

PRICE TRANSPARENCY: FRIEND OR FOE? HOW PRICE TRANSPARENCY MAY IMPACT COMPETITION IN THE HEALTH CARE INDUSTRY



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I. INTRODUCTION

The U.S. health care system is in the midst of disruptive changes designed to expand access, improve quality, and lower costs. The U.S. continually spends significantly more on health care than any other country in the world and also spends the greatest proportion of its Gross Domestic Product (“GDP”) on health care.² For example, health care spending now accounts for 17.7 percent of the GDP, compared to 8.8 percent for the average country.³ Moreover, total health expenditures in the U.S. have increased substantially over the past several decades. According to a study conducted by the Office of the Actuary at the Centers for Medicare & Medicaid Services (“CMS”), total national health care spending in 2018 grew 4.6 percent and reaching \$3.6 trillion.⁴

Amid rising health care costs in the U.S., many have sought to find a solution. Although price transparency has been touted by some as one solution, it is now a hotly debated issue in the wake of the government’s recent push for price transparency in certain sectors of the health care industry. This paper will explore the pros and cons of the government’s price transparency initiative while also weighing its impact when balanced against the goals of antitrust law. Part II provides a broad overview of price transparency, discusses its pros and cons, and provides some historical perspective on price transparency initiatives generally and its limits. Part III summarizes the Administration’s recent price transparency rules issued by CMS and discusses recent litigation filed to enjoin implementation of CMS’ final rule regarding hospital pricing. Part IV analyzes the antitrust implications of the CMS rule and the role antitrust principles and policy play in the overall dialogue regarding price transparency in the health care sector.

This paper argues that while price transparency in the health sector is necessary, price transparency, standing alone, will not solve the problem of growing health care costs. While the notion of injecting free-market principles into health care is intuitively sound, this paper argues that if the Administration’s price transparency rules are implemented as proposed, provider rates may actually increase to the detriment of consumers and thwart the rules’ efficacy. Instead, legislators and industry experts should consider a more targeted approach that balances consumer preferences with antitrust principles.

² Emily Rappleye, *U.S. Continues to Lead in Healthcare Spending*, BECKER’S HOSP. REVIEW (Nov. 7, 2019), <https://www.beckershospitalreview.com/rankings-and-ratings/us-continues-to-lead-in-healthcare-spending.html>.

³ *Id.* (comparing to the average Organization for Economic Cooperation and Development country).

⁴ CTMS. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURES BY TYPE OF SERVICE AND SOURCE OF FUNDS, CY 2018 (2018), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical>).

II. PRICE TRANSPARENCY DEFINED

A. What is Price Transparency?

Broadly, price transparency is defined as making available to the public, in a reliable and understandable manner, information on the price of health care services, that together with other information, helps define the value of those services.⁵ This includes physicians and hospitals publicizing their usual charges for particular health care services, insurers making available to their subscribers the rates they have negotiated with physicians and hospitals, and government agencies publicly reporting the average prices for common health care services.⁶ Transparent health care information is useful for a variety of stakeholders, including patients/consumers (hereinafter “consumers”), employers/purchasers (i.e. payers), health plans, health care professionals, and policymakers. A recent Commonwealth Fund survey of health care leaders concluded that “transparency in health care is essential for moving towards a higher performing health care system in the United States.”⁷

However, depending on who the targeted party is, the “price” of health care services can be defined as the (1) billed charge (Chargemaster data), (2) negotiated price or “allowed amount,” or (3) out-of-pocket costs.⁸ The billed charge is the total amount charged directly to either the consumer or the provider and tends to be only applicable to uninsured consumers. The negotiated rate is the amount an insurer contracts to pay for the procedures and services of the provider, and thus, is most applicable to these two contracting parties. These rates usually vary between different insurance companies but are generally lower than the billed charge. Finally, consumers tend to care the most about health care expenses that are not reimbursed by insurance. These “out-of-pocket” costs include deductibles, coinsurance, copayments, monthly premiums, and the costs of services that are not covered.

B. Price Transparency: Friend or Foe?

Those who are in favor of price transparency initiatives believe that disclosure of price data will result in a multitude of benefits for consumers and the health care industry as a whole.⁹ Namely, advocates state that price transparency is instrumental to consumer protection by allowing them to make informed health care choices, judge affordability, and plan for the expense of future health care services.¹⁰ For example, those who favor such initiatives believe that consumers will be able to use the data to identify providers who are offering services at the best price, and that providers, in turn, will be incentivized to offer the greatest value, which will also result in encouraging competitors to do the same.¹¹ The hope is that increased competition resulting from the implementation of price transparency initiatives will reduce price variation, decrease health care spending, and improve overall value of health care services. Moreover, price transparency advocates also assert that transparency efforts will enable policymakers to address unwarranted price variation and develop regulations to improve quality, safety, and efficiency throughout the health care system.¹² Advocates also laud price transparency for a recent study that showed, due to efforts to share critical data with consumers, increased trust in the patient-physician relationship and within health care systems.¹³

⁵ ASS'N OF AM. MED. COLL., PRICE TRANSPARENCY: COMMON DEFINITIONS 2 (n.d.), https://www.aamc.org/system/files/c/2/450000-pricetran_commondefs.pdf.

⁶ AM. COLL. OF PHYSICIANS, HEALTHCARE TRANSPARENCY—FOCUS ON PRICE AND CLINICAL PERFORMANCE 7 (2010), https://www.acponline.org/acp_policy/policies/healthcare_transparency_2010.pdf.

⁷ KATHERINE SHEA, ANTHONY SHIH, & KAREN DAVIS, HEALTH CARE OPINION LEADERS' VIEWS ON THE TRANSPARENCY OF HEALTH CARE QUALITY AND PRICE INFORMATION IN THE UNITED STATES 1 (2007), https://www.commonwealthfund.org/publications/other-publication/2007/nov/health-care-opinion-leaders-views-transparency-health-care?redirect_source=/publications/publication/2007/nov/health-care-opinion-leaders-views-transparency-health-care.

⁸ ALTARUM HEALTHCARE VALUE HUB, REVEALING THE TRUTH ABOUT HEALTHCARE PRICE TRANSPARENCY 2 (2018), https://www.healthcarevaluehub.org/application/files/3015/6322/4395/RB_27_-_Revealing_the_Truth_About_Healthcare_Price_Transparency.pdf.

⁹ AM. COLL. OF PHYSICIANS, *supra* note 6, at 5.

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.*

¹³ *Id.* (contending pricing information that is reliable and valid, transparent in its development, minimally burdensome to the reporting physician and other health care professionals, and comprehensible to the intended audience facilitates patient trust in the information and the health care system overall).

However, there are certain limits on the benefits that can be achieved from efforts to reduce information asymmetry in the industry. Retrospective studies in certain health care sectors only find minimal evidence that price transparency, alone, improves value by incentivizing consumers to shop for the best price.¹⁴ This is likely because health care markets differ from markets for other standardized commodities and these unique characteristics inherently limit the usefulness and demand for price information. First, by its nature, health care cannot be easily standardized.¹⁵ Different illnesses affect different people in different ways, and treatments that work for one patient cannot necessarily be replicated successfully for another.¹⁶ Because hospitals produce many different outputs with many of the same inputs, allocating costs to particular consumers can be somewhat arbitrary—based on industry norms rather than precise economic calculations.¹⁷

Second, many consumers do not view doctors, hospitals, and treatments as marketplace commodities and thus, may not believe that price is the most important factor when making decisions about their health care.¹⁸ Rather, consumers tend to believe decisions should be based on health needs and what providers recommend.¹⁹ This belief is exacerbated by consumers having preferences for the perceived “best care,” regardless of expense; often associating higher costs with better quality.²⁰

Third, the majority of health care services are not “shoppable.”²¹ Notably, only “33–43 percent of our current national healthcare spending” is used for non-urgent care that would give consumers a choice of providers and/or treatments.²² Price and quality information is most useful where consumers can, in fact, make an informed choice. However, in many cases, health care needs are acute and patients do not have the time or—in cases of critically ill patients—even the ability to consider the relevant price and quality information.²³ Moreover, recent studies have shown that even when consumers are given the tools to engage more directly in making their own medical purchasing decisions, they either fail to use the price transparency tools and/or ignore the data the tools provide and choose to use higher priced providers over lower priced providers that were available to them.²⁴

Finally, the agency relationships between consumers and insurers or providers may dampen the demand for price information.²⁵ Due to the inherent complexity of medical care, consumers face significant information asymmetries when it comes to determining the price and quality of their care. Information regarding health care prices and quality are often unavailable or muddled with so much jargon and detail that consumers cannot make any meaningful informed choices.²⁶ As a result, physicians end up serving as agents for their patients.²⁷ Physicians

14 See, e.g. Anna D. Sinaiko, et al., *Association Between Viewing Health Care Price Information and Choice of Health Care Facility*, 176 JAMA INTER. MED. 1868, 1868 (2016) (finding when price information in combination with insurance benefit design that shares savings when patients choose low-cost health care facilities has led to lower spending, the impact of price information on patient choices for patients in commercial insurance without such benefit design incentives is largely unknown); Ateev Mehrotra, et al., *Promise and Reality of Price Transparency*, 378 NEW ENG. J. OF MED. 1348, 1348 (2018) (finding limited evidence that price transparency leads to consumer shopping).

15 CONGRESSIONAL RESEARCH SERV., DOES PRICE TRANSPARENCY IMPROVE MARKET EFFICIENCY? IMPLICATIONS OF EMPIRICAL EVIDENCE IN OTHER MARKETS FOR HEALTH SECTOR 8 (2007), <https://fas.org/sgp/crs/secretary/RL34101.pdf>.

16 *Id.*

17 *Id.*

18 ALTARUM HEALTHCARE VALUE HUB, *supra* note 8, at 2.

19 *Id.*

20 *Id.*

21 Michael Chernen et al., *Are Health Care Services Shoppable? Evidence from the Consumption of Lower-Limb MRI Scans* (Nat'l Bureau of Econ. Research, Working Paper No. 24869, January 2019) (finding that, on average, patients travel past six-lower priced providers for lower-limb MRI scans en route to where they ultimately received care).

22 ALTARUM HEALTHCARE VALUE HUB, *supra* note 8, at 2.

23 *Id.*

24 Chernen, *supra* note 21, at 7–8 (noting that of the 50,484 lower-limb MRI scans in a sample, only in 0.7 percent of cases did patients use the price transparency tool supplied by the insurer to search for the price of MRI providers prior to receiving care).

25 CONGRESSIONAL RESEARCH SERV., *supra* note 15.

26 *Id.* at 10.

27 *Id.*

make the preliminary diagnosis, recommend which specialists will be seen, and suggest necessary medications or procedures.²⁸ Although ethical and professional guidelines stress that physicians must act in the best interests of the patient, they may still be swayed directly or indirectly by insurers, pharmaceutical companies, hospitals, and peers in ways that might not align with the patients' economic interests.²⁹

Insurers also act as agents for consumers, negotiating contracts with providers and bearing a significant portion of the financial responsibility.³⁰ While public or private insurance protects consumers from the financial consequences of a hospital stay, insurance also makes consumers more insensitive to prices. Consumers tend to focus only on out-of-pocket costs, which are often a much smaller percentage of the billed charge or negotiated rate. Although consumers can obtain information about the features of different insurance plans, that information is arguably incomplete and often confusing. Consumers may also lack interest in, or familiarity with, costs borne by insurers and society as a whole.³¹ Ultimately, these unique aspects of the health care industry may dilute the effects of price transparency initiatives.

III. PRICE TRANSPARENCY INITIATIVES

A. The Growing Demand for Greater Price Transparency in Health Care

The issue of price transparency is not a novel issue in health care. Many states have implemented programs designed to collect and disseminate various cost information and other data designed to control statewide health care costs and increase access to health care services.³² For example, in 2005, New Hampshire created NHHealthCost, one of the country's first all-payer claims databases to collect and disseminate health care price information.³³ This database provides the median bundled prices for the thirty most common health care services.³⁴ Similarly, in 2018, California created the Health Care Cost Transparency Database.³⁵ This all-payer claims database aimed to provide greater transparency regarding health care costs, by encouraging health insurers, providers and other industry participants to use such data to develop innovative approaches and services, and inform policy decisions to reduce health care costs and increase access.³⁶

1. Key Targets as One Approach for Price Transparency

When crafting price transparency initiatives, it is important to consider who the target audience is and whether or not the disclosure of certain data is likely to have a measurable impact on health care costs. A blanket reveal of health care costs may not be as useful or effective as a more appropriately targeted approach. So how do we determine what is the applicable "price" in connection with price transparency initiatives? As previously discussed, the effect of any particular price transparency initiative will depend significantly on the relevant stakeholders, the associated market conditions, the usefulness of the information disclosed, and the ability of the targeted group to act on that information.

There are numerous mechanisms that hinder price transparency.³⁷ Confidentiality, or "gag" clauses, and other laws prevent consumers and competing providers from knowing the rates that providers have negotiated with payers.³⁸ In some cases, even physicians are unaware of the

²⁸ Chernew, *supra* note 21, at 9 (concluding that referring physicians heavily influence where patients receive care and referrer fixed-effects explain the largest share of the variance in the price of MRIs and "money left on the table").

²⁹ CONGRESSIONAL RESEARCH SERV., *supra* note 15, at 9.

³⁰ *Id.*

³¹ ALTARUM HEALTHCARE VALUE HUB, *supra* note 8, at 2.

³² See, e.g. CAL. HEALTH & SAFETY CODE §§ 1339.55, .56, .58, .585 (West 2004); COLO. REV. STAT. ANN. §§ 6-20-101, 10-16-133, 10-16-134 (West 2004); MASS. GEN. LAWS ANN. ch. 224, § 228 (West 2014); N.H. REV. STAT. ANN. § 420-G:11-a (2014).

³³ ASS'N OF STATE AND TERRITORIAL HEALTH OFFICIALS, NEW HAMPSHIRE CASE STUDY ALL-PAYER CLAIMS DATABASE 2 (2017).

³⁴ *Id.* at 10–11.

³⁵ KATHERINE L. GUDIKSEN, ET AL., THE SECRET OF HEALTH CARE PRICES: WHY TRANSPARENCY IS IN THE PUBLIC INTEREST 5 (2019).

³⁶ *Id.* The push for price transparency has also occurred in the pharmaceutical industry. Faced with continuously increasing drug prices, state legislatures have considered a variety of initiatives, including: (1) establishing a commission to study drug pricing and identify key drivers of costs; (2) calling for CMS to negotiate reasonable prices with drug makers; (3) empowering state Medicaid agencies to negotiate drug price rebates; (4) establishing penalties on price gouging behavior by drug manufacturers; and (5) shining the spotlight on the way drug manufacturers set prices. Kaitlyn N. Dana, et al., *Drug Pricing Transparency: The New Retail Revolution*, 52 HOSP. PHARM. 155, 155 (2017).

³⁷ *Id.* at 327.

³⁸ *Id.* at 329.

true charge of their services, disincentivizing them to contain costs by reducing unnecessary tests and treatments.³⁹

Some studies show that price transparency initiatives targeted at insurer-provider relationships can be useful in controlling high spending, particularly with regards to unwarranted provider price variation.⁴⁰ According to these studies, disclosing information regarding negotiated rates, or which providers are pricing outliers compared to their peers, may force insurers and providers to lower their prices.⁴¹ One researcher studied the impact of New Hampshire's implementation of price comparisons among hospitals in 2010.⁴² Until 2010, payments to New Hampshire's most expensive hospital exceeded those of its competitors by nearly fifty percent.⁴³ Historically, the hospital's prestigious reputation and high-earning patient population insulated it from pressure to reduce prices.⁴⁴ The introduction of price comparisons, however, led to public scrutiny over high-price providers that shifted the bargaining power towards state insurers and narrowed price variation over time.⁴⁵

From a consumer-driven perspective, price transparency initiatives can also be implemented to provide consumers with instant, online access to an estimate of their out-of-pocket costs.⁴⁶ Insurers, having access to a plethora of historical price data, negotiated provider rates, and the consumer's current health plan, are well-positioned to provide this complete and personalized price information to consumers.⁴⁷ Equipping consumers with out-of-pocket cost data could facilitate their ability to shop around before they receive treatment for schedulable, non-emergency medical services, and as such, could directly contribute to reducing health care spending in measurable ways.

Employers represent the last target group for potential price transparency initiatives aimed at decreasing health care spending. As the leading source of health insurance in the U.S., covering approximately 149 million people under the age of sixty-five,⁴⁸ employers can substantially impact health care pricing.⁴⁹ If employers had access to both quality information on the providers included in a health plan as well as certain pricing data, they could use that leverage to demand higher value plans at lower costs.⁵⁰ Particularly, in comparison to individual consumers, employers are in a better position to not only accumulate and analyze price and quality data, but leverage their purchasing power to negotiate price.⁵¹

2. CMS's Price Transparency Rules

In November 2019, the U.S. Department of Health and Human Services ("HHS") and CMS issued a new proposed rule and finalized another, both with the aim of empowering health care consumers with price transparency information. The "Transparency in Coverage" proposed rule would require health plans, including employer-based plans, and group and individual plans, to inform participants, beneficiaries, and enrollees about price and cost-sharing information ahead of time.⁵² Health plans will be responsible for providing this information in real time using a digital tool and may also be required to display their negotiated rates with different hospitals on their own websites.⁵³ The public comment period for the

39 *Id.*

40 ALTARUM HEALTHCARE VALUE HUB, *supra* note 8, at 3.

41 *Id.* ("One way to incentivize change is for payers to publicly compare providers who are pricing outliers to their peers.")

42 *Id.*

43 *Id.*

44 *Id.*

45 *Id.*

46 Anna D. Sinaiko & Meredith B. Rosenthal, *Examining a Health Care Price Transparency Tool: Who Uses It, and how They Shop for Care*, 35 HEALTH AFFAIRS 662, 663 (2016) (reporting on the efficacy of Aetna's web-based price transparency tool that uses claims adjudication logic to provide real-time, personalized, episode-level estimates of patient's out-of-pocket expenses and total prices).

47 *Id.*

48 Jaime S. King, et al., *Clarifying Costs Can Increased Price Transparency Reduce Healthcare Spending*, 4 WM & MARY POLICY REV. 319, 338 (2013).

49 *Id.* ("At a time when employers are facing a number of long-term challenges, such as controlling costs, improving employee engagement and accountability, and determining how to comply with new healthcare reform legislation, price transparency initiatives targeting employers. . .have great potential to reduce overall healthcare costs.")

50 *Id.*

51 *Id.*

52 Transparency in Coverage, 84 Fed. Reg. 65464, 65464 (proposed November 27, 2019).

53 *Id.*

proposed rule closed on January 29, 2020.⁵⁴

More significantly, CMS finalized the 2020 Outpatient Prospective Payment System & Ambulatory Surgical Center Price Transparency Requirements of Hospitals to Make Standard Charges Public (the “Final Rule”), that specifically requires all U.S. hospitals to make their standard charges publicly available. CMS defines “standard charges”—or “price”—to include the following:

- the gross charge (the charge for an individual item or service that is reflected on a hospital’s chargemaster, absent any discounts);
- the discounted cash price (the charge that applies to an individual who pays with cash or a cash equivalent);
- the payer-specific negotiated price (the charge that a hospital has negotiated with a third-party payer for an item or service);
- the de-identified minimum negotiated charges (the lowest cost the hospital has negotiated with a third-party payer); and
- the de-identified maximum negotiated charges (the highest cost the hospital has negotiated with a third-party payer).⁵⁵

This information must be made available online in a “machine-readable” format and hospitals must provide an explanation for any service codes it might use, make these lists prominent on a hospital website or web portal, ensure this information is easily accessible, and update this data at least annually.⁵⁶ Hospitals are also responsible for displaying price transparency information for at least 300 “shoppable” services, defined as services that can be scheduled in advance.⁵⁷ The pricing for shoppable services will be displayed along with charges for ancillary items and services the hospitals customarily provide as part of, or in addition to, the primary shoppable service.⁵⁸

The Final Rule strives to provide consumers, employers, clinicians, and other third parties with the requisite information to make informed decisions about their health care. CMS reiterates traditional economic theories that suggest if consumers were able to have better pricing information for health care services, providers would face pressure to lower prices and provide higher-quality care.⁵⁹ According to CMS, falling prices may, in turn, expand consumers’ access to health care.⁶⁰ Particularly, CMS emphasizes that provider charge information is often either inconsistent or nonexistent, and that the lack of availability of provider charge information is one of the main obstacles limiting consumers’ understanding of price information.⁶¹ According to CMS, the Final Rule is designed to fill this information gap.

Although many commenters expressed broad support for the Final Rule, critics expressed strong concerns as to whether hospital charge disclosures would effectively reduce health care costs.⁶² Those who are skeptical about the efficacy of such an approach, highlighted the impracticalities and usefulness of displaying hospital standard charges, arguing that the disclosure of hospital charges would not sufficiently permit a consumer to determine her out-of-pocket estimate as she would need additional information from insurers.⁶³ In addition, some commenters

⁵⁴ *Id.*

⁵⁵ Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals to Make Standard Charges Public, 84 Fed. Reg. 65524, 65525 (proposed November 27, 2019) (to be codified at 45 C.F.R. pt. 180) [hereinafter Final Rule].

⁵⁶ *Id.* at 65555–57.

⁵⁷ *Id.* at 65564.

⁵⁸ *Id.* (providing examples of ancillary items and services to include laboratory, radiology, drugs, delivery room, operating room, therapy services, room and board charges, etc.).

⁵⁹ *Id.* at 65526.

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² *Id.* at 65528.

⁶³ *Id.*; Letter from Thomas P. Nickels, Exec. Vice President, Gov’t Relation and Pub. Policy, Am. Hosp. Ass’n., to Seema Verma, Adm’r, Ctrs. for Medicare & Medicaid Servs. (September 27, 2019) (on file with CMS) (highlighting that instead of helping patients estimate their out-of-pocket obligations, the Final Rule would introduce confusion and fuel anticompetitive behavior among commercial insurers in an already highly concentrated industry); Letter from Alyssa Keefe, Vice President, Fed. Regulatory Affairs, Cal. Hosp. Ass’n, to Seema Verma, Adm’r, Ctrs. for Medicare & Medicaid Servs. (September 27, 2019) (on file with CMS) (stating the Final Rule will result in hospitals diverting resources currently devoted to informing patients of their out-of-pocket costs for health care services to providing information that will be unhelpful and confusing to consumers).

raised concerns that the Final Rule would encourage anticompetitive behavior among commercial insurers in an already highly concentrated industry. Due to antitrust concerns, one commenter recommended that CMS conduct a pilot study in select markets to determine the impact of the policy on negotiated prices before finalizing the Rule.⁶⁴ Further, several commenters suggested that for consumers with health insurance, insurers should be responsible for informing and educating their members on potential out-of-pocket costs, rather than hospitals.⁶⁵

In response, CMS acknowledged the commenters' concerns that disclosure of hospital standard charges may not be sufficient "but disagree[d] that the availability of such data would be of little benefit to consumers generally."⁶⁶ Although CMS acknowledged the possibility that the Final Rule could encourage price-fixing and facilitate hospital collusion, it ultimately reiterated the standard economic theory underpinnings; holding firm to the belief that accessible pricing information will reduce health care costs by encouraging providers to offer more competitive rates.⁶⁷ CMS contended that pricing information not only benefits consumers, but also enables providers and employers to have well-informed conversations about the financial impacts of health care decisions with consumers.⁶⁸ Finally, CMS noted that the current antitrust legal framework can sufficiently address any anticompetitive practices and thus, additional testing was unnecessary prior to finalizing the Final Rule.⁶⁹

Nonetheless, the Final Rule has led to substantial litigation. On December 4, 2019, multiple hospital associations⁷⁰ jointly filed a lawsuit against HHS, challenging the Final Rule issued by CMS that requires hospitals to make their negotiated rates publicly available.⁷¹ While the plaintiffs endorse the Final Rule's stated goals of increasing health care cost information given to consumers, they argue the Rule actually frustrates these goals. Namely, they contend "[w]hen a patient chooses a hospital, what she wants to know is her out-of-pocket costs, not an insurer's 'negotiated charges'," and "there is no easy way to reverse-engineer one from the other to determine what the patient's co-payment and deductible will be."⁷² Further, the group states that the Rule is arbitrary and capricious, lacking any rational basis, exceeds the agency's statutory authority, and violates the First Amendment.⁷³

IV. PRICE TRANSPARENCY AND ANTITRUST POLICY

The administration's plan for broad implementation of CMS's Final Rule is difficult to reconcile with traditional antitrust doctrine and policy. Under the new policy, hospitals must make certain "standard charges" publicly available. This includes, the discounted cash price, the payer specific negotiated price, as well as the de-identified minimum and maximum negotiated charges. The rates negotiated between hospitals and various payers have been closely guarded information. Indeed, such data has been deemed highly confidential by health industry participants and viewed as competitively sensitive from an antitrust perspective.

Historically, antitrust agencies have challenged providers for engaging in unlawful price fixing and otherwise sharing rate and other competitively sensitive information with competitors. In fact, agreements among competitors to raise, lower, or otherwise stabilize prices have routinely been treated by the courts as *per se* unlawful under the antitrust laws. Moreover, the Department of Justice Antitrust Division ("DOJ") and the Federal Trade Commission Bureau of Competition ("FTC") have challenged the following types of conduct as *per se* unlawful under the

64 Letter from Kristi Sherrill, Chief Policy, Gov't and Cmty Affairs Officer, Baylor Scott & White Health, to Seema Verma, Adm'r, Ctrs. for Medicare & Medicaid Servs. (September 27, 2019) (on file with CMS) (encouraging CMS to establish a voluntary pilot program where health systems with mature pricing systems can opt-in to test alternative approaches to price transparency).

65 Final Rule, *supra* note 55, at 65528.

66 *Id.*

67 *Id.* at 65547 (citing to various studies concluding that one major barrier to fully understanding price variation is the lack of availability of negotiated charges to researchers and the public).

68 *Id.* at 65549.

69 *Id.*

70 This group includes the American Hospital Association, The Association of American Medical Colleges, the Children's Hospital Association, the Federation of American Hospitals, the Memorial Community Hospital and Health System, the Providence Health System – Southern California, and the Bothwell Regional Health Center. Complaint, *The Am. Hosp. Ass'n, et al. v. Sec'y of Health and Human Servs.*, No. 1:19-cv-03619 (D.D.C. filed Dec. 4, 2019).

71 *Id.*

72 *Id.* at ¶ 6.

73 *Id.* at ¶¶ 5–8 (arguing the rule runs afoul of the First Amendment by mandating speech in a manner that fails to directly advance a substantial government interest).

antitrust laws: (1) adoption and promulgation of relative value scales by medical societies or associations; (2) agreements among competing providers to establish uniform terms of sale, discount policies, or other underlying elements of price; and (3) agreements between two hospitals, through use of a common agent, to fix rates, contract terms, and conditions for the sale of various services.⁷⁴

Under current antitrust policy, “competing hospitals, physicians, and other providers who agree among themselves on the prices that they will charge for services [and] the prices that they will pay to suppliers for goods . . . expose themselves to *per se* liability for price fixing, even if they enter into those agreements for what they believe to be beneficial purposes, such as controlling costs to consumers or improving quality.”⁷⁵ As such, it would seem that the desire to make transaction specific data available to consumers needs to be carefully balanced against the goals of antitrust law to ensure that the disclosure of such data will not inadvertently cause prices and the cost of health care services to continue to rise.

While greater access to information is certainly viewed as important and beneficial for health care consumers, the FTC has previously noted that “[t]oo much transparency can harm competition in any market, including in health care markets.”⁷⁶ In weighing in on a Minnesota legislative proposal to disclose the terms of Minnesota’s public health care services contracts, the FTC stated:

Typically, health care providers (hospitals, outpatient facilities, physician groups, or solo practitioners) compete against each other to be included on a health plan’s list of preferred providers. When networks are selective, providers are more likely to bid aggressively, offering lower prices to ensure their inclusion in the network. But when providers know who the other bidders are and what they have bid in the past, they may bid less aggressively, leading to higher overall prices.

We believe it is possible to give consumers the specific kinds of information they need to make better health care choices, while avoiding broad disclosures of bids, prices, costs, and other sensitive information that may chill competition among health care providers. Striking the right balance and mitigating the risk of harm to the competitive process, requires careful fine-tuning of transparency laws and regulations. As with all things, details matter.⁷⁷

The federal antitrust agencies are not broadly opposed to the provision of fee-related information by competing health care providers to purchasers of health care services. From their perspective, the collective provision of fee-related information may yield certain procompetitive benefits stemming from an increase of information in the health care marketplace.⁷⁸ They caution, however, that such procompetitive benefits may not be realized if such information is shared without adequate safeguards in place. In Statement Five of the Health Care Statements, in order to “ensure that an exchange of price or cost data is not used by competing providers for discussion or coordination of provider prices or costs,”⁷⁹ the DOJ and FTC recommend that:

1. the collection and assembly of the fee-related information be managed by a third party (e.g. a purchaser, government agency, consultant, academic institution, or trade association);
2. while current fee-related information may be provided to purchasers of health care services, any information that is shared among or is available to competing providers furnishing the data must be at least three months old;
3. for any information that is available to the providers furnishing the data, there are at least five providers reporting data upon which each disseminated statistic is based;

74 Christine L. White, ET AL., *AHLA ANTITRUST AND HEALTH CARE: A COMPREHENSIVE GUIDE* § 2-2(c)(1)(i) (2d ed. 2017).

75 *Id.*; When the Pharmaceutical Manufacturers Association submitted a request to the DOJ to implement a program under which member companies would agree not to increase prices faster than the rate of inflation in order to help curtail the rise in drug prices, the DOJ denied the request, noting that such conduct would be *per se* unlawful. Letter from Anne K. Bingaman, Assistant Attorney Gen., Dep’t. of Justice Antitrust Div., to John R. Ferguson, Esq., Swidler & Berlin (Oct. 1, 1993) (on file with author).

76 Tara Isa Koslov & Elizabeth Jex, *Price Transparency or TMI?*, FED. TRADE COMM’N (July 2, 2015, 2:31 PM), <https://www.ftc.gov/news-events/blogs/competition-matters/2015/07/price-transparency-or-tmi>.

77 *Id.*

78 U.S. DEP’T JUSTICE & FED TRADE COMM’N, *STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE* (1996) STATEMENT 5.

79 *Id.*

4. no individual provider's data may represent more than twenty-five percent on a weighted basis of that statistic; and
5. any information disseminated must be sufficiently aggregated such that it would not allow recipients to identify the prices charged by any individual provider.⁸⁰

Economic research supports such an approach, particularly in concentrated markets. Hypothetically, when a “well-regarded hospital contracts with two insurers and offers a lower price to Insurer 1 because otherwise Insurer 1 would steer patients to a different institution,”⁸¹ if the hospital was required to adhere to a transparency rule that required the publication of its negotiated rates, the hospital would be “less likely to offer the low price to Insurer 1, because Insurer 2 would then pressure the hospital to lower its price as well.”⁸² As noted by economists Cutler & Dafny, publication of negotiated rates “would create a perverse incentive for the hospital to raise prices (on average), and as a result, its rivals could do the same.”⁸³

For many of these reasons, states that have already adopted and implemented price transparency initiatives have done so by adhering to certain safeguards designed to maximize the procompetitive benefits of the disclosure, while preventing the ability for such data to be used anticompetitively. “[T]o prevent potential anticompetitive use of the data, all states, to varying degrees, limit data release to specific data elements, entities or purposes.”⁸⁴

The Administration should revise its price transparency guidelines accordingly. Doing so is the best way to ensure that U.S. consumers benefit from increased information in the health care sector without being harmed by potential anticompetitive effects that could result from the dissemination of competitively sensitive data in the absence of safeguards.

V. CONCLUSION

While the goal of seeking to provide consumers with price information is laudable, it is important to ensure that the information disclosed will, in fact, help consumers make the necessary cost-effective health care decisions they need. The wholesale disclosure of sensitive data that (1) is not designed to maximize the decision-making process of consumers, and (2) is not likely to be used by consumers when making critical decisions, yet (3) can be used effectively by competing providers to reduce and/or eliminate price competition, is unlikely to have an appreciable short-term effect on stifling the rising cost of health care in the U.S. In other words, the risk of the anticompetitive use of such sensitive data does not justify the theoretical benefits of the wholesale disclosure of price information without safeguards —especially when studies show consumers may disregard, or simply, not utilize the data provided.

As noted by the FTC, information sharing and exchanges among competitors without the use of proper safeguards, particularly when the information shared involves specific prices or cost data, may have an anticompetitive effect. The impact of such effects is expected to be more severe in markets that are highly concentrated. “Other things being equal, the sharing of information relating to price, output, costs, or strategic planning is more likely to raise competitive concern than the sharing of information relating to less competitively sensitive variables.”⁸⁵ A common refrain in antitrust jurisprudence notes that direct exchanges of information among competitors may serve as a vehicle for providers to fix prices, allocate markets, or otherwise restrain competition.⁸⁶

⁸⁰ *Id.*

⁸¹ Gudixsen, *supra* note 35, at 11; David Cutler & Leemore Dafny, *Designing Transparency Systems for Medical Care Prices*, 364 *NEW ENG. J. OF MED.* 894, 894 (2011).

⁸² Gudixsen, *supra* note 35, at 11.

⁸³ *Id.*; Cutler & Dafny, *supra* note 81.

⁸⁴ Gudixsen, *supra* note 35, at 17.

⁸⁵ U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, *ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS* 15 (2000).

⁸⁶ *Id.* at 15–16.

Ultimately, unless a more tailored approach is adopted that appropriately employs antitrust safeguards, it is simply not possible for price transparency initiatives to effectively consider all stakeholders' interests in a way that simultaneously benefits them as health care consumers. Rather, the best approach may be to first implement transparency for those stakeholders that are in the best position to take advantage of that information (e.g. employers), followed soon thereafter by initiatives that help other stakeholders as well. If antitrust principles are ignored while crafting price transparency guidelines, the implementation of the rules, as proposed, may cause provider rates to increase to the detriment of consumers.



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