The Costs of Products and Services

Presented by the
American Society of Cosmetic Dermatology & Aesthetic Surgery

Wm. Philip Werschler, MD

With the increasing number of fee-for-service procedures (ie, cosmetic procedures that require payment from the patient) being routinely performed in dermatology practices, the issue of setting up fees is a common topic of conversation among dermatologists. Currently, dermatology practices have 2 fee schedules: one for disease dermatology that is billed back to an insurance company and one for nonbillable cosmetic dermatology procedures, also known as *desired procedures*. Whereas the fee schedule for disease dermatology is set for each office through third-party (insurance) contracts, dermatology fees associated with desired cosmetic procedures are left to each office to set individually.

The most common procedures that fall into this category for dermatologists are those procedures that involve aesthetic lasers, injectables, or cosmetic surgery. From a volume assessment, the most popular aesthetic procedures involve lasers and injectables. According to a recent poll conducted by the American Academy of Dermatology, these 2 groups of procedures are routinely performed by a significant number of dermatologists.[1] Unlike toxins and fillers, lasers have a relatively large sunk cost, which reflects the cost of acquiring capital equipment that has been purchased, leased, or rented. This makes pricing strategies more difficult to analyze, especially in regard to the variations among different manufacturers in what are known as *consumables*. With capital equipment such as lasers, the cost of flooring the devices, or having them available to use in the office, can be quite burdensome. As such, the lasers are not generating any revenue when not in use, and the pricing methodologies used to keep them active vary tremendously among offices and by community and region.

Dr. Werschler is Assistant Clinical Professor of Medicine/Dermatology, University of Washington School of Medicine, Seattle, and in private practice, Spokane, Washington.

Dr. Werschler is an advisory board member, clinical investigator, consultant, and/or speaker for Allergan, Inc; BioForm Medical, Inc; Pacific BioScience Laboratories; Dermik Laboratories; Galderma SA; Genentech; Medicis Pharmaceutical Corporation; MyoScience, Inc; and Peplin.

The simplicity of a cost-versus-charge analysis with regard to toxins and fillers lies in the fact that they are relatively inexpensive to acquire, they have a defined unit cost to purchase, they may be ordered in small or large quantities, and they have a minimal burden on inventory costs. Using toxins and fillers as an example of elective services that are sold on a fee-for-service basis, I will review and examine the pros and cons of various pricing methodologies that are commonly employed by dermatology practices throughout the United States.

Cost Versus Charge

The first step in this analysis is to clarify the difference between *cost* and *charge*. The *cost* of a product is the actual dollar cost per unit to purchase a given product. There may be certain considerations in establishing the cost basis, such as offering a certain volume of free additional product with purchase, which lowers the unit cost and is usually reserved for larger orders; shipping costs; any special handling or reconstitution requirements; and the materials necessary for procedures, such as needles, anesthetics, or diluents. Lastly, there may be a fee for administrative overhead added to the cost basis that some practices use to account for the staff's time when ordering and tracking inventory and to compensate for theft, loss, spoilage, and wastage. This is generally a small number, approximately 5% to 10% of the purchase price.

The *charge* for any given product is the fee that the patient pays at the time of service or, in some instances, as part of a prepayment program that is usually associated with a discount.

Calculating the total charge would account for any discounts, coupons, bonus products (as in buy 2, get 1 free), or touch-up visits that do not require a charge.

Pricing Strategies

Fixed Margin

In a *fixed margin*, or *cost plus fixed-fee* approach, the dermatology practice examines the relative cost of a product and adds a fixed fee to this amount for the technical component of administration or injection. For example, if a syringe of a product costs $200 and the fixed margin is a $200 injection fee, then the charge of the product would

be $400. If the product costs $100, then the total charge would be $300.

This example illustrates the margin of profit per syringe set to a fixed fee and then added to the cost of the product for the total charge. The margin stays the same regardless of the product being used. This is an effective and simple strategy, although it does not account for any technical considerations between products and assumes all products being used are the same with regard to the time and skill needed to perform the injection.

From a practice management perspective, this approach is easy to use and the simple calculation of the number of syringes used over a time period accurately reflects the revenues generated. For example, if 100 syringes are used in a quarter and the margin is $200 per syringe, then the net revenue generated (gross charges minus the cost of the product) is $20,000.

Fixed Markup—A similar pricing strategy is fixed markup, where there is a fixed amount of added charge to the cost of product. In this approach, the most common example is to double the cost of the product, which sets the charge. If a product costs $200, then the patient is charged $400. If the cost is $300, then the patient is charged $600.

In this setting, there is a tendency for the dermatologist performing the injection to favor the more expensive product, because while the percentage of profit remains the same, the actual dollar amount of profit goes up substantially as more expensive products are being used. Generally, this means there is an increase in both gross and net revenue per encounter when using higher-priced products.

The patient's response is to favor the less expensive product, as the price escalates very quickly with more expensive products. If the less expensive product is suboptimal for the best results for that particular patient's concern or desire, then the risk of an unhappy patient is increased. Because some patients lack the knowledge to make an informed decision on which products are best suited for their needs, they have a tendency to choose the less expensive products unless compelled to do otherwise.

Community Pricing

Community pricing is another model commonly used, where the dermatology practice sets the relative prices of products based on an unscientific survey of other practices that are considered part of the community. The community may be a large medical practice, a geographic area, a medical specialty (eg, dermatology, plastic surgery, family practice) or a practice setting such as a large shopping mall.

The problem with community pricing is that it fails to account for individual expertise, reputation, and experience. Essentially, it turns the product into a commodity, much like a carton of milk or a can of soda. Purchased at the local supermarket or the gourmet deli, there is no difference in the product itself, only where the service is received.

This approach also leads to a progressive downward spiral with pricing because when one office advertises a lower price point, the other offices using community pricing are pressured into matching the competitor's new and lower fee. This model also favors those who have less experience performing injections who are willing to work for a lower wage. If the profit margin is squeezed by the downward pricing pressure, at some point it becomes unprofitable for the more highly compensated employee to perform the service as compared to other, more profitable services.

Community pricing worked well when there were relatively few individuals who could deliver the service or injection. In some ways, it represents an outdated model of price range fixing where the providers of the service in question would all agree on a general range of prices that would be close enough to have an insignificant impact on patients shopping for prices, yet still be different in actual dollars.

Generally, although patients perceive that they are paying a fair market value, they will ultimately suffer when this pricing structure forces charges to drop below acceptable profit margins for those who have more experience performing injections, thereby favoring the less experienced injector.

In communities where there are still a small number of cosmetic injections being performed, community pricing continues to be successful and widely used. It also serves as a reality check for the actual charges of a practice as compared to those within the community.

Benchmark Pricing—Benchmark pricing is another term used to describe community pricing where benchmarks are used to determine the range of charges. Benchmark pricing is a more scientifically based, community-validating model of pricing. Because benchmarks are often used by practice consultants, they may serve a useful purpose of externally validating the charges used by the office and expose deviations above or below the range of community pricing.

Discount Pricing and Loss Leaders

Discount pricing and loss leaders are another approach to the cost-versus-charge model. In discount pricing, there is an externally focused approach to setting charges,

in that the dermatology practice monitors competitors' fees and then attempts to set charges at or below that level. This model usually disregards the actual cost of the product and instead focuses on the lowest possible price, sometimes focusing on a charge that is below cost.

When the cost-versus-charge ratio becomes inverted and the cost exceeds the charge, the term *loss leader* is commonly employed. Generally, with regard to injectables and medicine in general, this approach is seen when there is an attempt to rapidly gain new market share at the expense of a competitor, to introduce new products or services with a time-limited incentive, or when the use of adulterated or illegally imported products, which have a different cost basis, are being employed.

Although discount pricing and loss leaders may initially attract new patients to the office, they are not sustainable business models over the long term for the simple reason that the economics are upside-down. The practice that employs this model will need to either abandon it after a brief period of time or suffer the consequences.

Premium Pricing

Premium pricing is a model commonly employed by practices that have established a reputation of excellence within a community because of their experience, training, expertise, or certification.

Sometimes referred to as the Nordstrom approach, the premium pricing model has been successfully adopted by aesthetic plastic surgeons because it is analogous to the strategy of retailers of luxury goods. Because these plastic surgeons have developed a superior reputation based on length of training, skills, and marquee value, patients are willing to pay a premium to receive the same or a similar service that could be received from another equally competent non–plastic surgeon. To a limited degree, this premium pricing model also holds true for dermatologists as compared with noncore physicians, such as internists, those associated with a family practice, or obstetrician-gynecologists.

Premium pricing is ultimately at the mercy of the free market economy, as patients as consumers will determine the value added by the premium service and whether this value justifies the price difference. For those dermatologists who are highly skilled at cosmetic procedures and whose offices reflect the desired perception of the aesthetic consumer and consistently deliver superior service, this model works wonderfully. Unfortunately, this is a very thin market, especially for a dermatology practice that does not operate at cosmetic office practice level 4, which describes a practice that offers no disease procedures, only desired procedures.

Level Pricing

The level pricing model, or cost-averaging model, is rapidly gaining acceptance among dermatologists. This model uses a cost-averaging approach to level out price differences between products that are perceived as equivalents by the patient. With level pricing, the patient is essentially removed from choosing the product and instead is only responsible for determining the total dollars spent.

As more products are being introduced into the marketplace, consumer confusion is increasing. Advertising by competitors, commonly directed to the consumer as well as the professional, only further serves to confound aesthetic consumers over which products best serve their individual needs. The patient then relies on the provider to make the product recommendation. In the models where prices vary by product, the elements of cost, profit margin, and charge all begin to affect the decision-making process.

In the level pricing model, all products are priced the same for a given unit and decisions are made by the provider as to which products are best for the patient without cost considerations. The only decision the patient makes is the number of units of product to buy. For example, if a patient expresses an ability to purchase 4 U, or syringes, of filler for facial shaping, and the provider determines that this is a sufficient number to achieve the desired result, the actual product or products that are used are left to the discretion of the provider. This allows the provider, who is more educated about the products than the patient, to utilize their judgment and experience in order to obtain superior results. It also removes most cost considerations that potentially bias product choice.

The level pricing approach relies on 2 key assumptions. The first is that the unit cost of products is substantially similar, thus maintaining approximately equal profit margins. The second is that the provider uses a variety of different products across categories, thus taking advantage of unique features and benefits between products.

With the increasingly growing field of dermal fillers, the first assumption appears to be developing. The cost of syringes of dermal fillers has begun to stabilize at or near the $200 price point, with larger volume purchases routinely dropping below the $200 per unit barrier. While some products are priced substantially higher than $200 per unit, the charge can be controlled by adjusting the size of the unit. An example of this would be to use half of a vial of reconstituted poly-L-lactic acid as a unit, thus maintaining a near $200 price point for cost. Another example would be to use a smaller prepackaged syringe as a unit, such as polymethylmethacrylate, where the

0.4-mL syringe would be 1 U and the 0.8-mL syringe would be classified as 2 U. Again, the actual implementation is office specific, as is the unit price point, and these are examples of potential charge calculations.

Regardless of the methodology used to calculate level pricing, the strategy works best when the dermatology practice and the provider use multiple filler products across categories, such as hyaluronic acid, calcium hydroxylapatite, poly-L-lactic acid, and polymethylmethacrylate. As some offices have adopted a "couture" or "boutique" approach of using only one brand or family of products, the benefits of level pricing are lost with regard to provider choice.

Level pricing also works especially well with premium pricing because the typical office that uses level pricing will have achieved competence in the use of multiple products and a complementary advanced skill set to achieve the highest and best use of product for optimal outcomes.

Summary

Because dermatology practices often stumble into a pricing structure for aesthetic procedures, rather than deciding from a comparative analysis on the approach that works best for their particular needs, a careful review should be conducted at least annually. During this review there are 3 basic questions to ask: (1) are the cost-versus-charge strategies consistent across products; (2) does the charge strategy reflect positioning in the community, the skills of the providers, and the reputation of the practice; and (3) are expectations of the dermatology practice's growth being met? If not, why? Are charge strategies contributing?

Ultimately, where charges are established for cosmetic procedures is less important than understanding how they were determined and what business methodologies were employed and why. When these questions are answered satisfactorily, explaining to both patients and staff how the decision was made will be easier, and the outcome with regard to practice growth will be greater.

Reference

1. Cosmetic conditions and treatment options. American Academy of Dermatology Web site. http://www.aad.org/media/background/factsheets/fact_cosmetic_dermatology.html. Accessed May 15, 2008.