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Editor's Spotlight/Take 5

Editor's Spotlight/Take 5: What Does a Shoulder MRI Cost the Consumer?

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Anyone hoping to design a rational system of healthcare financing should look at the United States and do the exact opposite. While perhaps cynical, this observation is hard to refute. The entity paying for a service, whether government or commercial, is not the beneficiary. The amount paid for a given procedure or test often bears little resemblance to the true cost of providing the service, and differs substantially depending on where it is performed. In many instances, it is impossible to determine the cost of said procedure until it has been completed. If we are looking for an efficient or rational market, where prices fully reflect all available information, US healthcare isn't it.

In their article on consumer costs for shoulder MRI, Robert W. Westermann MD and his colleagues at the University of Iowa constructed a hypothetical patient paying cash out of pocket, who hoped to get a shoulder MRI. They called imaging centers around their state, both free-standing and hospital-based, to get a price quote as well as to learn whether a discount might be available. Their study highlighted the challenges in obtaining this information.

As a consequence of its lack of efficiency, the US healthcare system has consistently experienced price increases over and above those caused by inflation. In contrast to a typical market, where advances in technology and productivity cause prices to drop, costs in healthcare have steadily risen. In 1966, just after Medicare became law, total health expenditures were just more than USD 46 billion (the equivalent of USD 300 billion in 2009), of which USD 19 billion (USD 124 billion in 2009) were paid out of pocket by patients. By 2009, when the Patient Protection and Affordable Care Act (PPACA, aka Obamacare) was passed, total health expenditures had risen to USD 2.5 trillion, of which just under USD 300 billion were paid out of pocket [3]. Thus, one of the stated goals of the PPACA was ensure that patients have "skin in the game," and to "bend the cost curve down" [4].

Although an estimated 20 million people have gained health insurance since its passage [8], one of the consequences of the PPACA has been the advent of high-deductible policies. In essence, patients now must assume much of the upfront costs of their care. Presumably, this will make patients more cost-conscious, and more likely to seek lower-cost options for elective testing and procedures.

Paradoxically, however, the fraction paid by patients for their care has dropped steadily, even after PPACA passage [3]. The reasons for this are

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In "Editor's Spotlight," *one of our editors provides brief commentary on a paper we believe is especially important and worthy of general interest. Following the explanation of our choice, we present* "Take Five," *in which the editor goes behind the discovery in a one-on-one interview with an author of the article featured in* "Editor's Spotlight."
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not completely clear, but may be the result of a strong impetus under the PPACA to shift care away from private small-group providers and toward hospital-based networks [1]. We are now seeing the consequences of that movement—because of how Medicare payment has been structured until now, hospitals are able to charge substantially more for a given procedure than free-standing ambulatory centers or physician offices. Without going into excessive detail, Medicare computes payments to hospital outpatient departments based on the outpatient prospective payment system, which is determined by Medicare. Payment rates for physicians and other practitioner services are set by the Medicare physician fee schedule. When Higgins and colleagues [2] looked at payments by Medicare for seven commonly performed services, prices at hospital outpatient departments were higher in every instance than prices at physician offices; they ranged from 21% more for an office visit to 258% more for chest radiography in 2013. As they note, "Across product types, such as health maintenance organization, preferred provider organization, or consumer directed health plan, on average, an individual receiving care in an hospital outpatient departments paid between 1.06 and 2.94 times what they would have paid in a physician office for that same service" [2].

In essence, current healthcare policy has solidified existing perverse incentives that drive the sites where care is provided. As the RAND Corporation notes [9], the result is the exact opposite of the goals of healthcare reformers:

- Care is not necessarily provided in the least costly of medically appropriate settings. As we see in our spotlighted article, Medicare payments for outpatient diagnostic imaging services can be substantially higher if a community physician refers a patient to the hospital instead of a freestanding independent diagnostic testing facility.
- Hospital decisions to purchase physician practices are rewarded with higher Medicare payments even though the services and patient population may be unchanged. Beneficiaries face higher coinsurance to maintain their existing relationships with physicians and bill processing costs are doubled.
- Incentives lead to creative arrangements, such as hospitals securing outpatient diagnostic services under arrangements with radiologists and other nonreferring physicians.

Further, in many cases, patients who remain uninsured are dealt an especially cruel blow—not only must they pay out of pocket, but they also must pay full price for each service, with little thought or consideration by providers for affordability. And independent physicians run a substantial risk of prosecution if they perform a service below the prices set by Medicare.

The final question is whether patients will alter their healthcare choices in response to economic incentives. Here, several studies on reference-based pricing are of interest. Reference pricing is an insurance design that offers good coverage to patients up to a defined contribution limit but requires the patients who select high priced facilities to pay the remainder out of pocket. Robinson and colleagues at the University of California [5–7] have looked at patient choices for imaging and for outpatient arthroscopy. In all instances, patients responded by choosing lower cost options, with resulting cost reductions of 10% to 15%. Thus, when provided with information and competitive options, patients will reduce the amount spent on elective healthcare.

This sets the stage for a good, hard look at what patients can expect to pay when they are faced with potentially expensive procedures, such as advanced imaging. Join me in the Take-5 interview with coauthor Cameron Schick MD, as we discuss this and other healthcare financing issues.

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Take Five Interview with Cameron Schick MD, coauthor of "What Does a Shoulder MRI Cost the Consumer?"

Paul Manner MD: *When I shop for a car, there are several sites where I can find out what the cost to the dealer was, the average price paid in my area, and what sort of discounts the manufacturer might offer. Why is it so difficult to obtain the cost for a standardized medical study?*
Cameron Schick MD: There is no standardized cost for medical studies such as imaging. Costs for medical services are not advertised like most consumer products, and as a result, it is very difficult to find out the cost of services. Physicians who provide care often have no idea what price they charge for the service(s) they provide. This may change in the new era of delivery system reform.

Dr. Manner: *You found that hospitals typically offered discounts for up-front cash payments, but this was uncommon for independent imaging centers. Why might this be? Were there services or skill sets offered only at the hospitals?*
Dr. Schick: Independent imaging centers have considerably lower costs compared to hospitals. Since these costs are less, a discount is often not offered. Hospitals generally offer a


Cameron Schick MD

wider range of expensive services and often have the responsibility to care for the uninsured. To offset the increased costs in a hospital system, they may increase the costs for services such as imaging.

Dr. Manner: *Should physicians employed by a healthcare system continue to refer patients within the system or send them out for imaging, if the costs are so different? How should hospitals handle this? Should patients be counseled at the site of care?*
Dr. Schick: The focus should continue to remain on the patient, and whatever option is best for the patient is what should be pursued. If the quality of the MRI is better at the hospital, is more convenient for the patient, and costs are comparable, then referring within the same system makes sense. However, if the there is no difference in quality or convenience, and the costs are substantially different, then referring to an imaging center would be the better option for the patient and insurer. If costs were more transparent, it would be easier for hospitals and independent centers to counsel their patients regarding cost differences and what would be best for their patient.

Dr. Manner: *The major impetus for the Stark laws, which prohibit self-referral by physicians to entities in which they have a financial conflict of interest, was concern that physicians would unduly enrich themselves at the expense of patient care. In contrast, it seems that physician-owned entities offered better deals than hospitals. In an era where medical records and imaging are linked electronically, and where patients take on a greater burden of their healthcare costs, is it time to change Stark?*
Dr. Schick: Stark laws came to existence because of concerns that some physicians were manipulating the system for their own benefit. In the era of delivery system reform and rising healthcare costs, monitoring of fraud and abuse will become more stringent. It will be imperative that surgeons use guidelines and appropriate use criteria when using resources, particularly expensive imaging services.

Dr. Manner: *The PPACA placed a great deal of emphasis on patients*

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assuming more financial responsibility for their care, in an effort to "bend the cost curve down." The political landscape has changed quite a bit recently. What changes do you foresee for the consumer cost of imaging?

Dr. Schick: The healthcare landscape has changed a lot and is changing more each year. Monthly premiums are increasing and annual deductibles are higher than ever. As a result, people are seeking out the costs of services so they have a better idea of their out-of-pocket expenses. For this reason, it is important for independent centers to maintain imaging services for consumers who are seeking the better deal with similar quality. Ideally, hospital-based imaging costs will become more competitive with independent centers.

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