

To: Federal Trade Commission

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RE: FTC Public Workshop, Examining Health Care Competition P131207

Executive Summary

This memorandum is in response to the recent Federal Trade Commission (FTC) interest in understanding areas of competition that may affect the healthcare market, specifically price transparency in health services and goods costs. First, the background and possible consequences of implementing price transparency laws are discussed. At this time, little is known about the actual costs and benefits of price transparency legislation, creating a problem for policymakers. Three options to address this issue are outlined, positing antitrust research and action, long-term data collection in comparison areas, and quality rating comparative data analysis as potential means for addressing this unknown. Based on feasibility and usefulness of output, long-term data analysis is recommended.

Background

Healthcare costs have consistently been on the rise for many decades, with some estimating that healthcare expenditures will consist of $\frac{1}{4}$ of the US GDP by 2037 (Emanuel et al, 2012). Many attempts to contain costs have been employed nationwide, incorporating copays, high-deductible health plans and generic drugs (Hostetter & Klein, 2012). However, buoyed by the recent passage of the Patient Protection and Affordable Care Act, legislators and policy actors are looking for alternative methods of cost containment that address a reduction in the rate, rather than the level, of spending. The Federal Trade Commission (FTC) believes that price transparency may induce competition in the healthcare market and ultimately drive down costs. Price transparency here is defined as “provider-specific information on the price for a specific health care service or set of services to consumers...[reflecting] any negotiated discounts [and] all costs to the consumer” (Catalyst for Payment Reform, 2012, 1). It is difficult to ask patients to be responsible consumers if costs of services are unknown, and so price transparency is seen as a way to lower prices through changing consumer spending habits and seller-side competition

Price transparency laws are considered to be an alternative to the largely secretive practices surrounding spending and price setting in the healthcare market. Kyle & Ridley (2007) note that price transparency can be lacking in one of two ways: first, where a buyer does not know how much a health service costs and does not know what others pay for the same service, and second, where the buyer knows the price but does not know what others pay for the same service. Due to differences between state laws, ranging from no price disclosure to average prices disclosure to detailed prices disclosure, both types of price transparency absence are present in the US at this time (Sinaiko & Rosenthal, 2011; American Hospital Association, 2014). Theoretically, “publishing price information could both narrow the range and lower the level of prices...by permitting consumers to engage in more cost-conscious shopping...and [by] stimulating price competition on the supply side” (Sinaiko & Rosenthal, 2011, 892). Eventually, price transparency policies could enable a rise in value-based purchasing (Hostetter & Klein, 2012). In essence, a person would be able to shop for health services the same way s/he shops for a car, where the buyer knows all of the different prices at different dealerships, the seller knows competing prices, and both parties are able to negotiate.

However, the complexities of the healthcare market may produce negative consequences stemming from price transparency initiatives. First, as noted by the Government Accountability Office (2011) and reiterated by the Commonwealth Fund (2012), “the wide variety of insurance benefit structures, a lack of standard formatting for reporting prices...the difficulty of determining prices when charges originate from multiple providers...[and] legal hurdles to reporting prices” (Hostetter & Klein, 2012) can complicate simply stating what health services cost. Others agree, arguing that price transparency “can increase prices paid by poor people, delay or deter the launch of products in poor markets, reduce competition, lower investment spending, and mislead if inaccurately measured by a third party” (Kyle & Ridley, 2007, 1385). Second, without accompanying up-to-date quality information, consumers may erroneously assume that a higher price indicates a higher-quality good or service, and ignore cost savings indicated by transparent prices. Finally, due to the relatively small supplier market and low ability for substitution in the healthcare device market, it is also possible that price transparency may lead to supplier collusion, ultimately raising prices for consumers (Hahn et al, 2008). Price transparency policy development must take these possibilities into account.

Some federal action has been initiated, though jurisdiction for price transparency laws in non-Medicare and Medicaid markets falls at the state level. H.R. 1326, “to provide for increased price transparency of hospital information and to provide for additional research on consumer information on charges and out-of-pocket costs” (Govtrack.us) for Medicaid patients has been referred to the House Commerce Subcommittee on Health, but there has been no action on this bill since March 2013 (Congress H.R. 1326). In addition, the Physicians Payment Sunshine Act requires that both direct and indirect financial transfers from “manufacturers of a drug, device, biological, or medical supplies participating in federal health care programs” (American Medical Association) to doctors be disclosed to the Centers for Medicare and Medicaid Services. Though this is provider-side price transparency, some claim that this law was the first step to a sense of openness and disclosure in an otherwise guarded industry (Cutler & Dafny, 2011). Finally, “the Affordable Care Act requires hospitals to publish and annually update a list of standard charges for their services” (Hostetter & Klein, 2012). Implementation of this requirement has yet to occur.

Evidence

A wide variety of evidence sources were used to develop this memo. Google Scholar and PubMed were initially utilized with search terms including ‘price transparency policy’ and ‘price transparency healthcare’. Lists of works cited in papers read for the memo expanded the search. Final sources included the GAO, the Congressional Research Service, opinion pieces and research published in reputable journals, white papers from policy analysts, and reports issued by interest groups and think tanks. Please refer to the list of works cited.

Problem

Price transparency policies can instigate a competitive market, but transparent prices may induce “price coordination among health care providers and thereby undermine the potential benefits of competition” (Federal Register, 2014). In addition, recent FTC research into price transparency in the pharmaceuticals market found that price transparency policies might cause an increase in prices (Hahn et al, 2008). The uncertainty about outcomes generates the problem at hand. Economists and policy analysts disagree on the likelihood of negative consequences as a result of price transparency, and this argument makes it difficult to determine which predictions are

accurate. Price transparency may induce competition, but it may or may not be useless without quality reporting, may or may not lead to collusion, and may or may not be more or less effective based on how prices are reported. Deeming price transparency to be a solution for rate reduction in health spending is thus difficult to do without serious caveats.

Subsequently, this memo presents three potential actions the FTC can undertake to tackle questions surrounding price transparency and its potential negative effects. It considers analyzing market leverage and issuing a report on collusion, executing a longitudinal study comparing the efficacy of different types of price transparency, and examining the effect of quality reporting in conjunction with price transparency efforts.

Policy Options

Reporting on market leverage: If we consider the main issue with implementing price transparency in the healthcare market to be the potential for collusion among providers or suppliers, researching and strengthening antitrust legislation may circumvent this issue. As described by King et al (2013), “a combination of antitrust litigation and price transparency legislation has the potential to break down market leverage and produce price transparency” (King et al, 2013, ii). In this scenario, the FTC could prepare an in-depth analysis of two similar markets, one with price transparency and one without, and identify violations of the Sherman Act, if there are any. Simultaneously, the FTC would work to strengthen antitrust legislation in the healthcare market. Though this plan has merit, market collusion is entirely hypothetical. The FTC may look nervous or weak if this is the action that we choose and it turns out that market collusion is not in fact actually a problem.

Executing a longitudinal study: However, if we consider the main issue with implementing price transparency in the healthcare market to be the lack of information on the effectiveness of different types of price transparency in the healthcare market, another option would be appropriate. A long-term study comparing health spending across areas with varying price transparency strategies would reveal in-depth information about the efficacy of price transparency policies. The GAO 2011 report details different price transparency methodologies in several states that range from reporting of median insurance payments to the range of total billed hospital charges (GAO, 2011). In addition, CMS reports median physician payment rates, and Aetna discloses negotiated rates. Comparing health spending from 2010 (pre-ACA exchanges) to 2015 across these different types of price transparency may shed light on whether or not price transparency is at all effective. This option, while comprehensive, will require significant continuing effort on the FTC’s part, and the data that they need may not be readily available in a feasible timeline.

Examining quality reporting: Finally, if we consider the main issue with implementing price transparency in the healthcare market to be the unknown effect of available quality information on consumer choices, an option is to analyze health spending in a price-transparent state that details quality ratings. In addition to providing “summary and detailed average costs that commercial health plans pay, by provider” (Sinaiko & Rosenthal, 2011, 892), Massachusetts also specifies provider-level quality information where available. A detailed analysis on our part, surveying consumers and tracking consumption choices in the face of quality information and price transparency, may begin to answer the question of how these two entities work together or against each other in reality. This data could be compared to a non-price transparent state that reports quality information. However, though this option demonstrates how price transparency

may be supported by quality information, it does little to help the FTC understand the conditions that introduce or hinder competition in this particular market, and thus may be of little use of them for this particular angle.

Recommendation: Execute a longitudinal study

Though the information needed to fully consider the consequences of price transparency, both positive and negative, is multifaceted, the FTC's best course of action is to offer policy analysis for long-term data collection. By providing a strong framework for determining the effectiveness of price transparency policies, the FTC will be able to understand competition in the healthcare market as well as be positioned to advise the wider federal government on potential national legislation in this area. A strong understanding of the consequences of transparent price policies will ensure that future legislative action is as effective as possible.

I am a student at Columbia University. However, this comment to the Federal Trade Commission reflects my own personal opinions. This is not representative of the views of Columbia University or the Trustees of Columbia University.

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