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CASE AND COMMENTARY

Should a Good Risk Manager Worry About Cost and Price Transparency in Health Care?

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Abstract

Roles of hospital risk managers have grown over the last 30 years. Once largely focused on hospital liability risk management, risk managers today have a broader set of enterprise risk management responsibilities. The following commentary about a surprise billing case considers roles of risk managers in promoting cost and price transparency.

Case

JJ and KJ coparent EJ, their 16-year-old, who is recovering from being hospitalized for 8 days following a surgery. In the explanation of benefits they received from their insurer, a fraction of what the hospital charged was covered by the insurer, leaving JJ and KJ with a bill of about $190 000 for their child's inpatient care. Shocked and dismayed, JJ and KJ called the insurer to complain. Investigation ensued and revealed substantial variation in what different organizations charge for comparable surgical care. Results of the investigation were published by a national print media company. One organization offered the procedure with an inpatient stay of 8 days and estimated that the cost to the patient's family would be about $85 000. Another organization offered the procedure with 3 inpatient days for a total of about $35 000 with an estimated cost to the patient's family of about $25 000.

Members of the public began to ask, "Why is there such variation in what this procedure costs?" Recent responses to public concern about a lack of transparency in health care pricing and what's been called "no surprise billing" have prompted The White House to direct the US Department of Health and Human Services to develop rules requiring hospitals to publish prices "that reflect what people actually pay for services."[1]

A risk manager, GG, at the hospital where EJ had surgery is relieved that the organization seems to have weathered negative public attention generated by EJ's case. GG has been wondering, however, how other organizations offer the procedure at lower costs: *Are they saving the money by cutting quality and thus increasing patients' risks of postsurgical complications that would probably be identified in an inpatient care setting? What should patients be told about this risk?* GG notes that EJ's hospital and the 2 organizations that offered the same surgery at lower cost performed approximately

the same number of procedures and suspects that pricing differences cannot be explained only in terms of volume or economies of scale.

GG also wonders, *Why is our organization's length of stay (LOS) so much longer than some others'? If we can reduce LOS, we should, because each day in hospital increases a patient's risk of contracting a nosocomial infection. I wonder what our patients are told about this*.

Aside from these questions facing the hospital, GG has broader concerns, too: *If organizations respond to public and government demand for pricing transparency, health care networks might respond by consolidating prices. This move would result in less cost variation across a market and less competition and could raise overall costs of care*. For example, GG recently read that the president and chief executive officer of America's Health Insurance Plans warned that price transparency rules requiring "publicly disclosing competitively negotiated, proprietary rates will reduce competition and push prices higher—not lower—for consumers, patients, and taxpayers."[2]

GG notes that markets tend to initially react negatively to concerns about increased prices: *When stocks of major hospital operators and insurers fall, shareholder value falls, reducing organizational access to capital or increasing the cost of capital. As a result, strategic planning for broadening market share or making capital improvements necessary to remain competitive could be placed on hold*. So, GG considers the scope of her responsibility to the organization's shareholders, too.

GG wonders what to do over the short- and long-term.

Commentary 1

by Josh Charles Hyatt, DHSc, MHL, MBE(c)

Cost transparency in health care allows individual patients to exercise choice by deciding what is in their best physical and financial interests. According to the US Census Bureau, in 2018 there were 27.5 million uninsured in the United States; Blacks (9.7%) and Hispanics (17.8%) are uninsured at a higher rate than non-Hispanic Whites (5.4%).[3] Additionally, the number of underinsured people (whose out-of-pocket medical expenses are 5% to 10% of their annual income or who have deductibles that are more than 5% of their annual income[4]) grew to 44 million in 2018.[4] These inequities are at the heart of social justice, inhibiting fairness and placing an undue burden on the most vulnerable (who have the highest risk of harm and least ability to afford it). Hospital risk managers (hereafter, risk managers) have a stake in preserving justice—viz, fairness and equity as they concern patient rights, consent, satisfaction, and harm reduction.

As a profession, health care risk management has not been at the vanguard of social justice issues. Hospital executives, leadership teams, and ethics committee representatives generally discuss and develop policy related to ethical and values-based concerns without the input of risk managers who are responsible to manage the aftermath when those decisions result in liability exposure. The scope of risk management has traditionally encompassed daily firefighting (ie, triaging and investigating events, managing sentinel events, engaging in institutional and clinician consultation) rather than ethically normative concerns (ie, what we ought to do). Similar to bioethics, risk management was born of necessity. Risk management questions and concerns are rarely straightforward clinical, regulatory, or legal issues; rather, these

inquiries, though not the traditional questions faced by an ethics committee, are multifaceted in nature, with values at their core and informed by ethical principles.

Justice advocacy expands the risk manager's role from managing loss, ensuring compliance, and overseeing billable services to augmenting risk mitigation (by taking steps to reduce the impact of liability) and addressing risk concerns from a morally courageous position (doing the right thing). The risk manager has a unique perspective on managing loss while being in a position to address broader elements of justice by reflecting on whose interests are predominant (patient, institution, profession, or society) and acting in a manner that seeks to balance the best interests of stakeholders. Reflecting both a moral and operational risk management imperative, this essay explores the issue of cost transparency as it relates to justice in health care.

Cost Transparency as a Moral Imperative

John Rawls suggests that a just society is a fair society, wherein all persons are equal, all have access to needed resources, and the least advantaged benefit.[5] All health care professionals, including risk managers, embracing their obligation to work toward health care equality—currently a mere aspiration—is axiomatic to promoting a society in which fairness prevails.[6] Ideally, access to needed services should be guaranteed and health care policies that emphasize equitable systems that benefit the vulnerable should be ubiquitous.[7] Unfortunately, these conditions for distributive justice are not met in US health care. A record 25% of Americans reported in 2019 that they or a family member put off treatment for a serious medical condition in the past year because of cost, and, within this group, the income gap between top and bottom earners was 23%.[8] One important step for the health care system to take is to cultivate transparency so that people are aware of the costs of care up front and can triage their options and plan their diagnostic testing and care with this information in mind, in consultation with their health care physician.

On November 15, 2019, the US Department of Health and Human Services, the US Department of Labor, and the US Department of the Treasury published the Transparency in Coverage Rule, which calls for health care price information to be accessible to the public to permit "easy comparison-shopping."[9] As of the writing of this essay, the rule has just completed the public comment phase. The principle argument against price transparency is that publishing fee schedules would affect hospitals' ability to negotiate lower contract rates with payers, resulting in a "floor" for prices that hospitals would be willing to accept.[10] This argument appears to disregard the justice concerns of patient access and individual affordability.

As a result of this lack of transparency, the most vulnerable in our society are the most likely victims of predatory pricing via price fixing, a financial agreement between 2 parties (in this case, the payers and the institutions negotiating rates), and price discrimination, selling a product at different prices to different groups based on willingness to pay.[11] Price fixing and price discrimination primarily affect those who are uninsured or underinsured, are designed to exclude lower-priced managed care companies and Medicaid (the lifeline for vulnerable populations) from provider networks, and limit competition (driving up costs and limiting access to care). Ultimately, these agreements are socially unjust because they pose barriers to access and disenfranchise vulnerable populations.

Personal Liberty and Cost Transparency

Why is cost transparency a matter of personal liberty? Making autonomous, noncoerced, and informed health care decisions is the cornerstone of medical ethics and fundamental to health care policy and health law. Nevertheless, cost transparency and the impacts of care costs on the individual are not given adequate attention during informed consent deliberations and are more rarely discussed by risk managers as a tool for risk mitigation. People cannot thrive if they avoid seeking health care due to cost and a lack of control in the planning of their care. Health care policies at all levels (government, insurance company, and health care organization) should regard individuals, in Kant's terms,[12] as "an end" in themselves by ensuring cost transparency, thereby promoting patients' autonomy and collaboration with their clinicians.[13]

One area of health care in which price disclosure is commonplace, highly efficient, and upholds the individual's moral agency is dentistry. Dentists are often heavily constrained by insurance policies with varying levels of reimbursement and significant out-of-pocket expenses for the patient. Knowing that patients will have high expenses, dentists often provide patients with a summary of recommended procedures, triaged as to importance, and priced out for the patient's review.

Operational (Normative) Concerns

Billing. Surprise billing and billing for services that the patient believes are substandard generally lead to grievances, which are often the risk manager's first indications that a larger problem may exist (eg, quality of care concerns, patient injury, or interpersonal issues with the clinician or other staff). Risk managers walk a fine line between maintaining the institution's financial best interest and managing the patient's response to being blindsided by a surprise bill. Surprise billing has significant negative impacts on patient satisfaction (including by reducing patients' trust in the physician and institution); increases the risk of litigation and frivolous suits; consumes the time of the risk manager and staff; and increases conflict between clinicians, institutions, and patients. Effective transparency mitigates these concerns and time wasters.

Litigation risks. Patients who are harmed by or who are generally dissatisfied with care may not consider filing a lawsuit until they receive a bill for services they believe are substandard. This event might trigger distrust and rage in some people, leading to the first call to an attorney. Upstream actions, such as price transparency and discussing costs during informed consent deliberations, can avert litigation costs and the anxiety associated with them.

Safety risks. Patients with bills in collections for service they perceive as poor or for amounts they consider unreasonable can increase the risk of workplace harassment and violence. Workplace violence consists of both physical violence or threats and harassing or stalking behaviors. High concentrations of poverty and areas in which diminished economic opportunities exist are leading social and economic risk factors for type 2 (client-on-worker) workplace violence, per the Centers for Disease Control and Prevention classification.[14] Workplace violence has become a national epidemic and a significant cause of employment and vocational dissatisfaction.[15] For physicians and staff, violent behaviors consume time and energy, are morally distressing, and are potentially dangerous. Establishing clear billing expectations and having risk mitigation plans for when something unexpected occurs during treatment can decrease the risks of both litigation and workplace violence.

Limitations on Cost Transparency

I propose 2 specific reasons why risk managers may not see cost transparency as a social justice issue warranting their engagement. The first concerns the institutional burdens that it creates, and the second concerns the circumstances in which it is not feasible to get price consent prior to treatment.

Institutional burdens. Although transparency with patients regarding costs would preserve patients' autonomy and reduce their stress, it does present another unfunded burden with operational constrictions. Performing this function would involve either using clinical team members (ie, physicians, nurses, or other medical professionals), which would not be a good use of their time, or having nonclinical staff well trained in insurance complement the informed consent discussion provided by the physician, which, in adding a new administrative layer, would increase an already bloated system. However, cost transparency could potentially reduce administrative costs related to billing grievances, potential litigation, and safety risks.

Emergency services and competency. There will be times when transparency is not realistic or safe. The Emergency Medical Treatment and Labor Act (EMTALA) requires medical screening and emergent stabilization without consideration of ability to pay in emergency room settings,[16] and there is a perceived ethical duty to rescue when a person's life is imminently threatened.[17] However, the duty to treat does not alleviate the duty to be fair in pricing and explain existing costs when it is reasonable to do so.

Conclusion

It is incumbent upon the health care system to take the morally defensible position of ensuring fairness and equity for all stakeholders. Risk managers should advocate for transparency in pricing not only because ethics is an aspect of risk managers' daily work but also because transparency promotes personal liberty and fairness in society. Transparency is a means for the risk manager to advocate for patient autonomy and choice, encourage beneficent treatment and shared decision making, avoid harm from crippling debt and unnecessary treatment or service, and promote the general welfare. It also serves the secondary interests of improved patient satisfaction, increased patient trust in the institution and physician, improved patient relationships with clinicians, and reduced conflicts resulting from surprise billing.

Commentary 2: Peer-Reviewed Article

by Stephen L. Newman, MD

This case is familiar to clinicians, health care executives, payers, and many patients and their parents. The "balance after" is the amount a financially responsible party (EJ's family, in this case) owes after their insurance company pays its negotiated rate. For an 8-day, in-network hospitalization surgery, EJ's family owed $190 000; some individuals have been known to receive a $117 000 bill for surgical services provided at their local hospital, due to the assistant surgeon being out of network.[18] This article explains why pricing variations occur and considers hospital risk managers' responsibilities to serve both patients and organizations.

Chargemaster Manipulation

Variations in hospital inpatient and outpatient pricing schedules are the result of chargemaster manipulations that have occurred since Medicare adopted, in 1983, the

Diagnosis Related Groups (DRGs) system for bundling payments for diagnosis-specific services.[19] A chargemaster is a hospital-specific database of billable services and supplies used to itemize procedure-specific charges that are aggregated in bills sent to patients and insurers, although the amounts actually paid by patients and insurers are less. In response to increasing government regulation of payments through Medicare and Medicaid, hospitals inflate chargemaster prices to optimize reimbursement from these government programs. Such manipulations are also used in the commercial insurance sector, as insurers tend to adopt regulatory and payment practices first used in government payment systems. For example, a hospital that performs many orthopedic procedures but few cardiac procedures would disproportionately raise prices on orthopedic care items. Conversely, a hospital that performs many cardiac procedures but few orthopedic procedures would disproportionately raise prices on cardiac care items. Chargemaster manipulation explains why there is so much variation—and sometimes unexplained and ridiculously large variation—in prices of hospital inpatient and outpatient services among organizations that can be located in the same region.

Risk Managers' Responsibilities

Unsurprisingly, some hospital business practices are designed to optimize revenue, so let's turn now to hospital risk managers' duties in cases of surprise billing. A risk manager has a duty to serve his or her organization (shareholders, in this case), clinicians, external parties (for example, attorneys, payers, and regulators), and patients and their loved ones; the services a risk manager provides to each of these stakeholders might be different.

Responsibilities to patients. The American Society for Health Care Risk Management (ASHRM) lists several duties a hospital risk manager has to patients and families[20] that apply to the above case. First, a "health care risk manager has a responsibility to practice the profession with honesty, fairness, integrity, respect and good faith" and, second, "to help promote the overall quality of life, dignity, safety, and wellbeing of every individual needing healthcare services."[20] ASHRM also states that it is a risk manager's duty to "Communicate honestly and factually with patients and their families, as well as colleagues and others."[20]

Of course, hospital risk managers do not typically interact with each patient in a hospital. However, in cases like this one, interaction is certainly appropriate and advisable, since a "balance after" bill of $190 000 would very likely be an unpleasant surprise that could lead to litigation.[21] Specifically, in this case, a risk manager, along with a patient financial services staff member, could have an adjunctive role in discussing surprise billing with EJ's parents; this role would include offering financial education and support and acting as a liaison to help EJ's parents interpret technical financial language.

Responsibility to an organization. A hospital's direct and indirect costs for delivering health care services performed by clinicians is confidential, but what a hospital charges payers and other financial guarantors is public. This distinction is important in the discussion of risk managers' roles and responsibilities, since risk managers are uniquely positioned to help organizations mitigate litigation risk that can be generated by surprise billing. Specifically, risk managers can advocate for up-front hospital inpatient and outpatient pricing transparency, such that financially responsible parties are informed about their copayment or coinsurance obligations before a hospital admission or before a health care service is rendered rather than after discharge, as occurred in EJ's case.

Distinguishing Financial Risk From Health Risk

The family's out-of-pocket financial responsibility is distinct from what a hospital charges, which is public information, and some have argued that, to motivate transparency, the coverage rates hospitals negotiate with insurers should also be public. Others have suggested that pricing transparency should be part of informed consent processes. Although risks and benefits are intended to be communicated during informed consent, financial risks differ importantly from health risks. Health risks should be conveyed and clarified by a clinician, and financial risk should be conveyed and clarified by a financial counselor, perhaps with a risk manager. If up-front disclosure of financial burden to patients and their families were adopted by an organization, a good risk manager could try to serve all constituents without compromising the protection of any constituent.

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The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

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