AMERICANS FOR PROSPERITY

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Background on Hospital Price Transparency

Prepared Remarks of Dean Clancy, Senior Health Policy Fellow, Americans for Prosperity
at a meeting of the Pennsylvania Republican Policy Committee, Lewisburg, Pa.

Thank you for this opportunity to provide background on the important issue of hospital price transparency and the current lack thereof.

The Problem

Health care is the only industry in America in which it is not standard to provide good-faith price estimates up front, before the product is delivered. This is a side effect of the significant role of third-party payment. Most Americans get their health care through prepaid benefits arranged by a third party like an employer or an insurance company. As a result, patients are disconnected from the price of care, there is a lot of waste and paperwork and bureaucracy in the way it is delivered, and prices tend to be high and ever-rising.

Health care prices have risen faster than general inflation in almost every year for the past half century. The share of the median family's income devoted to covering the cost of health care has risen over the past twenty years from about 13 percent of income in 2000 to about 25 percent today — nearly double. That dynamic is squeezing people's ability to pay for other important things like housing, food, and education.

Consider the trend of prices in health care, education, and housing, versus the trend of the price of computers, televisions, telephones, and similar goods. The first set of prices, as I said, have all risen steadily, and at a comparatively steep rate, over the past fifty years. But during the same half-century, the price of computers, televisions, telephones, and similar goods have all plummeted. The difference is dramatic. What explains that difference? Well, an obvious difference is that government is heavily involved in subsidizing and regulating health care, education, and housing. Government is not nearly as involved in computers and TVs.

Put another way, prices are falling where markets are allowed to work. And I would add: prices are the most transparent where markets are allowed to work.

Health care pricing is a mess, and the main reason is that in America the patient is not the customer, the patient is the product. The real customers are big health care companies, insurers, employers, and drug and device makers. They do get to see prices, at the negotiating table. Patients do not see prices, because patients are not at that table. Instead, patients are treated as a source of leverage for those who are at that table. Employers tell insurers, "We have X thousand employees, so give us a good price." Insurers tell providers, "We have X hundred thousand covered lives in your area, so give us a good price." And so on. Patients are removed from the process, only seeing the real price when a surprise bill arrives after services have been rendered, informing them of their share of that price.

Now, there are exceptions. Markets *do* work in some areas of health care. For example, cosmetic, laser vision correction, direct primary care arrangements, and cash-only outpatient centers like the Surgery Center of Oklahoma.

- Markets work in cosmetic and laser vision correction. Prices in those markets continuously fall, outcomes continuously improve, and prices are always transparent and provided upfront before the service is delivered. This is quite different from most other kinds of health care. What explains the difference? The lack of insurance involvement. Most insurance will not cover these things. So there is no middle man. Instead, patients pay for care directly, in cash.

- Markets work in direct primary care. DPC practices publish all their prices, including their monthly subscription rates and any optional, a la carte items and services. Why are they so different from other medical practices? Because there is no insurance middle man. Patients pay for care directly.

- Markets work for outpatient hospitals like the Surgery Center of Oklahoma, which publishes on its website an all-in price for every procedure it offers. There are no hidden charges or fees. Its prices are transparent and easy to find, and generally competitive. Why is this outpatient facility so different from traditional ones? Because it does not accept insurance. Patients pay for services directly, in cash.

In each of these examples, we see that, instead of there being three parties to each transaction, there are only two: the patient and the provider. There is no middle man. And because the patient is the payer, the patient is the customer. And, well, the customer is king.

Markets work in health care when we let them.

Hospital Monopolies

Turning to hospital markets. Three big problems plague hospital markets today: a trend toward monopoly; non-transparent prices; and relentlessly rising prices that, in most years, rise faster than general inflation.

Large hospitals are becoming monopolies. They have been consolidating, with nearly 1,600 hospital mergers occurring over the past 25 years.

As hospitals have increased their negotiating power, the burden of drastically higher prices has fallen on patients and taxpayers. And those prices are rarely transparent.

This trend toward monopoly has been driven by several forces. One is Medicare payment policies. Medicare reimburses health care services at a higher rate when they are performed in a hospital rather than in a physician's office. This creates an incentive for physicians to sell their practices to hospital groups to receive higher reimbursements from Medicare.

A second cause is protectionist barriers to competition, such as state certificate-of-need laws and Medicare's ban on physician-owned hospitals.

A third cause is a reduction of federal antitrust enforcement of hospital mergers. Specifically, judges have broadened the definition of what constitutes a competitive market area, and this has enabled more hospitals to merge, reducing competition. The Federal Trade Commission estimates that consolidated hospitals charge patients prices 40 to 50 percent higher than those charged in more competitive markets.

Mandates or Markets?

So, what do we do? How do we bring about price transparency in hospital and other health care markets?

At AFP, we believe consumers need, want, and deserve price transparency, but we also believe mandates are never going to be the best way to achieve it. The only reliable way to achieve it is to empower patients, not just with information, but also, and more importantly, with control of the dollars. In health care like any market, the person who controls the dollars and can take his business elsewhere is the real customer. And that person is going to receive the respect and deference due to a real customer.

In a truly robust and competitive market, where end-consumers are the real customers, price transparency occurs naturally. There is no need for mandated publication of prices. Gas stations and grocery stores, for example, voluntarily publish their prices because their customers demand it. They would publish them even without a mandate.

Now, while we are not sold on the idea of government mandated price transparency as a silver bullet that will create a market by sheer willpower, and we are not asking to impose new price transparency mandates where they do not already exist, we are also not eager to repeal those that exist. At least not yet. It may seem odd, but we think it most prudent for the time being to enforce existing mandates to see if they work.

Price transparency mandates in health care are still relatively new. They are experiments. If they achieve their purpose of promoting market forces, with no significant negative effects, then we

should not only retain them, we should build on them. But if they do not work, or if they have significant negative side-effects, then the quickest way to obtain that information, and get them repealed or modified, is to enforce them vigorously.

Federal Mandates

Now I will turn to the most important of those experiments, the federal hospital price transparency regulation, which affects virtually all the nation's 6,000 hospitals. This regulation was first proposed in 2018 and became effective at the beginning of 2021. It has been in effect for two years and four months.

The regulation requires each hospital operating in the United States to publish its standard charges for those items and services, including bundled services, that it has established rates for. The specific information that must be published includes the list price, the discounted cash price, and the privately negotiated (i.e., payer-specific) price, along with the lowest price given to any payer.

This information must be made public in two ways: in a consumer-friendly display comprising at least 300 shoppable services and in a comprehensive, machine-readable data file. The consumer-friendly display can be satisfied by releasing a data file or by providing an online price estimator tool.

In 2021, only about 14 percent of hospitals complied with the rule, and not all of them complied fully. The information was often hard to find and hard to interpret. Some hospitals buried the information on their website. Some required patients to enter personal information to gain access to it. Some disclosed average, median, or estimated rates rather than the required standard charge for each item and service.

Why are hospitals reluctant to comply with the rule? A couple of reasons, I would say. First, they are embarrassed by their list prices, which are intentionally inflated because the purpose of those prices is to provide a starting point for private negotiation with payers. Second, and more importantly, hospitals are reluctant to reveal their privately negotiated rates, and especially their lowest rate for an item or service, because doing so reduces their negotiating leverage generally and drives down their revenue. That, of course, is the purpose of the regulation, to drive down prices.

In 2022, compliance with the federal rule rose, but by how much is disputed. CMS and the American Hospital Association claim 70 percent of hospitals are now fully compliant, but private surveys suggest the real number may be around 25 percent.

In any case, the information that is being published is still hard to find and, when found, is still confusing and hard to use for its intended purpose. Comparing prices across hospitals is not easy. Some hospitals publish the standard charge for an entire episode of care, while others do so only for particular procedures or per diem rates. Not every hospital describes all items or defines all bundles of services in the same way. The regulation itself does not impose stringent

uniformity in these matters. It does, however, require the use of relevant public payment codes where available.

Penalties for noncompliance are charged on a per bed per day basis, with a daily maximum of $5,500 and an annual maximum of about $2 million. CMS increased the penalties for hospitals larger than 30 beds last year. Originally, the maximum annual penalty was only $100,000. Now, as I say, it is a little over $2 million.

As of January, CMS had issued nearly 500 warning notices and more than 230 requests for corrective action plans. Nearly 300 hospitals have addressed problems and have become compliant with the regulations, leading to closure of their cases. While CMS issued penalties to two hospitals in 2022 for noncompliance (posted on the CMS website), the agency claims that every other hospital reviewed has corrected its deficiencies.

A movement has arisen to step up enforcement. CMS strengthened the federal penalties after the first year. And some states have considered enacting additional penalties, on top of the federal ones. Colorado enacted such a bill. It protects patients from collection for bills incurred at hospitals that are not in compliance with the federal transparency rules, and it gives them the right to sue hospitals to compel compliance.

Looking ahead, it is safe to guess that more mandates are likely to follow this one. For starters, policymakers will be tempted to try to impose more uniformity and standardization of price definitions to improve comparability across hospitals. That will affect how hospitals deliver care and could easily have stifling effects and lead to less flexibility and innovation. Paradoxically, it could even lead to higher prices — defeating the whole purpose.

And on that perhaps jarring note, I will close. I hope this brief background will helpfully inform your discussions on this critical issue. I will be happy to answer any questions.

Thank you again for this opportunity.

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About AFP

AFP is a national grassroots advocacy organization whose mission is to liberate every American to live their version of the American dream. We believe Americans are capable of extraordinary things when we have the freedom to do so. AFP's thousands of volunteer and paid activists across the country knock on doors, educate their neighbors, and engage with policy makers on important public issues.

A Personal Option

When it comes to health care, we at AFP believe every American should have a Personal Option. What is a Personal Option? It is an approach to reforming health care laws and systems that focuses on putting patients in the driver's seat rather than third parties like insurance

companies or the government. With a Personal Option, health care providers openly compete for patients' business and offer the best health care products and services at prices that meet patients' needs. You, the patient, can obtain the care you need, with the quality you deserve, at prices you can afford, from the medical professionals you trust. That is the vision.

We believe we can bring that vision to life through three main reforms.

First, fund patients rather than insurance companies. Money should follow people. *Second*, let every American have the option of using a tax-advantaged Health Savings Account. Currently only about 10 percent have this option, as a practical matter. HSAs help your health care dollar go farther, and they encourage patients to shop for value. Studies show they help reduce health care costs, without causing people to stint on necessary preventive care. *Third*, remove needless government barriers between patients and care. The list of these barriers is long. To learn more about them, and how we are working to remove them, visit our Personal Option website, personaloption.com. Also, be sure to read our health reform news stories and articles at americansforprosperity.org.

Personal Option