

Health Quality and Price Disclosure By Government: A Transparently Bad Idea

By John R. Graham

Key Points

- Politicians in favor of consumer-directed health care are threatening to force hospitals and other health providers to disclose prices publicly, and submit to measures of quality determined by the government.
- Outlandish prices charged to uninsured customers are a consequence of government regulation, not hospitals' greed, and the notion that "free market" prices are naturally transparent, especially in the Internet age, is a myth.
- Previous government efforts to force price transparency were a waste of resources, and empowered health consumers are already succeeding in negotiating prices without government intervention.
- The private sector *can* deliver information about quality – and such information is more useful than that which is coerced by the state.

the most common procedures and most frequently administered medications, on a website run by the Department of Health & Human Services.

After a few weeks of jawing about the need for transparency in health costs, the Administration has decided to take more forceful action. The Department of Health & Human Services plans to disclose the prices it pays hospitals and doctors in certain metropolitan areas for Medicare, Medicaid and other government programs. According to Michael Leavitt, Secretary of Health & Human Services, "People deserve to know, they have a right to know the quality of care they receive and its cost."¹ Unfortunately, these proposals are likely to have the opposite effect, raising prices and making it more difficult for patients to get the care they need.

It's not hard to be outraged at the prices hospitals charge uninsured patients. A recent CBS News *60 Minutes* episode featured two examples of absurd prices charged to the unemployed.² In one case, a retired plumber who suffered a fractured skull and ribs received a bill of \$246,000 for 18 days in the hospital, without even receiving surgery. This is almost five times what the hospital would charge an insurance company. In another case, a man had a mild heart attack, resulting in two stents inserted to open up a blocked artery. The charge was \$41,000, for which each stent cost \$9,500. However, each stent only cost the hospital \$2,300.

In these cases, the bills were eventually reduced, all due to *60 Minutes'* helpful intervention. In the latter case, the bill was reduced by one quarter. In the former it was eliminated: the plumber qualified as a charity case.

Pressured by those nervous that consumer-directed health care will not really get off the ground without a nudge from the state, the President and other conservative politicians are leaning towards forcing providers to disclose prices publicly and submit to government measures of quality.

Rep. Pete Sessions (R-TX) has introduced the Hospital & Ambulatory Surgery Center Price Disclosure & Litigation Act (H.R. 4450) that will protect hospitals from lawsuits related to the prices they charge patients, provided they agree to prices beforehand. Furthermore, the facility must disclose the prices it charges Medicare or private insurers for the same procedures. An even more restrictive bill is the Hospital Price Reporting and Disclosure Act (S. 1827) introduced by Senators Jim DeMint (R-SC), Richard Durbin (D-IL), and John Cornyn (R-TX), and its companion legislation in the House, H.R. 3139, sponsored by Representatives Bob Inglis (R-SC) and Dan Lipinski (D-IL). This measure would simply require all hospitals to post the prices they charge for

Obviously, the media love these horror stories. The result points towards a little recognized fact: what most hospitals *charge* uninsured patients is far greater than what they *collect* from them: about one dollar for every six it costs them to provide this care.³ This invites a question.

Why would a hospital waste its time and resources sending an invoice for almost a quarter million dollars to a retired plumber, with no hope of ever collecting a fraction of that charge? Hospital prices started to go off kilter with the establishment of Medicare in 1965. Rather than negotiate with every hospital in the country, the government preferred to pay based on an average charge in a community. Obviously, this motivated low-cost providers to raise their “list prices.”⁴

Medicare guidelines and federal kickback regulations prevent hospitals from giving immediate discounts to the uninsured.⁵ For example, the 1986 Emergency Medical Treatment and Active Labor Act (EMTALA) requires all hospitals with emergency rooms that participate in Medicare to screen and stabilize any patient seeking care — and prohibits them from delaying treatment to inquire about patients’ insurance status or means of payment. Thus, when providing acute care, the hospital may not even know whether or not it can claim reimbursement from a government program or private insurer.

Medicare will only reimburse a hospital’s bad debts from Medicare beneficiaries who fail to pay their co-payments, co-insurance, or deductibles if the hospital has used the same collection tactics as those employed against uninsured patients who have not paid their bills. The collection effort must be “genuine” and not “token,” comprising the usual litany of letters, phone calls, and even personal visits. Some states have similar rules that reinforce hospitals’ perverse behavior.

There can be exceptions if the patient is indigent, but the *hospital* must prove this situation, or risk a Medicare determination that its usual and customary charges are lower than they actually are. Worse, this indigence must be determined at each visit, a true bureaucratic nightmare. No wonder hospitals simply churn out meaningless invoices, send them to collection, and only forgive the debts after a drawn-out process.

Without government meddling, uninsured patients would find it easier to get a break on hospital prices. However, even if hospitals operated in a “free market,” prices need not be as transparent as these politicians expect. A relatively unexamined belief is that the Internet has lowered search costs for customers, thereby reducing prices. In some cases, this is obviously true. EBay™ and Priceline™ come immediately to mind — or do they?

In fact these businesses *decrease* price transparency. Rather, they reduce the cost of participating in an auction. When I use Priceline™ to book a hotel room, I get to choose the quality of the hotel and the neighborhood — but not even the name of the chain. I then name my own price. I usually get a great hotel for a fraction of the price I’d have paid if I’d booked it directly — but I have taken a risk, because I have *already paid* when Priceline™ tells me where it’s putting me, even if I get Hilton when I prefer Sheraton.

Thus, Secretary Leavitt had it completely backwards when he argued for price transparency based on the fact that the posted rack rate for his hotel room was \$449, but he only paid \$130 instead “*because the government had negotiated special prices*” (emphasis mine)⁶ The real price was low, but opaque, and the transparent price was fake (and only disclosed because of a local government regulation). Indeed, scholarly research has debunked the notion that the Internet creates perfectly competitive markets according to the classical economic definition.

There is no doubt that the Internet reduces the cost of searching out prices, but this does not necessarily imply that it also reduces prices or price dispersion. There is evidence of “bait and switch” behavior online, whereby posted prices are not actual transaction prices. Prices for cars, books and software offered online can be *higher* than those offline. Economists have developed models to explain this.⁷

My own interpretation is that customers “reward” vendors who make life easier for them by reducing search costs (although the customers may not be doing so deliberately). On the other hand, prices for some commodities are now subject to tremendous price transparency.

For example, there are a number of websites that compare prices at gasoline stations within specified geographic regions, which anyone can find by Googling “cheap gas.” If we had a free-market health system, prices for some health goods and services would be as transparent as those of gasoline, and some would be as opaque as those of hotel rooms. It is folly for the government to try to dictate these conditions in advance.

For example, retail prices of the same prescription medicine can vary drastically within an area that can be crossed within a few minutes by automobile.⁸ Driving around town in order to save a few bucks on a prescription might not be a very productive use of time, but an entrepreneur might set up a business to collect and communicate this information on a website. However, no such entrepreneur has arisen, to the best of my knowledge.

Certainly there are some Americans willing to risk the law and their personal safety by purchasing pirated medicines from other countries, but this business was never more than about \$0.5 billion annually out of a \$252-billion national U.S. prescription market.⁹ So far, government programs to compel prescription price transparency have not succeeded.

Illinois Governor Rod Blagojevich, joined by four other states, deliberately markets illegally acquired prescription meds from Canada to residents. However, although more than 27 million people are eligible, only 5,300 orders had been processed in the first half year since the program launched in October 2004. The program competes unsuccessfully with a private plan, operated by the drug companies and pharmacists, that offers discounted meds to low-income residents.¹⁰

Without breaking the law, Florida's Attorney General and Secretary of Health & Human Services report prices of the top 50 selling prescription medicines on a government website, myfloridarx.com. However, as the site notes: "Prices at your local pharmacy may change daily, so this website is only meant to help you compare prices at different pharmacies and are not a guaranteed price."¹¹

This should not be news. In New York, state law has long required pharmacies to post prices on large pink posters. Most pharmacies comply, but the posted prices were not actual transaction prices. A survey conducted in 2000 showed that only two of the 65 New York City pharmacies that were inspected posted accurate prices.

More broadly, California passed a law, a so-called "Patients' Bill of Rights" (AB1627) that requires hospitals to communicate fees to patients for 25 common services and post notices informing patients that such prices are available. However, a survey by "mystery shoppers" reported last year that hospitals were quite unwilling or unable to communicate this information.¹² One quarter of the mystery shoppers failed to get a price at all. Those who did generally had to persist through multiple telephone transfers, voice-mail messages, call-backs, and hold times. The shoppers often received different prices for the same procedure from different departments.

On the other hand, even though the U.S. has taken only taken baby steps towards empowering patients, those patients are already succeeding in whittling down prices for some procedures. These baby steps are Flexible Spending Accounts, Health Reimbursement Accounts, Medical Savings Accounts, and most importantly Health Savings Accounts. Health Savings Accounts, which I described and advocated in the January Health Policy Prescription, are savings accounts where individuals (or their employers) invest pre-tax dollars to spend on their

future health needs.¹³ As long as this money is spent on health care, *it is never taxed.*

HSAs have only existed for two years, so it is comes as no surprise that not too many people are flexing their muscles with providers. However, when they do, they find that providers are willing to negotiate fees. According to a *Wall Street Journal Online*/Harris Interactive poll from last autumn, only one in eight patients discussed prices with their doctor, and one in 10 with a hospital. However, about half of those who asked were successful. Further, if out-of-pocket costs increase substantially (as they will when these patients move into high deductible, HSA-qualifying plans) the numbers who are likely to negotiate jumps to more than one half of the sample.¹⁴

With respect to communicating quality, government intervention is also fraught with risk — and unnecessary under consumer-directed health care. Already, the argument that there is "no information out there" is clearly incorrect. *US News & World Report*, for example, publishes an annual ranking of the best hospitals across the country.¹⁵ On the website, a Google ad directs the reader to a for-profit business that sells information on prices and quality for \$9.95 apiece. For quality, the report (HealthGrades.com) uses data from the Leapfrog Group for Patient Safety, an effort established by health-care buyers that encourages hospitals voluntarily to report compliance with standards of safe practices and conduct of high risk treatments.

On the other hand, giving the state the power to decide quality runs risks too. A recent analysis of hospital report cards for cardiac surgery in New York and Pennsylvania, where they are mandatory, presented evidence that this reporting led to selection bias: hospitals tended to admit low-risk cardiac patients in order to improve their scores.¹⁶

Reporting quality is a costly activity, and it is more likely that increased demands to satisfy the government's definition of quality will distract resources required to communicate to patients the knowledge they need to decide effectively. Yes, the U.S. Department of Health & Human Services does operate a website that compares data on safety for hospitals (www.hospitalcompare.hhs.gov), but this is voluntary and hospitals receive payments of four-tenths of one percent of their Medicare revenue to disclose the data.

When it comes to the reporting of quality and prices to consumers, let's leave the government out of it and let patients determine what they need.

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¹ Quoted in Lueck 2006.

² CBS News 2006.

³ Dobson, *et al* 2006: 24. A contrary argument, namely that hospitals earn huge profits from the uninsured is presented by Matthews 2004.

⁴ Wielawski 2000.

⁵ Tompkins, *et al* 2006: 52; Pryor, *et al* 2003.

⁶ Connolly 2006.

⁷ Pereira 2005, and references.

⁸ Graham & Robson 2000, and references.

⁹ IMS Health 2006.

¹⁰ Bast 2005.

¹¹ Crist 2006.

¹² Gerber & DelPo 2005.

¹³ Graham 2006.

¹⁴ Bright 2005.

¹⁵ U.S. News & World Report 2006.

¹⁶ Dranove, *et al* 2003.

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