Economic Aspects of Price Transparency in Healthcare

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Price transparency has been the mantra of many advocates of reform in healthcare markets in recent years. Some believe that price transparency is the key to making markets work more effectively by improving patients' ability to respond to price information. Other parties are concerned, however, that price transparency will undermine helpful competitive market forces. Some initiatives, including on-going rulemaking by the Trump Administration, are intended to pull back the curtain of confidentiality of negotiated contract rates. In addition, many health insurers and state governments have developed tools that can give consumers different levels of access to rate information. What appears to be most helpful in reducing costs are tools that are easy for consumers to use and provide accurate measures of their expected out-of-pocket costs in advance of the healthcare service being provided.

A starting point for this conversation are the questions of what the term "price transparency" refers to and which prices should be transparent? In its simplest form, price transparency means that the price being paid for a product or service is known in advance to the consumer. Complexity is introduced in healthcare markets by the consumer (the patient) and the purchaser (the health insurance plan) not being the same entity. Some of that complexity is dealt with when the patient pays a portion of the total expenses for the service, even though the health plan often pays a much larger percentage. But the second part of the question remains: which

prices are being referred to in the quest for transparency, those affecting the patient's expenditures or those negotiated between the provider and the health plan? The two are often intertwined, but it makes a significant difference in how healthcare markets are affected whether patients' out-of-pocket expenditures are the focus or the negotiated provider prices are the focus. Transparency for patients of their out-of-pocket expenditures is likely to produce the greatest benefits with the least amount of potential competitive harm to healthcare markets.

Murkiness in Healthcare Markets Motivates, But Complicates, Price Transparency

Part of what drives the desire for price transparency in healthcare is the inherent murkiness of how healthcare markets work. That murkiness arises from difficulties in assessing important product attributes, uncertainty about future needs, and information asymmetries, among other reasons.

Measuring quality of services provided in the healthcare industry is notoriously difficult. It is often difficult *ex post*, and is even more problematic *ex ante* when the decision is being made whether to purchase the service. Yet consumers cannot accurately assess whether a service is worth the price without knowledge of the quality of the service being provided. Pre-consumption ignorance of quality is a common feature in "consumption goods" that must be consumed by the buyer in order to determine their quality, but it is made more complicated in healthcare. Among the reasons for that complexity is that post-treatment evaluations of some patients are not always good predictors that other patients will experience the same results. Most often, patients rely on the advice of a physician for information about the quality of healthcare services, but that highlights the problem facing patients of how to assess the quality of the physicians themselves.

Not only is it difficult for patients to determine the quality of the services they need, they often do not know which services to evaluate for either quality or price. Consequently, patients rely on physician advice, an important element of patients' choice of which services to receive. In this manner, physician serve as agents to patients, making decisions on patients' behalf. The agency problem, in which the principal (the patient) might not make the same choice that the agent (the physician) would make if the principal had the same information as the agent, arises because of information asymmetries between the patient and the physician. The physician has better knowledge and skills than the patient to diagnosis the illness and prescribe the treatment. Even if the patient would opt for the same treatment if he or she had the same training and experience as the physician, however, their economic incentives clash: the patient would prefer lower prices while the physician likely prefers higher prices for his or her services.

Even when a physician is acting in perfect alignment with the patient's wishes, there are many circumstances in which the services are not determined far enough in advance for that information to be useful to the patient in evaluating its price. This issue can arise in many contexts, especially for complicated and multifaceted courses of treatment, but it is most stark in the case of emergency care. By definition, emergency care is needed when the patient is *in extremis* with little or no time available in advance for the patient to consider the provider, the quality, or the price of the service.

For many treatments, patients do not receive a single service from a single provider for a single price at a specific level of quality, but rather they receive services from multiple providers. Consider even a simple outpatient hospital surgical procedure. The providers include the surgeon, the anesthetist, and the hospital, each of which comes with its own level of quality and its own price (unless the hospital employs or contracts with the surgeon and anesthesiologist).

Evaluating the quality of multiple providers for a single episode of care is difficult enough, but that is complicated further if the patient's referring physician is not properly discharging his or her role as the patient's agent or the patient has insufficient advance notice to research each provider's price and quality.

Certain publicly available information about provider quality is available to assist patients and their physician agents evaluate quality, but that does not fully resolve the question of determining whether the service is worth the price to the patient. The price that the patient pays directly, the out-of-pocket expenditures, typically depends on the benefit structure of the patient's health insurance coverage. An enormous variety of co-payments, co-insurance and deductibles are available for health plan enrollees, and those can vary across providers and services. How much of the deductible a patient has already paid, in particular, affects the out-of-pocket expenditure for a service being provided.

Empirical Evidence of Price Transparency for Patients

A variety of attempts have been made by government agencies, public interest groups, and health plans over the past 15 years to develop means for patients to better understand their likely out-of-pocket expenses. These price transparency tools have had varying degrees of success, depending on how they are constructed and, critically, how readily they are accessed by patients.

The New Hampshire state government began in 2007 to offer on-line estimates of patients' out-of-pocket expenditures for 35 mostly outpatient services. A recent empirical analysis of that program concluded that estimating patients' out-of-pocket expenses led to a 5% to 11% reduction in out-of-pocket costs for imaging services. The study found, however, that

only a small fraction of patients receiving imaging services in New Hampshire accessed the tool.[1] A study of on-line price transparency tools offered by health plans also showed significant reductions in patients' out-of-pocket expenditures: 14% for imaging services. Again, however, the percentage of patients who accessed this tool was only 1% during the study period.[2] A third study also focused on health plan price transparency tools, but examined results when the health plan pro-actively contacted patients by telephone to inform them of the availability of alternative providers that would reduce their out-of-pocket expenses. Also focused on imaging services, this analysis found a 19% overall (patient and payor) expense reduction accompanied by a 15% reduction in the share of MRIs provided by hospital-based facilities. The average price of hospital-based providers was 12% lower, though average prices in free-standing facilities rose by 18%. A number of providers renegotiated lower rates with health plans to be more competitive with low-cost providers.[3]

Transparency tools offered by health plans appear to have an advantage of being better able to incorporate information on the patients' benefit structure and thus more accurately estimate patients' out-of-pocket expenses. A survey of 31 health plans that account for 76% of commercially insured patients in the United States revealed some informative statistics.[4] Figure 1 displays some of the findings of the survey. About 94% of the health plans had some means for comparing expenses across providers, and 58% had tools for estimating prescription drug costs. Importantly, 77% of the price transparency tools accounted for the type of health

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1 Brown, Zach Y., Equilibrium Effects of Health Care Price Information, Review of Economics and Statistics, October 2019, 101(4): 699-712.

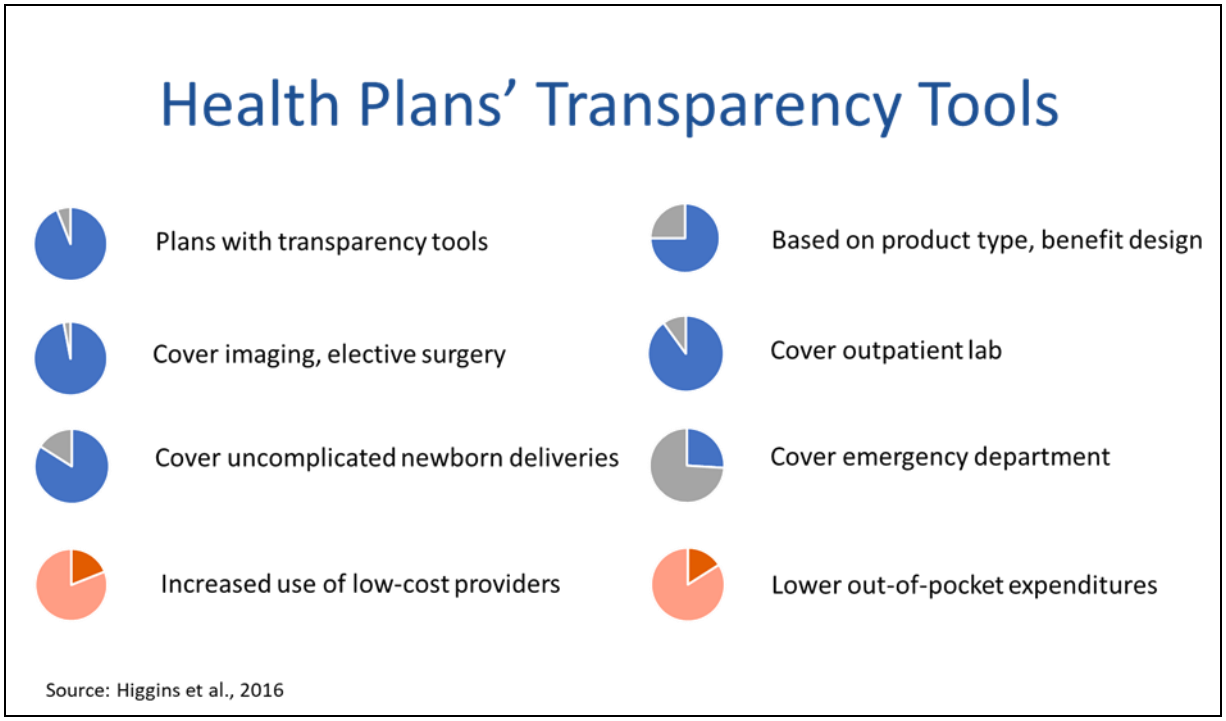
2 Desai, Sunita et al., Offering A Price Transparency Tool Did Not Reduce Overall Spending Among California Public Employees and Retirees, Health Affairs, 2017, 36(8): 1401-1407.

3 Wu et al., Price Transparency For MRIs Increased Use of Less Costly Providers and Triggered Provider Competition, Health Affairs, 2014, 33(8): 1391-1398.

4 Higgins, Aparna, et al., Characterizing Health Plan Price Estimator Tools: Findings From a National Survey, American Journal of Managed Care, February 2016, 22(2): 126-131.

insurance product chosen by the patient and the patient's benefit structure. Both of these features are critical to the patient being able to calculate his or her actual out-of-pocket expenditure rather than just getting an estimate for their community or for a collection of fellow health plan enrollees.

Figure 1



The survey also reported that health plan price transparency tools covered a variety of services, though with some significant differences. Nearly all tools (97%) could estimate out-of-pocket expenses for imaging, inpatient elective surgery and outpatient elective surgery.[5] Nearly as many (90%) covered outpatient lab expenses and 84% covered uncomplicated newborn deliveries and post-partum care. Not surprisingly, at the other end of the spectrum, only 26% of health plan tools included emergency room services and 32% included retail clinic expenses.

[5] Higgins et al., *supra* note 4 at 128.

The effectiveness of health plan price transparency tools is evident in some other statistics reported from the survey. It found that only 16% of patients who used the tool had lower out-of-pocket expenses and 19% had chosen a lower-cost provider after using the tool.[6] At this point, these survey data are five to six years old, however, and the general trend appears to be greater reliance on the tools. If that is so, the cost savings to patients and the impact on providers could be substantially greater than that evident from the survey.

Initiatives To Make Negotiated Provider Prices More Transparent

Among the most recent and controversial initiatives to make negotiated provider prices more transparent is the Trump Administration's proposed Transparency in Coverage Rule for health plans and another rule to require hospitals to provide price information. Ostensibly, these rules are designed to "empower patients and increase competition."[7] Both rules would require that rates negotiated between health plans and their in-network providers be made public, including provider prices for 300 "shoppable" services like imaging, outpatient visits, and bundled services like newborn deliveries. Currently, the American Hospital Association is the lead plaintiff in suit against the Administration to prevent negotiated rates from being revealed.[8]

An example of state-level rules regarding negotiated provider rates is provided in the 2015 amendment to the Minnesota Government Data Practices Act.[9] The Act is intended to

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6 Higgins et al., *supra* note 4 at 129.

7 Trump Administration Announces Historic Price Transparency Requirements to Increase Competition and Lower Healthcare Costs for All Americans, HHS press release, Nov. 15, 2019, available at: https://www.hhs.gov/about/news/2019/11/15/trump-administration-announces-historic-price-transparency-and-lower-healthcare-costs-for-all-americans.html.

8 *The American Hospital Association et al., v. Alex M. Azar II*, Civil Action No. 1:19-cv-3619-CJN, U.S. District Court for the District of Columbia, 2019.

9 Gudiksen, Katherine, et al., The Secret of Health Care Prices: Why Transparency Is in the Public Interest, California Health Care Foundation, July 2019, p. 13.

ensure overall transparency in state government contracting. The amendment specifically included healthcare services with the effect that contract terms between the state government and providers serving covered state employees would become public. The U.S. Federal Trade Commission recommended against making this information publicly available out of concern that revealing confidential pricing terms could harm competition among providers in Minnesota.[10]

The primary focus of efforts to publicize information in negotiated contracts appears to be the rates agreed upon between health plans and their contracted providers. The other terms of the contracts, however, are unlikely to be made public, or at least to receive as much attention, yet they can be essential elements to determining prices. These terms include patient steering efforts by health plans in exchange for rate discounts from providers; negotiated rate trade-offs across services (e.g., emergency v. elective services), locations (e.g., a system's rural hospitals v. its urban hospitals), or product types (e.g., HMO v. Medicare Advantage products); supplemental payments for meeting quality targets; and terms related to dispute resolution, timeliness of payments, and audit rights, among others. Negotiating managed care contracts is often a complex, detailed process and each of these terms as well as others are integral parts of the negotiation process that results in the final rates agreed upon. Knowing negotiated rates, therefore, gives an incomplete picture of what the provider actually receives from the health plan.

[10] Letter from Marino Lao, Deborah L. Feinstein, and Francine Lafontaine, Federal Trade Commission to The Honorable Joe Hoppe and The Honorable Melissa Hortman, Minnesota House of Representatives, June 29, 2015.

Impact of Provider Price Transparency on Healthcare Competition

While informing patients of their out-of-pocket expenditures in advance of receiving healthcare services is likely to make patients better off, the same cannot necessarily be said of publicizing negotiated rates between providers and health plans. Two potentially harmful results of revealing provider rates both concern the impact on healthcare competition: undermining providers' willingness to reduce their rates to be included in health plan networks and facilitating collusion among providers. Both of these effects seemingly would benefit providers, but the American Hospital Association is among the strongest opponents of legislative and regulatory attempts at provider price transparency.[11]

Negotiating contract rates is a key element to selective provider contracting, a hallmark of managed care market dynamics for the past few decades. Health plans frequently leverage providers' desire to be included in the plans' networks as a means of accessing patients to induce providers to discount their rates. Providers understand the profitability of incremental patient volume and compete with other providers through price reductions to be included in networks. This process routinely results in lower rates to providers in products with narrow networks or ones that otherwise incent patients to use lower-rate providers. Patients benefit from this health plan-induced provider competition both directly through lower out-of-pocket co-insurance payments and indirectly through reduced health insurance premiums insofar as health plan competition forces plans to pass through some of their lower provider costs.

[11] *The American Hospital Association et al., v. Alex M. Azar II*, Civil Action No. 1:19-cv-3619-CJN, U.S. District Court for the District of Columbia, 2019.

Publicizing negotiated provider rates, however, reduces the incentive of providers to negotiate aggressively to be included in selective networks. A high-priced provider, for example, may learn the negotiated rates of its high-priced rivals and thus know the floor of the rates it expects the health plan to accept in negotiation. Similarly, low-cost providers lose some of their bargaining advantage over high-priced competitors when information about the low-cost rates accepted by health plans is easily identified and matched by high-priced providers. Any diminution of the incentive of providers to reduce their rates to be in selective networks will harm competition and ultimately be harmful to the consumers.

Viewing that same process from a slightly different perspective shows the increased likelihood of collusion among providers in markets in which negotiated rates are made public. Confidential pricing terms in contracts might be learned by rivals by illicit communication between them, but the legal barrier would disappear if the terms were made public. Economic theory and evidence shows that suppliers need not reach an explicit agreement to fix their prices in order to develop a pattern of tacit cooperation. As two providers grow to understand each other's rates due to publicized contract information, they can develop an implicit agreement of lockstep rate increases. Any attempts by either provider to increase its patient volume through reduced rates would be readily observed by the others, thus undermining any incentive to cheat on a collusive agreement. Again, the harm to competition ultimately falls on the shoulders of patients through increased out-of-pocket expenses and higher insurance premiums than would otherwise be the case.

Concerns about competition do not necessarily impede all sharing of rate information, however. The federal competition watchdogs, the Federal Trade Commission and the Department of Justice's Antitrust Division, have outlined specific terms by which healthcare

rates can be made public. The agencies' terms are (a) that any survey of rates by conducted by a third party like a government or academic organization, (b) that the rate information in the survey is more than three months old, and (c) that a sufficient number entities respond to the survey and their responses are aggregated.[12]

One increasingly common approach to making provider price information more generally available is through All Payers Claims Data (APCD) databases. These data are typically collected from health insurers by state governments, aggregated to some degree, and made available for public scrutiny. The APCD information easily meets the first two criteria of the federal antitrust agencies, and would meet the third one as well except in states with highly concentrated health insurance markets. Almost all of the states that have APCD databases collect and release providers' list charges, allowed amounts, amounts paid by health plans, and average patient cost shares.[13]

Accessing APCDs is typically highly restricted, however. The data request process favors governmental and academic organizations (whose requests are presumed to be pro-competitive). A data requestor's intended use must meet criteria established by the state and is closely scrutinized. And there are strict limits on the accessibility of data elements, generally designed to prevent individual patients from being identified directly from the APCD data or when matched with other data sources.

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[12] U.S. Department of Justice and Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care, August 1996, pp. 49-52.

[13] Gudiksen, et al., *supra* note 9, p. 17.

Suggestions for Implementing Price Transparency

Two specific suggestions for implementing healthcare price transparency initiatives come to the surface. The first is to focus on out-of-pocket expenditures of patients. The more specific are expense estimates to the patients' health plan and benefit structure, the more likely will patients' receive information with which they can accurately base their decisions on choosing providers. It is critical that patients know that this information is available and have easy access to it. The second suggestion is to avoid making negotiated rates public and the likely ensuing harm to competition, but instead to follow the recommendations of the FTC and DOJ of how to release survey information.