



The Our American States podcast—produced by the National Conference of State Legislatures—is where you hear compelling conversations that tell the story of America’s state legislatures, the people in them, and the policies, process and politics that shape them.

You can subscribe through iTunes, Google Play, Stitcher or Spotify.

### Shining a Light on Health Care Prices | June 7, 2021 | OAS Episode 132

Ed: Hello and welcome to “Our American States,” a podcast from the National Conference of State Legislatures. This podcast is all about legislatures: the people in them, the policies, process and politics that shape them. I’m your host, Ed Smith.

*“I think the number one beneficiary of greater price transparency is American employers. They provide health insurance coverage to 150/160 million people. It’s the largest single block of the population with a single type of coverage. And we know that health care costs are slowly strangling and suffocating American businesses and their employees.”*

That was Niall Brennan, the President and CEO of the Health Care Cost Institute, a nonprofit that focuses on data to analyze key issues affecting the U.S. health care system. Brennan, who previously was Chief Data Officer for the Centers for Medicare and Medicaid Services, is my guest on the podcast.

There’s an increasing focus at the state and federal level on policies to require greater cost transparency in health care. While there’s debate about how effective these policies are, the goal is to allow comparison shopping on the part of consumers and employers with the aim of controlling the increasing cost of health care.

Brennan discusses the pros and cons of price transparency, examples of where it’s been effective, and his skepticism about the individual consumer’s use of the information. He also shares some surprising examples of price variation for the same medical procedure in the same area, even in the same hospital group.

Niall, welcome to the podcast.

Niall: It's great to be here. Thank you for having me.

*Time Marker (TM): 02:05*

Ed: First, thanks for taking the time to discuss this rather complex topic. I wonder if you could start by just explaining what price transparency is in the health care market and who it's intended to benefit.

Niall: I think price transparency means a lot of different things to a lot of different people and I think the drive for price transparency in recent years is rooted in the very real angst and sense of helplessness that people have in the face of inexorably rising health care costs.

I think people feel that we've tried a whole bunch of solutions over a 10 or 15 or 20 year or even longer period, and yet the only constant is that health care costs continue to rise. So, what we do know is that one of the reasons that health care costs are rising so relentlessly, it is price; it's not that Americans are necessarily consuming more health care. It's that each unit of health care that they consume is costing more from year to year, whether it's a drug or hospitalization or a doctor visit or whatever it may be.

There is also significant variation in prices, so one hospital in a city might charge \$45,000 on average for a C-section and another hospital might charge \$10,000 in the same city. Well, wait a second – that doesn't make any sense, right? So, I think the desire is if we uncover these prices and have a conversation both around the prevailing level of these prices, is it okay that this costs this much, period, and then also a conversation around: How on earth can we have 2, 3, 4, 5, 6, 10-fold variation in prices for the same service in the same city for the same population demographic, that in some way that might lead to downward pressure on prices?

I think where it has started to get a little bit muddled and confused is some people view price transparency as a very consumer-focused and consumer-empowering phenomenon and they believe if prices are made transparent, that people will take it into their own hands and shop for health care like they'd shop for a TV or shop for a car.

I personally pretty profoundly disagree with that thesis. So, I think that price transparency is very important, but if you frame price transparency as solely being something that consumers are expected to react to and that is what will drive health care prices down, I think you're going to be disappointed.

*TM: 05:17*

Ed: Well, that makes a lot of sense. I think very few of us as individuals do price comparison shopping on medical procedures. So, let's set individual consumers aside. Who else can benefit from price transparency and how is that price information used by people other than consumers?

Niall: I think the number one beneficiary of greater price transparency is American employers. They provide health insurance coverage to 150/160 million people. It's the largest single block of the population with a single type of coverage. And we know that health care costs are slowly strangling and suffocating American businesses and their employees. Right?

So, you can set away the consumer angle, but consumers can still benefit from price transparency if employers can in some way act on these prices being exposed to say: You know what? This is crazy. We're not going to continue to offer a benefit package that includes a hospital that's 50% more expensive than every other hospital in the area. We'll either take that hospital out of our network or maybe we'll engage in some constructive discussions with the hospital, showing them how far out of whack they are, or maybe we'll publicly embarrass them and see if that will cause them to lower the prices.

If that happens, I think it has the potential to have massive positive ramifications and stop health care costs being this giant millstone around the neck of American employers and employees.

*TM: 07:10*

Ed: So, how would that use of price transparency affect my health care costs? Would it lead to lower premiums or lower copays?

Niall: Yeah, exactly. When your employer prices your benefit package, they work with experts and those experts look at the number of employees that an employer has and do some modeling and say well, based on the demographic characteristics of your population and if you want them to have access to every hospital in the area, we think the price is going to be this.

So, if that includes hospitals or providers that are particularly expensive, that's baked into the premium price. If you take them out of the network, that will have the effect of lowering premiums. And people have done it and it is quite effective.

I think where the challenge lies is that, historically, health care coverage is viewed as a perk of employment. Really, we've been fortunate for the last 10 or 20 years that apart from occasional dips, the employment market has been pretty tight; unemployment has been low. And so, I think a lot of employers have been afraid to be the employer that says: I'm going to give you health insurance coverage, but it's only going to, again, cover 10 of the 15 hospitals in the area because it's viewed as a perk, and I think they're worried that they'll lose employees who are like: Americans love choice.

And they're worried that they're going to lose employees who are going to say: Well, I have a choice between employer A and employer B. Employer B is offering me a more generous health care package and I'm willing to pay that little bit extra in premium to have the greatest choice that I want. So, it can be difficult to do this and communicate this in a way that makes sense sometimes to employees.

*TM: 09:08*

Ed: You mentioned that this access to pricing has been used in some areas. How has it worked in places where they've tried this?

Niall: It has had mixed success. There have been a lot of efforts at price transparency, and we can talk later... I'm sure we will... about some of the new federal efforts. There have been a lot of state

efforts at price transparency. There are price transparency websites in Florida and Maine and New Hampshire. Honestly, the evidence has been mixed because, again, consumers don't really use these things.

Now, at the opposite end of the spectrum, my favorite example of this is the 32BJ Fund. It's a health insurance fund in New York that covers mostly low-income workers: office cleaners and maintenance people and things like that in the skyscrapers in New York. And the woman who runs that fund, Sara Rothstein, she took all the data and basically laid it all out and said: Well, we pay for 1,000 berks (??) in New York City every year.

And so, she could look at every hospital and what hospital was driving the overall price tag and not only was the most expensive hospital the most expensive hospital; it also had the highest rates of episiotomies and C-sections and different things like. So, not only was it the most expensive; it was actually bad for her employees or the people that she has an obligation to provide health insurance coverage to.

So, she took it, again, to these low-income workers who maybe are slightly more elastic in their demand or slightly more responsive to price signals and she said: Look, if we carve these two hospitals or this hospital... I can't remember the specifics... if we carve them out of the network, not only do you save money; the quality of your childbirth experience is going to improve.

We need a thousand Saras all across America to start doing that. And, again, it's one procedure in one city in the United States, but it did work. But it also shows how far we have to go because there are so many procedures and so many people. So, baby steps.

*TM: 11:45*

Ed: You mentioned the federal government has taken some action in this area. Can you talk about what that action is and how it has worked?

Niall: Yes. So, a couple of years ago... you might even be able to trace this back to seven or eight years ago when I was in the federal government. Prior to being at the Health Care Cost Institute I was chief data officer at the Centers for Medicare and Medicaid Services, which runs the Medicare/Medicaid programs in the United States.

We somewhat innocently and innocuously released the average charge for the top 250 hospital discharges. Now, bear in mind that the charge is based on a hospital charge master, which is mythical, not really reflective of what actually happens in real life. So, charge master is the amount that a hospital would love to charge a Saudi Arabian prince if they needed care at the hospital. Nobody actually pays the charge master, but it's the benchmark against which the other negotiated rates are calculated. And, again, massive variation in hospital charges.

So, we put out this file and overnight it became frontpage news in every newspaper and every television station in American, again, just talking about these crazy variations in charges for the same service. So, that was probably the beginning of it from a federal level.

Two or three years ago the Trump administration then proposed requiring that hospitals release their negotiated rates for certain services, and they have to release negotiated rates that they

had with every insurer. So, again, the average hospital is probably doing business with 15/20/25 health insurers depending on where they are and how competitive the insurance market is.

Bottom line, that law came into effect on January 1 of this year and compliance has been underwhelming to say the least. Now, first of all, the onus was on the hospitals – they had to put this information on their website. It didn't tell them where on their website. It didn't really tell them how consumer friendly it had to be. It didn't tell hospitals a standard of how to release the data. So, it's really hard to find the information.

And so, my organization and other researchers started looking for it. Our best estimate is about 25 to 30% of hospitals have complied with this legislation to release their negotiated rates with insurers.

Now, when it works, it's really kind of illuminating. Sutter Health, which is an 18- or 20-hospital system in the Bay area, Sutter Health has 223 different prices for C-sections. In my presentations I literally have a slide that says: Why does an 18-hospital system have 223 different prices for C-sections? It's completely inconceivable and unjustifiable, but this is where we are as a health care system.

And here's the thing: Sutter is being punished for complying with the regulation because people like me are highlighting the absurdity, and yet there are 50/60/70% of the hospitals which don't appear to be publishing the information, but the Wall Street Journal analyzed hospital websites and found that they had suppressed code that allowed for these datasets to be findable via Google or other search engines. So, they were on the website, but they weren't indexable in a Google search.

And then the final thing I'd say is the penalty for not complying with these new price transparency disclosures is \$300 a day, which, if you're a multi-billion-dollar... multi-hundred-million or multi-billion-dollar in some cases hospital system, pay the fine like a gentle person and then move on. It's a cost of doing business.

Ed: Niall, thanks. We're going to take a short break and then come back with the rest of our discussion.

MUSIC and Gene VO:

NCSL's 50-State Bill Tracking Database makes researching legislation quick and easy from agriculture to vaping and everything in-between. Simply select your topic, bill status or keyword to learn about legislation across the country. Visit our website at [nctl.org](http://nctl.org) and put the words state and tracking in the search bar or go to the research tab and select bill tracking. Let the 50-State Bill Tracking Database work for you. Try it out today.

*TM: 16:56*

Ed: I'm back with Niall Brennan. So, before the break you were talking about a regulation on price transparency from the Trump administration. Now we're dealing with the Biden administration and I wonder what your sense is of their enthusiasm for following up on this.

Niall: Right now, in the current political landscape, price transparency is sort of one of those motherhood and apple pie things where it's very hard to say you're against price transparency. I think it's too early for details. The Biden administration has been much more focused on rolling back other aspects of the Trump administration's priorities around Medicaid and Obamacare and different things like that.

I'm not sure that price transparency is at the top of the to-do list, but I also would be surprised if they took meaningful steps to roll it back in any way. It's not a good look. My guess is, and I could be wrong, that they will continue with the hospital price transparency regulations. I did read last week that they have sent warning letters or have started communicating with hospitals that don't appear to be complying, and I expect them to finalize the insurer price transparency plans that take effect in early 2022.

*TM: 18:27*

Ed: Well, it sounds like a little more motivation might be needed to make those hospital systems comply with that regulation.

Let me switch over to states. Most of our audience is state legislators, legislative staff and other state policymakers. So, what kinds of actions can state policymakers take around price transparency, and do they have some agency here?

Niall: They certainly do. As I noted earlier, there are several states which have engaged in price transparency efforts: Florida, Maine, New Hampshire, Colorado. I'm sure I am leaving out many great state price transparency efforts.

I think that states can also use the information that's publicly available now. There's nothing to stop a state from downloading and analyzing to the best of their ability these new federally required... (sounds like "slosures" ??) from hospitals. Maybe it will help the states, or they can aggregate it or analyze it in some way.

And then another big push for states in general is many states have created or are planning to create what are called "all-payer claims databases" that mandate insurance companies that do business in the state to give a state agency or a designee of a state agency all the health care claims for people who live in the state.

And that is actually a much more comprehensive and robust step along the road to greater transparency because if a hospital publishes its price for a specific service, all you have is the hospital's price for a specific service. You don't know how many people used the expensive health plan, getting a bad deal from the hospital, versus how many people used the health plan getting the good deal from the hospital.

You don't know if the person who went to the hospital required three months of physical therapy after they left the hospital or two weeks of physical therapy after the hospital. What an all-payer claims database does is helps you start to answer questions like that and really understand in totality what is going on with health care spending in your state.

*TM: 20:50*

Ed: We know the COVID-19 pandemic and response strained state budgets. As legislators focus on economic recovery, could price transparency initiatives help reduce health care costs to states?

Niall: Yes. There's no doubt that many state budgets are under some duress at the moment. I think it sort of depends on the outlook of the state. There is genuinely an affordability problem as it relates to health care generally in every state. States have direct responsibility for the Medicaid programs in their states and so Medicaid generally pays the lowest prices for services and states have kind of a take-it-or-leave-it approach.

So, I'm not necessarily sure that price transparency helps them from a Medicaid perspective. But I think price transparency absolutely helps states negotiate better deals for their state employees and teachers and firemen and policemen and women, etc., etc. So, I think there are steps they can take.

And then, more broadly, it affects American competitiveness. So, if an employer leaves a state and takes jobs overseas, one of the reasons they're doing that is because health care has become such a significant part of overall compensation and they don't have to deal with funding and paying for that in other countries.

*TM: 22:31*

Ed: Still thinking of those state policymakers, are there any resources you'd recommend for legislators for their education or to share with their constituents?

Niall: That's a great question. I do think that there are organizations like mine, the Health Care Cost Institute, in serving my obligatory promotional plug, that certainly help states, state legislators and the general public understand how their state and how areas in their state rank in terms of overall health care spending. That's price transparency in and of itself.

You can go to the Health Care Cost Institute website and you can see state and sub-state estimates of hospital inpatient, hospital outpatient, physician and prescription drug spending and it's all presented in a way that's super intuitive. And you can ask yourself: Well, wait a second... Why is our state the most expensive state in the country for hospital outpatient care? Or why has hospital inpatient care spending increased by 40% in Boise, Idaho over the past five years?

And I think those are really important questions to ask. Unfortunately, the answer to my hypothetical Boise, Idaho question is probably because three hospital systems became two, became one, and when there's a monopoly, you can extract significant pricing concessions from people seeking to buy your services.

*TM: 24:16*

Ed: I'll be sure to share your website along with other resources when this podcast is posted on ncsf.org. Niall, before we wrap up, is there anything else you'd like to share with our listeners?

Niall: I think it's a really important issue area, price transparency in general. I think that people should maybe be a little bit patient and give it a chance. It's something that's been talked about for a long time, but we're only starting to scratch the surface of truly actionable information getting out there in the ethos.

And so, once it's out there, I think it's really important for people to say: Why? How have we gotten to a stage where it's okay for emergency room prices to increase by 100% in a six-year period? Why is it acceptable that when the Health Care Cost Institute analyzed health care spending in 112 different metropolitan areas, that spending increased more than the rate of inflation in 111 of those areas?

I do think we're at a little bit of a crunch time. I worry that employers will start to radically scale back their benefit packages or stop offering health care at all. There are, I think, steps that we can take to try to avoid that.

Ed: Niall, thanks again for walking us through this complex topic. I know I have a better grasp of the issue after listening to you explain it. Take care.

#### MUSIC

Ed: And that concludes this edition of our podcast. We encourage you to review and rate our episodes on iTunes, Google Play or Spotify. You may also go to Google Play, iTunes or Spotify to have these episodes downloaded directly to your mobile device when a new episode is ready. For the National Conference of State Legislatures, this is Ed Smith. Thanks for listening and being part of "Our American States."