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BEFORE THE U.S. SENATE
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Chairman Baucus, Senator Hatch and members of the Committee, thank you for the invitation to testify on health care price transparency and costs. My name is Paul Ginsburg, president of the Center for Studying Health System Change (HSC) and research director of National Institute for Health Care Reform (NIHCR).

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Health Care Costs and Price Transparency

To date, most policy activity related to health care price transparency has missed the mark and has not achieved the prime goal of lowering prices by engaging consumers to choose providers on the basis of value. Without changes in insurance benefit designs that steer patients to high-value providers—those that provide high-quality care efficiently—price transparency initiatives are likely to continue to have limited impact. Additionally, the effectiveness of price transparency approaches is limited by a lack of useful quality information for consumers. I do believe, though, there is a role for federal and state policy to achieve lower prices through price transparency initiatives that engage consumers.

One source of confusion in discussions of price transparency comes from the fact that there are different goals for price information, and distinct audiences with different needs. The importance of transparency as a core value of our society continues to grow, and, by this light, transparency is a goal in and of itself. We have a shared belief that the public or individual consumers should know more about the products and services they are buying and what they cost, even in situations where someone else is paying. Some of the interest in price transparency on the part of policy makers reflects this important shared value. But the chief goal of price transparency initiatives is to encourage competition among providers on the basis of both price and quality of care. To the extent that consumers choose higher-value providers, they will save money and get higher-quality care. And, if enough consumers act on the basis of price and quality information, providers will feel significant market pressure to reduce prices and increase the quality of care. Such a market level effect will benefit all who use and pay for care.

At least three distinct audiences have the potential to benefit from health care price information. One audience is individual patients deciding what care to get and which provider to use. Patients need to know the differences in what they will pay if they choose different providers. The second audience consists of employers that purchase health benefits for their employees. For this audience, learning that prices vary a great deal from one provider to another, often in a way

unexplained by quality differences, can be very influential. Employers can change insurance benefit and network designs to make employees more sensitive to price and shift use of services to higher-value providers. The third audience is policy makers, who can pursue approaches to increase the degree of price competition in the market or, in some cases, regulate prices directly.

Transparency Initiatives are Coming Closer to the Mark

The earliest policy initiatives to promote price transparency required hospitals to publish their "chargemasters," which are list prices for thousands of services that hospitals provide, down to provision of an aspirin. Publishing chargemasters does not have the potential to lead to lower prices by engaging consumers, because the price information is far too complex to be useful, and does not reflect the prices most consumers and health plans actually pay. A later generation of initiatives reported average hospital prices for common treatments, such as a knee replacement. These data are more understandable to consumers and policy makers, but the price data are typically for list prices (billed charges). These are not very meaningful to policy makers or to consumers, however, because private insurers negotiate large discounts and public programs (Medicare and Medicaid) set payment rates administratively.

The Centers for Medicare and Medicaid Services (CMS) recently released hospital charges for common episodes of care along with Medicare payment amounts for those services.[1] For one audience—individual patients, these charges are generally irrelevant. They do not reflect what anyone pays for care, except for the few uninsured patients who can afford a hospitalization and a small number of privately-insured patients who choose a hospital not in their insurer's provider network. The Medicare inpatient payment amounts are irrelevant to Medicare patients, who pay the same deductible regardless of which hospital they use. And, what Medicare pays clearly isn't relevant to privately-insured patients. To me, the most important information from the CMS charge data was generated by a *New York Times* article about the hospital with the highest charges in the country, Bayonne Hospital in New Jersey. This information was important because it shed light on a relatively new business strategy where some hospitals refuse to contract with insurers and instead set extremely high charges, aiming to collect these amounts from insurers whose enrollees visit the hospital's emergency department.

The Massachusetts Attorney General (AG) in 2010 published much more meaningful price data, which have been influential with Massachusetts policy makers and employers and perhaps outside the state as well.[2] The AG report published data on the actual rates that private insurers paid for hospital care. It showed very large differences in rates across hospitals, with some of the highest-priced hospitals turning out to be the highly prestigious ones, but others apparently high priced because of a lack of local competitors. The report was an important factor behind 2010 Massachusetts legislation that prohibited hospitals from requiring placement in preferred tiers as a condition of contracting. This has opened the door to much greater enrollment in

[1] Administration Offers Consumers an Unprecedented Look at Hospital Charges, May 8, 2013. http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-05-08.html

[2] Office of Attorney General Martha Coakley, Examination of Health Care Cost Trends and Cost Drivers pursuant to g.l. c. 118g, § 6 ½(b): Report for annual public hearing (Mar. 16, 2010), *available at* http://www.mass.gov/Cago/docs/healthcare/final_report_w_cover_appendices_glossary.pdf

insurance products that differentiate hospital deductibles according to the tier of the hospital used.

I and others have raised the concern that the publication of negotiated rates could raise prices. There is evidence, albeit from outside the health care industry, that in concentrated markets price disclosure leads to higher prices.[3] Indeed, antitrust authorities throughout the world generally restrict how sellers publicly post prices.[4] Anecdotal information from some health care price transparency initiatives suggests that low-priced providers were unaware of their prices being substantially lower than those of their competitors. At this point, we can only guess about whether some providers subsequently succeeded in raising prices; I expect research to be appearing on this issue in the future.

Role of Insurance Benefit Design

For price information to influence consumers to choose different providers, those choosing lower-priced providers need to save money as a result. Enrollment in high-deductible plans has been growing rapidly, which makes individuals more aware of the prices they are paying for health services. But, even high-deductible plans likely have little influence inpatient hospital choice because the cost of almost all inpatient admissions will exceed the deductible. And, many current insurance benefit designs lead to patients paying the same amount regardless of provider. For example, many plans have uniform hospital deductibles physician copayments. The most important aspect of current benefit designs is the incentive to use network providers. Since the late-1990s, most plans' hospital networks have been very broad; recently plans have introduced more products that achieve lower premiums by offering a limited provider network.

Newer benefit designs are more effective in helping consumers identify lower-priced providers and rewarding consumers who use such providers. For example, high-deductible plans do provide opportunities for enrollees to save money if they choose lower-priced providers of outpatient imaging and procedures. Tools to help enrollees find lower-priced providers have advanced. For example, I was impressed with the United Healthcare's *myHealthcare Cost Estimator* tool, which was sent to me (they administer my health plan) a few weeks ago.

However, I perceive the greatest potential to obtain lower prices comes from approaches where purchasers and health plans, rather than report prices to their enrollees, analyze extensive data on costs and quality and provide their enrollees very simple incentives to choose providers determined to be higher value. For example, for inpatient care, sophisticated insurers can analyze total spending for an episode of care, including all of the providers involved, including various physicians and post-acute care providers as well as the hospital, and factor in data on quality as well. Such number crunching is behind tiered-network products.

Reference pricing is a more focused version of the tiered-network approach. CalPERS, which purchases health benefits on behalf of California state employees and employees of many local

[3] Ginsburg, Paul B. "Shopping for Price in Medical Care." *Health Affairs*, vol. 26, no. 2, March 2007, pp. w208-w216.
[4] A U.S. example is restrictions on airlines publicizing their prices.

governments, has used this approach for those enrolled in its preferred provider organization (PPO) plan administered by Anthem Blue Cross. For hip and knee replacements, CalPERS established a reference price on the basis of the average payment amount for the hospital bill (the surgeon's fee is not included in the program). Patients using hospitals where CalPERS pays more than that amount must pay the difference.

These approaches have the advantages of keeping things relatively simple for the enrollee, while being based on a sophisticated analysis of cost data. They do not fit with the common vision of transparency, such as when a plan provides prices on MRIs for those enrolled in a high-deductible design, but they may be more effective. Of course, the approaches can be combined, with network approaches used for inpatient care and price lists used for outpatient services. An irony is that hospital resistance has limited the development of tiered designs and reference prices, so that more growth has come in limited network plans, which are much more restrictive of provider choice.

Limited information on provider quality has held back the use of price transparency to obtain lower-priced care. Consumers need quality data that is meaningful to them before they decide to choose a lower-cost provider. Currently, perceptions of quality are based largely on reputation among clinicians, but it is by no means clear that a good reputation equates with better outcomes. Policy initiatives, such as Medicare Hospital Compare and the National Quality Forum, are helping to advance quality measurement and reporting, but much more could be done, especially shifting the focus from process measures to outcome measures of quality.[5]

Policies to Obtain Lower Prices through Transparency

Although I have been critical of many public price transparency efforts, federal and state policies can be effective. Two federal policies that are not transparency initiatives *per se* are likely to do a lot to change insurance benefit designs toward those that include incentives to choose lower-priced providers. I am referring to the "Cadillac tax" provision in the Affordable Care Act and the design of the premium credits to purchase coverage on insurance exchanges. The Cadillac tax will lead to strong incentives to keep premiums low enough to avoid the 40 percent excise tax. Since premium credits are based on the premium of the second least expensive silver plan in an area and do not vary according to the premium of the plan chosen by an enrollee, consumers will be highly sensitive to premiums charged. The Cadillac tax and premium competition in the exchanges will pressure plans to keep premiums down, and some of the tools that health will use will be higher deductibles, limited-provider networks, tiered networks and reference pricing. These benefit designs will increase consumer sensitivity to provider prices and consumer interest in tools to help them identify higher-value providers.

The federal government can support these approaches by making Medicare Part B claims data on physicians available to insurers and consumer organizations, which have been pressing for it for some time. This would allow insurers to assess physician efficiency and quality on the basis of

[5] See, for example, Berenson, Robert, "Seven Policy Recommendations to Improve Quality Measurement," Health Affairs Blog, May 22, 2013. http://healthaffairs.org/blog/2013/05/22/seven-policy-recommendations-to-improve-quality-measurement/

broader experience than they can obtain from their own claims data. Such a change would be particularly helpful to smaller insurers, thus making insurance markets more competitive. Legislation recently reintroduced by Senators Grassley and Wyden (Medicare DATA Act) would accomplish this. States can also contribute by designing their all-payer claims databases in a way that allows insurers to draw on the full database to assess the quality and efficiency of different providers. States can also facilitate use of tools such as tiered networks and reference pricing by prohibiting hospitals from blocking these tools through refusal to contract.