

***“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.”***

Federal Trade Commission  
Competition P131207

### **Memorandum: Price Transparency in Health Care**

**To:** Joshua D. Wright, Commissioner of FTC (Federal Trade Commission)

**From:** Brigid S.Y. Jung, Non-Partisan Think Tank Analyst

**Subject:** Reducing Unintended Consequences of Price Transparency

**Date:** April 23<sup>rd</sup> 2014

#### **Executive summary**

About 30 states have adopted various price transparency policies for certain elective services so far both on provider services and medical devices. Unfortunately unintended consequences arose such as collusion of prices, adverse effect on the poor and uninsured, and reduced Good Samaritan practices by providers. Studies on effects, economic speculations on potential effects and policy briefs have been used to bring forth alternative policies to reduce the problems. However, given the budget and political movements as per the ACA enactment, we recommend that information on quality of services be provided with prices in order to increase competition in this oligopoly market.

#### **Background**

Moral hazard in healthcare is an enduring issue and to understand the depth of the case at hand, a few considerations should be made. First, physicians and hospitals are utility maximizers and the current system “encourages wasteful use of high-cost tests and procedures,” (Emanuel). Second, some hospitals receive “almost 500% of what Medicare pays for hospital inpatient services,” and there is no logical explanation behind these prices (CPR). Third, consumers have no way to judge what is best for them in terms of quality of care nor are they aware of the price variations. Fourth, hospitals are also victims of price transparency because the medical device sellers “designed contracts that include language forbidding buyers from disclosing the negotiated price,” (Pauly).

In 2012, the New England Journal of Medicine (NEJM) recommends the “state insurance commissioners and exchanges to collect, audit and publicly report data on prices and claims,” as a way to reduce costs (Emanuel). The proponents of legislative price transparency policy state that healthcare consumers would benefit from this for several reasons: (1) purchasers can contain healthcare costs; (2) make informed decisions based on both cost and quality; (3) reduce price variations across the board (CPR).

Price Transparency is “the availability of provider-specific information on the price of a specific health care service or set of services to consumers and other interested parties,” according to the Catalyst for Payment Reform (CPR). As a way to address the ex-post moral hazard of overconsumption in health care and the consequent rise of health expenditures, Price Transparency was first addressed in 2006 when George W. Bush signed an executive order “requiring hospitals and physicians to disclose the price and quality of care” for Medicare and public employees (Kyle). The Transparency in Medical Device Pricing Act of 2007 also required Medical Device manufacturers to report to the Center for Medicare and Medicaid Services (CMS) the “mean and median prices for implantable devices as well as for services that normally ‘bundle’ with the prices,” (Lerner). As a result, 30 states created legislations on price transparency by the end of 2007, where some states “required hospitals to publicly report their charges to government payers” (Farrell). Recently, with the PPACA implementation, which introduced provisions to promote the

use of Shared Decision Making (SDM) between patients and providers, support for price transparency is on the rise (Tilburt).

Despite the effort put forth, the U.S. National health spending is growing from “18% to 25% of GDP by 2037” (Emanuel). Similarly, the FTC also “found that disclosure might increase consumer prices,” (Hahn). The price transparency legislation that was initially created to tackle issues of asymmetric information between the buyers and providers, as well as manufacturers was initially believed to promote market competition. Unfortunately the evidence shows a prolonged market failure, lack of equity and an absence of a fair market price. In order to ensure health care cost containment, FTC’s action may be necessary.

### **Evidence**

We have compiled the evidence from three main streams of data: (1) Economic cost-benefit analysis data on price transparency, (2) Randomized studies on the effect of price transparency, and (3) Journals delineating observed effects in states with price transparency legislations in the US.

### **Problem**

The main complication of the Price Transparency is that it did not translate to behavior that was intended. Instead, negative impacts were seen including: (1) Collusion of prices, (2) Inequitable effects on population segments, and (3) Reduced good Samaritan services. Price transparency leads to price uniformity in the industry. However, uniformity doesn’t mean that the prices are lower than before. In 2006 when the HCA imposed transparency at a north Texas hospital, they found out that their demand elasticity decreased, where they couldn’t give as much discount to the poor and uninsured as before. Also, due to their oligopoly market, transparent prices facilitated collusion. Moreover, due to the reduced profits, hospitals often discontinued unprofitable services and the much needed charitable services.

How can we prevent these negative consequences whilst still promoting market competition to protect our consumers?

### **Policy options to address the problem and criteria for selection**

1. Quality information published alongside prices

As of now, in the 30 states with price transparency legislations implemented, there are few incentives for consumers to compare prices. This is because most patients are insured and also because there is a lack of proxy for quality of services (Sinaiko). Without the quality information published, patients are most likely to assume that the greater the price, the greater the quality, as in most industries. “Lower-cost providers may lack the necessary market power to make such demands,” therefore failing the market (Sinaiko). With the quality ratings, the consumers who care about their health will base their decisions on the price and quality. According to a BMJ study on Shared Decision-Making (SDM), 67% of physicians were very enthusiastic about promoting SDM, and 70% agreed that support tools including costs would be helpful in their practice (Tilburt). Also, the ACA has “several provisions to promote the use of SDM,” that includes patient knowledge enhancement, clarifying patient preferences and assisting in forming realistic expectations (Tilburt). Since SDM is all inclusive of quality and costs, it is safe to say there is political support as well as provider support. This will not only foster competition but also achieve “hither quality care that may also achieve cost containment as well,” (Tilburt).

Nonetheless, there are roadblocks to this alternative. Patients often do not know “in advance what exact combination of services a patient will need,” (Sinaiko). Also, there is asymmetric information where the doctor knows the condition best whereas the patient has no idea in most cases. Quality information could improve patients’ choice but a new organization/panel of experts who can objectively evaluate the quality of each technique, physicians and hospital may be needed. This could offend the AMA and require bundle

payments to set up this organization. The CBO (Congressional Budget Office) must decide on whether some funds can be set aside, or even from the CMS (Center for Medicaid and Medicare Services).

## 2. Provide financial subsidies for providers to promote treatment of the poor & uninsured

The poor under the legislation of price transparency can face more difficulty because hospitals do not want to “undermine Medicare and private insurance plans,” and because charging them more on paper can “make the hospital look more charitable” (Kyle).

This would be advantageous for the poor and uninsured population because of several reasons. In a 2009 California study by Farrell et al., they had uninsured patients request information on prices of elective procedures mandated to be transparent by law (Farrell). However only 28% of the hospitals responded and only 64% of those responded within 2 weeks (Farrell). The most interesting however, was “non-profit hospitals and government hospitals were more likely to respond to the request,” (Farrell). This shows that hospitals/providers with financial incentives are likely to avoid treating the uninsured, and the prolonged response time could cause worse health outcomes in the long run. If subsidies were given to the providers by the government, the equity of services could be maintained in transparency without discrimination. Also, it is often common that hospitals “prefer to charge lower prices to poor or uninsured patients,” and this alternative could potentially help subsidize the cost differentials instead of charging the insured more (Kyle). Also, “Stuart Altman and colleagues argue that price transparency would have severe consequences unless payers increase reimbursement for underfunded services,” so it seems to be a quite necessary part of the legislation.

A great disadvantage of this policy is where the funds will be coming from. With health expenditures on the rise, price transparency has been suggested as a way to reduce federal health costs by “allowing consumers to plan ahead and choose lower-cost providers,” (Emanuel). However, this method could potentially increase the overall costs defeating the fundamental purpose of this legislation. There is also a logistical argument that there is no clear line in which we can define the ‘poor’. The Medicaid limit is at 138% of the PLL according to the ACA, but we can suspect a strong backlash from those who don’t meet the criterion. Hospitals that don’t get these subsidies because they are for-profit might cause an unintended segregation between the hospitals for the poor/uninsured and the wealthy/insured. Rather than making the market more competitive, this could work in reverse by separating it into two smaller markets. This decision should be made by the CBO (Congressional Budget Office) with a Cost-Benefit analysis.

## 3. Tackle the Medical Device Industry’s Price Transparency as a form of R&D investments

Medical Device is a billion dollar industry, mostly because they can set their own prices. With price transparency, they have experienced collusion of prices instead of market competition due to it being an oligopoly market. One reason why hospitals and providers need to have positive financial standings is because there is a large fixed cost investment on these devices. According to Hahn et al., “in contrast to the benefits, the costs of mandatory disclosure are likely to be large,” mainly because of the high seller concentration, limited substitution device companies available and because there is specialization in this market. Hence, disclosure of prices of devices is rather driving up search costs for hospitals and consumers as a consequence (Hahn). By including a supplemental legislation of Federal R&D investments in the device company, they will be able to lower the prices and still be motivated to develop new products. Instead of the consumers paying more due to price collusion, this would prevent this negative effect.

However, there are again funding issues here that the CBO will have to consider as well as the Senate Finance Committee. This may also not be feasible in terms of Kingdon’s model politically because the medical devices belong in a private market.

## Recommendation

The preferred solution would be to present quality information by creating a state mandated database. Although investments in R&D and financial subsidies for non-profit hospitals would reduce the problems of unintended consequences, budget is always an issue. Because the health expenditures are already on the rise, spending more to regulate these consequences might end up having no effect overall. Posting quality information is scalable, and feasible. It will not only facilitate competition, but also reduce collusion, which can solve the problems facing the poor and uninsured.

According to the Pacific Business Group on Health (PBGH), information on quality will be utilized to reduce patient choice of higher-cost providers. The following is an example of the model:

Figure 1: Sample View of Price and Quality Information

	Consumer Ratings of Provider	Provides Excellent Preventive Care	Your Price
Provider A	★★	★★	\$20
<b>BEST VALUE!</b> Provider B	★★★★	★★★★	\$50
Provider C	★★★	★★	\$180
Provider D	★★	★★★	\$510

Pacific Business Group on Health (2013)

When Safeway published price with the quality labels on colonoscopy services, “the number of employees who selected a higher-cost provider went from 30 to 11 percent,” (PBGH). Likewise, when the “California Public Employees’ Retirement System (CalPERS) instituted a similar transparency program for hip and knee replacement surgeries,” costs decreased by 30% overall (PBGH). It is recommended that FTC consider a strategy that includes:

- Enhance market competition not addressed solely by price transparency
- Mandate All-Payer Claims Databases (APCD) that allows aggregation, analysis and report of the price changes in all states
- Address the market power imbalance by educating patients on the importance of quality in care
- Creating a non-partisan, objective team to assess quality of services

FTC’s action could potentially fix many problems associated with pure price transparency policies.

## References

Emanuel, Ezekiel, et al. "A Systemic Approach to Containing Health Care Spending." *New England Journal of Medicine* 367.10 (2012): 949-54. Print.

Farrell, Kate S., et al. "Does Price Transparency Legislation Allow the Uninsured to Shop for Care?" *Journal of General Internal Medicine* 25.2 (2009): 110-14. Print.

Fox, Daniel M., and Diana M. Zuckerman. "Commentary: Regulatory Reticence and Medical Devices." *Milbank Quarterly* 92.1 (2014): 151-59. Print.

Hahn, Robert W., Keith B. Klovers, and Hal J. Singer. "The Need for Greater Price Transparency in the Medical Device Industry: An Economic Analysis." *Health Affairs* 27.6 (2008): 1554-58. Print.

Hall, Alicia. "Financial Side Effects: Why Patients Should be Informed of Costs." *Hastings Center Report* (2014): 1-7. Print.

Kyle, Margaret K., and David B. Ridley. "Would Greater Transparency and Uniformity of Health Care Prices Benefit Poor Patients?" *Health Affairs* 20.5 (2007): 1384-90. Print.

Lerner, Jeffrey C., et al. "The Consequence of Secret Prices: The Politics of Physician Preference Items." *Health Affairs* 27.6 (2008): 1560-64. Print.

Pauly, Mark V., and Lawton R. Burns. "Price Transparency for Medical Devices." *Health Affairs* 27.6 (2008): 1544-52. Print.

"PBGH Policy Brief: Price Transparency." *Pacific Business Group on Health* (2013): 1-10. Print.

"Price Transparency: An Essential Building Block for a High-Value, Sustainable Health Care System." *Catalyst for Payment Reform*: 1-10. Print.

Roosevelt, James, Jr, Terence Burke, and Paul Jean. *Commentary on Part I: Objectives of the ACA*. New York: Springer Science, 2014. Print.

Sinaiko, Anna D., and Meredith B. Rosenthal. "Increased Price Transparency in Health Care - Challenges and Potential Effects." *New England Journal of Medicine* 364.10 (2011): 891-94. Print.

Tilburt, Jon C., et al. "Shared Decision-making as a Cost-containment Strategy: US Physician Reactions from a Cross-sectional Survey." *BMJ* (2014): 1-7. Print.

Tu, Ha T., and Johanna R. Lauer. "Impact of Health Care Price Transparency on Price Variation: The New Hampshire Experience." *Health System Change* 128 (2009): 1-7. Print.