Orthopaedic Healthcare Worldwide

Orthopaedic Healthcare Worldwide: The Transparent Pricing Revolution in Healthcare

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Historically, matters of pricing in the US healthcare system were not of particular concern to patients or physicians. Such issues were of primary importance to hospitals, health maintenance organizations, insurance companies, and the government (as the administrator of Medicare), but there was no impetus for public disclosure of prices to a broader audience. This is no longer the case. Both patients and physicians now are paying attention to healthcare costs.

One of the primary drivers of this transition has been the rise of the

Consumer-Driven Health Care (CDHC) model, as advocated by Regina Herzlinger [8] and others. Under traditional insurance plans, patients may consider cost when selecting a plan (in the comparison of premiums). However, since the cost of care usually far exceeds the patient's out of pocket expense (copay), there is often little incentive to consider cost when actually seeking medical care, which makes patients relatively insensitive to the overall cost of care. The CDHC model, on the other hand, promotes high-deductible plans that encourage patients to consider cost in the selection of routine medical

services, while also providing protection from catastrophic risk; the patient's motivation to choose such a plan is that the premiums patients pay in those plans generally are much lower. The Bush administration supported this market-driven approach, and in 2003, passed a series of measures that created tax incentives for these high-deductible plans. Specifically, the measures established health savings accounts from which individuals could pay the medical costs associated with their high-deductible plans [4]. While there were 1 million individuals covered by Health Savings Accounts and high-deductible health plans in 2005, that number had increased to 15.5 million by January 2013 [3].

Recently, other forms of cost-sharing have emerged. Under the reference-pricing model, which targets inpatient hospital services, insurance companies establish a threshold payment value (the "reference price") for a particular diagnosis that requires hospitalization, such as total joint replacement. If an individual chooses to have his or her procedure done at an institution that charges less than the reference price, the hospitalization is fully covered. If the individual instead chooses to have their procedure done

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Orthopaedic Healthcare Worldwide

at a higher-cost center, however, (s)he will then be financially responsible for the difference between the reference price and the actual hospital charge (not limited by any deductible). The reference pricing model has been shown to be highly effective in reducing costs employers pay for common surgical procedures, including total joint replacement [12]. Given these successes, it is likely that this strategy will continue to grow in popularity in the upcoming years.

Due to the increasing prevalence of cost-shifting, as well as the persistently high number of uninsured and underinsured patients, calls for price transparency in healthcare have grown substantially in the past decade. Hospitals, insurance companies, and others have responded, providing cost information that was previously unavailable.

The most prominent releases of information, however, have come from the Centers for Medicare & Medicaid Services (CMS). In May 2013, CMS released data on hospital charges for the 100 most common Medicare inpatient stays, including several common orthopaedic procedures. Total joint replacement was specifically mentioned in the CMS press release: “For example, average inpatient charges for services a hospital may provide in connection with a joint replacement range from a low of \$5,300 at a hospital in Ada, Oklahoma, to a high of

\$223,000 at a hospital in Monterey Park, California” [6]. As one might expect, this was widely covered by the mainstream media. A *New York Times* article directly addressed the variability in joint replacement costs: “For example, billing records showed that Keck Hospital of the University of Southern California charged, on average, \$123,885 for a major artificial joint replacement, six times the average amount that Medicare reimbursed for the procedure and a rate significantly higher than the average for other Los Angeles area hospitals.... Centinela Hospital Medical Center, also in Los Angeles and owned by Prime Healthcare Services, charged \$220,881 for the same procedure” [10]. While the release of this information was widely lauded as helping patients choose where to obtain care, it also subjected a number of hospitals to intense scrutiny, requiring several to defend their charges.

Recently, payments made to physicians have also become subject to public dissemination. In April of this year, CMS for the first time, released data on Medicare payments for services provided to Medicare beneficiaries by approximately 880,000 physicians [5]. This data release was widely covered in the mainstream media, including *The New York Times*, which compiled a database that is searchable by physician

name. Of the specialties listed, orthopaedic surgery ranked thirteenth with total Medicare payments of USD 205 million in 2012 [1].

For patients and the general public, efforts to increase price transparency have generally been well received. Individuals enrolled in high-deductible and reference-pricing plans are the most obvious beneficiaries, as they can use the cost information to make informed decisions about their medical care. However, those enrolled in traditional insurance plans (the vast majority of Americans at the present time) may also stand to benefit from these disclosures. In the past, for example, patients had no objective means of determining the number of procedures that their surgeon performed on an annual basis. As a result of the Medicare data release, patients interested in total joint arthroplasty — or any other orthopaedic procedure — will be able to query the database to determine if, for example, their provider is a high- or low-volume surgeon.

The net effect of these disclosures on physicians remains uncertain. Most physicians support the idea of price transparency, but some are concerned about how this information will be used. While some physicians may have direct influence on the amount that a particular patient is required to pay for a procedure, many surgeons practice in

Orthopaedic Healthcare Worldwide

an environment where the cost of the procedure is determined primarily by hospital charges and not the physician's fee. There also are concerns that price transparency initiatives may increase the administrative burden on physicians and their offices [4]. Despite these concerns, we believe that increased price transparency in healthcare will encourage both providers and patients to pay greater attention to the cost of care they deliver and receive.

The transparent pricing revolution may also have important effects on the ways in which physicians select treatments for their patients. As the number of individuals subscribing to high-deductible plans increases, so too will the number of patients who will want to know how much a test, medication, or procedure costs before agreeing to proceed [7]. Given that many physicians [2] and surgeons [9, 11, 13] have limited knowledge regarding the prices of healthcare services, additional education may be required before providers are in a position to give patients all the information they need to make informed decisions regarding their care.

Spurred by the growth of high-deductible insurance plans, pricing information regarding healthcare services is now more readily available. Price transparency is increasing rapidly within the US healthcare system. We can expect these trends to continue, as a

greater proportion of healthcare costs are shifted from employers and other healthcare purchasers directly to patients. While patients and the general public have generally welcomed these disclosures, the net effect on the healthcare system remains uncertain. As the costs associated with healthcare delivery become increasingly transparent, it is incumbent upon the medical profession to develop and publicly report clinically relevant measures of healthcare quality, in order to engender true value-based competition in healthcare.

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Orthopaedic Healthcare Worldwide

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