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Searching for Useful Health Care Prices

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Daphne A. Kenyon, Ph.D.

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The objectives of this paper are several.¹ First, pricing in health care is compared to pricing in other parts of the economy. Next, some of the basics of pricing in health care are explained, including definitions of important terms. Another section discusses why information on health care prices is useful and to whom it is likely to be useful. Then an overview of available health care prices in New Hampshire is presented, followed by conclusions.

Comparing Health Care Prices to Other Prices

Getting information on prices in most parts of our economy is not too difficult, whether we are looking for prices of gasoline, milk, digital cameras, restaurant meals, houses, or college tuition. Consumers, producers, policymakers or policy analysts have access to readily available prices in many forms. For example, online or printed restaurant guides provide information on likely prices of restaurant meals, quality ratings, location, and any special attributes we might be interested in, such as weekend hours or handicapped accessibility. When we step into a restaurant, we are given a menu of current prices, and when we pay our bill we can readily check the prices we are paying for each item.

¹ Thanks to Doug Hall, Steve Norton, and Peter G. Kachavos, M.D., for their helpful comments on a previous draft.

Availability of health care prices is an entirely different matter. An individual who undergoes surgery, for example, is unlikely to be able to find out before that surgery what it is likely to cost and may not be able to understand the bills sent after the surgery is completed. A recent study of pricing at California hospitals used mystery shoppers to pose as uninsured patients requesting pricing information for elective procedures. These shoppers found that, “[o]btaining a price depended primarily upon luck and persistence.” Often there was no designated person or department for providing price information, and different prices were sometimes given by different people within the same hospital.²

Dr. David Brailer, President Bush’s senior advisor on health information technology, describes hospital prices as follows:

Suppose you walk into a restaurant, . . . and you don’t get a menu, you don’t get any choice of food you’ll eat, they don’t tell you what it is when they’re serving it to you, they don’t tell you what it’s going to cost. Then, weeks or months later, you get a bill that tells you all the food you ate and the drinks you had, some of which you remember and some you don’t, and although you get the bill, you still can’t figure out what you really owe. . .³

On the other hand, there are reasons why pricing in health care is inherently complicated. Ideally one might want to phone a local hospital to ask: “what is the price I will be charged for an appendectomy?” There are difficulties with this question that the average auto mechanic who is asked to give an estimate for car repair does not face. A New Hampshire internist frames the challenge this way:

Suppose you are an auto mechanic. You know how to fix cars. However, each and every car you have to fix is custom made. No two cars you work on are exactly alike. A customer asks you “what is it going to cost to fix my car?” Some cars are new, some old, some well cared for, some treated like “rentals.” In this setting, how does the mechanic give the customer a cost estimate?⁴

What are Health Care Prices?

In order to understand health prices, it is important to note that for most health services there is a difference between *charges* (list prices) and *net prices* or payment (actual amounts paid). The discussion below will refer to hospitals, but the same holds for physicians’ services and most other health care services.⁵

² “Price Check: The Mystery of Hospital Pricing,” California HealthCare Foundation, December 2005, www.chcf.org. Ironically, the study did not find that hospitals were failing to comply with the 2003 California Payers’ Bill of Rights which requires hospitals to publicly post information on the fees for common health care services.

³ David Brailer quote in Katie Hafner, “Treated for Illness, Then Lost in Labyrinth of Bills,” *New York Times*, October 18, 2005, p.A18.

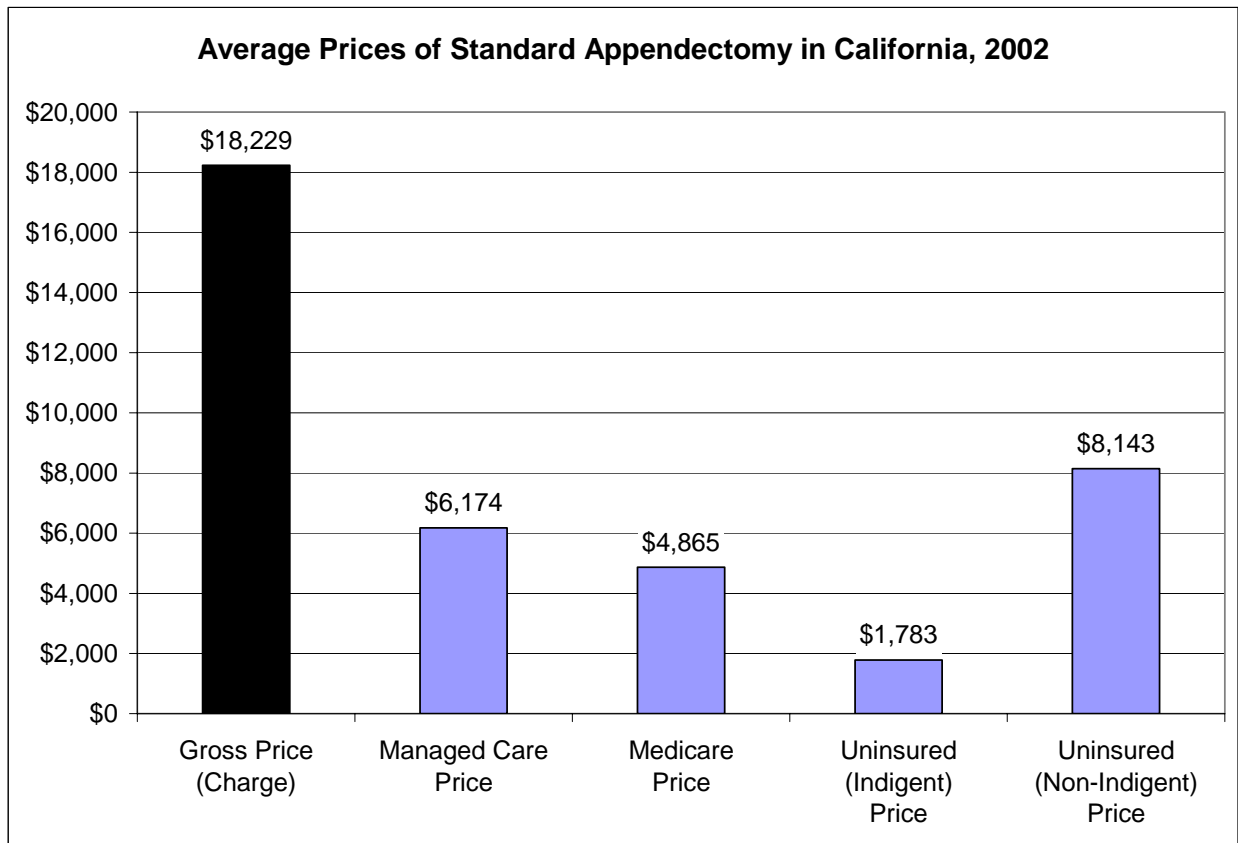
⁴ Personal correspondence from Peter G. Kachavos, M.D., December 30, 2005.

⁵ In 2005, hospital care and physician and other professional services accounted for almost two-thirds of personal health care spending in New Hampshire. Other categories included dental services, home health care, prescription drugs, other medical non-durables, durable medical equipment, nursing home care, and other personal health care.

List prices are similar to a standard hotel rate before one inquires about applicable discounts. Most hospital patients and their payers do not pay the charges, but some lesser amount. Charges serve as an upper bound for net prices, and there appears to be no clear relationship between charges and net prices.⁶

This can be shown by the following example provided by a California health finance professor.⁷ Although the average *charge* for a standard appendectomy in California in 2002 was \$18,229, the price paid differed according to who was paying the bill, with average discounts from the charge or list price ranging from 55 to 90 percent. Figure 1 understates the range in net prices, however, as different managed care plans are likely to be able to obtain different discounts, and hospitals typically offer discounts to low-income patients that vary with their incomes.

Figure 1



See Douglas E. Hall, “Health Care Dollars and Health Insurance in New Hampshire, 2004” New Hampshire Center for Public Policy Studies, pp.4, www.nhpolicy.org.

⁶ Professor Glenn Melnick finds that “the difference between hospital list prices and net prices varies substantially across hospitals within the same state...” “Hospital Pricing and the Uninsured,” Testimony Before the Subcommittee on Health of the House Committee on Ways and Means, March 9, 2004. Data source: 2002 Annual Hospital Disclosure File, California Office of Statewide Health Planning and Development.

⁷ Glenn Melnick, Ph.D., “Hospital Pricing and the Uninsured,” Testimony Before the Subcommittee on Health of the House Committee on Ways and Means, March 9, 2004. Data source: 2002 Annual Hospital Disclosure File, California Office of Statewide Health Planning and Development.

Thus, if one wants information regarding the amounts actually paid for hospital health services, it is important to ask for net prices, not list prices (charges).

Challenges in Defining Health Care Services and Prices

A further challenge involves defining the specific health care service. Those in the health care sector define health care services through codes, such as CPT codes.⁸ CPT codes have become the standard for coding physician's office, outpatient, and ambulatory care, but there are approximately 8,000 such codes. Consider an office visit by an established patient. One could choose between coding it as an "established patient office visit, level 1" when a patient is seen for a "simple" problem, which is coded as CPT code 99211 or "established patient office visit, level 2" when a patient is seen for a "minor" problem, which is coded as CPT code 99212. According to the Dartmouth-Hitchcock web site, the charge for the level 2 office visit is \$83, while that for the level 1 visit, \$50.⁹

Another code that is important is the DRG, which stands for Diagnostically Related Group. This represents a classification for a patient's diagnosis. Hip replacement surgery, for example, is assigned a particular DRG code. At the same time, specific components of this surgery (e.g., the surgery itself, anesthesia and radiology) are assigned specific CPT codes. The consumer is likely to be totally confused by DRG and CPT codes, the magnitude of such codes, and the difficulty of determining which code is appropriate in which circumstance.

A more daunting problem is the "slippery" nature of classifying diseases or procedures according to these codes. Natural operation of the business of health care leads providers to want to choose those codes that will result in higher reimbursement, while utilization review by managed care workers will press providers to choose lower codes. Recognition of this phenomenon has led researchers to refer to "DRG creep" as in the journal article entitled "Hospital Case-Mix Change: Sicker Patients or DRG Creep?"¹⁰

The problem of multiple prices and inexact definitions of health care services is described by a California health care economist as follows:

[P]eople will say...there's no price data in hospital markets. Well, in a sense, that's actually backwards. The problem is there are millions of prices. There's too many prices. [F]irst there are thousands of services that are individually priced on the fee-for-service side, and the definitions aren't even perfectly standardized. The second point is, a typical hospital will have at least tens and

⁸ CPT stands for Current Procedural Terminology. CPT codes were developed by the American Medical Association, but have been adopted by the government. (Karen A. Wager, Frances Wickham Lee, and John P. Glaser, *Managing Health Care Information Systems*. San Francisco: Josey-Bass, 2005, p.21).

⁹ http://www.dhmc.org/webpage.cfm?site_id=2&org_id=564&morg_id=0&sec_id=0&gsec_id=29698&item_id=29698. Viewed January 26, 2006.

¹⁰ Bruce Steinwald and Laura A. Dummit, "Hospital Case-Mix Change: Sicker Patients or DRG Creep?" *Health Affairs*, 1989, 8(2), pp. 35-47. In a related article, Leemore Dafny found that hospitals reacted to large price increases in 1988 for Medicare admissions "by 'upcoding' patients to diagnostic codes with the largest price increases." "How Do Hospitals Respond to Price Changes?" *The American Economic Review* Vol. 95, No. 5, December 2005, p. 1525.

maybe hundreds of payers with different prices. [T]he prices [are] not only different, the very bases of the price, what gets priced, is different.¹¹

Fragmented Pricing

It is also important to note the fragmented nature of pricing complex procedures that is typical in health care. If a person requires an operation, she may be billed separately by multiple physicians, therapists, and laboratories, in addition to being billed by the hospital. Bills tend to be detailed line-item documents with confusing codes and obscure, technical language. Compare this to a college tuition bill, which includes payments for instruction, recreation, food and housing for an entire semester. Most of the bill is a single payment for a package of services, e.g., education of a first-year student at a residential liberal arts college.

Secrecy of Prices

A critical complexity arises because most of the net prices are negotiated in secret and both parties to the agreement are likely to want to keep the price secret. For example, suppose that Insurance Company A manages to obtain a discount on appendectomies that it suspects is better than its competing insurance companies have obtained. Neither the savvy insurer nor the hospital is likely to find it in its best interest to broadcast this deal.

Price negotiations between insurers and hospitals don't typically take place on a service-by-service basis, though. Insurers "pay hospitals on the basis either of steeply discounted charges (with discounts in excess of 50 percent), negotiated per diems, or flat charges per entire episode (DRGs)."¹² Annual negotiations between insurers and hospitals are simplified, then, by focusing on the percentage of discount from charges or the average price per DRG. "These actual dollar payments have traditionally been kept as secret, proprietary trade secrets by both the hospitals and the insurers."¹³

Prices vs. Costs or Expenditures

It is also important to distinguish between prices and related dollar figures, such as costs or expenditures. Economists typically use the term "price" to refer to the amount paid by a buyer, but the term "cost" to refer to the amounts expended by the producer of the good or service. However, in popular discussion the terms "price" and "cost" are often used interchangeably to refer to what a consumer pays for a good or service.

When policy observers bemoan increasing health care costs sometimes they are referring to the increasing share of the nation's GDP spent on health care. In this context, the term "cost" has been used to refer to a different entity which economists would call "expenditure" or "spending."

¹¹ University of California, Santa Barbara, health economist H.E. Frech quote in Michael F. Cannon and Michael D. Tanner, *Healthy Competition: What's Holding Back Health Care and How to Free It*. Washington DC: Cato Institute, 2005, p.55.

¹² The quotations in this paragraph are from Uwe E. Reinhardt, "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy," *Health Affairs*, Vol. 25, No. 1, January/February 2006.

¹³ In principle, because net prices are revealed on the bills of individual patients, a researcher could collect a sample of patient bills in order to obtain "back-door" information on the payments negotiated between insurers and the hospital. However, in practice, given the fragmented nature of these paper bills, this would be an impossible task.

Health care spending is equal to price times quantity. Thus, even if health care prices were to remain constant, health care spending would rise if there were more physician or hospital visits.

Usefulness of Price Data

We have identified at least three potential uses of health care price data. Publication of health care price data can facilitate choice, allow analysis of particular aspects of the health care system, and make the health care market more efficient.

Facilitating Choices

Health care price data can facilitate choices made by individuals, employers, and health plans. The increasing trend toward consumer-directed health plans, health reimbursement accounts and health savings accounts appears to be making individuals more interested in obtaining health care prices.¹⁴

In order to facilitate choices, health price data should be available for a wide range of frequently used health services. Price lists will be most useful when the service is described in plain English. Thus a listing of “gallbladder removal” with a related code will be more useful to a consumer than a listing such as “laparoscopic cholecystectomy.”

For the purpose of facilitating choice among hospitals, it is important that prices, not merely charges, be available. Having knowledge of charges is similar to having knowledge of the highest possible price. Knowing charges is better than having no price information, but knowing the distribution of net prices, the amounts actually being paid, would be better. It is also important to know which provider offers which price. In addition, price data must be current. It is not helpful to have accurate price data for the past; prices currently offered are the most useful.

Most individuals want to consider quality information at the same time as price, so having quality information readily available is important. A recent study of consumer choice in health care recommends that consumers be provided sources that integrate multiple types of information, such as data on quality, out-of-pocket costs, choice of providers and ease of access.¹⁵ Individuals, employers or health plans might want to consider tradeoffs between price and quality or, once quality requirements were met, they might aim to choose the hospital with the lowest prices.

One of the best currently available sources for information on hospital quality is Hospital Compare, hosted by the U.S. Department of Health and Human Services.¹⁶ Hospital Compare is

¹⁴ American Health Line, “Consumer-Driven Plans: Lack of Information on Prices Examined,” December 13, 2005 and Jane Sarasohn-Kahn, “Consumers Want Health Care Costs Information,” California Healthline, California HealthCare Foundation, September 1, 2003, www.californiahealthline.org. A consideration which is beyond the scope of this paper is the appropriate decision-making agent for the consumer of health care. Many fans of consumer-driven health care assume that the patient will be the one making the health care choice. However, that patient is likely to be guided by relatives, friends, and physicians. Employers can guide consumer choice by the menu of health plans the employer makes available. Even direct consumer choice can be influenced by simple information guides similar to *Consumer Reports*.

¹⁵ Dale Shaller, “Consumers in Health Care: The Burden of Choice,” California HealthCare Foundation, October 2005, p.29, www.chcf.org.

¹⁶ See www.hospitalcompare.hhs.gov.

easy to navigate and focuses on measures of clinical effectiveness, not measures of consumer satisfaction. The Joint Commission on Accreditation of Healthcare Organizations has information on a wide array of health care organizations from assisted living facilities to office-based surgery facilities, but it has a narrow focus on accreditation.¹⁷ NH Quality Care is a new web site hosted by the Foundation for Healthy Communities and the Northeast Health Care Quality Foundation, which provides some information about clinical quality of New Hampshire hospital care in selected areas such as care for heart attacks.¹⁸ None of these web sites includes price data with its quality indicators.

Providing Information for Policy Analysts and Policymakers

Policymakers, policy analysts and industry analysts will have somewhat different data interests. For these individuals, data sets that include both price and quantity will be of greatest interest, as they are more likely to focus on total expenditures and trends in total expenditures. (In contrast, to a consumer making health care choices, quantity information is not particularly helpful.) It is still helpful to have current data, but for analysts prices that are a year old will not present a real problem. Insurance claims databases such as New Hampshire's anticipated Comprehensive Health Care Information System can be a good source for data analysis with some limitations. Quality information is also important for analysts, but claims databases may need to be supplemented with data from clinical records in order to have sufficiently sensitive measures of quality.

Analysts will have to be wary of three problems when using health care price data. First, given that there is no clear public understanding of the difference between gross and net prices and costs, the existing literature will have to be scrutinized carefully to ascertain how prices are being defined and whether costs are really prices. Second, the classification of health care services by CPT and other codes is not as "cut and dried" as researchers may like, with providers having a natural interest in "up-coding" and managed care companies having an interest in "down-coding."¹⁹ Finally, to the extent that previously secret, negotiated prices are made public, one should expect that deals will be renegotiated and prices will change. Thus the very fact of revealing health care prices can change those prices.

If revealing health care prices tends to change those prices, this raises the question whether prices are likely to be higher or lower when health care pricing becomes transparent. Common sense, standard economic theory²⁰, and analysis of health care markets all indicate that revealing health care prices will tend to drive those prices down. Indeed, one of the concerns raised about

¹⁷ www.jcaho.org.

¹⁸ www.nhqualitycare.org.

¹⁹ Coding battles between managed care companies and providers have become the subject of major lawsuits. In July 2005, the insurance company WellPoint agreed to pay up to \$135 million in damages to doctors for systematically "down-coding" in order to reduce reimbursements. At least six major U.S. insurers and 700,000 physicians have been affected by such class action law suits. (American Health Line, "HMOs: Wellpoint Settles Claims in Physician Lawsuit.")

²⁰ For a good discussion of how prices tend to fall in a competitive market, see "Chapter 8: Competitive Markets" in Bradley R. Schiller, *The Micro Economy Today*, Seventh Edition, New York, McGraw-Hill, 1997.

the move to transparency in health care prices is that it may make it impossible for providers to “cost-shift” or recoup losses from charity care by charging other patients higher prices.²¹

Making the Health Care Market Work Better

A more fundamental reason for making health price data available is to make the health care market work better. Effectively competitive markets tend to produce what consumers most desire at the lowest possible prices. There are a number of requirements for an effectively competitive market (e.g., no monopolies), but of all those requirements the most important may be information on prices. Why is price information so important?

In competitive markets, prices that are available to all and that can change in response to changing market forces serve both an incentive function and an information function. Although the health care market will never be a perfectly competitive market,²² if health care prices are made more transparent, they will come to serve some of the information and incentive functions that prices serve in other markets. Unless there is a systematic bias in these transparent prices, the information and incentive functions that they serve can have a beneficial effect on the overall health care market.

Prices ration services in that those who place a value on that service that is greater than or equal to that price will purchase the service and those for whom the value is less than the price will not obtain the service. At the same time that prices act to ration services, they provide information on the minimum value that consumers place on those services. There can be good reasons for providing a service for free, but doing so may require finding another mechanism for rationing the scarce services. Providing a service for free will encourage anyone who receives even a negligible benefit from that service to obtain it.

Prices also affect the supply of health care services. Health care providers act out of a combination of profit motives and altruism. Providers will tend to provide more of the health care services that have a high ratio of price to the cost of providing that service and less of health care services that have a low ratio of price to cost. Recent research has indicated that there is a systematic bias in the payments (prices) that physicians and hospitals receive for their services that favors newer services, which involve complex technology. In this case, the price system is working to impede effective functioning of the health care market. The suggested solution is to “make payment rates more accurate,” or else “another powerful driver of health cost trends may have been created.”²³

²¹ Stuart H. Altman, David Shactman, and Efrat Eilat, “Could U.S. Hospitals Go the Way of U.S. Airlines?” *Health Affairs* Vol. 25, No. 1, January/February 2006. They conclude, “...pure price competition maximizes economic efficiency. It produces the most possible goods for a given amount of resources at the lowest possible prices for consumers. But it also squeezes out any nonessential services and amenities.” (p. 20.) Thus their article implies that price transparency will reduce prices for most consumers, except for the poor, some of whom have been receiving free care, and whose free care would be jeopardized by the move to transparent prices.

²² See Daphne A. Kenyon, Ph.D., “Health Care and Market Competition,” November 2004, New Hampshire Center for Public Policy Studies, www.unh.edu/nhcpps/health/ibmarket.pdf.

²³ Paul B. Ginsburg and Joy M. Grossman, “When the Price Isn’t Right: How Inadvertent Payment Incentives Drive Medical Care,” *Health Affairs, Web Exclusive*, August 9, 2005, pp. W5-376-W5-384.

An example in which the price system can be helpful in holding down health care costs is “gainsharing” under which hospitals try to motivate surgeons to be more cost conscious in their use of medical devices, while not compromising patient care. Given the wide range in the cost of hospital supplies (supplies for a standard defibrillator procedure can range from about \$16,000 to almost \$35,000) this innovation has the potential to significantly reduce hospital costs.²⁴

An influential article by Michael Porter and Elizabeth Teisberg asserts that competition in the health care market needs to change in order to make the market more efficient.²⁵ According to Porter and Teisberg, competition in many markets creates value, but in health care much of the competition that currently takes place does not lead to higher value, but merely shifts costs from one payer to another. They argue that moving to a more efficient mode of competition rests on having proper health care information available. As they put it, it will be important to have information on prices by disease or procedure. That is, rather than having list prices for various components of the treatment for a diabetic (i.e., physician visits, lab tests, drug prices, etc.) it would be useful to have package quotes for the complete care package for a specific period of time, such as a year.

They further argue that patients should get a single bill for each hospital stay, rather than multiple bills for each procedure related to that stay, and that price estimates should be made available in advance in order to facilitate comparisons. Under this system of health care information, providers would be more likely to compete to provide quality care for the same or lower prices, or as Porter and Teisberg put it, health care would more likely exhibit healthy competition in which “relentless improvements in processes and methods drive down costs.”²⁶

Differing Interests in Price Data

Potential users of health care price data are varied, including consumers, providers, insurers, employers, policymakers, and policy analysts. Because these parties have different concerns, their interest in price data differs. In order to illustrate this, the table below compares dimensions of price data of most interest to consumers to dimensions of most interest to policy analysts.

To examine one entry, policy analysts are interested in comprehensive data because it is an essential input into their research. As many work with data for a living, they know how to manage large quantities of data, and typically prefer more data to less. Consumers on the other hand, “may or may not have the cognitive capacity or motivation necessary to process every bit of information...evidence from decision-making research demonstrates that more information does not always improve decision making, and often may undermine it.”²⁷

²⁴ Reed Abelson, “Dr. Saves-a-Lot” *New York Times*, November 18, 2005.

²⁵ Michael E. Porter and Elizabeth Olmsted Teisberg, “Redefining Competition in Health Care,” *Harvard Business Review*, June 2004.

²⁶ Alain C. Enthoven and Laura A. Tollen present a critique of Porter and Teisberg’s proposed type of competition in health care in “Competition in Health Care: It Takes Systems to Pursue Quality and Efficiency,” *Health Affairs Web Exclusive*, 7 September 2005. In essence Enthoven and Tollen argue that direct consumer choice among individual providers is not likely to produce the best health care system. Instead, Enthoven and Tollen propose that consumers should choose among integrated delivery systems (IDS). A typical IDS would include a multi-specialty medical group practice, hospitals, labs, and pharmacies. The Mayo Clinic is an example of an IDS.

²⁷ Dale Shaller, “Consumers in Health Care: The Burden of Choice,” California HealthCare Foundation, October 2005, pp. 19, 18, www.chcf.org.

Policy Analysts will be interested in:	Consumers will be interested in:
Data sets which can generate information on trends or central tendencies	Information tailored to their specific health needs, location, and preferences
Comprehensive data	The smallest unit of data that will answer their particular questions
Data for the most recent time period possible	Information on prices applicable today or in the future
Utilization together with price to obtain total expenditure	Not interested
Clinical quality together with price to obtain value	Clinical quality and consumer-service aspects of quality together with price to obtain value
Comparable data for other states, the U.S. as a whole, or other nations	Comparable data for all potential providers within a reasonable travel distance

Role of Government in Making Information on Prices Available

Because markets can only function properly when consumers are informed about quality and prices of the goods and services they purchase, and sometimes that information is not readily available, governments may intervene. There are numerous examples outside of the health care field. For example, federal financial regulations require that a company reveal certain information about its financial condition when selling stocks. State governments regulate the real estate market, and thus realtors are required to present homebuyers with certain information, such as the existence of liens, radon test results, recent property taxes, age of roofing, or energy efficiency of furnace. Similarly, both federal and state governments can intervene in order to make health care prices more readily available.

There are several ways that state government could make health price more readily available. Through its regulatory powers it could mandate that providers reveal their prices. Alternatively, state government could obtain health price data and make it available for the general public.

Health Price Data in New Hampshire

This section describes four important sources of health price data in New Hampshire. These will be ordered from the most useful for consumers (and least useful for policy analysts) to the least useful for consumers (and most useful for policy analysts). The New Hampshire Center for Public Policy Studies website contains a page with direct links to each of these four sources of information as well as others that may be created: <http://www.unh.edu/nhcpps/marketdriven.htm>.

New Hampshire's Medicine Cabinet

The most consumer-friendly current source of health price data is a web site that can be found on the home page for the State of New Hampshire. Clicking on "Rx Drug Price Finder," one of 15 items listed under "News & Events" will take you to "New Hampshire's Medicine Cabinet."²⁸

²⁸ www.egov.nh.gov/medicine-cabinet.

The major headings on that site are:

- NH Drug Listing & Price Lookup
- NH Pharmacy Locator
- Top 25 Drug Listing
- Frequently Asked Questions
- Drug Health Tips

The sections likely to be most useful for consumers are the pharmacy locator and the drug listing and price lookup. Within the pharmacy locator, one can select a town and find complete address and phone information for pharmacies in that town. The drug listing and price lookup function operates as follows. One inputs a drug name, then is given pricing information for a number of different towns for different quantities of that drug. Prices are updated monthly. By clicking on one town, it is possible to obtain the complete address and phone information for pharmacies in that town. At the side of the screen one is also given the option of checking prices at CanadaDrugs.com (along with a caution that ordering drugs online from Canada may not be a less expensive alternative after shipping costs are factored in). Each drug listing also includes the generic name of the drug so that knowledgeable consumers could investigate whether a generic equivalent might be less expensive.

One limitation of the site is that not all New Hampshire towns are listed. Another is that it is unclear how well known the site is or how easily consumers would be able to learn of this helpful tool. In addition, this web site presents no information on the impact of health insurance on drug prices. An individual with health insurance may want to investigate whether her insurance company hosts a web site with additional drug price information. For example, Cigna recently launched a web site that allows its members to compare drug prices at many pharmacies, including mail-order and generic drug options.²⁹

Dartmouth-Hitchcock Medical Center Quality Reports

The Dartmouth-Hitchcock Medical Center web site has a section entitled “Quality Reports,” which in turn has a section for “Charges for Healthcare Services.”³⁰ That section is divided into the following sections and subsections:

- Average Health Care Charges
 1. Office visit and emergency department charges
 2. Diagnostic test charges
 3. Medical and surgical service charges
- Frequently Asked Questions
- Financial Assistance
- Contact Us

There are a number of particularly helpful aspects of this web site. First, a Dartmouth patient looking for a clinic address is likely to see the heading “Quality Reports,” and thus find the web site. Second, a wide range of charges is quoted. Each charge includes both the hospital-based

²⁹ “Cigna: Launches Web Site to Help Customers Compare Rx Prices,” American Health Line, August 26, 2005. This site, which is accessible only for members, is <https://my.cigna.com/corp/portal/app/member/public/guest>.

³⁰ www.dhmc.org.

charge and associated professional charge. Either a CPT or DRG code is also included. It is helpful that the charge information is nearby the quality information, as consumers typically need both in order to determine the value of the service. The quality information includes both clinical measures of quality (e.g., percentage of pneumonia patients who receive antibiotics within 4 hours of arrival) and consumer-oriented measures (e.g., how long does it take on average to obtain an appointment). Finally, the web site on charges includes a link to an explanation of financial assistance and phone numbers and e-mail addresses for those who have questions.

There are also some drawbacks to this web site. Since the web page for charges is a subset of the quality page, this makes it more difficult to find. There is a brief explanation that charges are the same as “list prices” used by stores, but many consumers will not know the big difference that exists between charges and typical net prices, so a lengthier explanation would be helpful. It would also be helpful to provide an example of the typical difference between charge and net price, as well as an example of the typical difference between the actual prices paid by those with and without health insurance.

NH Health Cost

This web site, hosted by the New Hampshire Insurance Department beginning in 2005, focuses on “the typical prices of common inpatient and outpatient services.”³¹ The information was gleaned from 2003-4 insurance claims from the three largest insurers in the state. For each inpatient or outpatient procedure the following information is provided:

- Typical price and range of prices³²
- Plain English definition of procedure
- Technical definition of procedure, including applicable code
- A link to more information about the procedure and to the Medline Encyclopedia.

Providing a plain English definition of each procedure in connection with the technical definition is likely to be very helpful to consumers. The special section on “Health Care Costs 101” is also likely to be useful. Those who want to know the amounts typically actually paid for various procedures by patients with insurance will appreciate that the dollar values presented here are prices and not charges.

However, the site is not set up to allow consumers to do comparison shopping. The web site notes that the typical price for a hip replacement ranges from \$11,140 to \$41,656 but does not give the consumer any information regarding which New Hampshire hospital charges the low price and which the high price. Furthermore, this site provides no information on provider quality. Also, without a close reading of the site, a person could get confused between “prices” and “costs.” The title of the site uses the word “cost”, but its mission statement says that it provides information on “typical prices.” In the section on “Health Care Costs 101” the site provides the technically correct definition of cost: “the amount of money a hospital or doctor actually spends to provide a particular health care service.” Finally, it may not be easy for

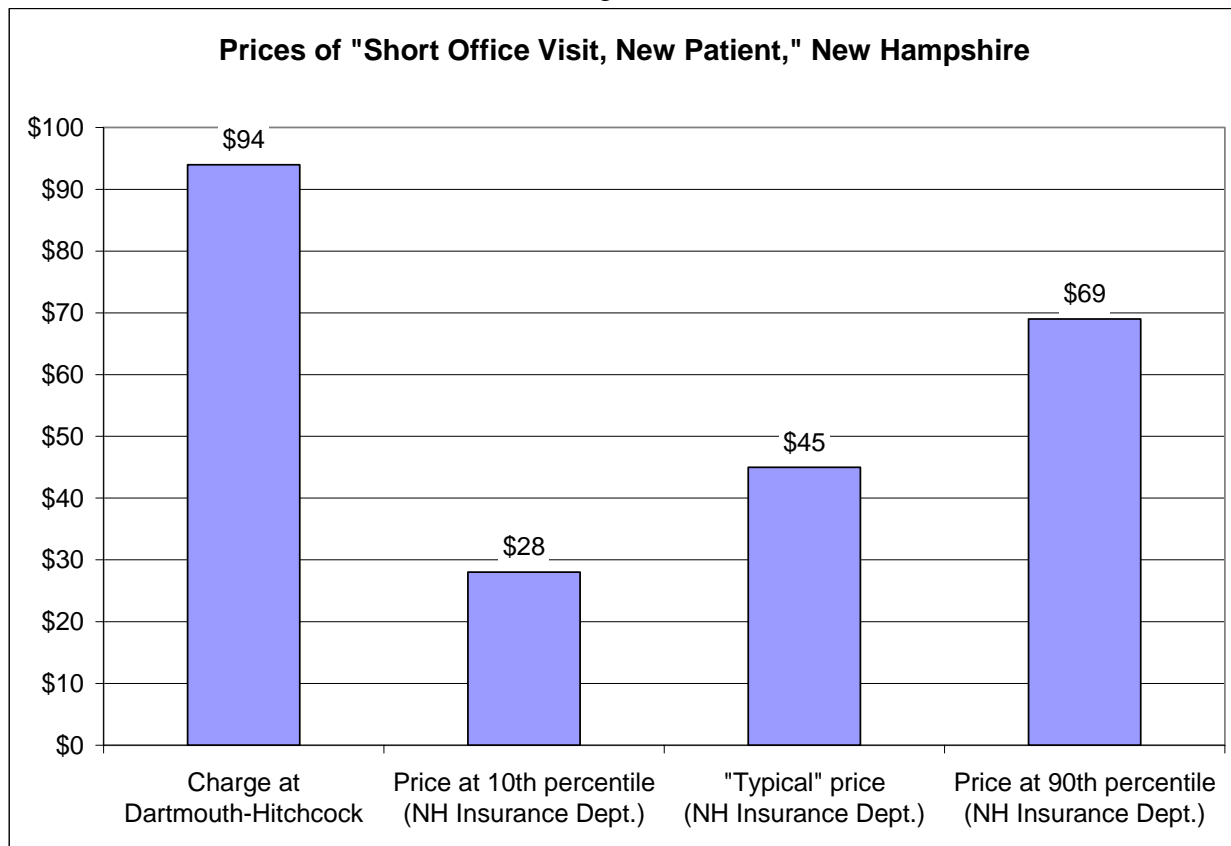
³¹ www.nhhealthcost.org.

³² The range was computed after outliers (the top 10 percent and bottom 10 percent) of observations were excluded.

consumers to find this site unless they are in the habit of perusing the web site of the New Hampshire Insurance Department.

Figure 2 provides an illustration of the difference it can make when prices or actual payments are reported rather than charges. The charge information is from the Dartmouth web site and the price data is from the New Hampshire Insurance Department (NHID) web site.³³

Figure 2



In the example above, Dartmouth-Hitchcock’s *charge* for a short office visit is more than double the *net price* reported on the NHID web site. The NHID reports price information for eight examples in the office visit and emergency department category. For each of these examples, Dartmouth’s charge or gross price was significantly higher than the top of the range of net prices reported by the NHID. Because Dartmouth-Hitchcock’s website does not include the actual amounts they are paid by insurance carriers, comparison is unfortunate and unfair, but such is the state of presenting true price information to consumers.

New Hampshire Comprehensive Healthcare Information System

In 2003, the New Hampshire legislature authorized the creation of a Comprehensive Healthcare Information System (CHIS) modeled after a similar system in Maine. This is a system of payer claims data for all insured individuals who are New Hampshire policyholders. The system is still

³³ The Dartmouth quote may be for a year later than the Department of Insurance quote.

under development, but when it is up and running in 2006, it will be a rich source of information on such things as:

- Trends in payments for and use of health care services
- Use of specific procedures and therapies
- Use of services and payments for treating selected diseases
- Use of preventive services
- Geographical variations in use and payments per service.³⁴

CHIS will contain 30-60 million claims annually and the record for each claim will include data elements for both “charge” and “paid amount.” CHIS will not contain information on the identities of patients or employers or purchasers.

The primary audience for the data sets produced under CHIS and the reports prepared by the Departments of Insurance and Health and Human Services with CHIS data will be researchers, providers, elected officials and employers who are interested in understanding trends in health care costs and utilization.³⁵ Because of its size and complexity the CHIS database will not be a tool that forward-looking consumers will be able to use unaided. Rather, consumers will probably rely on reports state agencies and others may create based on an analysis of the CHIS data.

CHIS data are likely to be helpful for providing guidance for the Medicaid program (once the private claims data can be compared to Medicaid claims) and for providing important public health information. For example, CHIS data could be used to track the percentage of individuals receiving recommended preventive tests across the state or in specific counties.

Conclusions

Be aware that health care prices are called by many different names. Some people refer to health care prices as “costs.” Others don’t distinguish between list prices (also called charges or gross prices) and net prices (also called payments, prices, or actual prices).

If you are interested in actual payments made, charges will be of little use. Charges or list prices are a starting point for negotiations (in the case of managed care companies) or for discounts (in the case of insured patients). There is no clear, predictable relationship between charges and prices.

Price alone is not likely to be very helpful. Consumers are likely to want information on both price and quality; policymakers are likely to want information on both price and utilization rates. Thus consumer-oriented web sites should pair price and quality data, while analyst-oriented data bases should include data on utilization and other measures in addition to price data.

³⁴ Powerpoints “Uses of CHIS Data: Maine’s Experience” Prepared by the Maine Health Information Center for the New Hampshire Citizens Health Initiative Finance and Information Systems Team, October 12, 2005, slide 10. Because the slide uses “cost” to refer to “payments,” which could be confusing, the body of the paper changed each use of the word “cost” to “payments” or “payments made.”

³⁵ Inferred from the Winter 2005 Maine Health Care Claims Data Bank *Status Report*, p.1.

As consumer-directed health care becomes more important, consumer interest in prices will increase. Consumers who bear little of the financial burden of health care prices are likely to have little interest in those prices. However, as deductibles and co-payments increase, along with the rise of health savings accounts, consumer interest in health care prices is likely to increase significantly.

Making health care prices of specific providers available is likely to change those prices. Currently there is very little information about net prices charged by particular providers. To the degree that these prices are revealed, one should expect that prices will be renegotiated and that prices will change. One should expect that for the most part transparency will tend to drive prices down.

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