South Dakota's Hospital Price Disclosure Law: Spittin' into the Healthcare Wind?

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By Michael J. Myers

Editor’s Note: This article is the first of a two-part commentary related to a 2005 law requiring South Dakota hospitals to publicly disclose certain prices. It is written in advance of the statute’s implementation and is therefore anticipatory, offering 1990 data as a baseline against which 2005 pricing will be compared in a subsequent article.

Once upon a time—little more than a decade ago—South Dakota hospitals briefly flirted with industry-initiated hospital price disclosure. I wrote about it in a 1992 South Dakota Business Review article comparing average charges among 12 hospitals located in South Dakota, North Dakota, Iowa, Minnesota, and Nebraska.1

About the same time, some physicians seeking to build the Sioux Falls Surgical Center used the promise of price competition to help persuade Governor William Janklow to initiate the repeal of South Dakota’s certificate-of-need law.2 The repeal led to the establishment of a number of physician-owned surgery centers and specialty hospitals, earning South Dakota a reputation as a haven for doctor-owned hospitals.3 Both flirtations with price disclosure were brief, provider-initiated, market-driven, and politically opportunistic.4

Now, South Dakota hospitals are again confronting price disclosure. The state legislature enacted a 2005 statute requiring all licensed hospitals to report annually to the state Department of Health the charges (prices) for the 25 most common inpatient diagnostic-related groups (called “DRGs”) for which there are at least 10 cases rendered by the hospital during the 12 months preceding the report.5 The law requires the Department to place the hospital charge reports on its website and, upon request, provide the charge reports by first class mail. South Dakota hospitals, through its trade organization, resisted earlier proposals requiring price disclosure. “What a difference a year can make,” commented the trade organization’s executive director in expressing belated support for the disclosure requirement.6 It is a relatively modest disclosure requirement when compared to those of other states, as well as a number of health plans.7 A California law, effective July 1, 2005, requires hospitals to post their “chargemaster,” a complete list of non-discounted prices charged for each service, item, or product for which a charge is made. The South Dakota law also contained a July 1, 2005, effective date. However, the law’s language requiring the submission of data for “the 12 months preceding the report” is being interpreted by some that July 1, 2005, is the starting date for data collection, and that the data need not be submitted until July 1, 2006. Presently this interpretation is being negotiated between the hospitals and the health department.8 The bill’s sponsor and driving force says he expects the data to be assembled and published in January or February, 2006.9

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The South Dakota law is part of a nationwide challenge to hospital pricing practices. At the federal level Rep. Dan Lipinski (D-III) and Rep. Bob Inglis (R-SC) have introduced legislation that would require all hospitals to report to a government-run public web site prices charged to patients for the 50 most frequently prescribed drugs and biologics administered to inpatients and the 50 most commonly performed inpatient and outpatient procedures. The sentiment has high-profile bipartisan support. Senators Bill Frist (R-TN) and Hillary Clinton (D-NY) co-authored a Washington Post Op-Ed calling for public access to provider quality and price information. The pricing disclosure movement is being fueled by organizations such as the Council for Affordable Health Insurance and initiatives such as “Cover the Uninsured Week.”

In my 1992 article I speculated about the short-term and long-term effects of community hospital price disclosure and

(1) whether price information in the possession of healthcare purchasers carries the potential for altering regional referral patterns,

(2) whether periodic and ongoing publication of audited prices would constitute sound public policy, and

(3) whether such publication would alter hospital and/or physician pricing behavior.

Such speculation proved to be hollow. It was predicated on the false assumption that voluntary hospital price disclosure would continue and that the 1992 publicized debate between the two Sioux Falls hospitals, regarding which was less expensive, signaled an era of price competition. Sioux Valley initiated the debate when it went public with a database purchased from a healthcare consulting firm that had regionalized charge data submitted to Medicare. Sioux Valley compared its top 10 DRG (diagnostic related groups) prices with McKennan’s, offering it as evidence that the Sioux Valley price structure was 30- to 40 percent lower than McKennan’s. The most notable price discrepancy was the DRG for coronary bypass with cardiac catherization. Sioux Valley’s charge was $24,058, McKennan’s was $40,007. The regional reference group median price was $32,695, and the national median was $39,962.

McKennan was in the costly start-up phase of its cardiac program, a service that likely would have had difficulty passing a certificate-of-need review. The CON repeal also allowed McKennan to duplicate other services that had been provided exclusively at Sioux Valley, including neo-natal intensive care and air ambulance service.

“City’s hospitals continue the fight over best prices,” headlined a Sioux Falls Argus article describing McKennan’s contention that since its overall DRG average cost was lower than Sioux Valley’s, it was clearly the low-cost hospital. Sioux Valley’s administrator argued that the McKennan position was disingenuous; that its average cost was lower since it provided less intensive services; that it was akin to comparing the cost of a garage that replaced transmissions to a garage that replaced carburetors. A year later the price war dissipated into a cordial exchange of public statements complimenting each other for responsible cost control, publicly agreeing their prices were within 5 percent of each other. The two Sioux Falls hospitals turned their attention to acquiring hospitals and clinics in developing their respective health systems. The federal government grew as a monopolistic buyer and managed care plans were able to negotiate discounts. Hospital prices—called “charges” in the industry—became increasingly irrelevant. The chief executive officer of the South Dakota State Medical Association wrote an Argus “Counterpoint” piece analogizing the complexity of the U.S. health system to “one of those hopeless backlashes in the line on a fishing reel.” He said “It is unrealistic to think that further government intervention and management of the system will produce greater efficiency or lower cost.”

Taking him at his word, then, is it unrealistic to believe the disclosure statute will have a measurable impact on the healthcare system’s “hopeless backlash”? How low should our expectations be? Is it, as the law’s chief sponsor contended, a first “baby-step” toward introducing needed transparency into an industry insulated by third-party payment and government subsidy?
Will the growth of health and medical savings accounts, with their high deductibles, cause patients to compare prices? Will South Dakota hospitals seek the law's repeal because, as expected, the website receives little attention from consumers? Who will determine whether the cost of maintaining the database is justified?

Table 1 lists the average charges for the top 150 DRGs, as reported to Medicare by selected regional hospitals. This information is contained in my 1992 article. During the past 15 years each of these hospitals has been integrated into health systems. For example, St. Mary's is now part of the Mayo System. McKennan Hospital and St. Luke's of Aberdeen are part of the Avera Health System. St. Luke's Regional is part of the Iowa Health System.

Also my article compared charges for the top 10 DRGs as reported by Sioux Valley and McKennan Hospitals in 1990. This information is listed in Table 2.

In part two of this research I will use the 1990 data as a baseline for measuring the pricing behavior of regional hospitals during the past 15 years. It will be applied in testing the following hypotheses:

1. That charges for the 10 identified DRGs have increased at the rate of two-to-three times the consumer price index;
2. That prices among the listed regional hospitals will not have the degree of variance reported in 1990 because of profit maximization practices adopted by sophisticated corporate staffs;
3. That the 1990 pricing gap between the two Sioux Falls hospitals will have disappeared;
4. That surgical center and specialty hospital prices are equal to or greater than the prices prevailing within community hospitals.

Also, part two will further test the accuracy of my contentions that:

1. The consolidation of virtually all of the state's hospitals into three healthcare systems has marginalized pricing as a competitive strategy;
2. Sioux Valley's 1992 public disclosure of its pricing advantage over McKennan, and the market's indifference, was a classic illustration of the inelasticity of hospital services in a third-party payment environment;
3. Physicians are politically well-connected and generally exhibit appetites for profit comparable to that of hospital executives;
4. Nearly 90 percent of payments made to South Dakota hospitals come from Medicare, Medicaid, Wellmark Blue-Cross Blue-Shield, DakotaCare and a handful of other insurers, all of whom have long known what each hospital charges for its services, and
5. While individual consumers will make little use of the pricing data base, the legislative mandate is symbolically important and a measure of public resistance to healthcare's intractable inflation.

An article directed at hospitals, said, "Picture a day when a patient walks into your finance office and asks how much a unit of A-positive blood used during surgery costs. What about the sutures? After leaving, he goes to your competitor and does the same thing. All else being equal, he'll likely pick the low-cost alternative to his surgery."

During the 1992 price debate between the two Sioux Falls hospitals, a reporter wrote, "Rising costs could well make comparison shoppers of Sioux Falls employers who provide health care for their workers. In a series of "employer briefings" that began in January, Sioux Valley Hospital has been touting a study that shows its charges less for some procedures than 11 regional medical centers, including competitor McKennan Hospital." I have had numerous occasions to accompany a family member to clinics and hospitals during the past 10 years, and occasionally I ask prior to the provision of services how much they expect to charge for the service. Uniformly, the puzzled response of clerks and nurses have confirmed what we all have known: it is rare for patients to treat an encounter with a hospital or physician as the sell-buy transaction it in fact is. It is more likely that employers will use the data to influence insurers and health plans to become prudent buyers of healthcare services. The price information assembled by the health department, when combined with the incentives of health and medical savings accounts, may influence long-term pricing decisions by hospitals. But if past behavior is the best predictor of future behavior, the new law is not likely to produce measurable change. We may, once again, be spittin' in the wind of a healthcare system suffering from market failure.

| Table 2 |
| Top 10 DRGs, 1990 |
| Sioux Valley and McKennan Hospitals |
| 1. Major joint and limb procedure; |
| 2. Percutaneous cardiovascular procedure; |
| 3. Chemotherapy without acute leukemia; |
| 4. Circulatory disorder with cardiac catheterization; |
| 5. Heart failure and shock; |
| 6. Coronary bypass with cardiac catheterization; |
| 7. Cerebrovascular disorder, excluding trans ischemic attack; |
| 8. Simple pneumonia, pleurisy; |
| 9. Esophagitis/gastroesophageal reflux disease; |
| 10. Medical back problems; |

*Diagnostic Related Groups
Source: Sioux Valley and McKennan Hospitals
Footnotes
2 South Dakota’s repeal of its certificate-of-need law was probably influenced less by the promise of price competition than the fact that in 1987 federal funding for state CON programs was terminated. See An analysis and Evaluation of Certificate of Need Regulation, MD Health Care Commission, Division of Health Resources, Aug. 18, 2000.
3 The author was a consultant and an initial investor in the Siouxland Surgical Center, Dakota Dunes, along with founders of the Sioux Falls Surgical Center who repeatedly described how Sioux Valley Hospital lowered its ambulatory surgery prices by 25 percent when they filed their letter of intent and another 25 percent when they filed their CON application as evidence of the benefits of price competition. Since their establishment, however, research fails to identify public price disclosure by South Dakota’s doctor-owned surgery centers and specialty hospitals.
4 South Dakota has the highest number of specialty hospitals per capita in the nation. In 2005 they are Avera Heart Hospital, Sioux Falls, 55 beds; Black Hills Surgery Center, Rapid City, 26 beds; Sioux Falls Surgical Center, Sioux Falls, 13 beds; Siouxland Surgery Center, Dakota Dunes, 10 beds; Dakota Plains Surgical Center, Aberdeen, 8 beds; Spearfish Surgery Center, Spearfish, 8 beds; Lewis & Clark Specialty Hospital, 6 beds, and Same Day Surgery, Rapid City, 6 beds. Sioux Falls Argus Leader, Patients Have Stake in Specialty Hospital Ban, 6/5/05, 5A.
5 SB 169, 2005 SD Legislative Session, Public & Safety, amending Chapter 34-12E, SDCL.
6 Audio link to SD Senate Health & Human Services Committee, 2005 Session Laws.
7 Several states including Maine, California and Wisconsin require hospitals to post prices for their most common services. AHA Pub., 7/15/04.
8 Discussion by author with Health Department spokesperson, June 8, 2005.
9 Senator Tom Dempster, an advocate of market forces in healthcare, is credited with being the driving force behind the law’s enactment. He acknowledges that without the support of the South Dakota Association for Healthcare Organizations the bill would not have passed.
10 The Hospital Price Disclosure Act, H.R. 1362.
12 CAHI reports two examples of pricing differentials between the insured and uninsured:
(1) “The average operating cost per patient per day at St. Louise Regional (Catholic), California, is $1,376, but an uninsured patient would be billed $5,508; and
(2) The Chicago Sun-Times tells of Carlos Colon who was treated for a back problem. He was charged $74,996—10 times what an insurance company would pay.” See CAHI Newsletter, May 10, 2004.
13 Argus, 1993, “McKennan Says Cost Not High,” quoting a McKennan administrator: “Recent statements by insurance officials would leave the impression that McKennan’s prices are 30 to 40 percent higher than Sioux Valley. We categorically deny that McKennan’s prices are significantly higher than other area providers.” 7/24/92 B1
14 Myers, fn 1.
15 Argus, 1993, 10/5/94 B1
16 Robert Johnson, Counterpoint, “Reform won’t lower costs of services,” Argus, April 26, 1993, A9
17 Johnson, at fn 16.
18 Senator Dempster statement to senate committee.
19 The number of people covered by health savings accounts has more than doubled from 438,000 last September to more than 1 million, according to America’s Health Insurance Plans, the industry’s Washington-based trade organization. Gosselin, Corporate America Pulling Back Pension Safety Net, Los Angeles Times, May 15, 2005.
20 Conversation with J. Hoefer, SD Health Department, June 8, 2005, suggesting that long-term industry support for the web site may depend upon its usefulness to consumers.
21 This hypothesis will not be tested since the South Dakota law addresses only inpatient charges. The state’s doctor-owned specialty hospitals are overwhelmingly surgical centers with overnight capability. Only a small portion of their business will be subject to the reporting requirement.
23 T. Nelson, Examining Local Health Costs, Argus, 2/18/92.

About the author:
Michael J. Myers is an associate professor with joint appointments to the School of Business, where he teaches Healthcare Finance and Health Economics and the School of Law, where he teaches Health Law & Policy and ElderLaw. He manages the USD Senior Legal Helpine, offering pro bono legal assistance to persons 55 and older. He writes a weekly newspaper column and broadcasts a weekly radio program over WNAX, Yankton, and KDSJ, Deadwood, and recently authored a book entitled “Mayo Clinic and Blue Eyes.”