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## **Costs and Benefits: Price Transparency in Health Care**

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## I. Introduction: Price and the Revolution

On March 4, 2019, buried within a proposed Rule on "health care ecosystem interoperability" the Department of Health and Human Services sowed the seeds of a transformation in healthcare cost transparency in the United States. The news of the proposal did not begin to spread for a few days as health care policy analysts and interest groups read through the nearly 200-page draft rule.<sup>1</sup> Perhaps it should not have come as a surprise: the summary of the rule indicated that it was intended to signal the Administration's commitment to "improve access to, and the quality of, information that Americans need to make informed health care decisions, including data about health care prices and outcomes, while minimizing reporting burdens on affected plans, health care providers, or payers." The striking element of the proposed rule was the call for hospitals to disclose not only their master charge lists—a requirement that began earlier in the year—but also "the secretly negotiated prices they charge insurance companies for services, a move that would expose for the first time the actual cost of care."<sup>2</sup>

The fact that the actual cost of care is largely unavailable today is a result of the uniquely opaque system of health care costs and payments that developed in the United States over the course of the last half-century. As health care costs climbed, policymakers and economists have touted price transparency as a means of influencing patients to behave more like consumers, and ultimately reign in rising costs. While price transparency is a critical piece of controlling health care costs, relying on patients to use price data in a way that fixes structural issues with the health care economy is unrealistic. This paper will discuss the origins of the current extra-market system of health care charges and payments, examine the implications of price transparency for patients and policymakers, and suggest some regulatory approaches to reduce costs and improve health outcomes.

## II. Transformation of the Healthcare Economy in the 20<sup>th</sup> Century

A century ago in the United States, health care costs and prices were largely unregulated.<sup>3</sup> Most providers were paid directly by their patients and their fees were clearly stated or negotiated in advance.<sup>4</sup> While some European countries began to adopt compulsory national health programs, "resistance from physicians and commercial insurers" stopped such proposals in the United States.<sup>5</sup> By 1920, physicians were both a cultural and political force.<sup>6</sup> They used this cultural and political power to create market structures that preserved physician autonomy and compensation. Paul Starr argues that "the emergence of a market for medical services was originally inseparable from the

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<sup>1</sup> 21<sup>st</sup> Century Cures Act: Interoperability, information blocking, and the ONC Health IT Certification Program Proposed Rule, 84 FR 7424-7610 (Mar. 4, 2019) (hereinafter Cures Act Proposed Rule), available at: <https://www.govinfo.gov/content/pkg/FR-2019-03-04/pdf/2019-02224.pdf>; <https://www.federalregister.gov/documents/2019/03/04/2019-02200/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-interoperability-and>

<sup>2</sup> Stephanie Armour and Anna Wilde Mathews, *Trump Administration Weighs Publicizing Rates Hospitals Negotiate with Insurers*, WALL ST. J. (Mar. 7, 2019)

<sup>3</sup> George B. Moseley, III, *The U.S. Health Care Non-System, 1908-2008*, 10 AM. MED. ASS'N J. OF ETHICS 5 (May 2008) at 324.

<sup>4</sup> *Id.*

<sup>5</sup> *Id.*

<sup>6</sup> *Id.*; see also, PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY* (2d Ed. 2017).

emergence of professional authority."<sup>7</sup> The burgeoning competitive market in the early 20<sup>th</sup> Century threatened not only physician's income, "but also their status and autonomy."<sup>8</sup> Starr also argues that the market structure itself was in unavoidable conflict with the strictures of medical professionalism: markets "presume[d] the 'sovereignty' of consumer choices; the ideal of a profession calls for the sovereignty of its members' independent judgment."<sup>9</sup> From the start, the health care economy was nothing like what we generally consider a free market, with consumer demand driving pricing and supply.

*a. Insurance and payments*

Physicians were only one small part of the health care economy. Today, most Americans are covered by some form of health insurance, which sits at the nexus of the modern system of health care payments and pricing. The origins of the modern system of health insurance in the United States can be found in the Great Depression, right in our backyard. In 1929, the Baylor University Hospital noticed that "Americans...were spending more on cosmetics than on medical care" in part because they were able to pay small amounts over time, rather than large amounts up front.<sup>10</sup> Baylor tried out this novel approach by contracting with a group of Dallas teachers for small annual payments that would guarantee up to three weeks of inpatient care.<sup>11</sup> That same year, the first health maintenance organization (HMO) system was created to provide care for Los Angeles City and County employees.<sup>12</sup> Just three years later, there were enough plans like the Baylor plan that the American Hospital Association formed a plan network, under the familiar name Blue Cross.<sup>13</sup> Fearing that hospital-dominated health plans would drive down physician compensation, physicians organized their own network of insurance plans for medical services, under the name, Blue Shield.<sup>14</sup> By 1937, there were 26 health plans covering more than half a million people.<sup>15</sup>

Spurred by the success of the hospital-and physician-led plans, commercial insurers began entering the market. By 1940, more than 20 million people were participating; ten years later that number reached over 142 million, driven largely by increases in employer-sponsored plans that emerged during the Second World War.<sup>16</sup> Driven by competition for workers during World War II, employers began offering generous health benefits to lure new employees. Workers came to expect these benefits, and they became standard across many industries.<sup>17</sup> Tax law changes in the 1940s made employer-provided health benefits tax-free, making them even more attractive. By

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<sup>7</sup> STARR, *supra* note 6, at 22.

<sup>8</sup> *Id.*

<sup>9</sup> *Id.* at 23.

<sup>10</sup> Alex Blumberg and Adam Davidson, *Accidents of History Created U.S. Health System*, All Things Considered, NPR (Oct. 22, 2009), <https://www.npr.org/templates/story/story.php?storyId=114045132>.

<sup>11</sup> Moseley, *supra* note 3 at 325.

<sup>12</sup> *Id.* at 327.

<sup>13</sup> *Id.*

<sup>14</sup> *Id.*

<sup>15</sup> STARR, *supra* note 6, at 23.

<sup>16</sup> Moseley, *supra* note 3, at 325.

<sup>17</sup> *Id.*

the 1960s, more than 70% of the U.S. population was covered by some form of private health insurance, the majority of which was provided through employers.<sup>18</sup>

The War Years also gave birth to the modern Health Maintenance Organization (HMO), although the term was not coined until 1970. In 1941, Henry Kaiser partnered with a physician named Sidney Garfield to provide care to the workers in Kaiser's shipyards. The following year, the Richmond Shipyard became home to the first Kaiser Permanente hospital.<sup>19</sup> After the War, faced with declining plan participation, Kaiser and Garfield opened up membership in their Permanente Health Plan to the public.<sup>20</sup> HMOs combined health care delivery and financing functions into one, and as a result were able to drive down cost and utilization of acute health care by focusing on preventative care—hence the term health *maintenance* organization.<sup>21</sup> Recognizing the potential benefits of the HMO model, the Health Maintenance Organization Act of 1973 was designed to encourage the growth of HMO plans in the healthcare market.<sup>22</sup> The law required that companies with over 25 employees that offered health insurance, include an HMO option as part of their employer-provided health care, reduced regulation of HMOs, and offered financial assistance to start or expand HMOs.

The focus on employer-provided health care meant that large portions of the population, in many cases the most economically vulnerable such as the elderly and the unemployed, were without coverage. Responding to this need, Lyndon Johnson's Great Society programs created government-funded health safety-net insurance for the elderly and poor: Medicare and Medicaid. With the passage of the enabling legislation in 1965, the government overnight became "the largest single purchasers of health care services..."<sup>23</sup> Physician groups had broadly opposed the creation of the health safety net programs, fearing a loss of autonomy and income under a government-controlled health care system. Both programs, however, softened physician resistance by adopting a fee-for-service model, billed at the "usual and customary" rate.<sup>24</sup> The result of this model was that "taxpayers now funded a systems in which hospitals and physicians decided what to charge...doctors who had initially opposed Medicare now raised their fees by as much as 300 percent to benefit from it..."<sup>25</sup> Medicare and Medicaid had not created a revolutionary new way of determining prices for health care, though. They had merely adopted a pricing system put in place by early health insurance plans.

The early hospital and physician-led health care plans compensated facilities and providers using a cost-plus system in which payments were based on "reasonable and customary charges"

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<sup>18</sup> *Id.*; see also Richard Kaplan, *Who's Afraid of Personal Responsibility? Health Savings Accounts and the Future of American Health Care*, 36 MCGEORGE L. REV. 535 (2005), 538 (noting that two-thirds of all Americans have health insurance provided through their employment; among Americans with health insurance, the percentage who get their insurance through their employment is 88%).

<sup>19</sup> See KAISER PERMANENTE—CALIFORNIA: A MODEL FOR INTEGRATED CARE FOR THE ILL AND INJURED, THE BROOKINGS INSTITUTION (May 4, 2015), [https://www.brookings.edu/wp-content/uploads/2016/07/KaiserFormatted\\_150504RH-with-image.pdf](https://www.brookings.edu/wp-content/uploads/2016/07/KaiserFormatted_150504RH-with-image.pdf).

<sup>20</sup> *Id.*

<sup>21</sup> See Diana Beardon and Bryan Maedger, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 BAYLOR L. REV. 285 (Spring 1995) (describing the various forms of HMOs under federal and Texas law).

<sup>22</sup> See 42 U.S.C.S. § 300e et seq. (LexisNexis, Lexis Advance through PL 116-7, approved 2/21/19); Moseley, at 327

<sup>23</sup> Moseley, *supra* note 3, at 326

<sup>24</sup> NANCY TOMES, REMAKING THE AMERICAN PATIENT: HOW MADISON AVENUE AND MODERN MEDICINE TURNED PATIENTS INTO CONSUMERS (UNIV. OF N. CAROLINA PRESS, 2016), 256.

<sup>25</sup> *Id.*

set by the physicians themselves.<sup>26</sup> Hospitals were reimbursed a percentage of their costs and working capital.<sup>27</sup> Both payment systems encouraged cost increases, because increased costs meant increased income.<sup>28</sup> When commercial insurance arrived, and later government-funded Medicare and Medicaid, both types of payers adopted the existing payment model.<sup>29</sup> In doing so, Medicare and Medicaid "adopted the same defects that were found in the private health insurance industry accelerating the rate of price inflation."<sup>30</sup>

Over time, Medicare attempted to use its market power to change how payments were calculated. In 1983, a prospective payment system (PPS) was initiated which paid hospitals based on 475 diagnosis-related groups of illness.<sup>31</sup> The result was hospitals shifting much of the "patient cost burden to activities not covered by the controls."<sup>32</sup> By the 1980s, hospitals were being reimbursed through two payment systems: "legislated government rates, and privately negotiated rates based on charges...each system generated a unique set of prices based on the payer and thus heralded the beginning of differential hospital pricing."<sup>33</sup> Over the next decade, as major insurers consolidated and increased their bargaining power, they moved from payments based on charges to "contracts based on lower fee schedules or negotiated rates."<sup>34</sup> As a result, the master price lists maintained by hospitals became less and less reflective of the actual costs paid—except by those individual patients without insurance.<sup>35</sup>

The disproportionate power of Medicare meant that a completely irrational market for health care emerged.<sup>36</sup> Through the 1980s, charges for inpatient stays remained a reasonable proxy for actual payment.<sup>37</sup> Over time, "payments from public programs and many third-party payers were increasingly below what hospitals believed to be appropriate for the services provided."<sup>38</sup> Hospitals responded by raising their billed charges, those amounts paid by patients and third-party payers not able to access the artificially low rates paid by large insurers and Medicare. In 2006, the gap between charges and actual payments averaged about 255%, more recent studies suggest that the average is about 450%.<sup>39</sup> As a result, "powerful payers have pushed many hospitals into the position of 'price takers' for a large proportion of services, pressuring them into being aggressive 'price setters' for some of their other patients to maintain target revenues."<sup>40</sup> In practice,

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<sup>26</sup> Moseley, *supra* note 3 at 326.

<sup>27</sup> *Id.*

<sup>28</sup> *Id.*

<sup>29</sup> *Id.*

<sup>30</sup> *Id.* at 326-27.

<sup>31</sup> *Id.* at 327

<sup>32</sup> *Id.*

<sup>33</sup> Christopher Tompkins, Stuart Altman, and Efrat Eilat, *The Precarious Pricing System for Hospital Services*, 25 HEALTH AFF. 1 (Jan/Feb 2006), <https://doi.org/10.1377/hlthaff.25.1.45>.

<sup>34</sup> *Id.*

<sup>35</sup> *See infra*, section III. a.

<sup>36</sup> *See* Vineet Arora, Christopher Moriates, and Neel Shah, *The Challenge of Understanding Health Care Costs and Charges*, 17 AM. MED. ASS'N J. OF ETHICS 11 (November 2015) 1046-1052 (discussing the complex vocabulary and practices of health care billing), <https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-05/stas1-1511.pdf>.

<sup>37</sup> Hannah Hamavid et al, *Assessing the Complex and Evolving Relationship between Charges and Payments in US Hospitals: 1996-2012*, 11 PLoS ONE (7): e0157912, doi:10.1371/journal.pone.0157912, at 2.

<sup>38</sup> *Id.*

<sup>39</sup> *Id.*; *see also* Ge Bai and Gerard Anderson, *US Hospitals are Still Using Chargemaster Markups to Maximize Revenues*, 35 HEALTH AFF. 9 (September 2016), <https://doi.org/10.1377/hlthaff.2016.0093>.

<sup>40</sup> Hamavid, *supra* note 37, at 2.

this means that those least able to afford the cost of care—such as individual self-pay patients and those with high deductible and high-cost sharing (e.g. consumer-driven) health insurance—are underwriting the cost of the sub-market rates paid by large insurers and Medicare.<sup>41</sup>

Driven by concern over the rising cost of care in the United States and the sense that a lack of transparency has contributed to failures in the health care market, policymakers at the state and federal level attempted to legislate improved price transparency.<sup>42</sup> Some of these policymakers attempted to use price transparency to understand the structural issues that led to increased cost and inefficiency, others to try to shift the responsibility for solving these problems to individual consumers.

### III. Regulatory Attempts to Create Greater Transparency in Price and Cost

According to a recent article by Dr. Ahteev Mehrotra of the Harvard Medical School, price transparency is intended to serve several goals: "doing right" by patients by giving them price information to help guide treatment decisions; "lifting the veil" on real prices and costs; encouraging a transparent market where patients can comparison shop like consumers in other markets; and "helping providers ensure their patients can afford care..."<sup>43</sup> Unfortunately, price transparency has been largely unsuccessful in any of these areas.<sup>44</sup> Perhaps most important for the advocates of price transparency as a means of influencing patient spending, early attempts at increased price transparency by some insurers failed to have meaningful impacts on patient behavior.<sup>45</sup>

#### a. *First Steps Toward Increased Transparency*

In 1969, *Fortune* described the American medical system as "inferior in quality, wastefully dispensed, and inequitably financed."<sup>46</sup> Attempting to remedy this, in the midst of what President Nixon termed a "\$60 billion crisis" in health care, cost transparency became part of the push for increased information and autonomy for patients.<sup>47</sup> In 1971, the Pennsylvania Insurance Commissioner, Herb Denenberg, after learning in a hearing that Blue Cross had an agreement with hospitals not to disclose their negotiated rates, published the first *Shopper's Guide to Hospitals*.<sup>48</sup> The *Shopper's Guide* contained previously-undisclosed information on both mortality rates and costs.<sup>49</sup> His hope was that greater transparency about safety and cost would lead to "more hospital economy, especially if the public begins to question costs..."<sup>50</sup> Unfortunately, these guides were short lived. The idea of patient consumerism, autonomy and greater insight into medical treatment

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<sup>41</sup> *Id.*

<sup>42</sup> *See infra*, Sec. III.

<sup>43</sup> *See*, Ateev Mehrotra, et al., *Defining the Goals of Health Care Price Transparency: Not Just Shopping Around*, NEJM CATALYST (June 26, 2018), <https://catalyst.nejm.org/health-care-price-transparency-goals/>.

<sup>44</sup> *Id.* (arguing that "skeptics have judged price transparency ineffective and possibly even a fool's errand.")

<sup>45</sup> *See* Reed Abelson, *On-Line Tools to Shop for Doctors Snag on Health Care's Complexity*, N.Y. TIMES (June 16, 2016), B1 (as "Unused Tools for Health Savings"), <https://www.nytimes.com/2016/06/17/business/online-tools-to-shop-for-doctors-snap-on-health-cares-complexity.html>.

<sup>46</sup> *Id.*

<sup>47</sup> STARR, *supra* note 6, at 381.

<sup>48</sup> TOMES, *supra* note 24, at 280-281.

<sup>49</sup> *Id.* at 347.

<sup>50</sup> *Id.* at 281.

and costs, however, was not. Over the next decade, "old debates about how much information American patients needed to make good medical choices took on new policy significance..." for politicians on both the left and the right.<sup>51</sup>

In the 1980s and 90s, the focus shifted from cost transparency to quality assurance as the focus of attempts to increase accountability in health care. This shift led to a "proliferation of rankings and report cards," none of which resulted in the wholesale change sought by Congress and interest groups.<sup>52</sup> In 2001, the pendulum swung back to health care cost transparency with the publication of a 2001 study by the Institute of Medicine (IOM) entitled, *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*.<sup>53</sup> The IOM's calls for increased price transparency were reinforced by advocates of consumer-driven health care (CDHC).<sup>54</sup> As CDHC made its way into federal policy through tax incentives for high deductible plans, the federal government joined the calls for greater price transparency. Over time, the government mandated small moves toward increased transparency in price and quality information in federal health care programs such as Medicare, Federal Employee Health Benefits, and Veterans Affairs hospitals.<sup>55</sup>

#### *b. States and Health Care Cost Transparency*

The federal government was not the only entity facing, and trying to stem, increasing health care costs. States bore the cost of much of the health care within their borders. Following the lead of the federal government, many states also took aim at increasing price transparency, and beginning at the turn of the century, began passing a variety of laws mandating more disclosure, many of which established state-level All Payer Claims Databases (APCD). As of March 2017, 28 states had laws addressing price transparency in health care.<sup>56</sup> The laws vary significantly in what hospitals, providers, and insurers must disclose, in what format, and to whom.<sup>57</sup> They also vary in the efficacy of their implementation, having faced challenges at both the state and national level.

State attempts to mandate the provision of data for APCDs met with resistance from insurers. For example, in 2011, Vermont's APCD faced a legal challenge from Liberty Mutual Insurance Company. Five years later, the case made it to the Supreme Court as *Gobeille v. Liberty*

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<sup>51</sup> *Id.* at 288.

<sup>52</sup> *Id.* at 351-52.

<sup>53</sup> INSTITUTE OF MEDICINE, *CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21<sup>ST</sup> CENTURY* (Washington, DC: The National Academies Press, 2001), <http://nap.edu/10027>. See also, AMERICAN COLLEGE OF PHYSICIANS (ACP), *HEALTHCARE TRANSPARENCY: FOCUS ON PRICE AND CLINICAL PERFORMANCE INFORMATION* (Philadelphia: American College of Physicians, 2010), at 5. [https://www.acponline.org/system/files/documents/advocacy/current\\_policy\\_papers/assets/transparency.pdf](https://www.acponline.org/system/files/documents/advocacy/current_policy_papers/assets/transparency.pdf).

<sup>54</sup> ACP, *supra* note 53, at 5.

<sup>55</sup> *Id.* at 6.

<sup>56</sup> See *National Conference of State Legislatures (NCSL), Transparency and Disclosure of Health Costs and Provider Payments: State Actions* (March 2017), <http://www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx>.

<sup>57</sup> See FRANCOIS DE BRANTES AND SUZANNE DELBANCO, *REPORT CARD ON STATE PRICE TRANSPARENCY LAWS—JULY 2016* (Catalyst for Payment Reform 2016), [https://www.catalyze.org/wp-content/uploads/woocommerce\\_uploads/2017/04/2016-Report-Card-on-State-Price-Transparency-Laws.pdf](https://www.catalyze.org/wp-content/uploads/woocommerce_uploads/2017/04/2016-Report-Card-on-State-Price-Transparency-Laws.pdf). The U.C. Hastings College of Law also maintains a database of state legislation and litigation related to healthcare price transparency at [www.sourcehealthcare.org](http://www.sourcehealthcare.org).

*Mutual Insurance Co. Inc.*<sup>58</sup> The Supreme Court found for Liberty Mutual, holding that the Employee Retirement Income Security Act of 1974 (ERISA) preempted the Vermont law requiring provision of claims data from employer-provided health plans.<sup>59</sup> The majority, led by Justice Kennedy, found that ERISA preempted any state laws insofar as they relate to an employee benefit plan.<sup>60</sup> Since the Vermont law governed "plan reporting, disclosure and record keeping" which were also part of the "plan administration" under ERISA, the law was invalid.<sup>61</sup> In its brief, Liberty Mutual argued that if reporting like that required for the APCD were to be implemented, it should be implemented at the national level.<sup>62</sup> The dissent, written by Justice Ginsburg and joined by Justice Sotomayor, argued that the court's ERISA preemption precedents suggested that the Vermont law should have been valid, since it addressed itself to a valid state interest in regulating "matters of health and safety," improving quality and reducing cost, not regulating how plan benefits are administered.<sup>63</sup> The *Gobeille* decision had a chilling effect on insurer participation in state ACPDs. After the decision, states were unable to compel self-funded insurance providers and their third-party administrators to provide data to ACPDs, depriving the states of a large amount of data.

More recently, Ohio transparency laws have also been blocked by insurers. Ohio law requires physicians and other providers to give patients a good faith estimate of the out of pocket cost of care in advance of providing care.<sup>64</sup> In 2016, the Ohio Hospital Association, along with other provider organizations, sued to stop the law taking effect.<sup>65</sup>

Despite the limited success of state attempts to legislate price transparency, state regulation has demonstrated the value of APCDs in understanding and addressing the structural causes of health care cost increases. As of October 2018, 21 states had legislatively-mandated APCDs, six more had voluntary APCDs.<sup>66</sup> APCDs collect vast amounts of data, including medical claims, eligibility determinations, provider costs, and payments from health plans and patients, as well as diagnoses, procedures, and patient demographics. Analysis of the data in Minnesota's APCD revealed a significant cost savings opportunity by reducing unnecessary visits to the emergency rooms for conditions that could have been treated in a less expensive setting.<sup>67</sup> In Colorado, APCD data was used to analyze proposed increases in insurance premiums, determine the underlying

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<sup>58</sup> *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936 (March 1, 2016). The *Gobeille* decision got little attention, and there is a surprising lack of Law Review articles analyzing the case and its implications.

<sup>59</sup> For a description of ERISA preemption prior to *Gobeille*, see Larry Pittman, *ERISA's Preemption Clause: Progress Towards a More Equitable Preemption of State Laws*, 34 IND. L. REV. 207 (2001); see also, Russell Korobkin, *The Failed Jurisprudence of Managed Care, and How to Fix It: Reinterpreting ERISA Preemption*, 51 UCLA L. REV. 451 (Dec. 2003).

<sup>60</sup> 136 S. Ct. at 943.

<sup>61</sup> *Id.*

<sup>62</sup> *Id.* at 951 (Ginsburg, R., dissenting).

<sup>63</sup> *Id.* at 953-54.

<sup>64</sup> Ohio Rev. Code Ann. § 5162.80 (2015).

<sup>65</sup> Mehrotra, *supra* note 43; See also Jim Butler Ohio 41, letter to Mr. Michael Abrams, Dec. 27, 2016, <http://www.ohiohouse.gov/Assets/Media/Content/58833.pdf>

<sup>66</sup> Megan O'Leary and Tiffany Wang, Issue Brief: Beyond Price Shopping: How Stakeholders Utilize All-Payer Claims Databases to Address Rising Health Care Costs, Jan. 22, 2019, <http://sourceonhealthcare.org/beyond-price-shopping-how-stakeholders-utilize-all-payer-claims-databases-to-address-rising-health-care-costs/>

<sup>67</sup> *Id.*, cf. Rebekah Davis Reed, "Patient, Diagnose Thyself: Emergency Care Rationing and the Prudent Layperson Standard," *Health Law Perspectives* (forthcoming 2019) (arguing that it is difficult to determine using retrospective diagnosis information which ER visits were truly avoidable).



causes of price increases, and suggest alternatives that would spread risk and lower premiums.<sup>68</sup> In Massachusetts, APCD data demonstrated that one of the major drivers in increased medical care costs was pharmaceutical prices, not hospital or physician prices, which are the focus of much of the recent emphasis on price transparency.<sup>69</sup> APCD data has also been used to characterize the effect of responses to major public health issues like opioid addiction, and to "understanding the burden of chronic conditions...and aging populations."<sup>70</sup>

Oregon has one of the most robust payment information collection systems in the country, called the Oregon All Payer All Claims Database (APAC). Oregon collects payment data from commercial health insurance, third-party administrators, pharmacies, Medicaid managed care organizations, Medicaid-fee for service and Medicare parts C and D. APAC compiles medical and pharmacy claims, non-claim payments, enrollment data, billed premiums, and perhaps most significantly, both the charged amount and the paid amount for claims as well as alternative payment methods. APAC covers almost all of Oregon's population.<sup>71</sup> This data is allowing the state to analyze trends in price and cost and identify drivers for increased spending. Clearly, price transparency, coupled with more complex data sets on utilization, outcomes, and quality, has the potential to inform structural improvements in health care cost and delivery. It is questionable whether price data alone, particularly when targeted toward individual consumer use rather than state or federal analysis, would have an appreciable impact.

*c. Federal Disclosure Rules Mature*

As the idea of price transparency and consumer-driven healthcare grew in popularity, the Department of Health and Human Services promulgated rules that required hospitals to disclose their chargemaster lists on request. On January 1, 2019, a rule went into effect that required Hospitals to post their master charge list on the web in machine-readable format.<sup>72</sup> Federal regulations have only recently required that hospitals publicly post their charge master lists. The new rule required hospitals not just to make their charge lists available on request, but to post them on a publicly available website in machine readable format.<sup>73</sup> Although such disclosure of the chargemasters sounds like a move toward price transparency, it does little to inform patients what their care will cost.

The chargemaster prices are effectively the artificial retail price of individual components of care, they do not reflect the negotiated rates paid by insurers.<sup>74</sup> A 2016 study by Johns Hopkins researchers found that in some specialty areas, chargemaster prices can exceed hospital costs by

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<sup>68</sup> O'Leary and Wang, *Op cit.*

<sup>69</sup> *Id.*

<sup>70</sup> *Id.*

<sup>71</sup> *Id.*

<sup>72</sup> 83 FR 160 (Aug. 17, 2018), 41686-688.

<sup>73</sup> *Id.*

<sup>74</sup> See Erin C. Fuse Brown, *Irrational Hospital Pricing*, 14 HOUS. J. HEALTH L. & POL'Y 11 (2014) (explaining the "mind-boggling complexity, opacity, unfair and inefficient price discrimination" in hospital pricing due to the lack of relationship between chargemaster pricing and actual costs to healthcare payors); see also George A. Nation, *Hospitals Use The Pernicious Chargemaster Pricing System To Take Advantage Of Accident Victims: Stopping Abusive Hospital Billing*, 66 DRAKE L. REV 647 (2018) (discussing the large difference between chargemaster rates and negotiated rates, and how this difference affects third-party billing).

more than 2000%, while the average markup was approximately 400%.<sup>75</sup> Because of the discrepancies between the chargemaster prices and the actual costs paid by insurers, the lists are effectively useless to patients who wish to determine cost, other than the uninsured who without the negotiating power of insurers may be forced to pay the artificially inflated costs.<sup>76</sup>

Nor are the chargemaster lists easily interpretable, by patients or providers. The chargemaster prices are not listed by procedure, but by individual item priced. Without a key to tell patients which items are required for which procedure, there is no way to determine, for instance, even the total chargemaster price of knee replacement or a normal birth, let alone what an insurer would actually pay the hospital for that procedure, and what proportion of that cost would be borne by the patient. In short, the chargemaster lists are data, but not information. Without the decoder ring that would provide the negotiated prices paid by insurers, the total cost of common procedures, or the total cost to both insured and uninsured patients, the chargemaster lists are of little use to patients.

*d. Redefining Information Blocking*

Recognizing that providing list prices to the public was of little utility in determining what health care might actually cost individual patients, the March 2019 Proposed Rule implementing 21<sup>st</sup> Century Cures took a novel approach to increasing price transparency. Using a somewhat arcane regulatory concept: the prohibition against "information blocking" and an expansion of the definition of "electronic health information" contained in the Act, the Department of Health and Human Services is making strides toward real cost transparency.<sup>77</sup>

The concept of "information blocking" became a focus for federal policymakers with the passage of the Health Information Technology for Economic and Clinical Health (HITECH) Act in 2009.<sup>78</sup> This Act gave the Department of Health and Human Services' Office of the National Coordinator for Health Information Technology (ONC), authority over "coordinating federal policies and investments to support the development of a nationwide health IT infrastructure that would enable and support the kinds of robust health information exchange that Congress envisioned."<sup>79</sup> This mandate was further strengthened by the Patient Protection and Affordable Care Act (ACA), passed in 2010. The ACA provided incentives for the use of health IT and the creation of health information exchanges.<sup>80</sup> ONC defines information blocking as "when persons or entities knowingly and unreasonably interfere with the exchange or use of electronic health information."<sup>81</sup> In its 2015 report to Congress on information blocking, ONC discussed many types of information blocking; none of those was information blocking related to health care prices.<sup>82</sup> Instead, ONC focused discussion of information blocking with respect to prices on health

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<sup>75</sup> See Bai and Anderson, *supra* note 35.

<sup>76</sup> *Id.*

<sup>77</sup> *Id.*, see also 84 FR 7610 <https://www.federalregister.gov/d/2019-02200/p-86>

<sup>78</sup> Pub. L. 111-5, Division A, Title XIII, & Division B, Title IV.

<sup>79</sup> DHSS, ONC, Report to Congress: Report on Health Information Blocking (April 2015), 6, 11.

<sup>80</sup> *Id.*, see Patient Protection and Affordable Care Act, Pub. L. 111-148.

<sup>81</sup> *Id.* at 8.

<sup>82</sup> The report did address price transparency among developers of health IT systems, which it hoped would drive down costs, see *Id.* at 14.

IT developers, whose fees were prohibitively expensive and impeded the sharing of information across platforms.<sup>83</sup>

Similarly, the definition of "information blocking" in the 21<sup>st</sup> Century Cures Act does not specifically mention price and cost data. Instead, it has a broad sweep, gathering under the prohibition "a practice" that is "likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information."<sup>84</sup> It also includes practices that "if conducted by a health care provider...is unreasonable and is likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information."<sup>85</sup> The shift to using the idea of information blocking to force disclosure of health care prices represents a significant pivot.

Despite the lack of reference to health care pricing (as opposed to health care IT pricing) in earlier discussions of the 21<sup>st</sup> Century Cures Act, the proposed rule the ONC released in March 2019 tackled the issue in an unprecedented way.<sup>86</sup> ONC's proposed to redefine electronic health information (EHI), providing "an expansive set of EHI" which "could include information on an individual's health insurance eligibility and benefits, billing for health care services, and payment information for services...which may include price information."<sup>87</sup> The proposed rule invites public comments on the "parameters and implications of including price information within the scope of EHI for purposes of information blocking" and provides an argument for increasing price transparency:<sup>88</sup>

The fragmented and complex nature of pricing within the health care system has decreased the efficiency of the health care system and had negative impacts on patients, health care providers, health systems, plans, plan sponsors and other key health care stakeholders. Patients and plan sponsors have trouble anticipating or planning for costs...Pricing information continues to grow in importance with the increase of high deductible health plans and surprise billing, which have resulted in an increase in out-of-pocket health care spending. Transparency in the price and cost of health care would help address [these] concerns...by empowering patients to make informed health care decisions. Further, the availability of price information could help increase competition...pricing within health care demands a market-based approach whereby, for example, platforms are created that utilize raw data to provide consumers with digestible price information through their preferred medium.<sup>89</sup>

The proposed rule noted that the price *insurers* paid for procedures varied materially, even within the same locality. For instance, insurers in Minnesota paid as much as \$47,000 and as little

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<sup>83</sup> *Id.* at 15.

<sup>84</sup> An Act to Accelerate the Discovery, Development, and Delivery of 21<sup>st</sup> Century Cures, and for Other Purposes, 114 P.L. 255, 130 Stat. 1033 (Dec. 13, 2016), § 4004 (hereinafter, 21<sup>st</sup> Century Cures Act).

<sup>85</sup> *Id.*, §4004 (1)(B)(ii).

<sup>86</sup> It is interesting to note that despite the importance of the redefinition of price blocking and the inclusion of cost and price data in the definition of EHI, neither of those issues is mentioned in the ONC's fact sheet summarizing the major elements of the proposed rule. *See* Fact Sheet: CMS Advances Interoperability & Patient Access to Health Data through New Proposals (Feb. 9, 2019), <https://www.cms.gov/newsroom/fact-sheets/cms-advances-interoperability-patient-access-health-data-through-new-proposals>.

<sup>87</sup> Cures Act Proposed Rule, 84 FR 42, at 7513.

<sup>88</sup> *Id.*

<sup>89</sup> *Id.*

as \$6,200 for knee replacement surgery.<sup>90</sup> ONC concluded that recent studies of price variation "illustrated the secretive nature of pricing in the health care market, as well as the extreme variations in price that can exist for the same procedure within the same locality."<sup>91</sup> They also asserted that "making such price information available to insurers through APIs would drive health care prices down, which could lead to significant benefits across the health care continuum."<sup>92</sup>

The proposed rule contemplates health care providers providing data on both negotiated rates paid by insurance companies and Medicare or Medicaid, and rates charged to uninsured patients.<sup>93</sup> This level of disclosure would be far more meaningful to consumers and insurers than the charge master lists currently required by law.<sup>94</sup> However, the effects of price transparency are unlikely to yield what its proponents have sought: a free market health care system made more economical when patients can act as informed consumers.

#### **IV. Effect of the Proposed Transparency Rules**

##### *a. Consumer-Driven Healthcare*

The movement toward consumer-driven health care has grown over the past fifty years, based on several distinct interests:

For its true believers, medical consumerism holds out the hope that individual patients can not only avoid bad outcomes...but also that their collective actions can become a force for reform throughout the whole system. This influence has been conceived of in terms of both the therapeutic quality...and of cost control...Thus medical consumerism rests on a faith that well-informed patients can help curb our dysfunctional medical culture, with its tendencies to undertreat, overtreat, misuse, and overcharge for medical services."<sup>95</sup>

It is based on several premises. The first is that health care can and should be handled through a market analogous to other markets in our economy; in other words, it is premised on the conviction that "health care should be treated as a private consumable product rather than a public good."<sup>96</sup> Second, in order to make the transition to a system in which consumers have more control over their health care access, use and spending, the health care system needs increased transparency in price, cost, and quality.<sup>97</sup> Third, that patients who must spend more of their own money to obtain care will be better stewards of the resources required to obtain care, consuming

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<sup>90</sup> *Id.*

<sup>91</sup> *Id.*

<sup>92</sup> *Id.* at 7475.

<sup>93</sup> *Id.* at 7514.

<sup>94</sup> See Brown, *supra* note 73; see also George A. Nation, *Hospitals Use The Pernicious Chagemaster Pricing System To Take Advantage Of Accident Victims: Stopping Abusive Hospital Billing*, 66 DRAKE L. REV 647 (2018) (discussing the large difference between chagemaster rates and negotiated rates, and how this difference affects third-party billing).

<sup>95</sup> TOMES, *supra* note 24, AT 8. The seminal work advocating for CDHC is REGINA E. HERZLINGER, ED., CONSUMER-DRIVEN HEALTH CARE: IMPLICATIONS FOR PROVIDERS, PAYERS, AND POLICYMAKERS (San Francisco, CA: Jossey-Bass, 2004).

<sup>96</sup> Moseley, *supra* note 3, at 328.

<sup>97</sup> *Id.*

less care in general, and less unnecessary care in particular.<sup>98</sup> In theory, consumer driven health plans "encourage patients to comparison shop, find less expensive care and forgo unnecessary care, patients find this virtually impossible to do."<sup>99</sup>

Although CDHC may sound like a smart way to limit costs, it has the effect of shifting risk away from large insurers who have the capacity to spread risk among many members and the financial wherewithal to bear unexpected costs, to individual patients who lack bargaining power and financial reserves to account for significant medical bills. It may also provide a perverse incentive to forgo needed medical care in a way that reverses the early gains made by HMOs in controlling costs: failing to address medical issues before they become acute, failing to comply with needed care for chronic conditions because of the cost of medications or ongoing care will ultimately lead to higher costs found in acute care settings, like the emergency department.<sup>100</sup> Ultimately, consumer-driven health care has the potential to increase the overall cost of care, rather than shrink it. These negative effects are particularly acute for the poor.<sup>101</sup> This is borne out by attempts to create "consumer driven" versions of Medicaid, which have largely failed.<sup>102</sup>

*b. Price Transparency and Overall Health Care Spending*

Price transparency, and patient choice, is only a small piece of a complex system of increased costs.<sup>103</sup> Patient decision-making is primarily driven by out-of-pocket costs, rather than overall cost. For patients other than self-pay and those in consumer-driven plans with high deductibles, the out-of-pocket costs bear little resemblance to the total cost of care. Some physicians argue that while necessary to improve costs, price transparency is not sufficient. Rather, moving away from a system that provides incentives for defensive medicine and over-treating is more important as a means to control total costs.<sup>104</sup> Others argue that the structure of the health care system, where patients (consumers) are mostly insulated from the actual costs creates inefficiencies.<sup>105</sup> The suggestion is that if we abandoned the idea of health care as a right and held individuals accountable for the full cost of their care, the price would go down. There is no evidence to support this assertion. In fact, in nations where health care is a right and is provided

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<sup>98</sup> See Sidney Watson, *Supply Side and Demand Side Approaches to Health Care Financing: Putting the Brakes on Consumer Driven Medicaid: The Failures and Harms of Healthy Indiana Plan (HIP) 2.0*, 11 ST. LOUIS U. J. HEALTH L & POL'Y 275 (2018), 282, at 278-79.

<sup>99</sup> *Id.* at 281.

<sup>100</sup> See *Id.* at 282-83 (noting that research confirms that cost savings in these plans results from reduced spending on necessary care such as medication for chronic disease and preventative care, but may not result in reductions in unnecessary care). *But see*, Christopher Limbacher, *Comment: Healthcare Price Transparency: Reintroducing Competition*, 53 HOUS. L. REV. 939 (Winter 2016) (arguing that history and legislation have impeded competitive forces within the healthcare market and that increased transparency would drive costs down without impacting the quality of care).

<sup>101</sup> Watson, *supra* note 98, at 284.

<sup>102</sup> See, *Id.* (discussing the challenges of implementing a consumer-driven Medicaid model with high deductibles, a version of the health savings account, and larger copays).

<sup>103</sup> John Bees, *Survey Snapshot: Is Transparency the Answer to Rising Health Care Costs?* NEJM CATALYST, March 20, 2019), <https://catalyst.nejm.org/health-care-cost-transparency-answer/>.

<sup>104</sup> *Id.*, quoting William Mayer, MD.

<sup>105</sup> *Id.*, quoting Charles Thayer.

through universal care, the overall cost of providing care both per capita and as a percentage of GDP is lower than in the United States.<sup>106</sup>

It's also worth noting that advocates of price transparency seem to make the assumption that the responsibility for lowering the costs of care rests with the consumer/patient.<sup>107</sup> Advocates of increased price transparency also make the assumption that increased transparency will lead to lower cost and better care.<sup>108</sup> In fact, "research indicates that in situations in which healthcare services are highly concentrated, there is a likelihood that the increased availability of price information will lead to higher prices and/or less price variability."<sup>109</sup> Further, creating a market place for healthcare in the way envisioned by proponents of price transparency could ultimately compromise care by emphasizing competition for consumers rather than appropriate care.<sup>110</sup>

## V. Conclusion: Recommendation for an Improved Regulatory Framework

Perhaps, in the end, Liberty Mutual was right in its challenge to state price transparency requirements. Relying on states to create a patchwork of inconsistent reporting requirements will not adequately address the complex national system of health care. Federal regulation that requires the disclosure of the type of data included in the most robust APCDs, including not only price and cost data, but diagnoses, outcomes, denials of care, charge offs, and other measures of quality and actual cost, would allow more nuanced analysis of the sources of increased health care costs and spending, and perhaps allow the development of solutions that focus on those actors with the greatest ability to make change: insurers and hospital systems, rather than the regressive approach favored by proponents of CDHC.<sup>111</sup>

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<sup>106</sup> See Rabah Kamal and Cynthia Cox, *How Do Healthcare Prices and Use in the United States Compare to Other Countries?*, Peterson-Kaiser Health System Tracker (May 8, 2018), <https://www.healthsystemtracker.org/chart-collection/how-do-healthcare-prices-and-use-in-the-u-s-compare-to-other-countries/#item-start> (showing that Western European countries spend roughly half of what the United States spends per capita on health care).

<sup>107</sup> See Bees, *supra* note 103. The NEJM Catalyst survey provided to physicians posed the following question: "What are the top two changes need to support patients/consumers in lowering total healthcare costs without compromising quality?" The top two survey answers were to provide more transparency in cost and quality and to "design coverage models that incentivize utilization of lower-cost settings." The second tier of responses focused on providing incentives for patient behavior. It's worth noting that none of the suggested responses included structural changes to how care is provided or addressing institutional sources of increased cost, such as the administrative burden of managing multiple payer and cost structures. See also, Leemore Dafny and Chris DeRienzo, *Patients Lack Information to Reduce the Cost of Care*, NEJM CATALYST INSIGHTS REPORT (March 2019). While the title of the report suggests that patients are key to reducing health care costs, and the analysis in the paper focuses on patient behavior, a survey included in the report suggested that to the contrary, among hospitals and health care systems, the government, clinicians, and patients, patients were perceived as *the least* responsible for lowering the costs of care. *Id.* at 4.

<sup>108</sup> See, Paul Ginsburg, *Shopping for Price in Medical Care*, 26 HEALTH AFF., at w208 (2007), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.26.2.w208>.

<sup>109</sup> *Id.* at w214. Ginsburg notes that this unexpected result of increased price transparency was seen in the concrete industry in Denmark. After the government of Denmark required full price transparency to combat what looked like a lack of competition, prices rose between 15-20% despite the cost of raw materials falling. After the fact, researchers determined the price increases were due to the end of "secret discounts" offered to preferred customers, not unlike the privately negotiated rates offered to large insurers.

<sup>110</sup> See Robert Berenson and Christine Cassel, *Consumer-Driven Health Care May Not be What Patients Need—Caveat Emptor*, 301 J. AM. MED. ASS'N 3 (2008) 321-323, doi:10.1001/jama.2008.994.

<sup>111</sup> See Abbe Gluck and Nicole Huberfeld, *What is Federalism in Healthcare For?* 70 STAN. L. REV. 1693 (June 2018).

Individual patient choices have not been the force that drove increased health care costs over the decades.<sup>112</sup> Rather, "the basic incentives in the health care system, especially its financing arrangements" have been the main drivers of increasing costs.<sup>113</sup> Distorted prices, not patient choice, "distort decisions about services, careers, and investments...the biases they create regularly produce overuse of hospital care, tests, and surgery..."<sup>114</sup> As a result, efforts at price transparency that are directed at individual consumers, rather than systemic actors, are misguided. Expanded insight into the entire system of payments and incentives in health care may yield benefits as states and the federal government use that data to analyze trends, spread risk, and shape investments. The ability of a patient, or even a group of patients to predetermine the costs of their care will not. Uninsured and underinsured diabetics know exactly how much their insulin costs. Their decision to ration it does not fix the health care system.<sup>115</sup>

As comments to the Proposed Rule on Interoperability and Information Blocking are coming in, it will be interesting to see whether stakeholders in the health care system will embrace a more nuanced approach to health care price transparency, and perhaps advocate for information geared not to the individual consumer, who can do little to change the structure of the health care system itself, but rather to state and federal policymakers who can use price and outcome data to identify structural challenges to the provision of appropriate and affordable care.

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<sup>112</sup> See STARR, *supra* note 6, at 450-93 (discussing the various market and regulatory forces that drove health care organization and pricing from 2000 to 2016).

<sup>113</sup> *Id.* at 384-388.

<sup>114</sup> *Id.* at 386.

<sup>115</sup> See Darby Herkert, et al, *Research Letter: Cost-Related Insulin Underuse Among Patients with Diabetes*, 179 JAMA INT. MED. 1, 112 (noting that the cost of insulin has tripled in the United States over the last decade, and that nearly 30% of patients in the study used less insulin than prescribed due to costs).