

STRATEGIC FINANCIAL PLANNING

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In Light of Transparency, How Are Hospitals Changing Their Prices?

By Jamie Cleverley

Analysis reveals that hospital prices are spreading further from the average.

Each year we're asked about national trends for hospital gross charge inflation as hospitals prepare for implementing pricing changes. This past year was no different, and our discoveries were interesting: In general, the rate of price increase has dropped and fewer hospitals fall into the "average" range.

Understanding the Basics

Before we discuss those findings, here are some basics. Pricing changes—applied at the individual chargemaster code level—are accomplished either by applying one percentage point across the board for all items or by applying different amounts by code. In either scenario, understanding the overall rate of change is important for three primary reasons.

Net revenue impact will result from different levels of gross charge change. Consider a hospital with \$500 million in gross charges that is deciding between a 3 percent increase that would add \$15 million in new charges and a 5 percent increase that would add \$25 million in new charges. Assuming a 10 percent recovery (overall net revenue change to gross charge change), the net revenue difference between the two rates of change would be \$1 million. That additional net revenue could be vital to the attainment of budgeted net income levels.

Many payer contracts contain rate limit provisions that change payment amounts based on differing price change levels. In our example on page 3, the hospital would face



decreased recovery at a 5 percent rate of change if payer rate limits exist at some amount less than 5 percent. Without appropriately understanding and adjusting for the presence of rate limits, budgeted payment levels may not materialize.

Rate changes impact relative pricing position among peer facilities. Let's assume our case hospital increases rates annually by 5 percent while its peer increases by 3 percent. Given equivalent current charges, in five years our case hospital will have gross charges that are 10 percent above the peer. That would be nearly \$60 million more in gross charges, assuming volume stays the same for both hospitals. While the hospital may benefit from the increased net revenue that would also result, it could also be costly if those charges needed to be reduced at some point

in order to be competitive with the peer hospitals.

In the past, it was relatively easy to provide information on gross charge trends as there was general consistency in the overall rate of change among hospitals from year to year. With increased transparency pressure, though, we've seen a variety of different approaches to annual rate changes among hospitals around the country. This emphasizes the importance for hospitals to understand how the peers in their area are changing rates. To illustrate, if the peer in our example above decreased rates by 1 percent each year while our case hospital increased by 5 percent, our case hospital's rates would be about 35 percent higher than the peer in five years. In an era of increased transparency, that is significant.

With this information as context, here is some information on what is being done with regard to overall hospital rate change.

Analyzing Overall Rate Change

It's interesting to see how fast and how far we've come on four inflation rates—Medicare charge per visit (relative weight/wage index [RW/WI] adj.), Medicare charge per discharge (case mix index/wage index [CMI/WI] adj.), consumer price index (CPI) across all segments of the economy, and hospital services CPI.

Medicare charge per visit (RW/WI adj.):

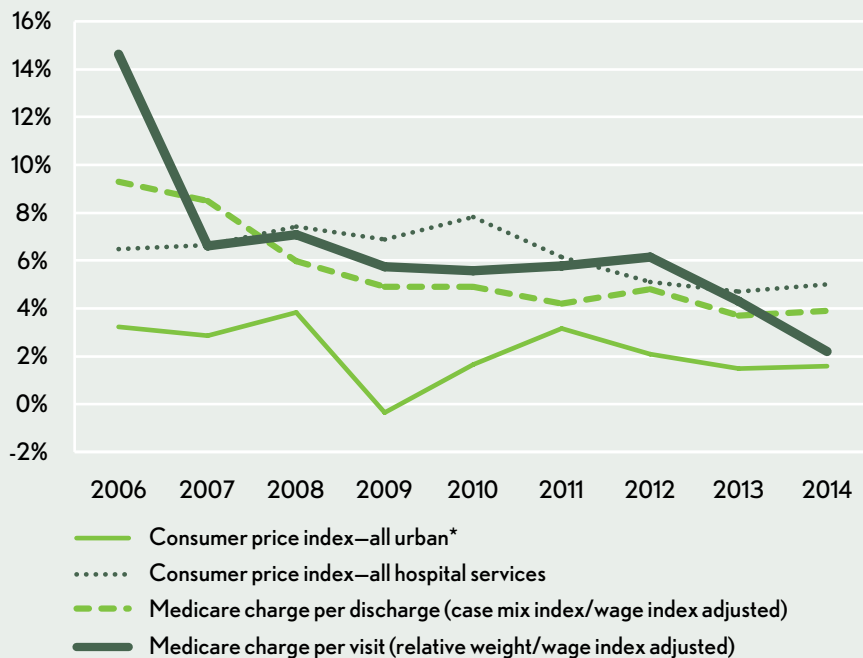
This metric is derived from charges at U.S. hospitals to Medicare patients for outpatient services. The percentage change represents year-over-year change in the average total charge for a patient encounter adjusted for case intensity (relative weight) and cost of living (wage index). This metric has shown the most dramatic decline (see the exhibit on this page). In 2006, the average outpatient charge per visit increased by 14.6 percent from the prior year, but by 2014 that dropped to 2.2 percent. From this trend we could certainly draw the conclusion that hospitals are experiencing the most price pressure on the outpatient side—a point that is consistent with anecdotal information.

Medicare charge per discharge (CMI/WI adj.):

This metric is identical in construct to the outpatient measure, but it uses Medicare inpatient claims and is case mix index (as opposed to relative weight) adjusted. Inpatient annual rate changes were nearly 10 percent in 2006 but decreased to about 4 percent in 2014. Of interest, 2014 represented the first time in many years that inpatient charge growth exceeded outpatient charge growth. This could be the result of hospitals trying to create more patient-sensitive pricing for outpatient services or a response to increased price competition for those services among free-standing providers. Furthermore, it could represent a strategy to move more revenue into the inpatient services that freestanding centers do not provide.

U.S. Inflation Rates

The disparity between general inflation and healthcare inflation explains why so much attention has been generated.



*Bureau of Labor Statistics measure of general market inflation across all segments of the economy.

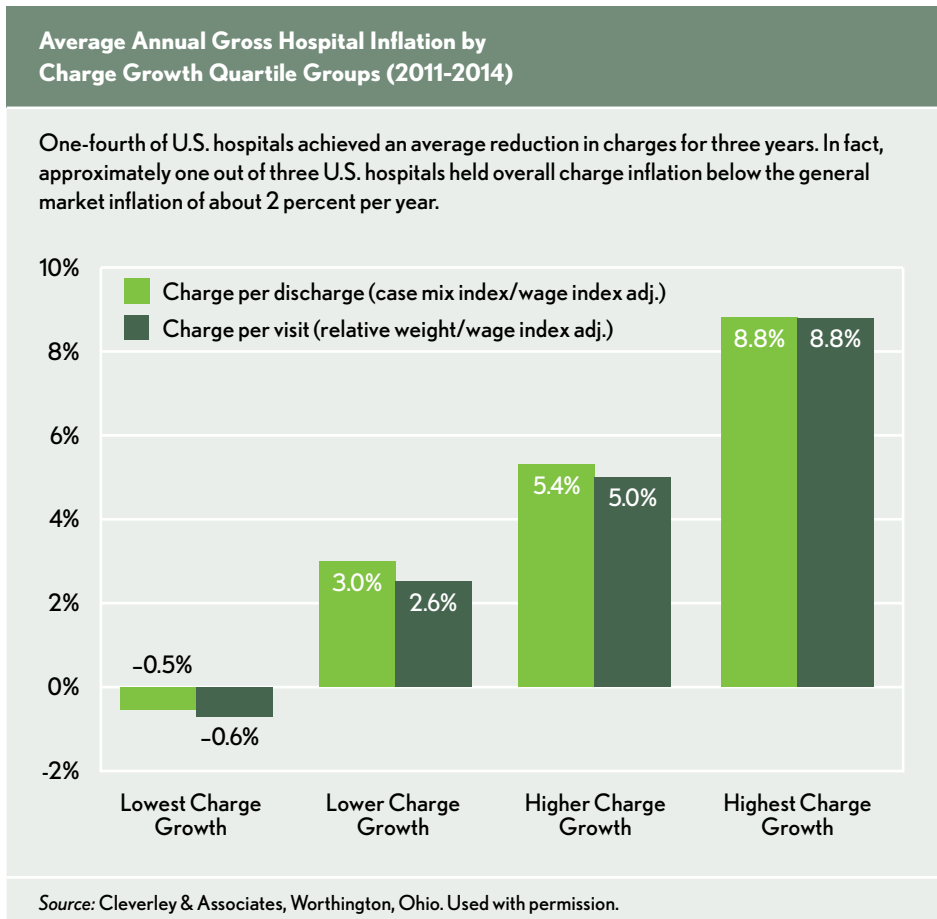
Source: Cleverley & Associates, Worthington, Ohio. Used with permission.

CPI—all hospital services. This value, coming from the Bureau of Labor Statistics (BLS), looks at changes in net payment for services year-over-year. Net payment has been more stable for hospitals, but it has decreased to about 5 percent. In relation to charges, it's interesting to note that hospitals are now increasing their list prices at lower percentages than the increases received in net payment. This is important, as patients are often exposed to both pricing and payment values. If work is only being done to make list prices more "reasonable" or "competitive," consumers may still choose facilities with lower net rates. Managing both list and net is critical for hospitals as they evaluate how to present more transparent overall rate strategies.

CPI—all urban. This value, also coming from the BLS, is a measure of general market inflation across all segments of the economy. For many years, hospital prices increased at rates far greater than the national rate of inflation. While we in the industry know that hospitals only capture a small percentage of that increase, this disparity between general inflation and healthcare inflation explains why so much attention has been generated. Furthermore, even from a net perspective, hospitals are still increasing faster than the national average. This net revenue increase, coupled with increases in utilization, is why hospitals—and health care, in general—are absorbing more and more of the country's gross domestic product, although that has slowed somewhat in recent years. This fact suggests that the attention on hospital pricing and payment is likely to continue.

Finding Significant Overall Rate Changes

In the past, there was more consistency in overall rates of change among hospitals. However, as we have seen more variety in approaches to pricing transparency and defensibility, we have also seen more variety in overall rates of change. We decided to test this through an analysis of Medicare claims data from 2011 to 2014. From those years, we examined data on all



hospitals in the United States (excluding critical access hospitals) to see how gross charges changed on the inpatient (from the Medicare charge-per-discharge metric) and outpatient (from the Medicare charge-per-visit) service areas. We used a combination of these two metrics to evaluate which hospitals had the highest and lowest overall charge growth during the three-year period. We then divided the country into four quartiles to examine the rates of change among the lowest charge growth hospitals (25 percent of U.S. hospitals with the lowest rate of gross charge change during the three-year period) to the highest charge growth (25 percent with the highest rate of change).

While the average U.S. hospital increased inpatient and outpatient charges approximately 4 percent per year from 2011 to 2014, the lowest charge quartile group actually decreased charges by about 0.5 percent per year. Furthermore, the highest charge

quartile group increased charges by about 9 percent per year. While the majority of these changes are due to increases or decreases to the price per unit of service, there may be some utilization differences that should be mentioned. Because the charge per discharge and charge per visit represent total claim charges, as a hospital becomes more efficient in patient care through decreased utilization (e.g., running fewer lab or imaging tests), the charge per patient encounter decreases. So, the lowest charge quartile group could be achieving some total charge reduction through enhanced efficiency.

Regardless of the mechanism, lowest charge quartile hospitals have been able to reduce overall patient charges year-over-year for the three-year period. In fact, we found that approximately one out of three U.S. hospitals held overall charge inflation below the general market inflation of about 2 percent per year.

Rates of Healthcare Cost Inflation by Charge Group (2011-2014)

The slowest rates of growth are seen in the emergency department, while the highest rates of growth are in lab, imaging, and room rates. The latter is significant as it could be an explanation for higher overall inpatient inflation.

	Lowest Charge Growth Group	Lower Charge Growth Group	Higher Charge Growth Group	Highest Charge Growth Group	All-U.S. Group
Emergency department	-4.5%	-0.8%	0.3%	3.1%	0.2%
Surgical procedures	-1.5%	1.5%	3.4%	6.7%	2.8%
Imaging	1.2%	4.2%	6.5%	9.5%	5.9%
Lab	1.2%	4.0%	5.6%	8.2%	5.5%
Therapy	0.7%	3.2%	4.8%	6.4%	4.3%
Routine room rates	1.8%	4.4%	4.7%	7.3%	4.9%

Source: Cleverley & Associates, Worthington, Ohio. Used with permission.

The differences between the lowest and highest charge growth groups are striking. Interestingly, they both started in 2011 with nearly the same overall charge per discharge and visit position. By 2014, however, the highest charge group had a median charge position that was approximately 48 percent higher than the lowest charge growth group. This demonstrates how quickly relative charge positions can change—and the importance of knowing how area providers are changing their rate structures.

Our analysis also pointed to regional differences—we found that hospitals located in the Western portion of the United States had the lowest rates of inflation for the three-year period (just under 3 percent per year). This might suggest that hospitals in that region are facing increased pressure to lower the rate of growth, as their overall charge position is the highest in the country. The highest rates of growth were in the South (just over 5 percent per year),

followed by the Midwest (approximately 4 percent), and the Northeast (approximately 3 percent).

Reviewing Levels of Rate Change

The final area of our analysis reviewed areas where hospitals are making changes. At times, hospitals do uniformly change rates for all service areas by the same percentage. However, in many cases, different rates of change are applied to individual codes or code groups.

The slowest rates of growth are seen in the emergency department, while the highest rates of growth are in lab, imaging, and room rates. The latter could be an explanation for the higher overall inpatient inflation mentioned previously. The lab and imaging growth rates are interesting because these areas are the greatest areas for retail price pressure (Houk, S., Gardner, S., “Insights into Hospital Retail Pricing Strategies,” *Strategic Financial Planning*, Summer 2015). They are also the

areas with the highest price-to-cost relationship among U.S. hospitals. So, it would appear that hospitals have not been able to make reductions in these areas as easily—perhaps because many still have stronger connections between price and payment for these areas. Even the lowest charge growth hospitals had year-over-year increases in these areas.

Of note, however, are the reduced growth rates in emergency and surgical care—perhaps because of increased competition in these areas or better contractual ability to slow inflation without the same level of net revenue impact as lab and imaging.

Managing Charge Increases

While the national inflation rate for gross charges has been approximately 4 percent per year from 2011 to 2014, we do see that the distribution around that average is not nearly as tight as it once was. Hospitals are increasingly challenged with increased price pressure, which has resulted in a variety of strategies. While many hospitals are increasing rates well above that average, a large portion are making strategic decisions to lower overall rates of change.

While these decisions could be forced through rate limit provisions in contracts, it is clear that gross charge inflation is decreasing and those reductions are occurring in specific service areas. In the end, it has likely never been more important for hospitals to understand and manage the level of their gross charge change. Those that don't could see charge positions that are well above peers in a very short period of time. //

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