The problem with healthcare price transparency: We don't have cost transparency

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US$2.4 million. $1.5 million. $2.28 million. These are the amounts of money the health system where I work, teach and receive health care spent purchasing a PET scanner, a CT scanner and a three-month supply

of pembrolizumab, a drug that treats a variety of solid-organ cancers.

To meet the clinical (read "market") demands of patients, who are typically disinclined to wait for diagnosis or treatment, UVA Health already owns seven CT scanners (that I know of) and three PET scanners, which are used to detect small deposits of known cancer. It also has enough "Pembro" to treat all patients who will or might benefit from it. Guess how much of their costs are billable to insurance?

Zero.

In my dual roles at the University of Virginia, as both associate chief medical officer for clinical integration for the health system and director of the Center for Health Policy at the Frank Batten School of Leadership and Public Policy, I see this disconnect play out continuously.

For some drugs, Medicare doesn't pay everything

Here's why. Hospitals and physician practices have a single source of revenue: payment for patient care services rendered. To buy the PET scanner, CT scanner or Pembro, the university health care system collects money from our patients, largely through the insurer. In turn, our clinics, operating rooms and emergency departments treat the patient.

Simply put, the money collected from patients is used to buy everything the hospital uses to provide health care. Sometimes the health system borrows money from banks or the public, but even that debt is almost entirely serviced through payment for services rendered. Consumers bear the brunt; as in any business, those costs are passed on to the customer.

To be fair, Medicare Parts B and D may offset, but not pay for, the cost

of many drugs. For Pembro, for example, a Medicare recipient may be left with a 20% co-pay, or $30,000 a year. Different drugs incur different costs driven by market forces, including greed.

Which brings me to my point: Price transparency is the wrong goal for the free-market health care structure we have in the U.S. Instead, consumers need to know not so much the price, but the costs of things.

The difference between price and cost

Here's an analogy: There's the sticker price of the car you want to buy, and then there's the price you pay. Those numbers are almost always different, and no two buyers necessarily pay the same. Instead, a negotiation between buyer and seller (the dealership, in this example) takes place. Ultimately a price is agreed upon. But whatever that number is, it's never the actual cost of producing the car.

The carmaker knows, down to the penny, the production cost of that car. The consumer doesn't know. The dealership doesn't know, either; the dealer is privy only to the acquisition cost (price per vehicle) it pays. The automaker aggregates the costs of the aluminum and steel, the electronics, the glass, the tires, etc., and incorporates it all to derive a unit price per vehicle. The manufacturer knows all the costs of each component before the company starts to build a single vehicle, including labor and overhead.

Think of hospitals and physicians as the dealership. They don't know the actual cost of things either, partly because there's not just one "maker." Instead, many "makers" are in the supply chain—all the companies providing hospitals and doctors with thousands of medical products and services. Just imagine all the suppliers involved in making sure a patient receives a chemo treatment.

For far too long, the lay media has confused price and cost. So have health professionals and policymakers. When the Centers for Medicare and Medicaid Services references costs, it's essentially telling consumers how much it will pay to Medicare in premiums, deductibles and co-pays. Or, alternatively, it is telling consumers how much it will pay based on what each hospital indicates its costs are. These costs are different for every facility, because they are by-and-large derived, not calculated, numbers. No payer—that is, the insurance company for the patient—ever asks about how much it actually costs to provide health care. Here's why: No one knows. Health care prices are made-up numbers.

The practice goes back to the earliest days of modern medicine. Prices (also known as "fees") are determined by the time-honored standard of "usual and customary fees" charged locally and regionally for a service. That's it. The federal government added the word "reasonable" to its definition some years ago.

Health care reform proposals such as "Medicare for All," and its variations, will never control the cost of doing business until there's a better understanding of what precisely that is. Big Pharma claims that research and development of drugs costs so much that pricing has to recoup the investment. I don't subscribe to this claim at all, because they didn't provide sufficient data to convince me.

Our country has never even had the corresponding conversation in health care, writ large.

There are better ways to do it. Activity and time-driven cost accounting have emerged as methods to actually calculate how much individual units of health care cost.

Essentially, each step in a care process, be it bypass surgery, antibiotic

administration or an MRI, is costed out and aggregated through direct observation of the care processes. This is not something that might be implemented in the distant future—in some places, it's happening now. I'm proud to state that the University of Virginia Health System has taken the first steps to join them.

How much time does the technician take to perform a task? How much is she paid per hour? How much fringe benefit does she receive? How much time does the patient transporter take? How much does he earn per hour plus fringe? What is the purchase price of the MRI machine?

To calculate the true cost of care per care unit, a hospital must add up all the costs of all the component parts of the procedure or process. This allows hospitals to apply some rigor to their pricing schema. Some are doing this already with good results. Seeing how much care costs and the prices all hospitals charge would allow market forces to actually inform consumerism in health care.

From that starting point, a national dialog concerning prices in health care might have meaning. So would public policymaking. "Out-of-network bills" and "price transparency" would have real-world relevance. Finally, our country could have the long-overdue dialog about health care costs as a profession, an industry and a nation.

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