The Pricing Strategies Available to a Healthcare Manager

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Introduction

Healthcare managers make pricing decisions in an unusually complex environment because the word “price” can refer to several different amounts for the same service. A hospital may have a gross chargemaster charge, a discounted cash price, a payer-specific negotiated rate, a Medicare or Medicaid payment, and a patient-specific estimated liability. None is automatically equal to the economic cost of delivering care. Costing methods are therefore essential inputs to pricing, but they are not themselves pricing strategies. Cost-to-charge ratios, relative value units, activity-based costing, and time-driven activity-based costing estimate or allocate resource consumption in different ways, while actual prices must also reflect payer contracts, capacity, quality, market conditions, access, regulatory requirements, and financial risk (Reiter et al., 2021). This distinction matters in the transplant case because a calculated marginal cost should not automatically become the contract rate. A healthcare manager needs to know which costs change with volume, when new fixed capacity will be triggered, how outliers are handled, and whether a proposed rate supports safe and sustainable care.

Costing Methods and What They Actually Measure

A cost-to-charge ratio estimates cost by multiplying recorded charges by a relationship between reported costs and charges. The method is convenient for broad administrative analysis but can be misleading when markups differ substantially across departments (Shwartz et al., 1995). Relative value units compare the resources associated with professional services and can support physician compensation or resource allocation, but they do not capture every local facility, nursing, device, or capacity cost. Activity-based costing identifies discrete activities and assigns overhead according to cost drivers, allowing managers to see which processes consume support resources. Time-driven activity-based costing simplifies this approach by estimating a capacity cost rate per unit of time and mapping the time required for each step in a patient’s care pathway (Kaplan & Porter, 2011). Each method answers a different question. None should be described as the universally correct way to set a market price. The strongest pricing process uses the costing method that best matches the service, then tests the result against capacity, contracts, outcomes, and risk.

Pricing Strategies Available to Managers

Once managers understand cost, they can select among several pricing approaches. Cost-based pricing adds a target margin to full or incremental cost, which can protect sustainability when the underlying cost model is credible. Market- and contract-based pricing considers negotiated benchmarks, network needs, referral patterns, payer alternatives, and the hospital's bargaining position. Bundled or value-based pricing sets one amount for a defined episode of care and may tie payment to quality, complications, or outcomes. Discounted cash pricing can provide a simpler amount for self-pay patients, particularly for shoppable services. These approaches can be combined. A transplant contract, for example, may use an episode rate with explicit carve-outs for organ acquisition or unusually expensive complications. Price should never be evaluated only through revenue. A high negotiated rate may still be unattractive if denials, outlier exposure, staffing shortages, or new capacity costs outweigh the payment. Conversely, a lower rate may be financially useful when unused capacity exists and incremental revenue exceeds incremental cost without compromising access or quality.

Applying Marginal Cost and Capacity to the Transplant Case

The case states a marginal or variable cost of $71,468 per additional transplant and assumes that 30 additional cases can be performed without expanding fixed capacity. Under those assumptions, the total incremental variable cost for 30 cases is $2,144,040. That figure is the correct arithmetic result of $71,468 multiplied by 30. It is not necessarily an appropriate contract price because a rate equal to marginal cost would contribute nothing toward existing fixed costs, capital replacement, teaching, administrative support, uncompensated care, or clinical risk. Once volume exceeds existing capacity, the economics change because new staff, beds, operating-room time, equipment, or support services may be required. The scenario model assumes added fixed costs equal to 15%, 20%, or 25% of current fixed cost. These estimates should be treated as scenarios rather than facts. Before accepting a contract, management should reconcile each input with the general ledger, staffing plan, transplant volume history, capacity thresholds, and expected case mix, then test whether the proposed rate remains sustainable under lower volume or higher complication rates.

Marginal Contract Volume	15% Fixed-Cost Scenario	20% Fixed-Cost Scenario	25% Fixed-Cost Scenario
31	$99,534	$108,890	$118,264
60	$85,969	$90,803	$95,636

Outliers, Quality, and Ethical Pricing

Transplant episodes can vary dramatically in cost because of organ acquisition, intensive care, complications, length of stay, readmission, pharmacy use, and post-discharge needs. A flat bundled rate can therefore create substantial financial risk if outlier protection is poorly designed. Contracts may reimburse a percentage of costs above a specified threshold, but the agreement must define which expenses count, how costs are audited, whether selected services are carved out, and whether the percentage applies only to the excess amount. Quality must also remain part of financial analysis. Shortening length of stay is not efficient if it increases complications or readmissions, and reducing staffing below safe levels can create apparent savings while increasing downstream cost. Pricing also affects patient access. Managers should avoid setting rates below the resources required for safe care, but transparency and market power should not be used to justify amounts unrelated to defensible costs or value. Costing systems are most useful when they identify waste and support sustainable care rather than simply providing a technical rationale for whatever price an organization prefers.

Hospital Price Transparency in 2026

Federal transparency rules add another layer to healthcare pricing. CMS requires hospitals to publish standard charges in a machine-readable file and provide consumer-friendly information for shoppable services. The current program is described at https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency. Beginning in 2026, CMS also requires hospitals to report median, 10th-percentile, and 90th-percentile allowed amounts, together with counts of allowed amounts, when payer-specific negotiated charges are based on percentages or algorithms. These changes are summarized at https://www.cms.gov/newsroom/fact-sheets/cy-2026-opps-ambulatory-surgical-center-final-rule-hospital-price-transparency-policy-changes (Centers for Medicare & Medicaid Services [CMS], 2026). Transparency does not determine the ethically or financially correct price, but it increases the need for consistent definitions and auditable data. Managers must understand the difference between gross charge, cash price, negotiated charge, allowed amount, and patient liability. A large machine-readable file can satisfy regulation while remaining confusing to consumers, so useful communication still requires estimates, context, and explanation of insurance effects.

Conclusion

Healthcare pricing requires managers to connect resource measurement with contract design, capacity, quality, patient access, risk, and regulation. Cost-to-charge ratios, RVUs, activity-based costing, and time-driven activity-based costing are different costing tools rather than interchangeable pricing strategies. In the transplant scenario, $2,144,040 is the correct total variable cost for 30 cases

at $71,468 each, while the proposed $108,890 rate is only one modeled negotiating point under a particular fixed-cost assumption. It should not be adopted without validating staffing, capacity, outlier risk, payer requirements, and case mix. Current CMS transparency rules further require hospitals to publish more standardized charge and allowed-amount information, making data quality increasingly important (CMS, 2026). The strongest healthcare pricing decision is therefore not the number generated by one formula. It is a rate supported by accurate cost data, clearly defined contractual terms, realistic volume assumptions, adequate protection for unusually costly cases, and evidence that the organization can deliver safe care without shifting unreasonable financial burden onto patients or undermining long-term service capacity.

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