your customer segments—patients, payers, and value-based care organizations—and how much they value other factors. (See Exhibit 2.)

The only facility in a market that offers a particular service should be able to charge a premium of all three segments. A hospital with a great reputation for surgery may be able to charge payers because its presence in the network is a strong selling point for employers. On the other hand, a physician-led population health manager looking at the same hospital might decide that high price is a deal-breaker because of its potential impact on total cost of care. Price transparency will lower prices overall—but providers need to be conscious of areas where they provide unique value and have particular market strength and where it may be appropriate to raise prices.

Exhibit 2: The work of the strategic pricing function can directly illuminate margin improvement opportunities



WHERE TO START

Pricing strategy needs to become a core skill in healthcare, just as it is in other industries. But, unfortunately, whereas other industries have had decades to build tools and procedures and develop data, healthcare providers are already facing serious price-based threats and need to move quickly to address them, while setting the stage for a more complete solution that will evolve over time. Here are some issues to consider:

1. **What are the immediate threats?** For most organizations in most markets, the first place to look is in commoditized diagnostics. Who are your competitors? What do they charge? Where are they taking market share from you? Remember that customer needs are changing quickly. The fee-for-service network that accepted your price for colonoscopies may now be operating under shared-savings contracts—and looking for a way to slash its diagnostic costs. A key employer in your region could adopt reference-based pricing. Retail-based clinics are ramping up their services and will soon be in a position to compete with your emergency room on less-complex services.

2. **What is your market position? Where do your services sit on the shoppability continuum?** How do your prices compare to your competitors'? Which customers select which services and what do they base their decisions on? What is your market share with payers, risk-bearing providers, and consumers? What is the price sensitivity of each of those customer groups?
3. **How competitive are your operating costs across service lines?** Are there areas where current underlying costs may limit your ability to price competitively? Could pressure from retailers impact primary care competitiveness? Are there areas where you could operate more efficiently, or are there new structures you could adopt that would fundamentally alter your overall structure?
4. **Where are you differentiated?** Virtually all hospitals in large and medium-size markets will lose volume, margin, or both on shoppable services over the next few years. To preserve revenue and viability, you needed to identify areas where quality matters and price appropriately. Remember that you will be facing buyers who are increasingly sophisticated. Payers will know exactly the tradeoff you face between volume and margin. You need to be able to answer them with a similar understanding of their tradeoff between higher initial expenditure and long-term savings on total cost of care.
5. **Where are you going?** Today most hospitals are generalists. We expect that within five years, many will be operating under different, often narrower models. Some will deal mainly with complex life-threatening conditions and they will draw their patients from broad multistate catchment areas. Others will focus deeply on particular conditions. Still others will be low-cost "factories" for procedures. As you face decisions on where to eliminate programs and where to invest, it pays to have a vision of your destination. And indeed the exercise of understanding your market position, threats, and opportunities is a good first step in understanding where it lies.

LOOKING FORWARD

For providers, a "head in the sand" approach is no longer viable; understanding and adjusting to the risks and opportunities that price transparency will drive is critical. With that said, it is still early in the game, and those who are proactive can help shape the story in their markets. There is a precious window of time in which providers can analyze their own and their competitors' prices, analyze the data, engage in aggressive cost cutting, and test the market. It is vital to take advantage of it.

The current round of transparency is just the first. The institutions that fail to meet its challenges will likely find themselves with deteriorating economics just at the point when they are called on to respond to demands for new forms of transparency—such as patient experience, quality, and the ability to manage population health. For the foreseeable future, transparency will be the new, unforgiving basis of competition in healthcare.

ABOUT OLIVER WYMAN

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