SUMMARY REPORT:

MEETING ON TRANSPARENCY IN HEALTHCARE COSTS AND QUALITY

CONVENED BY THE HEALTH SERVICE SYSTEM OF THE CITY AND COUNTY OF SAN FRANCISCO

OCTOBER 1, 2015

Background

The Board of Supervisors Resolution 271-14 (file number 140788) recommended that the Health Service System (HSS) work towards the achievement of a more transparent health system. One of the specific recommendations of this resolution was that the HSS convene a transparency advisory group to outline a framework for a transparent healthcare system in San Francisco and potentially across the Bay Area.

In response to the Board of Supervisors' recommendations, the HSS convened a meeting of experts on healthcare transparency on October 1, 2015. In preparation for the meeting, the HSS distributed a set of background materials concerning transparency in general, and the specific features of the HSS's context in order to provide a common frame of reference (all of these documents are included as appendices to this report).

"Transparency" in healthcare has multiple dimensions, or components. Thus, one of the objectives of the meeting was to establish definitions of transparency in healthcare costs and quality. The HSS also proposed several possible courses of action for the achievement of greater transparency at the local level and at the state level, and sought panelists' input on these strategies.

Going into the meeting, the HSS had the following potential courses of action in mind (as articulated in the Background and Meeting Objectives document):

1. Introduce legislation similar to California government code § 22854.5 which allows CalPERS to obtain data on cost, utilization, actual claim payments, and contract allowance amounts from the plans they contract with, and deems this data confidential trade secret information, exempt from the California Public Records Act, and protected by HIPAA and CMIA.
2. Keep moving forward with the HSS all-payer claims database (APCD).
3. Continue to put pressure on Sutter Health to be transparent in their contracting until state laws which compel them to do so are passed.

The discussion of these options, along with related matters and possibilities, will be summarized in this report.

Meeting participants and attendees

Meeting participants included Andy Bindman of UCSF; Andréa Caballero of Catalyst for Payment Reform; Marina Coleridge of HSS; Catherine Dodd of HSS; Mark Farrell of the San Francisco Board of Supervisors; Jaime King of UC Hastings; Chris Miles of Aon Hewitt; Marie Murphy of HSS; Erik Rapoport of the CCSF Attorney's Office; Paige Sipes-Metzler of Aon Hewitt; Kristof Stremikis of the Pacific Business Group on Health. Attendees included Larry Bradshaw of SEIU 1021; Rebecca Rhine of the Municipal Executives Association; Bob Muscat of Local 21; Michael Seville of Local 21; Pamela Levin of HSS; Amara Malik of

HSS; Amy Willis of SEIU Local 1021; Randy Scott of the Health Service Board; Wilfredo Lim of the Health Service Board; Karen Breslin of the Health Service Board; Catherine Stefani of Supervisor Mark Farrell's office.

Structure of meeting

After welcoming and introductory remarks from HSS Director Catherine Dodd and Supervisor Mark Farrell, Andréa Caballero gave an overview presentation of price transparency (see Appendix B). Then Chris Miles presented examples of price and quality transparency and what it takes to get there, along with hurdles to transparency in California and possible approaches to those hurdles (see Appendix C). Marina Coleridge then reported on the status of the HSS APCD (see Appendix D), and Catherine Dodd summarized the HSS key relationships (see Appendix F). Following these presentations, the general discussion among participants commenced. The meeting lasted three hours.

Preface: making sense out of "transparency," and other general points

Theoretically, the concept of transparency in healthcare costs and quality is straightforward. Within a "transparent" healthcare environment, data on the costs of healthcare services and the quality of healthcare services (measured in terms of outcomes, such as readmission rates, average length of hospital stays, patient experience metrics, etc.) are readily available, and purchasers of health insurance and individual consumers of health insurance can make informed decisions based on this information. In practice, data on healthcare costs and quality are difficult to obtain for a host of reasons, making the achievement of transparency in healthcare very challenging. This is problematic because in the absence of transparency, it is difficult to contain the cost of healthcare, which threatens the ability of the HSS to offer comprehensive employee benefits – and thus, threatens the ability of the City and County of San Francisco to attract and retain high caliber employees.

Several points about the relationship between transparency and cost containment are important. First, although transparency and cost containment are sometimes closely related, and/or have a reciprocal relationship, they are distinct and may not always occur together. In some instances, cost containment may be possible in the absence of greater transparency, and thus may be very worthy of pursuit in the short term even if greater transparency is not achieved at the same pace. On the other hand, it may also be important to pursue measures that promote heightened transparency, even if they do not provide an immediate payoff in terms of cost containment.

In addition to demonstrating the complexity inherent to these issues, the meeting made clear that carefully considering the broader causes and consequences of strategies designed to promote or achieve transparency is essential. Some strategies that might seem like attractive options may hold the potential for unintended consequences to arise later on – including, for example, obtaining trade secret protection for health plans' data in a manner similar to CalPERS (this particular point will be discussed in greater detail later in the report).

Summary of content of discussion

After the opening presentations, the discussion did not follow a strictly prescribed course, and the conversation covered an array of topics and sub-topics which were addressed iteratively. The following summary distills the key points from these discussions without attempting to situate them within a cohesive, overarching narrative arc.

The HSS APCD

The HSS APCD was created as part of HSS's overall effort to contain costs and keep our healthcare system sustainable. Hosted by Truven Health Analytics, the APCD went live in October 2015. The HSS APCD will help HSS compare cost and utilization across its health plans and will inform the wellness program's strategies. HSS hopes its wellness program initiatives can be truly preventative, by preventing costly conditions from developing in the first place, or from becoming as costly as they might otherwise.

One of the challenges associated with the HSS APCD is obtaining the data that is needed to populate it. (This is of course symptomatic of transparency challenges everywhere. Legislation does not compel health plans to share their data, and if providers have substantial market power, there is little incentive for them to share price information.) It has been difficult for HSS to obtain the data that it has from the plans, and some of what HSS has is incomplete or not populated. HSS only get summary claim announcements from Sutter; it receives a total dollar amount per quarter and then a separate statement of utilization data. Thus HSS is not able to draw links between particular services and particular costs. Sutter is the worst of the HSS plans in terms of detail, but the data received from our other plans also leaves much to be desired.

Proxy pricing is a possible workaround for these data availability challenges, but developing a system of proxy pricing would require additional funding. Although Truven provides the advantage of a market scan database which allows for benchmarking price data, it does not offer a Northern California-specific benchmark. This is important because the healthcare market in Northern California is relatively unique; comparing HSS data to Northern California data is far more meaningful than comparing it to other benchmarks, such as the Southern California market (which Truven does offer). Although developing a Northern California-specific benchmark is not impossible, it would require additional funding. It is also important to keep in mind that while these sorts of benchmarks could help HSS identify dollar thresholds to inform reference pricing strategies, price information alone may not necessarily enable HSS to negotiate better prices with its health plans.

During the meeting, participants made a number of recommendations concerning the HSS APCD. Defining the objectives of the APCD and basing short-term strategies for the use of the APCD on a well-thought-out vision of the APCD's long-term purposes and impact was considered important. The HSS was urged to understand the angles of the various stakeholders, and to make clear to stakeholders what's in it for them to engage with (e.g., submit data to) the APCD. Knowing the data really well and ensuring that it is both correct and used appropriately was also emphasized. This includes packaging the data appropriately for distinct groups of stakeholders, and ensuring anti-trust oversight as there are legitimate concerns to be had about the availability of price information leading to collusion among providers. To this effect, it was also suggested that any APCD-related legislation include a provision granting state action immunity to the entity running the APCD for any kind of collusion claims.

Price transparency may enable cost containment

The discussion of APCDs included comments that were specific to the HSS APCD, and comments that pertained to other APCDs. Some APCDs have client-facing portals which allow patients to shop for health care services by looking at the cost and quality of services offered by providers. Some studies show that patients will indeed make use of cost and quality data, if they are available, to shop for

services that are considered "shoppable" – services that can be anticipated and researched in advance, such as tests/scans, joint replacements, and childbirth. For patients to change their healthcare utilization practices, the information that they have access to needs to be patient-specific, provider-specific, and plan-specific. Some studies suggest that patients need to be incentivized to make use of price information.

However, price information on shoppable services is likely to have less of an impact on patients who are only responsible for a copay and who do not have high deductibles, if they have a deductible at all – and this is exactly the situation for most HSS members. (In addition, most HSS members currently do not even see the dollar amounts associated with the care they receive on their explanation of benefits documents. It is at best extremely difficult for members to become aware of the costs of the services they utilize, whether before or after care has been obtained.) Finally, it is important to note that many healthcare needs cannot be anticipated and shopped for in advance. Thus, while enabling patients to shop for services may be a valuable component of a broader cost containment strategy, it should not be considered a keystone element of such an initiative.

There is evidence that suggests that when providers have price information, they will alter their practices. They may adjust their own rates if they find their pricing is out of step. They may alter their referral practices based on their knowledge of other providers' performance on quality indicators, and how much they're charging. Better data will also help doctors gain a more comprehensive understanding of what is happening with their own patients, which may lead to cost reductions and improved health outcomes.

Currently, the HSS APCD does not have member-facing or provider-facing portals, but might try to develop them in the future. Patients would ideally be able to access information that would allow them to shop for some of their health care services – and access information that would allow them to become more informed about the costs of healthcare and the impact of their utilization patterns. Although patient education may never be the paramount driver of cost containment, HSS firmly believes that educating members about the costs of health care and empowering them to become knowledgeable consumers of health care is one component of engendering a more sustainable healthcare system. And as suggested in the meeting, giving providers access to price and quality data will hopefully lead to more informed decision making on their end, leading to better patient outcomes in terms of both quality and cost.

Starting in Q2 of 2016, the APCD will enable the HSS to calculate risk scores, which can help with rate setting and with establishing targets within ACO risk sharing models. In the future, HSS also hopes to use the APCD to quantify costs associated with unnecessary care. In addition, HSS would like to leverage the APCD to support California state policy initiatives, such as the reduction of opioid use by analyzing prescribing practices across providers and reviewing medication adherence as well as number of medications at the patient level (patients would be de-identified, of course). This would entail working with the health plans via feedback mechanisms.

<u>Strategies for obtaining data which is currently unobtainable</u>

Legislative approaches

Barring any unforeseen developments in the healthcare arena, legislative change will be necessary to compel health plans to release data that they currently do not share. One key recommendation that emerged from the meeting was that HSS should pursue 'public interest' or 'public good' exemptions to the trade secret protections that plans have relied upon to avoid sharing price information. Going into the meeting, HSS had suggested the strategy of seeking an expansion of Chapter 698 of § 22854.2 of government code which allows CalPERS to get data on cost, utilization, actual claim payments, and contract allowance amounts; meeting participants discouraged the pursuit of this strategy. If HSS were to enter into an agreement that granted trade secret protection, this would further entrench the belief that healthcare data are deserving of trade secret protection. Doing this might be detrimental to the HSS's long-term efforts to achieve a more transparent health system, and might also be used as precedent in future cases. Although health plans have used the trade secrets protection to their advantage as a justification for not sharing data, this was never the intended purpose of the doctrine of trade secret protection. Thus, a public good exemption from trade secret protection has more potential to both meet short-term transparency needs and create a better legal climate for the future than would obtaining an expansion of Chapter 698 of § 22854.3.

Colorado and New Hampshire have already successfully marshalled the argument that price information needs to be disclosed for the public good, and Maine and Vermont have successfully defended challenges to their provision of price data by justifying their "release for the public good." In California, the opportunity to do this would come through a rewrite of Senate Bill 26 (which pertains to establishing the California healthcare cost and quality database). Working with the Bill's sponsor, Senator Hernandez, to incorporate a clearly defined objective of making health care costs and quality transparent for the public good may be a strategy worth pursuing.

The trouble with this strategy is that Senate Bill 26 suffers from a lack of funding. Senator Hernandez's office estimates that creating California's APCD could cost between $18 - 40 million, and thus far, federal grant requests have been denied. Nor is it likely that this funding will become available from the California state budget anytime soon.

Moving to a self-insured model

There was discussion during the meeting of the opportunities that having all HSS plans be self-insured would present for accessing data. Boeing serves as a great example of how going self-insured can work out well. They have had tremendous success in negotiating direct contract arrangements at a global cap level, with terms of their specifications. During the meeting it was noted that Boeing is well adapted to the risks associated with being self-insured, but the discussion did not delve into the specifics of how they bear these risks.

The reason HSS has not adopted a self-insured model for all of its plans is because of the cost. Self-insured plans cost more than managed care plans, because of the absence of care management. If it were possible to integrate some sort of care management component into self-insured plans, this might be an option worth pursuing, but the financial risk associated with going self-insured is formidable and thus this may not be a desirable strategy.

(Continue) seeking contractual provisions that require full price transparency as a condition of doing business

In the absence of legislative changes that compel insurance companies to share data, contractual provisions that require full price transparency as a condition of doing business could be a way to obtain data from fully-insured plans. In the past, these contractual provisions have been difficult for HSS to obtain. In a context where market power is concentrated, as it is within the San Francisco Bay Area, plans may include gag clauses or most favored nation clauses within their contracts – and whether providers or health plans are to blame for these arrangements depends on who you ask. Either way, the issue has been the market power held by the plans and providers.

In response to this challenge, meeting participants emphasized the extent to which the HSS as a major purchaser of health care should recognize and wield its purchasing power in order to demand contractual provisions that grant data. Teaming up with the Pacific Business Group on Health and/or other big employers in the area might make this approach a more viable option. Doing this could be an uphill battle with undesirable political repercussions, but the purchasing power that the HSS has should be regarded as a valuable bargaining chip. Catalyst for Payment Reform is available to offer support within contract negotiations.

Dealing with Sutter

Sutter's market dominance in the Bay Area creates a host of problems. Sutter would like to contract directly with HSS, and they would initially come in low – however, this would not in and of itself solve the problem of obtaining data more detailed data from them. Furthermore, contracting directly with Sutter would reinforce Sutter's market dominance, which is not desirable.

Theoretically, HSS could design plans with narrow networks that exclude Sutter in order to drive members out of Sutter (by compelling members to pay more if they wish to stick with Sutter), but again, Sutter's market dominance in the Bay Area makes this a difficult proposition to pursue because the non-Sutter options in some areas are extremely limited.

Pending legislation

California Senate Bill 26 is currently being held on suspense in the Senate Appropriations Committee. Senator Hernandez's office hopes to get it out with some modifications that could help with the cost estimate, but they are not sure if this will be possible.

An amended version of California Assembly Bill 463, Pharmaceutical Cost Transparency Act of 2016, sponsored by Assemblymember David Chiu, was scheduled to be voted on by the Assembly Health Committee on January 12, 2016. This bill is thought to be the first legislative attempt of its kind in the United States.[1] It would require prescription drug manufacturers to file a report with the Office of Statewide Health Planning and Development (OSHPD) on the costs associated with the development of pharmaceutical drugs which cost $10,000 or more annually or per course of treatment. Originally introduced in 2015, the Bill drew staunch opposition from the pharmaceutical industry, which led to it being shelved. Pharmaceutical industry representatives claimed that some of the costs associated with

[1] George Lauer. "Drug Price Transparency Bill Shelved in California, Push Continues." California Healthline, May 7, 2015. http://www.californiahealthline.org/insight/2015/drug-price-transparency-bill-shelved-in-california-push-continues

drug development are hard to quantify, and that compiling the data would be burdensome.[2] The amended Bill would require OSHPD to maintain the confidentiality of any information submitted by a prescription drug manufacturer pursuant to those provisions that the director of the Office deems to be confidential and proprietary. The amended Bill further stipulates that this confidential proprietary information is exempt from disclosure under the California Public Records Act, and that in order to protect the integrity of the competitive market, the public's right of access to this information will be limited. Assemblymember Chiu pulled the Bill from consideration on January 12 at the Assembly Health Committee Meeting because he did not have enough votes to pass the Bill through the Health Committee.[3] According to Assemblymember Chiu's staff, the pharmaceutical industry is still putting up formidable resistance to the Bill - despite the revisions that were made.

Transparency of pharmaceutical drug pricing is a different issue than transparency of healthcare costs and quality, in many respects: unlike in healthcare, the prices of pharmaceutical drugs are known. The transparency issue is not the prices themselves, but the processes by which they are determined. While pharmaceutical drug prices are a significant driver of health care costs, and while scrutiny of the processes by which pharmaceutical companies determine their prices could potentially contribute to containing these costs, these issues are not a direct parallel to the need for transparency of costs in healthcare services.

The case of Gobeille v. Liberty Mutual was argued before the Supreme Court of the United States on December 2, 2015. At issue in this case is the question of whether self-funded insurers should have to relinquish data to state APCDs upon request, or whether federal law (ERISA) protects those insurers from having to do so. Analysts hesitate to presume the outcome of the case, but predict the Justices will struggle to define the appropriate framework for analysis, and that the eventual decision will not be unanimous.[4]

Next steps towards transparency for the HSS

Legislative change is indubitably a key component of making healthcare more transparent. HSS cannot single-handedly bring about legislative change, but will request that the City and County of San Francisco go on the record as supporting legislation should any be introduced or re-introduced.

Within the current legal climate, HSS plans to continue to maximize the use of the APCD. HSS will also explore joining forces with other large employers who are major purchasers of health care. Doing this could help HSS gain leverage when negotiating with plans to obtain more information on cost and quality measures, even in the absence of legislative change which compels insurers to share data.

Beyond these steps, there were no insights or recommendations raised in the meeting that HSS is able to implement.

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[2] The Editorial Board. "Runaway Drug Prices." *The New York Times*, May 5, 2015. http://www.nytimes.com/2015/05/05/opinion/runaway-drug-prices.html?_r=0

[3] David Gorn, "Drug Pricing Bill Can't Pass Committee." *California Healthline*, January 13, 2016. http://www.californiahealthline.org/capitol-desk/2016/1/drug-pricing-bill-cant-pass-committee

[4] Ronald Mann, Argument analysis: Justices spar over ERISA preemption of state health-care databases, SCOTUSblog, December 3, 2015. http://www.scotusblog.com/2015/12/argument-analysis-justices-spar-over-erisa-preemption-of-state-health-care-databases/

Appendices

Appendix A: Meeting Agenda – Transparency in Healthcare Costs and Quality

Appendix B: Catalyst for Payment Reform's PowerPoint Presentation, "Price Transparency: Current State, Future State"

Appendix C: Aon Hewitt's PowerPoint Presentation, "Price and Quality Transparency – Achievable in San Francisco?"

Appendix D: Marina Coleridge's Handout, "The HSS's strategy for accountability and transparency included the establishment of an APCD."

Appendix E: "Meeting on Transparency of Health Care Costs and Quality: Background and Meeting Objectives," distributed prior to meeting.

Appendix F: Diagram of the CCSF Health Service System Environment, distributed prior to meeting.

Appendix G: White Paper: "Price Transparency in the Healthcare Market," UCSF/UC Hastings Consortium on Law, Science and Health Policy, March 18, 2013.

Appendix H: "Report Card on State Price Transparency Laws," Catalyst for Payment Reform

MEETING AGENDA – TRANSPARENCY IN HEALTH CARE COSTS AND QUALITY

"We're writing big checks and we don't know what we're buying." – Catherine Dodd

MEETING INFORMATION

Objective: To outline a framework for health care transparency within the Health Service System (HSS) of the City and County of San Francisco

Date: October 1, 2015

Time: 1:00 p.m.

Location: San Francisco City Hall, Room 278

Called By: Catherine Dodd, Director, HSS

Participants: Andy Bindman, UCSF
Andréa Caballero, Catalyst for Payment Reform
Marina Coleridge, HSS
Catherine Dodd, HSS
Mark Farrell, San Francisco Board of Supervisors
Jaime King, UC Hastings
Chris Miles, Aon Hewitt
Marie Murphy, HSS
Erik Rapoport, City Attorney, City and County of San Francisco
Paige Sipes-Metzler, Aon Hewitt
Kristof Stremikis, Pacific Business Group on Health

AGENDA ITEMS

1. Introduction of Supervisor Farrell / Catherine Dodd, HSS
2. Welcome and Introductory Remarks / Supervisor Mark Farrell

1145 Market Street, 3rd Floor San Francisco, CA 94103
Phone: (415) 554-1750 or 1-800-541-2266 Fax: (415) 554-1721
myhss.org

3. Overview of Transparency in Health Care

    a. Andréa Caballero, Catalyst for Payment Reform
    b. Chris Miles, Aon Hewitt

4. Overview of the HSS All Payer Claims Database (APCD) / Marina Coleridge, HSS

5. Brief overview of the HSS context / Catherine Dodd, HSS

6. Discussion: Given the features of the HSS context…

    a. How do we define “transparency”?

        i. Of costs
        ii. Of quality

    b. What would it take to get the HSS to having a transparent health system?

        i. At the local level?
        ii. What are some of the things that could be done at the state level that we could advocate for?

7. Conclusion and next steps: Scheduling a call to formalize a document to present to the San Francisco Board of Supervisors / Catherine Dodd, HSS

Price Transparency: Current State, Future State

Andréa Caballero
Program Director, Catalyst for Payment Reform
October 1, 2015

Agenda

- CPR: Who We Are
- The Need for and Challenges of Quality and Price Transparency
- Current State of Transparency Laws
- The Benefit of APCDs
- Q&A

CPR: Who We Are

- A **critical mass of voices** all asking for the same thing at the same time
- **A light shining** on the urgency of payment reform

- 3M
- Aircraft Gear Corp.
- Aon Hewitt
- Arizona Health Care Cost Containment System (Medicaid)
- AT&T
- Bloomin' Brands
- The Boeing Company
- CalPERS
- Carlson
- The City and County of San Francisco
- Comcast, NBCUniversal & Spectacor
- Dow Chemical Company
- eBay Inc.
- Equity Healthcare
- FedEx Corporation
- GE
- Group Insurance Commission, Commonwealth of MA
- The Home Depot
- Maine Bureau of Human Resources
- Marriott International, Inc.
- Mercer
- Michigan Department of Community Health (Michigan Medicaid)
- Ohio Medicaid
- Ohio PERS
- Pennsylvania Employees Benefit Trust Fund
- Pitney Bowes
- Qualcomm Incorporated
- South Carolina Health & Human Services (Medicaid)
- TennCare (Medicaid)
- Towers Watson
- Verizon Communications, Inc.
- Wal-Mart Stores, Inc.
- The Walt Disney Company
- Wells Fargo & Company
- Woodruff Sawyer & Company

Shared Agenda

20 Percent of Payments Proven to Enhance Value by 2020

- National Scorecard
- Regional Scorecards

Leverage purchasers and create alignment

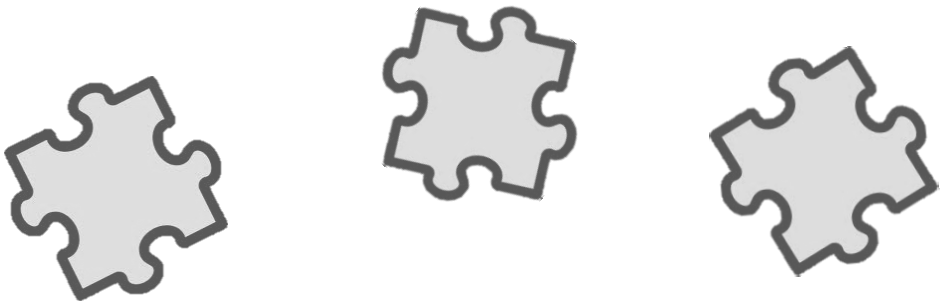
- Health plan sourcing, contracting, management and user groups
- Alignment with public sector

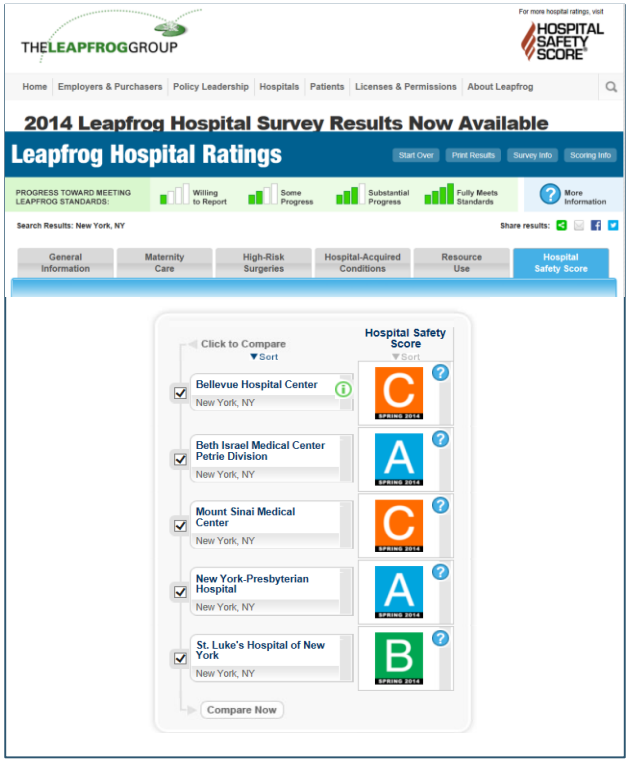
Implement Innovations

- Payment reform
- Pairings for payment reform with benefit and network design
- Price transparency
- Enhance provider competition

The Need for Quality Transparency

- Quality and safety vary tremendously, even within a physician practice or hospital
- It is one facet of importance to patients… but not the only one
- Helps determine which choice is the “best buy?”
- You can’t improve what you don’t know or measure





Challenges to Quality Transparency

- **Too Many Measures:** Big burden on providers
- **Not Shaping the Market:** Evidence that providers improve with public reporting, but little consumer shift
- **Not the Right Measures:** Today's measures are the easiest to collect and show the least differentiation among providers; criteria for selection would be different if consumers and purchasers in charge
- **Gaps in Measurement:** Major areas lacking… Diagnosis errors, etc.

View Graphs / View More Details	ADVENTIST MEDICAL CENTER 115 MALL DRIVE HANFORD, CA 93230 (559) 582-9000 Add to my Favorites Map and Directions	AHMC ANAHEIM REGIONAL MEDICAL CENTER 1111 W LA PALMA AVENUE ANAHEIM, CA 92801 (714) 774-1450 Add to my Favorites Map and Directions	ALTA BATES SUMMIT MEDICAL CENTER - ALTA BATES CAMP 2450 ASHBY AVE BERKELEY, CA 94705 (510) 204-4444 Add to my Favorites Map and Directions
Rate of readmission for heart attack patients	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate
Death rate for heart attack patients	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate
Rate of readmission for heart failure patients	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate
Death rate for heart failure patients	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate

The Need for Price Transparency

Purchasers with rising health care expenditures are asking consumers to take on more financial responsibility, motivating them to be more cost sensitive.

Purchasers believe that pressure from consumers is a powerful, underused lever for improving efficiency.

Unwarranted price variation needs to be exposed and consumers need price transparency to help identify high-value providers.

Price is an estimate of a consumer's complete health care cost on a health care service or set of services that: reflects negotiated discounts; is inclusive of all costs to the consumer associated with a service or services, including hospital, physician and lab fees; identifies the consumer's out-of-pocket costs.

Challenges to Price Transparency

- **Accuracy of Price Estimates:** The methods being used to estimate price are typically misleading and inaccurate.
- **Provider Market Power:** Lack of provider competition in a market, particularly among hospitals and specialists, makes it easy for some providers to refuse to reveal prices to consumers, and even increase prices
- **Contractual Barriers:** Major health plans say they are attempting to address these by removing gag clauses from their contracts, providers say it's the plans insisting on them.
- **Concern about Collusion:** Will competing providers work together to raise prices in a market?
- **Communication to Consumers:** Despite progress, many gaps in information, little effort to help consumers use it.
- **Evolution of New Payment Models:** Still relevant with global payment?

The Current State of Quality and Price Transparency

Many commercial health plans offer tools…but not all consumers are members of these plans, and there are benefits to using all-payer data.

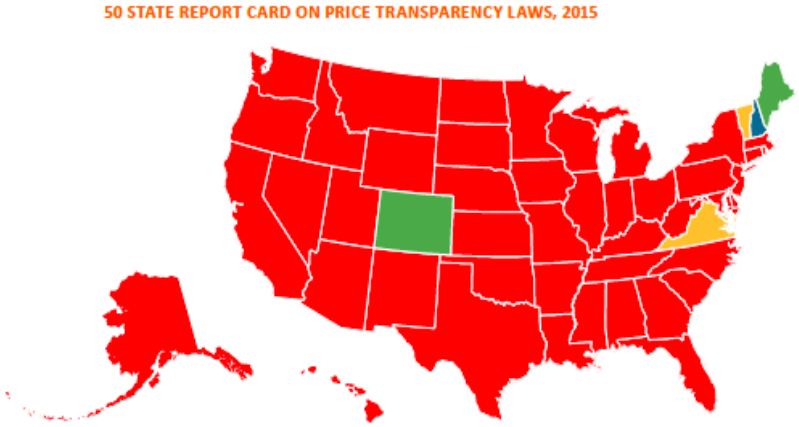
CPR released its third annual **Report Card on State Price Transparency Laws**, reflecting how well states ensure that consumers have access to health care prices.

The Report Card reflects that there has been little progress. Much more needs to be done to provide price and quality information to consumers.

State Action (…or Inaction)

Several states are ahead of the others in offering price and quality information to their residents.

New Hampshire	APCD and consumer-facing public website
Colorado	APCD and consumer-facing public website
Connecticut	Assembling an APCD and consumer-facing public website
New York	Assembling an APCD and consumer-facing public website
Maryland	In the process of publishing prices on health care services
Washington	Enacted law requiring insurance companies to provide price and quality information directly to patients
Kansas	Requires plans provide all patient cost and provider reimbursement information to providers upon request.



STATE	GRADE	STATE	GRADE	STATE	GRADE	STATE	GRADE
Alabama	F	Indiana	F	Nebraska	F	South Carolina	F
Alaska	F	Iowa	F	Nevada	F	South Dakota	F
Arizona	F	Kansas	F	New Hampshire	A	Tennessee	F
Arkansas	F	Kentucky	F	New Jersey	F	Texas	F
California	F	Louisiana	F	New Mexico	F	Utah	F
Colorado	B	Maine	B	New York	F	Vermont	C
Connecticut	F	Maryland	F	North Carolina	F	Virginia	C
Delaware	F	Massachusetts	F	North Dakota	F	Washington	F
Florida	F	Michigan	F	Ohio	F	West Virginia	F
Georgia	F	Minnesota	F	Oklahoma	F	Wisconsin	F
Hawaii	F	Mississippi	F	Oregon	F	Wyoming	F
Idaho	F	Missouri	F	Pennsylvania	F		
Illinois	F	Montana	F	Rhode Island	F		

APCDs: A Superior Source of Data

Why are data from APCD's superior to an individual health plan?

1. Sample size. Larger sample sizes help differentiate price and quality.

2. Multiple payers. APCDs carry information from commercial and public payers, mainly Medicaid.

3. Independent reporting mechanism. Surveys continue to indicate consumers lack confidence in health plan reported quality and price information.

The Future: Transparency for Use by Health Care Providers

Providers need price and quality transparency to:

- Select higher value, lower cost procedures;
- Refer patients to higher value, lower cost physicians;
- Have informed conversations with patients/shared decision-making

But they rarely have it today…

Questions?

Contact information:
www.catalyzepaymentreform.org

Andrea Caballero, Program Director
acaballero@catalyzepaymentreform.org
714.815.8425

Price and Quality Transparency—Achievable in San Francisco?

October 1, 2015

Prepared by Aon Hewitt
U.S. Health & Benefits

Presentation to City and County of San Francisco

Aon
Empower Results®

Topics for Discussion

- Colorado Example of Price and Quality Transparency
- Hurdles to Transparency in San Francisco Today
- Potential Actions to Address Hurdles
- Appendix

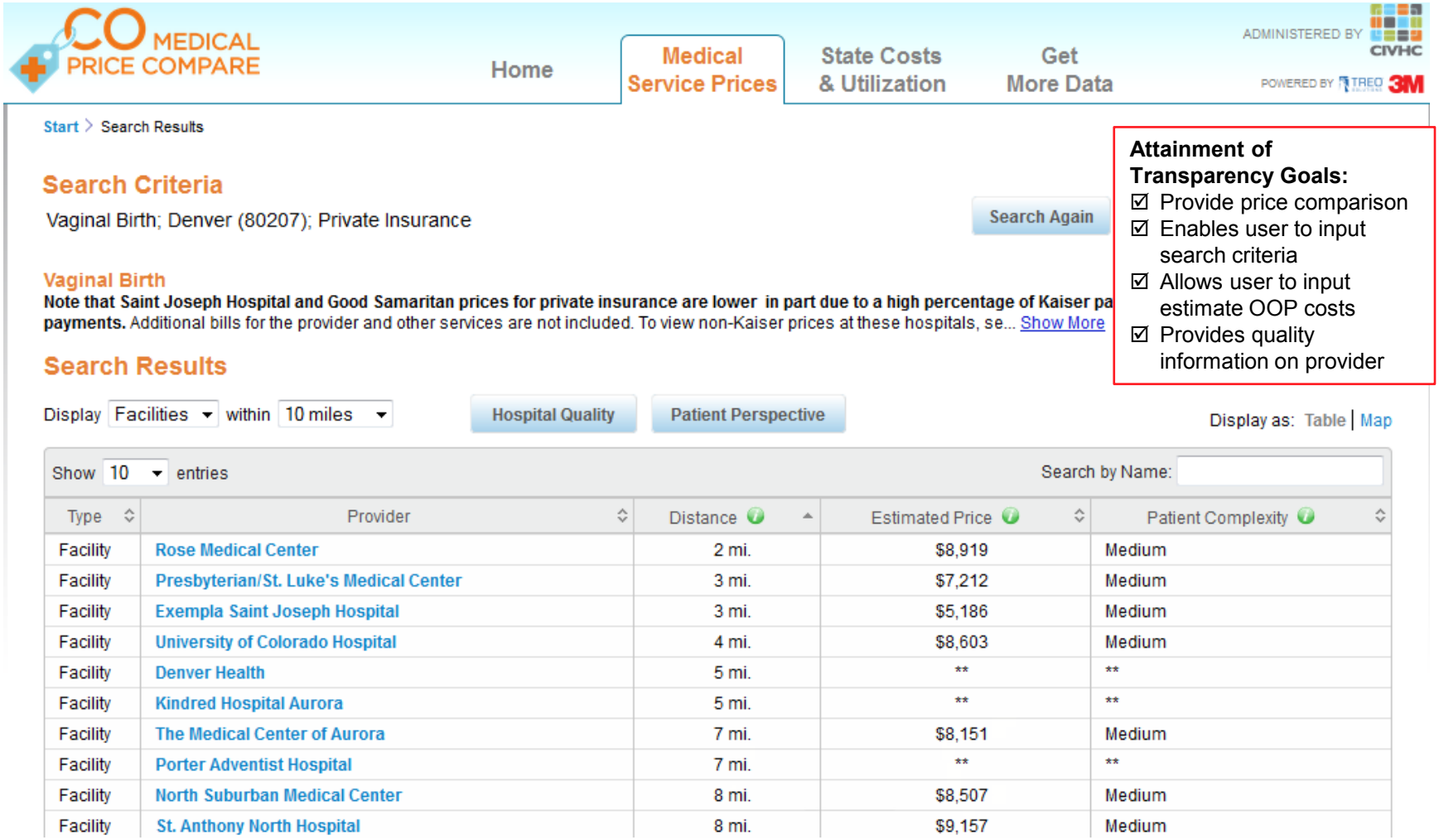
Colorado Example of Price and Quality Transparency

Colorado Example

Legislation Paves the Way

- 06-20-101 C.R.S.: Hospital Disclosures to Consumers
  - Requires hospitals/certified health facilities to disclose the average facility charge for frequently performed inpatient procedures prior to admission for such procedures
- 25-3-601 C.R.S.: Colorado Hospital Report Card Act
  - Created hospital report cards available on the Colorado Hospital Association's website
- 10-16-133 C.R.S.: Health Carrier Information Disclosure
  - Made information regarding the price of health care insurance readily available to consumers through the Division of Insurance
- 25-3-705 C.R.S.: Health Care Transparency Act
  - Creation of the "Health Care Transparency Act" to assist and allow consumers to make educated choices regarding their health care needs and to require health care providers and carriers to share more information on prices and reimbursement rates
- Fair Accountable Insurance Rates Act
  - Requires insurance plans to file detailed descriptions of rating and renewal underwriting practices with the Commissioner of Insurance
- 25.5-1-204 C.R.S.: Advisory Committee to Establish an All-Payer Health Claims Database
  - Bipartisan recommendation via the Blue Ribbon Commission for Health Care Reform in 2008
  - Legislation passed in 2010
  - Data collection started in 2012
  - Website implemented in 2014
  - APCD includes PHI used within to track data on a individual patient; this data is aggregated on the site
  - Originally funded by private foundation grants
- 25.2-1-204(9): Power to Impose Fines
  - "Rules shall include the assessment of a fine for a payer required to submit data that does not comply with this section…"
  - Committee has the legal authority to impose fines on institutions that do not comply

Colorado Example
A Look at CO Medical Price Compare's Website



Attainment of Transparency Goals:

- ☑ Provide price comparison
- ☑ Enables user to input search criteria
- ☑ Allows user to input estimate OOP costs
- ☑ Provides quality information on provider

Colorado Example

Keys to Success

- Know the market (consumer and provider side)
  - How do we sustain the initiative?
  - What are the opportunities?—this is key for skeptical stakeholders
- Know the data and that it's right
  - Data needs to be correct
  - It needs to be used correctly
  - **But** don't wait for perfect data—when is data "good enough"?
- Align expectations and time frames
  - Advisory Committee and broad-based stakeholder participation
  - Don't wait to bring in consumer and provider groups
- Learn from others
- Be proactive vs. reactive

Coming Soon!

- Secure funding
  - Government and institutional grants
- WIIFM as a provider?
  - ED identification utilization and post-discharge analysis
  - Insight into Total Cost of Care and referral patterns aiding physicians in shared savings and those assuming downside risk
  - Readmission data
  - Data on bundled payments and referrals

Note: *It has taken nearly 10 years to implement this process in Colorado*

Hurdles to Transparency in San Francisco Today

Hurdles to Health Care Transparency in California—California Antitrust Laws

Statutory Antitrust Law[1]

- Under these acts and the guidance thereunder
  - It is illegal for business competitors to have any agreement to raise, stabilize, or otherwise affect prices; the agreement need not be in writing or otherwise formalized
  - *Even a practice of exchanging price information with competitors, where this practice affects prices*, violates the antitrust laws
  - However, with respect to insurance carriers, while state antitrust laws prohibit price fixing, they do permit the exchange of *historical* data on paid claims and reserves

Penalties for California Antitrust Law Violations

- Treble damages and recovery of attorney fees are available for both private and government enforcement
- Criminal penalties include fines of $1 million for corporations and $250,000 and imprisonment for up to 3 years for individuals

Aon Perspective on Law

- Objective is to make health care costs and quality transparent to the public utilizers of services—for the "public good"
  - Not directly giving data to providers' competitors
  - Data would be provided to an all-payer claims database run by a third party
- Allowing universally-accessible price information to providers and payers in densely populated areas with limited provider options could unintentionally lead to price collusion or price leveling
  - Rules on provider access to data are necessary to prevent anti-competitive effects
- Want an independent third-party committee/institution that provides administration and oversight that is objective and unbiased to establish rules and methodology

[1] Consists of the Cartwright Act, the Unfair Practices Act (UPA) and the Unfair Competition Act (UCL).

Hurdles to Health Care Transparency in California—Federal Antitrust Laws

Statutory Antitrust Law[1]

- Under these acts and the guidance thereunder
  - Price fixing occurs where there is an agreement, collusion, or coordination among competitors to set prices
- The FTC recently responded to a request for comment by members of the Minnesota state legislature regarding pending amendments to the Minnesota Government Data Practices Act (MGDPA), which would classify health plan provider contracts as public data
- **The FTC cautioned against the amendment**
  - It would require competitors to publicly disclose competitively sensitive information, including disclosure of fees, discounts, and other pricing terms that typically are negotiated in confidence between health care providers and networks and other vendors
  - Such a disclosure could chill competition by facilitating or increasing the likelihood of unlawful collusion among competitors

Aon Perspective on Law

- Provider contracts themselves need not be publically disclosed in order to provide transparency to the public
- Other states (e.g., Colorado and New Hampshire) have relied upon disclosure of price info for the public good
  - Maine and Vermont challenges to provide this data were upheld for the “release for the public good”
  - Decision appealed to the Supreme Court, which has agreed to hear the case

[1] Consists, in relevant part, of the Sherman Act, the Federal Trade Commission Act and the Clayton Act, enforced by the FTC and Justice Department.

Hurdles to Health Care Transparency in California—Trade Secret Laws

California Trade Secret Law[1]

- To qualify as a trade secret
  - The secrecy of the information must provide a competitive advantage to its owners
  - The owners of the information must make an effort to maintain its secrecy
- Trade secrets are fact specific and are determined in the courts
- Health insurers and providers may allege trade secret protection to prevent negotiated pricing information from being disclosed
  - Trade secret protection usually granted where trade secret protection would promote vigorous competition in the market
  - Courts have not settled the question of whether pricing information in health care context can be a trade secret
  - Certain exemptions under California Public Records Act and local city ordinances could shield disclosure of health care pricing information regarding negotiated rates for health care services between providers and state and local agencies

Aon Perspective on Law

- While the California courts have not officially ruled on health care pricing information being a trade secret, it is difficult to conceive of examples where health care prices are defendable as a trade secret
  - The public benefit analysis provides a strong basis for disclosure of health care pricing information
  - Providers may have difficultly proving that they currently maintain the secrecy of pricing information necessary to establish a trade secrete
  - Providers have hid behind this concept which has allowed some of them to set above-market prices for services that others do at a fraction of the cost
- No providers or insurers have challenged current efforts to create price transparency; to do so, they would need to proactively file a lawsuit to categorize price information as a trade secret
- Strongly recommend either
  - A public interest/entity exemption of trade secret protection **or**
  - Expansion of Chapter 698 of Sec 22854.5 of Govt. Code (CalPERS example) to all public employers enabling price transparency

  In either case, legislation will be required

[1] Adopted Uniform Trade Secrets Act; Codified at Cal. Civ. Code sections 3426 *et seq.*

Hurdles to Health Care Transparency in California—Contractual Provisions Binding Vendors

Gag Clauses

- Commonly used in health insurer contracts to forbid health insurer and health care provider from disclosing negotiated pricing information
  - *California has enacted legislation to overcome this health care transparency barrier*
- In 2012, California banned contractual gag clauses that restricted the ability of health plan or health insurer to furnish cost and quality information to enrollees and insureds on the cost range of procedures or quality of services performed by the facility (SB 751)
  - Ban applied to hospitals and certain facilities owned by hospitals
- In October 2014, California expanded prohibition on gag clauses to also apply to any health care provider or supplier (SB 1340)[1]
  - Gag clauses are prohibited on the cost of a procedure or a full course of treatment, including faculty, professional and diagnostic services, prescription drugs, durable medical equipment, and other items and services related to the treatment
  - Permits sharing of information with beneficiaries of a self-insured plan or other persons entitled to access services through a network established by the health plan or health insurer

Aon Perspective on Law

- Providers aren't able to hide behind these gag clauses any longer
- However, nothing to compel providers to provide cost information
- With the elimination of gag clauses, providers are citing trade secrets and antitrust issues as reasons to not provide the information

[1] Prohibition codified at CA Health & Safety Code 1367.49 and CA Insurance Code 10133.64.

Hurdles to Health Care Transparency in California—Proposed SB 26: California Health Care Cost and Quality Database

Legislative Intent

- To make available valid performance information to promote care that is safe, medically effective, patient centered, timely, efficient, affordable, and equitable
- Put provider cost and performance information into the hands of consumers and purchasers so that they are able to understand their financial liability and realize the best quality and value available to them

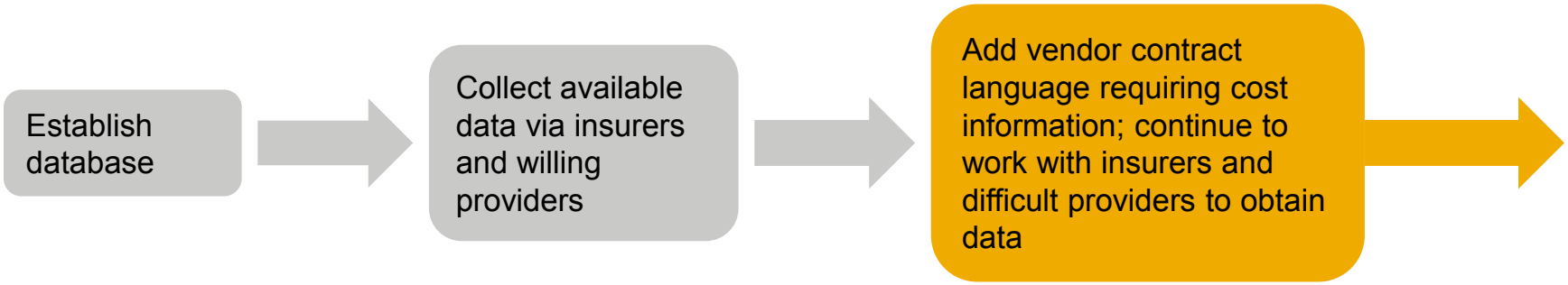
Biggest Perceived Hurdle to SB 26

- Federal grant requests have been denied
- Independent costs estimates of $18–$40 million

Potential Actions to Address Hurdles

Potential Actions to Address Hurdles

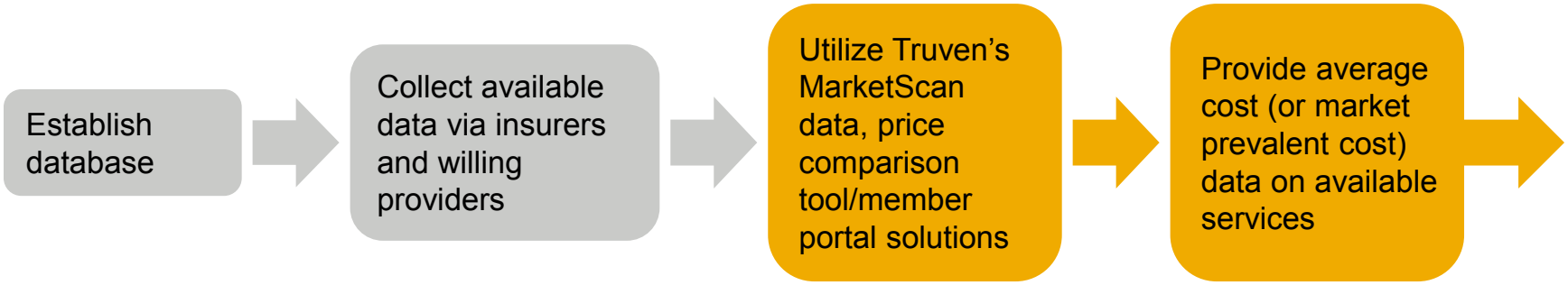
Hurdles	Actions
▪ Incomplete data ▪ Fully insured funding limiting the type of data being shared	▪ Option 1: Continue to negotiate to obtain detailed encounter and cost data – Require full price transparency in contracts with insurers as a condition of doing business – Require that insurers are collecting detailed encounter data and associated costs from contracted providers on individual members; data to be shared with the plan sponsor even for fully insured arrangements – Then need to build price comparison tool and member portal – Implement a "penalty" to any insurer that is unable to negotiate full price transparency with their providers; penalty would be in the form of a discount off the premium (e.g., reduce the premium by 10% in the event that the insurers do not agree to the transparency conditions or, if they do agree to the transparency conditions, that they fail to fulfill the transparency conditions during the course of the contractual relationship)



Completed
In Progress/Not Yet Started

Potential Actions to Address Hurdles

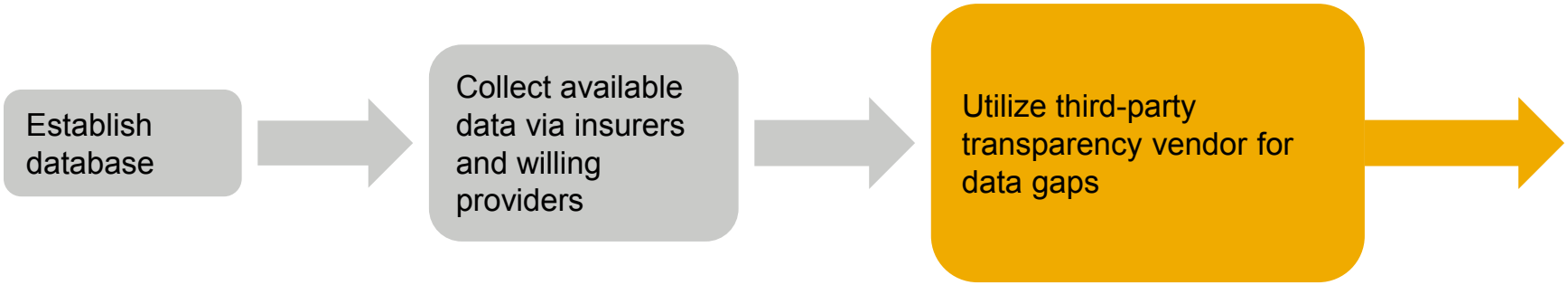
Hurdles	Actions
▪ Incomplete data ▪ Fully insured funding limiting the type of data being shared	Supplement current data set with additional tools ▪ Option 2: Truven's MarketScan database can provide average cost of services or most prevalent rate in the Bay Area market – Able to drill down to county level – Will provide top diagnoses, but may not be able to get to specific procedures – Will not be able to get to costs for individual providers (provider anonymity) – Explore price comparison tool/member portal solutions available through Truven – Could be a temporary fix until full price transparency disclosure from insurers and providers



Completed
In Progress/Not Yet Started

Potential Actions to Address Hurdles

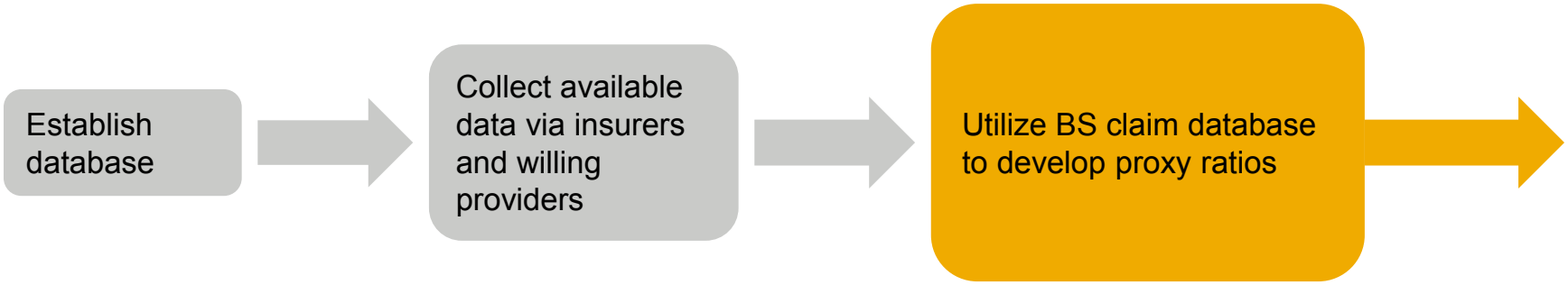
Hurdles	Actions
▪ Incomplete data ▪ Fully insured funding limiting the type of data being shared	Supplement current data set with additional tools ▪ Option 3: Third-party transparency vendor (e.g., Healthcare Bluebook) – Have UHC and BlueShield data – Would use Truven APCD as additional data source and for Kaiser cost information – Has data on local provider unwilling to share data – Shows price via a red/yellow/green ranking system—does not show specific dollars – Includes quality rankings via CMS Med Par data (including Kaiser) – Includes member portal to access data – Implementation in 60–120 days



Completed
In Progress/Not Yet Started

Potential Actions to Address Hurdles

Hurdles	Actions
▪ Incomplete data ▪ Fully insured funding limiting the type of data being shared	Supplement current data set with additional tools ▪ Option 4: Work with BlueShield to enhance access to their claims database for price information – Identify certain high-frequency admissions – Create a cost profile of these admissions – Develop a proxy of the charges and allowed amounts for application to all admissions – Implementation in 60 days



Completed
In Progress/Not Yet Started

Potential Actions to Address Hurdles

Hurdle	Actions
Proposed SB 26	▪ Work with Senator Hernandez's staff to incorporate the following into a potential rewrite: – Clearly define the objective: to make health care costs and quality transparent to the public utilizers of services—**"for the public good"** – Third-party/committee oversight should be empowered to establish rules and methodology including rules on provider access to data to prevent anti-competitive effects (e.g., price fixing and price collusion) whether or not unintentional – Most Favored Nation Clauses should be prohibited – Modify to address federal antitrust and ERISA pre-emption issues (as needed) based on the pending Supreme Court case *Gobeille v. Liberty Mutual Insurance* – Incorporate the following provisions from Colorado's APCD legislation (25.5-1-204 C.R.S): • Appointment of specific member roles to the APCD Advisory Committee • Specify creation of the APCD if sufficient funding is received via gifts, grants, and/or donations by the proposed effective date • Include mandatory and voluntary reporting of data • Allow for the sharing of the data back with providers and payer to quality check for accuracy prior to public release • Authorize the use of publically available data if needed to "measure and analyze a significant health care quality, safety or cost issue that cannot be adequately measured with administrative claims data alone" • Require payers to submit data to the APCD

Potential Actions to Address Hurdles

Hurdle	Actions
Proposed SB 26	▪ Work with Senator Hernandez's staff to incorporate the following into a potential rewrite: – Incorporate the following provisions from Colorado's APCD legislation (25.5-1-204 C.R.S) (continued): • Ensure that data collection elements and reporting formats follow suit with other national, regional, and other standard APCDs as possible • Contain audit rights to ensure accuracy of data submissions • Require that Social Security numbers contained in the data be encrypted • Allow for the assessment of fines for a payer that is required to submit data but does not comply; fines should be deposited in the APCD cash fund and maintained in the state treasury; APCD funds are to be used for maintaining the APCD; moneys in the fund should remain in the fund and not "revert to the general fund or any other fund at the end of a fiscal year" ▪ Proactively work with the Director of Finance and other supporters to develop funding options including identification of and application for federal or state grants as well as private foundation funding as Colorado did

Potential Actions to Address Hurdles

Hurdle	Actions
California **and** **Federal** Antitrust	▪ Transparency database should have oversight by an appointed, objective third party/advisory committee ▪ Third party/committee, or their designee, establishes rules and methodology ▪ Rules must be established on protecting data, releasing data, and provider access to data
California Trade Secret	▪ Expand Chapter 698 of Sec 22854.5 of Govt. Code to allow public entities to collect detailed price information and make the data available "for the public good" **or** ▪ Request a public interest/entity exemption of trade secret protection for price transparency

Appendix

Hurdles to Health Care Transparency in California—Proposed SB 26: California Health Care Cost and Quality Database

Bill Summary

- Requires Secretary of California Health and Human Services Agency to contract with an independent, nonprofit organization to administer the California Health Care Cost and Quality Database by January 1, 2017
- Requires the nonprofit organization to make a publicly-available, Web-based, searchable database no later than January 1, 2019
- Requires the information and analysis included in the database to be presented in a way that facilitates comparisons of cost, quality, and patient satisfaction across payers, provider organizations, and other suppliers of health care services
- Data requirements
  - Requires health plans, insurers, self-insured employers, and suppliers and providers, as defined, to provide the nonprofit organization
    - Utilization data from medical, dental, and pharmacy claims…
    - Pricing information for health care items, services, and medical and surgical episodes of care gathered from allowed charges for covered health care items and services…
- Enforcement
  - Permits the nonprofit organization to report an entity's failure to comply with to the entity's regulating agency
  - Permits the regulating agency to enforce the requirement using its existing enforcement procedures
  - Requires moneys collected pursuant to the authorization to enforce to be subject to appropriation by the legislature

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Health Service System
CITY & COUNTY OF SAN FRANCISCO

The Health Service system's (HSS) strategy for accountability and transparency included the establishment of an all-payer claims database (APCD). This approach was supported by the Mayor, the Controller, the Board of Supervisors, the Health Service Board, Labor and other key City departments. HSS has just completed a 2 year initiative towards establishing that database. The next steps are to develop competencies, and incorporate best practices shared by expert panelists towards leveraging the APCD to improve cost and quality. It is important to realize however, HSS' analytical capability is still limited by a lack of transparency in the data.

HSS is dependent upon the data suppliers (the various health plans) to share the claim information. Because two of HSS' health plans are fully insured, HSS is limited on what data is supplied. Additionally, where the health plan has agreed to share claim information, they are in turn limited by their contracts as to what information can be shared. Case in point, Blue Shield and Sutter. Other health plans either have policies of not sharing provider level information, or their source systems cannot support data capture, file layouts or have data quality problems which further constrain HSS.

The two tables below provide an overview by the measures (Quality and Cost/Utilization), and by the data sources (health plans) as to the limitations.

Note: Analysis of the APCD Usability is an ongoing effort. The information presented below is subject to change and likely revision will occur prior to the Transparency in Health Care Costs and Quality meeting.

HSS APCD Analytics (Quality and Cost/Utilization):

Data populated into the APCD is sourced from Medical and RX claims. The measures in the table below are calculated or derived based on the claim information. Only challenges to useful information by the measure have been itemized. If there are no comments for a specific provider or health plan, this indicates there is no currently known issue impacting the reporting.

Measures	Detail	Challenges
Financial, Prevalence and Quality by Clinical Condition	Financial metrics include allowed amounts and net payments. Quality indicators vary by condition. Prevalence is per/1000	Because Sutter only provides a summary claim amount for all claims within the time period, none of the financial metrics by clinical condition are available for Sutter.

Utilization	Claims, Days, Patients, Providers, Services, RVU, units and visits.	If attempting to correlate utilization to financial metrics for Sutter, data is not available. However utilization measures on their own should be relatively complete for all health plans.
Financial	Financial metrics include allowed amount, coinsurance, copayments, deductible, net payments, discount, out of pocket, and Total cost of coverage / Total plan payments where the metrics apply. Additionally claims processing (lag metrics) are available.	Coinsurance is not populated as this metric does not apply to HSS' HMO plan design. Discount amount would allow for validation of regional pricing and validating vendor contractual obligations. However, allowed amount is available and this is more critical to understanding price due to its comparability across health plans.
NCQA endorsed measures	NCQA endorsed measures to calculate quality of delivered care at patient and provider level for Behavioral Health, Cardiovascular, Endocrine(Diabetes), Gaps in Care, Medication Management, Musculoskeletal, Preventive Health and Respiratory (Asthma, COPD, URI)	Individual provider profiling is limited for all health plans. Some claims only report at the medical group/IPA level, others do not populate provider name information.
Care Management Utilization	NCQA endorsed measures to calculate completeness of delivered care at patient and provider level via Gaps in Care and Preventive Health Measures: Vaccines, Screenings, Immunizations, medications, exams)	Individual provider profiling is limited for all health plans. Some claims only report at the medical group/IPA level, others do not populate provider name information.
Disease Staging, Financial and Utilization by Admission	Financial metrics include allowed amount, net payments and charge submitted.	Because Sutter only provides a summary claim amount for all claims within the time period, none of the financial metrics can be linked to the utilization. For Kaiser and UHC, inpatient claims generally roll-up payment information to the claim header and not the claim detail which restricts the available analysis in terms of financials by procedure/service. However since the aggregate dollar is reported by the individual (unlike Sutter), viewing the financial metrics by other groupings is possible (for example by diagnosis, provider, location, patient demographics, etc.)

Avoidable Admissions / Readmissions	Readmissions (within 15 days) and associated financials.	UHC only provides 3 Diagnosis codes. Special studies involving patient safety indicators may be impacted. Financials cannot be associated for Sutter since claim detail with financials is not provided.

HSS APCD Data Sources:

Data populated into the APCD is sourced from Medical and RX claims. To facilitate a quick overview of what analysis is possible, the below table highlights problem areas of missing or inconsistent data. What is available in the APCD is based on information normally found on professional / facility claims and from their adjudication. For example: Diagnosis, Dates of Service, Procedures/Services, Provider Name, Patient Name, Patient DOB, Sex, Admission Date, DRG, Revenue Code, Charges, Allowed Amount, etc.

HSS has only just begun to evaluate the data usability. Improvement/remediation is expected for some of the known issues as they relate to data quality and file layout. Issues related to an unwillingness to provide the information will continue to exist.

Data Source	Health Plan	[1]Excluded from Data	Inconsistent Data
Medical (Commercial)	Blue Shield	Service line details for Sutter financials, date of service for Sutter claims, Discount amount, DRG MS of payment code, present on admit DX	Allowed amount is calculated by Truven since amount on raw file is not truly plan allowed amount, provider name tends to be more the IPA vs. individual provider name
RX (Commercial)	Blue Shield	Discount amount, RX Mail or Retail	
Medical (Commercial)	Kaiser Permanente	Detail payment information on Facility records (header payment record only), Provider Name/ID, Service count, Discount amount	Procedure Code on Facility claims with surgical procedure, Place of Service, DRG MS of payment code
RX (Commercial)	Kaiser Permanente	Dispense as Written, Discount amount, Dispensing fee, Ordering Provider, identification of Mail or Retail, Ingredient Cost	
Medical (Commercial)	United HealthCare	Detail payment information on Facility records (header payment record only), More than 3 DX codes, DRG MS of payment code, Ordering Provider Id/Name,	5% of professional claims have place of service as “Other Location”, Quantity of Service on Professional claims due to codes being used to report patient specific

			compliance to quality performance measures.
RX (Commercial)	United Healthcare		
Medical (Medicare Advantage)	Blue Shield	Not Available until 11/5	Not Available until 11/5
RX (Medicare Advantage)	Blue Shield		
Medical (Medicare Advantage)	Kaiser Permanente	No Financials. Utilization only	
RX (Medicare Advantage)	Kaiser Permanente	No Financials. Utilization only	
RX (Medicare)	United Healthcare	Not available until 10/5	Not available until 10/5
Mental Health (Commercial)	Blue Shield	Discount Amount, Ordering Provider Name/Id	
Provider	Blue Shield		

[1]Data excluded from the APCD source data files may be due to file layouts, data quality or a deliberate lack of transparency.

MEETING ON TRANSPARENCY OF HEALTH CARE COSTS AND QUALITY

October 1, 2015 at 1:00 p.m.
San Francisco City Hall, Room 278

BACKGROUND AND MEETING OBJECTIVES

Overview

The Health Service System of the City and County of San Francisco covers over 112,000 lives, which currently costs more than $720 million annually. HSS is one of the largest purchasers of health insurance in the San Francisco Bay Area.

This meeting of experts on health care transparency and relevant policy matters is convened, per the San Francisco Board of Supervisors Resolution No. 271-14 (File No. 140788) in order to outline a framework for a transparent health care system in San Francisco.

Greater transparency in healthcare costs and quality is an essential component of achieving the formidable goals of improving population health, minimizing waste, and stabilizing costs. Resolution 271-14 stipulates the following components of a framework for transparency:

- Vendor contracts:
    - Should not have anti-competitive provisions, such as:
        - Anti-tiering
        - Bundled all-or-nothing requirements
        - Confidentiality gag clauses
    - Should contain language requiring health plans, health care providers, and physician groups to submit data to the Health Service System All Payer Claims Database (APCD)
    - Should contain provisions requiring transparency on cost, price, provider practice information, quality and safety, use of services and access measures by all products and facilities

1145 Market Street, 3rd Floor San Francisco, CA 94103
Phone: (415) 554-1750 or 1-800-541-2266 Fax: (415) 554-1721
myhss.org

Key features of the HSS context

- **THE STRUCTURE OF OUR PREMIUMS KEEPS CONSUMERS INSULATED FROM THE COSTS OF HEALTH CARE.** Thus, the issues related to consumers taking on a greater portion of health care costs (through higher premiums, deductibles, co-pays, etc.) that affect many Americans are not as applicable to our members.

- Our members are geographically concentrated – into an area that is a largely managed care market. Within this market, Sutter is the dominant health system.
    - **We can't get detailed price information from Sutter. We can only get aggregate dollar summaries from Sutter.**

- Overview of HSS's APCD (see supporting document)

Key legal challenges

- HIPAA
- Confidentiality of Medical Information Act (CMIA)
- Trade Secrets Act
- California Public Records Act
- Sunshine Ordinance

Possible courses of action

At the state level

- California state law (California government code § 22854.5) allows CalPERS to get data on cost, utilization, actual claim payments, and contract allowance amounts from the plans they contract with – and for this data to be deemed confidential and protected by HIPAA and CMIA, and deemed confidential trade secret information, exempt from the California Public Records Act.

- We need similar legislation that

    - Deems our data protected as a confidential trade secret
    - Deems our data confidential in accordance with HIPAA and CMIA
    - Exempts our data from the California Public Records Act and the Sunshine Ordinance

At the local level

- Move forward with our all payer claims database
- Continue to put pressure on Sutter to be transparent in their contracting until we can pass state laws

Meeting objectives

- Define what we mean by "transparency"
    - In terms of cost
    - In terms of quality

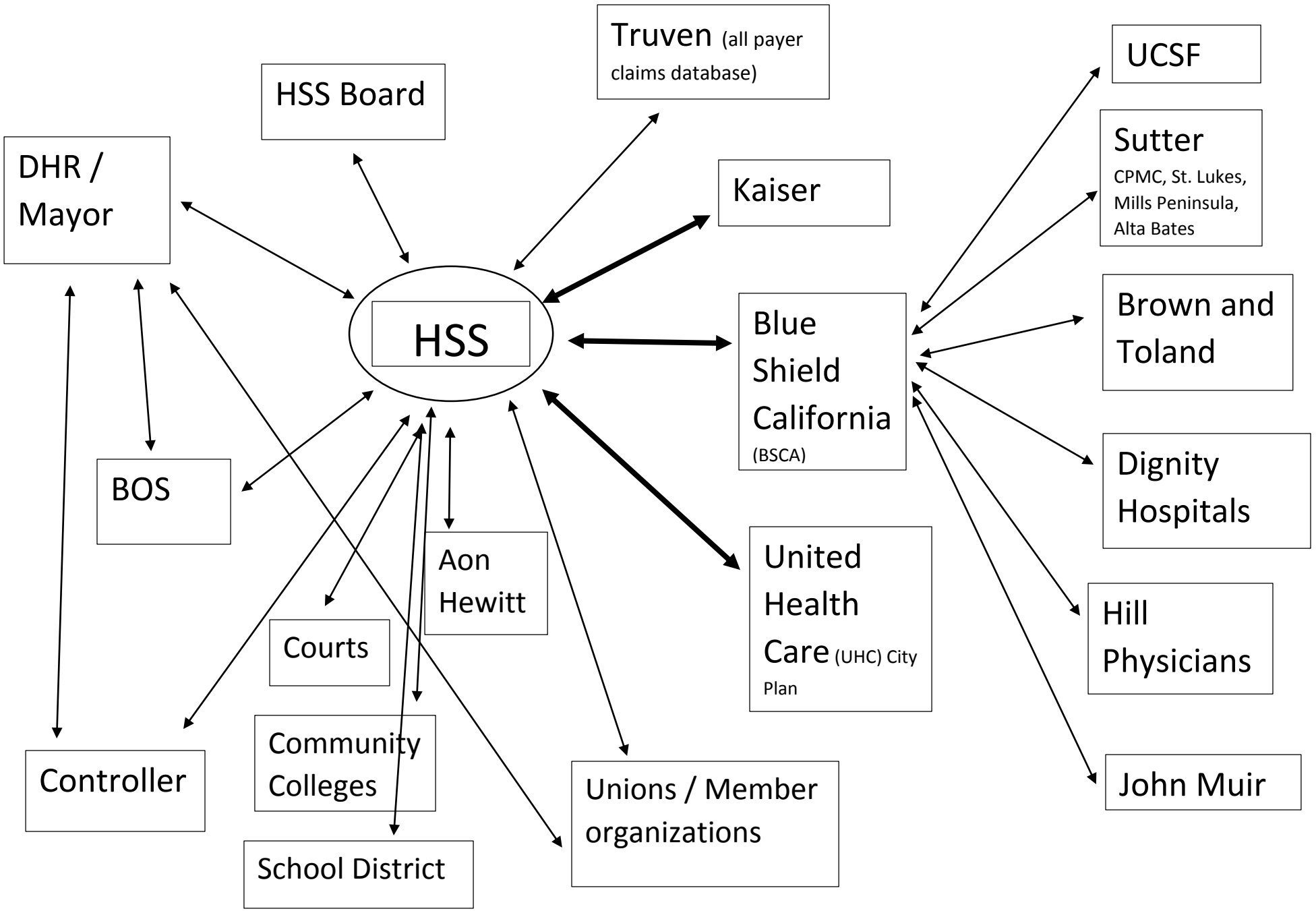
- Given the features of the HSS context, what would it take to get us to having a transparent health system?
    - At the state level?
    - At the local level?

Materials distributed for participants' review

- White paper: "Price Transparency in the Healthcare Market," UCSF/UC Hastings Consortium on Law, Science and Health Policy, March 18, 2013
- Report Card on State Price Transparency Laws, Catalyst for Payment Reform, July 2015
- Overview of HSS's APCD (HSS_APCD_Overview)
- CCSF Health Service System Landscape diagram
- Background and Meeting Objectives (this document)

CCSF Health Service System Environment

HEALTH SERVICE SYSTEM
CITY & COUNTY OF SAN FRANCISCO



Price Transparency in the Healthcare Market

UCSF/UC Hastings Consortium on Law, Science and Health Policy

March 18, 2013

Authors
Jaime S. King, JD, PhD
Associate Professor of Law
University of California, Hastings College of the Law
Associate Director, UCSF/UC Hastings Consortium on Law, Science and Health Policy
kingja@uchastings.edu (Contact)

Morgan Muir, JD
Research Fellow
UCSF/UC Hastings Consortium on Law, Science and Health Policy

Stephanie Alessi
Research Fellow
UCSF/UC Hastings Consortium on Law, Science and Health Policy

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David Faigman, JD, MA
John F. Digardi Distinguished Professor of Law
University of California, Hastings College of the Law
Director, UCSF/UC Hastings Consortium on Law, Science and Health Policy

Clay Johnston, MD, PhD
Director, Clinical and Translational Science Institute (CTSI)
Associate Vice Chancellor of Research
University of California, San Francisco

R. Adams Dudley, MD, MBA
Professor of Medicine and Health Policy
Associate Director for Research
Phillip R. Lee Institute for Health Policy Studies
University of California, San Francisco

Thomas Greaney, JD
Co-Director, Center for Health Law Studies
Chester A. Myers Professor of Law
Saint Louis University, School of Law

Ann Marie Marciarille, JD
Associate Professor of Law
University of Missouri-Kansas City, School of Law

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Executive Summary

Introduction

In an eleven-point plan released this summer, a group of the nation's top healthcare experts listed "full transparency of prices" as one potential solution to reduce healthcare costs. The experts, some of whom helped write the Patient Protection and Affordable Care Act, argued that price transparency would allow consumers to compare prices before choosing a provider or hospital and, consequently, better anticipate their overall costs. In turn, they argued that making price information publicly accessible would also reduce excess healthcare spending by encouraging providers to offer more competitive pricing.

Other research suggests that market conditions may determine whether price transparency lowers or increases health care pricing. In markets lacking competition and consumer choice, making prices available may have the perverse effect of incentivizing non-dominant providers to raise prices to match or resemble the prices demanded by dominant providers. For example, if consumers lack the power to demand prices that match the quality of the services they receive, price transparency may result in collusive price-matching behavior by making providers aware of the reimbursement rates insurers pay competing providers. Consequently, any price transparency initiative must not only make prices transparent, but also account for the economic differences between markets, either by reducing the economic inefficiencies that keep price transparency from being effective or by targeting only the specific regions where the market would support such an initiative. The most effective solutions will mandate disclosure of price and quality information at the appropriate stakeholder levels and, simultaneously, break down provider market leverage where it prevents price transparency from helping consumers. Together, these two elements have the potential to lower healthcare costs across California.

I. Recommendations

This paper recommends four ways to achieve these two outcomes: First, a combination of antitrust litigation and price transparency legislation has the potential to break down market leverage and produce price transparency. In particular, an antitrust suit would aim to break apart coercive ties that dominant providers use to leverage their market power in one geographic market to force insurers to contract with them in other, more competitive markets where they lack that power. Breaking apart these unrelated services would allow for the effective implementation of price transparency legislation, because it would force providers to compete on price and quality measures that consumers in the immediate market could respond to. This option, while it offers the greatest consumer benefits, carries the highest risk of failure during both the litigation and legislative processes.

Second, a regulatory initiative could be passed by the Department of Insurance or the Department of Managed Health Care to divide California into independent healthcare regions and, simultaneously, mandate price transparency in the more competitive markets. These regulations would eliminate existing geographic ties among regions without going through the expense and risk of antitrust litigation, thereby breaking up market power and forcing providers to negotiate rates for their distinct geographic services.

A third strategy would create an education initiative to encourage employers to exercise their purchasing leverage to demand price transparency. This strategy would be implemented in markets where there is already competition among providers and insurers, in order to encourage price transparency only in the markets where it would have a positive impact due to the presence of meaningful competition. By educating employers on both how to purchase and create incentives for their price-conscious employees to select higher value healthcare plans, this solution would allow

employers to build narrower, more cost-effective provider networks. As a result, they would have more leverage to demand price and quality information in negotiations with providers and health plans, thus compelling market competition on these measures.

Finally, offering Exchange-level certification of certain health plans that provide high quality health care without engaging in anticompetitive tactics, both within and outside of the Exchange, stands to provide Californians with easy-to-identify health plans of great value and integrity. By opting to disclose price and quality information to a designated government agency, health plans that demonstrate a lack of anticompetitive tactics and meet low-cost, high-quality criteria could be certified as "Golden State Standard" health plans. Such a certification process may not only encourage competition across the healthcare market, but also serve to inform individuals and employers.

Each of these four strategies addresses the dual concerns of breaking down market leverage and making price and quality information transparent in a meaningful way. This paper describes and analyzes the background from which these solutions arise, as well as some of the legal, regulatory, economic, and political hurdles that each potential solution would have to overcome.

II. Existing Efforts

Although California has attempted on multiple occasions to enact legislation promoting price transparency, each of the four existing transparency initiatives—the Payers' Bill of Rights, California Hospital Compare, and Senate Bills 751 and 1196—fall short of stimulating the change necessary to reform healthcare pricing. Similarly, the California Health Benefit Exchange has not utilized its full authority to ensure price transparency on the Exchange, despite its power to set minimum standards for plans on the Exchange or, as Massachusetts has done, to screen and rate the quality and prices of plans offered on the Exchange. Learning from these shortcomings, as well as

other attempts at price transparency across the country, this paper crafts new solutions to create a more effective initiative in California.

III. Potential Solutions

The options this paper proposes target price transparency initiatives to a variety of healthcare stakeholders. Insurers, providers, employers, and consumers are all potential targets, and the most effective disclosure strategy will differ from group to group. Between insurers and providers, mandating disclosure of price terms may successfully stimulate competition given the right market conditions. For consumers, providing a side-by-side comparison of complete cost and quality information can facilitate better-informed decision making in choosing a health plan and provider. Employers, in contrast, may benefit most from knowing negotiated insurer-provider prices, as well as specific provider quality information, so that they can offer their employees the highest value health plans. While initiatives aimed at revealing the prices of services, products, and provider reimbursement rates have the potential to increase market competition and drive down healthcare costs, they will not be successful in all situations. This paper analyzes the potential impact of several different solutions.

A. Antitrust Litigation

Antitrust litigation is one way to break down the market power that allows certain providers and insurers to drive up prices and conceal them from consumers. Antitrust law seeks to prevent harm to competition caused by anticompetitive conduct, which can arise in a variety of ways during the contracting process between healthcare insurers and providers. Most notably, dominant insurers often demand "most favored nation" clauses that require providers to guarantee they will not offer a competitor a better rate, and dominant providers often coerce insurers to purchase services that they did not intend to purchase by leveraging their market power in a different geographic area or set of

services. Although there are currently some legal challenges to most favored nation clauses across the country, the crucial step in enacting price transparency is to break apart the market leverage that allows providers to create coercive ties. Thus, an antitrust suit focusing on these ties has the potential to break down this coercive power and force dominant parties to offer competitive prices. In addition, as a result of increased price transparency, certain competitive harms with the potential for antitrust liability may become more apparent to consumers and competitors, making the viable threat of antitrust litigation a deterrent to anticompetitive behavior. Combining the two strategies of breaking apart anticompetitive markets and increasing price transparency may thus be an effective approach to lower prices for consumers.

B. Legislation and Regulation

Legislative and regulatory solutions are also potentially viable avenues for increasing price transparency. Mandating price transparency in isolation through state legislation or regulation could drive prices up or down, depending upon the particular conditions in the target market. Therefore, a blanket price transparency initiative through either process is not recommended. Instead, the legislature should focus on incentivizing price transparency in urban areas where its intended effects are most likely, due to the existence of greater competition in the market (or within certain markets, as designated in the solutions). State regulation, especially by the California Health Benefit Exchange through its contracting power as an active purchaser, could also impose transparency requirements on those health plans offered in certain geographic markets through the Exchange. Alternatively, the Exchange—or, potentially, a multi-stakeholder organization (comprised of a range of healthcare consumers, providers, and payers) that met certain regulatory requirements—could apply to become a qualified entity to collect price information that it could then use to inform regulatory decisions.

C. Market Solutions

Alongside the legal, legislative, and regulatory solutions, several market-based educational solutions targeting employers and consumers would serve to effectively supplement a more formal price transparency initiative. As employers increasingly shift more healthcare costs onto their employees via high deductible health plans (HDHPs), making provider payment and quality information transparent to employers would provide them the tools and knowledge to demand particular low-cost, high-quality health plans. With a growing number of employees enrolled in HDHPs, and employees' salaries unable to keep up with the growth rate of healthcare, consumers are poised to begin applying user-friendly price and quality measures to their healthcare decision-making processes.

IV. Barriers to Price Transparency

Any effective price transparency initiative must surmount several hurdles. Currently, confidentiality clauses in insurer-provider contracts prevent parties from knowing the prices their competitors charge. In competitive markets, a transparency initiative to eliminate these clauses may force providers to demonstrate valuable and transparent justifications for charging higher prices than their competitors, otherwise they would have to lower their prices to maintain a profitable patient base. Providers and insurers, however, may claim that their price agreements deserve trade secret protection and are not subject to disclosure. Price transparency proponents must demonstrate either that this information does not meet the definition of a trade secret or that it falls within a valid exception, otherwise the prices can legally remain confidential.

Additionally, before a price transparency initiative can have its intended effect of lowering healthcare costs, it must overcome resistance from providers and consumers. Providers may oppose mandated disclosure of negotiated prices if value-based incentives do not replace the fee-for-service

reimbursement system, which incentivizes them to perform a high volume of procedures. Transparency would undermine physicians' current financial incentives by making visible this overconsumption of healthcare. At the same time, effective consumer-directed price transparency will require translating the complicated language of healthcare billing into easy-to-understand information that is presented in connection with quality measures, such that consumers can be expected to use it in their decision-making.

It is thus evident that price transparency cannot happen in a vacuum; analyzing a price transparency initiative requires the consideration of a variety of potential hurdles. Consequently, an effective policy solution must address the implications of these barriers.

Conclusion

The recommendations that this paper provides take into consideration California's varying market conditions, prior and current attempts at price transparency across the country, and the market barriers and legal hurdles that price transparency initiatives will face. By offering several potential solutions to simultaneously reduce anticompetitive behavior in healthcare markets and make price and quality information available in a meaningful way, these proposals provide healthcare consumers a viable path toward fair and visible prices.

Table of Contents

Introduction

In 2011, the United States spent $2.7 trillion dollars on healthcare.[1] National healthcare expenditures accounted for 17.9% of the gross domestic product and have nearly doubled since 2000.[2] In recent years, American businesses have begun to falter under the weight of providing affordable insurance to their employees and the number of uninsured Americans has increased to over 46 million.[3] The need to reduce healthcare costs is more apparent than ever and the Affordable Care Act has brought numerous cost-reduction initiatives to the forefront.

In August 2012, several of the nation's top healthcare experts who helped write the Affordable Care Act (ACA) included "full transparency of prices" in an eleven-point plan to reduce health costs.[4] They argued that price transparency would permit consumers to compare available prices before choosing a provider or hospital and anticipate overall costs.[5] In turn, publically accessible price information would encourage providers to offer more competitive pricing and thereby reduce excess healthcare spending, a view consistent with predictions of standard economic theory.[6]

However, whether price transparency will have this effect on the healthcare market remains speculative. Those who believe price transparency, alone, will reduce healthcare costs assume that the healthcare market will respond like other industries. Economists have long concluded that

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[1] CTRS. FOR MEDICARE AND MEDICAID SERVS., NATIONAL HEALTH EXPENDITURES 2011 HIGHLIGHTS, *available at* http://cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and Reports/NationalHealthExpendData/Downloads/highlights.pdf (last visited February 11, 2013).
[2] *Id.*
[3] ROBIN A. COHEN & MICHAEL E. MARTINEZ, NAT'L CTR. FOR HEALTH STATISTICS, CDC, HEALTH INSURANCE COVERAGE: EARLY RELEASE OF ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY, 2011, at 2 (2012) [hereinafter 2011 NATIONAL HEALTH INTERVIEW SURVEY], *available at* http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201206.pdf.
[4] Ezekiel Emanuel et al., *A Systemic Approach to Containing Healthcare Spending*, NEJM, Aug. 1, 2012, *available at* http://www.nejm.org/doi/full/10.1056/NEJMsb1205901.
[5] *Id.*
[6] *Id.* at 2-4; see also CRS REPORT FOR CONGRESS: DOES PRICE TRANSPARENCY EFFECT MARKET EFFICIENCY? IMPLICATIONS OF EMPIRICAL EVIDENCE IN OTHER MARKETS FOR THE HEALTHCARE SECTOR (Apr. 29 2008) [hereinafter CRS REPORT FOR CONGRESS].

markets work best when consumer prices reflect the actual cost to create and deliver the product.[7] In fact, a majority of the empirical studies on price transparency in other markets shows that transparency initiatives tend to lead to more consistent, lower prices.[8] While similarities exist between healthcare and other consumer markets, some economists believe price transparency will not ameliorate rising healthcare costs due to unique characteristics of the healthcare market.[9]

One major difference is that patient demand for healthcare services generally does not respond in the same manner as consumer demand for other goods in terms of price elasticity, which estimates how consumer demand changes as price changes.[10] Consumers can delay healthcare due to cost, but once a condition becomes severe or life threatening, consumers will generally seek care regardless of price. This makes the demand for certain healthcare services uniquely inelastic. Price inelasticity in the healthcare market is further exacerbated by the fact that consumers generally learn of their healthcare costs after receiving care, making these costs seemingly unavoidable. In addition, complex billing practices, secretive insurer-provider contracts, the sheer number of third party payers, and major quality variances in delivery of healthcare may mean that it will be difficult for price transparency initiatives to achieve economic efficiency.[11]

Unfortunately, the unique characteristics of this market make analogies and predictions based on other markets less reliable. Each unique quality of the healthcare market is analogous to another market, but no one market contains all of the special characteristics of healthcare. Loosely analogous to corporate managers, who make business decisions that affect the price of stockholders' shares, are providers, who negotiate with insurers over covered treatments and procedure prices.

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[7] Robert Murray, *Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience,* 28 HEALTH AFF. 1395, 1397 (2009).
[8] CRS REPORT FOR CONGRESS at 9.
[9] *Id.* at 4-5.
[10] SU LIU & DEBORAH CHOLLET, MATHEMATICA POLICY RESEARCH, INC., PRICE AND INCOME ELASTICITY OF THE DEMAND FOR HEALTH INSURANCE AND HEALTH CARE SERVICES: A CRITICAL REVIEW OF THE LITERATURE—FINAL REPORT (Mar. 24, 2006).
[11] CRS REPORT FOR CONGRESS, *supra* note 9, at 5.

Thus, a price transparency initiative that targets consumers alone may be less effective than a multi-faceted one that targets decisions made at the insurer-provider level as well. Similar to the automobile and airline industry, price discrimination can affect healthcare prices when providers charge different payers different prices for identical services, adding to the growing price discrepancies for healthcare within the same geographic region.[12] Further, third party payers insulate consumers from the full price of healthcare, allowing price to play less of a role in treatment choice than location, physician quality, or other non-price factors.

To date, most transparency initiatives have targeted consumers. In fact, more than 30 states are considering or pursuing legislation to increase price transparency.[13] This article analyzes the current debate about price transparency in the healthcare market and the role that law and policy play in the implementation of price transparency initiatives to lower the cost of healthcare. The analyses herein will critique existing consumer-directed price transparency legislation and examine potential provider- and insurer-targeted initiatives.

Part I provides information on the healthcare market as it relates to price transparency and presents the different levels of implementation of transparency initiatives. Part II breaks down the different levels at which a price transparency initiative could be aimed and the benefits and downfalls of each level. Part III analyzes the potential effects of price transparency on various aspects of the healthcare market. Part IV explains the substantial legal barriers to price transparency initiatives, as well other obstacles from within the healthcare industry. Part V examines current transparency legislative initiatives across the country, with a special focus on California, as well as the potential for regulation from the Health Benefit Exchanges. Part VI then analyzes a range of

[12] Uwe E. Reinhardt, *The Price of U.S. Hospital Services: Chaos Behind A Veil of Secrecy,* 25 HEALTH AFF. 57 (2006).
[13] Anna D. Sinaiko & Meredith B. Rosenthal, *Increased Price Transparency in Healthcare—Challenges and Potential Effects,* 364 New Eng. J. Med. 891, 891 (2011).

possible price transparency initiatives, including consumer and employer education, antitrust litigation, state legislation, and state agency regulation. This Part proposes a framework for analyzing price transparency initiatives that accounts for varying healthcare market conditions, attempts at legislating and regulating price transparency across the country, and a range of market barriers and legal hurdles.

Lastly, based on the analysis in Part VI, Part VII recommends four possible legal, regulatory, and educational solutions that might be taken alone or in combination to form an effective price transparency initiative. By offering several potential solutions to simultaneously reduce anticompetitive behavior in healthcare markets and make price and quality information available in a meaningful way, these proposals provide healthcare consumers a viable path toward fair and visible prices.[14]

I. The Healthcare Market and Price Transparency

According to the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS), an estimated 46.3 million persons of all ages (15.1% of the United States population) were uninsured in 2011.[15] 63.9% of insured persons were covered by private health insurance plans – 82.1% of those persons obtained employer-based coverage, while 15.3% purchased their plan directly or through means other than employment.[16] The biggest change in recent years, however, has not been to the number of insured, but to the way insured individuals pay for healthcare.

[14] While the analyses and recommendations provided herein use California as the target case study, many of the issues also pertain to markets in other states across the country.
[15] ROBIN A. COHEN & MICHAEL E. MARTINEZ, NAT'L CTR. FOR HEALTH STATISTICS, CDC, HEALTH INSURANCE COVERAGE: EARLY RELEASE OF ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY, 2011, at 2 (2012) [hereinafter 2011 NATIONAL HEALTH INTERVIEW SURVEY], *available at* http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201206.pdf.
[16] U.S. CENSUS BUREAU, CURRENT POPULATION SURVEY, ANNUAL SOCIAL AND ECONOMIC SUPPLEMENT (2012), *available at* http://www.census.gov/cps/data/cpstablecreator.html.

Employer-sponsored health insurance is the leading source of health insurance in the United States, covering about 149 million persons under age 65.[17] Employer-sponsored health insurance premiums have continued to rise in recent years, rising three and four percent for individuals and families, respectively, from 2011 to 2012 alone.[18] One factor that contributes to increasing cost is continued demand for plans with broad healthcare networks for their employees. In the 1990s, managed care organizations with narrow provider networks received immense backlash due to the public perception that the narrow networks amounted to indirect healthcare rationing.[19] Employers consequently began to demand broader provider networks from health plans to meet employees' needs for greater provider options.[20] This demand gave providers significant bargaining leverage to negotiate higher payments from insurers, and even greater leverage for certain "must-have" providers,[21] especially hospitals, while leaving other providers, with less influence, to accept lower payments in comparison.[22] Overall, though, all providers have been able to increase their prices.

Since the economic recession began in 2008, employers have increasingly shifted a larger amount of the growing healthcare costs onto employees in the form of high deductible health plans (HDHPs).[23] In both the individual and employer markets, HDHPs are the latest trend in health

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[17] KAISER COMM'N ON MEDICAID & THE UNINSURED, THE UNINSURED: A PRIMER (Oct. 2011), *available at* http://www.kff.org/uninsured/upload/7451-07.pdf. 56.2% of the non-elderly American population receives insurance coverage through an employer-sponsored plan.

[18] KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS: 2012 SUMMARY OF FINDINGS 1 (2012), *available at* http://ehbs.kff.org/pdf/2012/8346.pdf.

[19] David Mechanic, *The Rise and Fall of Managed Care*, 45 J. HEALTH & SOC. BEHAV. 76 (2004).

[20] *Id.*

[21] Robert A. Berenson et al., *The Growing Power of Some Providers to Win Steep Payment Increases from Insurers Suggests Policy Remedies May Be Needed*, 31 HEALTH AFF. 973, 973 (2012) (defining physicians and hospitals as "must-have" providers if they are necessary to attract employers and consumers, or they provide a unique service to a certain geographic area).

[22] *Id.*

[23] A Milliman, Inc. study released February 13, 2012 found that the ACA's Medical Loss Ratio rule may make it difficult for HDHPs to compete against higher-cost low-deductible plans in a ACA Insurance Exchange. The study also concludes that the Medical Loss Ratio creates disincentives for insurance companies to continue offering HDHPs. See Mark E. Litlow et al., *Impact of Medical Loss Ratio Requirements Under PPACA on High Deductible Plans / HSAs in Individual and Small Group Markets* http://www.hsacoalition.org/wp-content/uploads/2012/02/Report-ABAImpactofMedicalLossRatioRequirements.pdf.

insurance, frequently accompanied by either a health savings account or reimbursement arrangement.[24] HDHPs require consumers to pay out-of-pocket for healthcare services up to a certain threshold, i.e. $10,000, before the health plan will begin to cover a portion of healthcare costs like a traditional PPO plan. HDHPs thus trade lower monthly premiums for higher deductibles, in an effort to reduce the moral hazard that typically accompanies insurance.[25]

Enrollment in HDHPs has grown rapidly over the last five years. Based on data from 2011, 52.4% of persons with a private plan, directly purchased or obtained through means other than employment, were enrolled in an HDHP, up from 39.2% in 2007.[26] Employers, too, have discovered HDHPs as a cost-saving solution to the rapidly rising cost of insuring employees, with 26.9% of individuals with employer-based coverage enrolled in an HDHP in 2011, up from 15.6% in 2007.[27] This shift to HDHPs means that insured individuals are, arguably for the first time, incentivized to pay more attention to the price and quality of healthcare. Unfortunately, unlike the rapid growth of HDHP enrollment, the availability of price information to consumers has not grown with equal speed.[28] As a result, recent price transparency initiatives often target consumers, but initiatives focused on other entities including employers, providers, and insurers may prove more effective.

[24] A health savings account (HSA) is a tax exempt account owned by an individual consumer. Funds contributed to an HSA roll over and accumulate year-to-year, and job-to-job, if not spent. A health reimbursement arrangement is an employer-funded account that reimburses employees for out-of-pocket medical expenses and premiums, where any unused dollars remain with the employer.
[25] Moral hazard exists when an insured individual consumes more services or engages in riskier behaviors than he or she otherwise would because he or she is shielded from the true cost of care by insurance.
[26] 2011 NATIONAL HEALTH INTERVIEW SURVEY, *supra* note 6, at 6. These figures are based on persons under age 65 with private health insurance.
[27] *Id.*
[28] Jon B. Christianson et al., *Employer-Sponsored Health Insurance: Down but Not Out,* CENTER FOR STUDYING HEALTH SYSTEM CHANGE (Issue Brief No. 137), Oct. 2011, at 2.

II. Different Levels of Price Transparency

The price of healthcare carries a different meaning depending on the targeted party. Insurers, providers, employers, and individual consumers are all potential targets for price transparency initiatives. Price information aimed at facilitating competition between providers or insurers differs from information aimed at providing guidance to consumers. To illustrate these levels of transparency, consider the following example of an MRI.

Provider A's gross charge for an MRI is $2,000.[29] However this is not the price an insurer pays, or the price for which the insured consumer is responsible. For this MRI, Provider A has negotiated a rate of $1,000 with Insurer X and a rate of $1,500 with Insurer Y, but Patient B will pay a copay of $50 with Insurer X or a 10% co-insurance of $150 with Insurer Y.

The outcome of a price transparency initiative will vary significantly depending upon who receives what price information. The following subsections demonstrate different price disclosures and their impact on market dynamics.

A. The Insurer-Provider Level

Between insurers and providers, mandating disclosure of contract price terms is one way to create price transparency. Currently, confidentiality clauses and so-called "gag clauses" in provider-insurer contracts ensure that knowledge of negotiated prices stay between the parties in privity of contract.[30] As a result, third party insurers and providers are kept in the dark as to the prices being charged and collected by their competitors. Without knowledge of what providers are charging other insurers, insurers remain at a disadvantage at the bargaining table.[31]

[29] The gross charge for a medical procedure is the price billed to uninsured consumers. This amount is often different from the actual price recovered by providers.
[30] See *infra* Part IV.A
[31] Berenson et al., *supra* note 24, at 2.

Using the illustration introduced above, Provider A is able to charge Insurer X a lower rate than it charges Insurer Y. However, because the contract price terms between Provider A and Insurer Y are protected by a gag clause, Insurer Y is unable to use those price terms to negotiate a lower rate with Provider A. Mandating price transparency of negotiated rates at the insurer-provider level may facilitate more competitive pricing by allowing Insurer Y to use its knowledge of the contract with Insurer X to negotiate a lower rate. This would, in theory, drive down overall healthcare costs as competitors would be able to use their knowledge of these prices to increase their bargaining leverage and negotiate for lower prices.

Some existing price transparency initiatives mandate the availability of gross charges.[32] However, since this is not the price that is actually paid to providers by insurers, disclosure of more specific negotiated price information is necessary in order for, insurers to have the leverage required to negotiate for a lower rate.[33]

B. The Consumer Level

The goal of consumer-level price transparency is to create more well-informed consumers of healthcare.[34] The hope is that well-informed consumers will use easily accessible and comprehensible price and quality information to purchase lower-priced, higher-quality healthcare, thereby changing market demand and lowering overall prices. Consumers of healthcare include both individual persons and employers who purchase healthcare benefits for employees. Consumer-directed price transparency initiatives can mandate disclosure of prices at three levels: 1) individuals at the point of plan selection; 2) individuals at the point of provider selection; and 3) employer-purchasers. While many existing consumer-level transparency initiatives target individuals, these

[32] See *infra* Part V.A.I.
[33] See, e.g. David Cutler & Leemore Dafny, *Designing Transparency Systems for Medical Care Prices*, 364 NEJM 894 (2011), 895. (Cutler and Dafny are economists at Harvard and Northwestern Universities, respectively, who specialize in economic analysis of healthcare cost and quality.)
[34] *Id.* at 894.

initiatives have had only moderate levels of efficacy because patients do not have access to complete price and quality information in an easily comprehendible and usable format.[35] On the other hand, consumer-directed initiatives targeting employers that either purchase health insurance or healthcare services directly from providers have greater potential to reduce overall healthcare costs.[36]

Price transparency at the individual consumer level is defined as the amount of payment for which the consumer is responsible. For uninsured consumers, the price of care is also the same as the total payment to the provider. However, for insured consumers the price they pay for care will often represents only a small fraction of the overall cost; the insurance plan will pay for the rest, often at negotiated and discounted rates. Prior to selecting a health plan, individuals typically receive information on the different pricing structures associated with various insurance companies. Access to meaningful price and quality comparison data would enable them to carefully evaluate health plans before becoming a member. Historically, at the point of plan selection, consumers have had access to plan premiums, deductible and coinsurance amounts. However, as more individuals move into high deductible health plans (HDHPs), consumers will have to pay the actual prices of specific services out of pocket, making them also relevant to plan selection. Second, once enrolled in a health plan, consumers will require additional information regarding the price tiering of providers within their chosen plan, such that certain providers will require a higher level of coinsurance or copay. Price transparency initiatives targeting individual consumers should offer access to provider reimbursement rates that, along with provider quality information, can assist consumers in plan and provider selection. Unfortunately, providing meaningful price and quality information in a usable

[35] JH Hibbard & E Peters, *Supporting Informed Consumer Health Care Decisions: Data Presentation Approaches That Facilitate the Use of Information in Choice*, 24 ANNUAL REV. PUB. HEALTH 413 (2003), 414-16.
[36] See *infra* PartVI.D.

format for individual consumers has proven very challenging. Attempts to do so have resulted in only marginal consumer uptake.[37]

Rather than focusing on individual consumers, price transparency initiatives targeting employers may prove more effective. If employers could obtain both quality information on the providers included in a health plan as well as the negotiated prices, they could begin to use their leverage as purchasers to demand higher value plans and avoid plans that pay inflated rates to certain providers. Knowledge of insurer-negotiated prices will also enable self-insured employers to demand lower prices and develop networks of high value providers. Employers, especially larger ones, are in a better position to accumulate and analyze price and quality data than individual consumers and they also have the ability to leverage their employees purchasing power to negotiate price. Further, groups of like-minded employers, like the Leap Frog Group or The Pacific Business Group on Health, may have even greater ability to leverage their position to insist on higher value plans.[38]

The effect of any particular price transparency initiative will depend significantly on the targeted entities, the relevant market conditions, the usefulness of the information disclosed, and the ability of the targeted entity to act on that information. A well-designed price transparency initiative that takes into account these factors can reduce healthcare costs, while others will have little effect, or worse, could increase healthcare costs.

[37] CRS Report for Congress, *supra* note 9.
[38] *See* The Leapfrog Group, http://www.leapfroggroup.org, and The Pacific Business Group on Health, http://www.pbgh.org.

III. Price Transparency and its Effects

Economists and health policy scholars have debated the effects of transparency on the healthcare market for years.[39] While traditional economists argue that access to meaningful information in any market will result in a decrease in product cost,[40] others caution that in the healthcare market, healthcare costs may rise and other unintended effects may result from such disclosure if not implemented properly.[41] This Part describes these different theoretical effects and considers the reasoning behind each in order to better craft an economically efficient initiative.

In 2008, Congress commissioned the Congressional Research Service (CRS) Report to examine the effect of greater price transparency on the healthcare market.[42] The CRS ultimately concluded that greater price transparency might lead to lower prices.[43] In preparing the Report, CRS examined several empirical studies on price transparency in other markets and several economists' opinions on what these studies predict for the healthcare market. Generally, the Report concludes that if the healthcare market reacts to price transparency like other markets, then increasing the transparency of price information available to consumers will improve competition and drive down prices.[44] On the other hand, because of the special characteristics of healthcare, the Report also warns that increasing price transparency may increase prices in certain situations.[45] For instance, the Report highlights the effects of price transparency on the airline industry, which, like the hospital

[39] *See, e.g.*, JH Hibbard, J Stockard, and M Tusler, "Does publicizing hospital performance stimulate quality improvement efforts?, *Health Affairs*, 2003; 22(2): 84-94 (demonstrating that the debate about transparency in the healthcare market goes back at least a decade).
[40] Cutler & Dafny, *supra* note 36, at 894.
[41] *Id.* at 894; *see also* Sinaiko & Rosenthal, *supra* note 16, at 892.
[42] CRS Report for Congress, *supra* note 9.
[43] *Id.* at 33-4.
[44] CRS REPORT FOR CONGRESS, *supra* note 9, at 39 (citing Per Baltzer Overgaard, *Market Transparency, Information Exchange and Competition*, presented at the workshop on Competition Strategies and Competition Law, Swedish School of Economics and Business Administration, Helsinki, Oct. 14, 2003, *available at* http://mit.econ.au.dk/vip_htm/povergaard/pbohome/webpapers/transpcomphelsinki.pdf).
[45] CRS REPORT FOR CONGRESS, *supra* note 9, at 38 (citing Morten Hviid & H. Peter Møllgaard, Univ. of Copenhagen, Dep't of Econ., *Countervailing Power and Price Transparency* (Ctr. for Competition & Regulation, Working Paper CCR 01-2, 2001) (arguing when less informed buyers can observe prices negotiated by more informed buyers, sellers are less willing to offer lower prices to the informed buyers)).

industry, has high fixed costs and a non-storable product.[46] After the Airline Deregulation Act of 1978, increased competition led to lower fares for consumers and lower salaries for many employees. The most valuable components of the industry, however, such as pilots and mechanics, like highly specialized surgeons in healthcare, did not experience a salary reduction.[47] The Report concluded that well-designed price transparency initiatives could improve efficiency, while permitting innovative and highly valued providers to avoid operating at a loss.[48]

David Cutler and Leemore Dafny similarly analogize to other markets in order to analyze the potential effects of price transparency on the healthcare market.[49] Their article on increased price transparency looks to the Danish ready-mix concrete industry in the early 1990s, where Danish authorities implemented a price transparency policy against suspected anticompetitive practices by publishing actual invoice prices.[50] Within one year from the dissemination of that information, average prices in the industry rose 15 to 20%.[51] The most likely explanation for the price increase is that publishing transaction prices quickly revealed competitor price cuts, which made it easier for ready-mix concrete firms to avoid competition.[52]

To avoid the potential for an increase in healthcare costs, Cutler and Dafny argue that disclosing more limited price information, such as average provider reimbursement rates instead of complete cost information, may make price cuts to certain insurers less detectable, collusion efforts more difficult, and prices less likely to rise.[53] But, while the disclosure of average prices reduces

[46] CRS REPORT FOR CONGRESS, *supra* note 9, at 33.
[47] *Id.*
[48] *Id.*
[49] Cutler & Dafny, *supra* note 36.
[50] *Id.* at 895; *see also* CRS REPORT FOR CONGRESS, *supra* note 9, at 31, 38-39; STEPHEN MARTIN, *Chapter 3: Collusion and Tacit Collusion, in* INDUSTRIAL ORGANIZATION: A EUROPEAN PERSPECTIVE 49, 56-57 (2001).
[51] MARTIN, *supra* note 53, at 56-57 (stating that it is not possible to explain the price increase in terms of demand factors because "[d]uring this period, there was no particular boom in the construction industry, the major user of ready-mix concrete"); *see also* CRS REPORT FOR CONGRESS, *supra* note 9, at 31, 38-39.
[52] MARTIN, *supra* note 53, at 57.
[53] Cutler & Dafny, *supra* note 36, at 895.

price secrecy, such limited disclosures will not be sufficient to also affect patient healthcare decisions. Average prices can depict such an expansive range that consumers are often unable to draw helpful price comparisons among providers. Further, limited disclosure cannot capture the many variables affecting price variation -- including condition severity, geographic location, and quality of provider -- that will inevitably affect price.[54]

Other scholars have examined different models and markets to determine the effect of price transparency in healthcare. Michelle Kim, a PhD in healthcare management and economics, also uses economic theory to examine the effect of transparency measures on the healthcare market.[55] Her dissertation focused on the clearinghouse model for transparency. This model focuses on the effects of consumers who have access to a list of prices charged by different sellers in a market, and assumes that "informed" consumers with access to such a list will choose the lower-cost products, whereas "uninformed" consumers without access will purchase products in the market at random.[56] Kim reports the effect of healthcare price transparency on (1) market share, (2) market efficiency, and (3) price sensitivity among medical care consumers.[57] In terms of market share, Kim states that if more informed consumers search for the lowest priced providers the market share shift will be greater, with the greatest shift seen in consumers away from fee-for-service plans.[58] However, Kim notes the difficulty of providing price and quality information to consumers in one central location, as opposed to piecemeal reporting of quality information on one website and price on another.[59] Without quality information available in the same location as price information, Kim suggests that

[54] The limitations of average price disclosure are discussed in more detail in Part IV.B.
[55] Michelle Kim, The Effect of Hospital Price Transparency in Healthcare Markets (2011) (Ph.D. dissertation in Health Care Management and Economics, University of Pennsylvania).
[56] *Id.* at 16.
[57] *Id.* at 61-69.
[58] *Id.* at 12.
[59] *Id.* at 30.

consumers will be reluctant to choose lower-priced providers.[60] Instead, consumers will continue to equate cost with quality, likely causing prices to remain constant, if not increase.[61] Kim's results for consumer price sensitivity suggest that increased price transparency in a cost sharing system will lead to a reduction in healthcare expenditures, but only if it is possible to provide cost and quality information together such that consumers can understand the true value of services before receiving them.[62]

Given the varied hypotheses and dearth of actual studies, the effect of price transparency on the healthcare market remains largely uncertain. It seems at least possible that some price transparency initiatives could lower healthcare costs in certain markets, but this may be merely one piece to the larger transparency puzzle. Initiatives targeted at providing greater transparency between insurers and providers could, on one hand, inspire providers to raise prices to a uniform or near uniform level. On the other hand, transparency at the provider-insurer level could empower insurers to negotiate for lower prices which would contribute to an overall decrease in healthcare prices. At the consumer level, many empirical studies of consumer-directed transparency initiatives have reported little to no effect on healthcare prices.[63] If these consumer-targeted initiatives have any hope of effecting the healthcare market, it will be essential to link quality to price and to present consumers with this information in a useful and easily digestible format. Otherwise, an initiative could have no effect—or worse, increase costs.

While research on the effects of price transparency often generates mixed predictions and unknown results, one consistent conclusion prevails: Making price information publicly available

[60] *Id.* at 68.
[61] *Id.* at 128-29.
[62] *Id.* at 66. Note that Kim's study used charges billed and not actual out-of-pocket costs.
[63] *See e.g., supra* Part V.A.1.

must be done with extreme care in order to begin to shape healthcare decision-making and avoid unwanted price increases.

IV. Barriers to Price Transparency

Unfortunately there are multiple barriers to price transparency. First, confidentiality clauses, or "gag clauses," in provider-insurer contracts prevent consumers and competing providers from knowing negotiated provider rates. Second, to oppose mandated price transparency, providers and insurers may allege trade secret protection of negotiated prices to prevent disclosure of that information. Finally, general provider resistance, the question of whether consumers will seek out available price information, complex cost-shifting, and complex billing practices in the healthcare market create hurdles to achieving price transparency that must be cleared before implementing a successful initiative.

A. Contractual Barriers

Contract terms can prevent disclosure of negotiated rates to anyone outside of the contracting parties.[64] This section addresses the barriers to price transparency created by confidentiality clauses, also called "gag clauses," and most-favored-nation (MFN) clauses. Gag clauses in contracts between insurance companies and providers currently constitute a significant barrier to third party disclosure of much of the relevant healthcare pricing information.[65] These gag clauses between hospitals and manufacturers of healthcare devices can even keep physicians from knowing true price information about the technology they use every day,[66] leaving some providers

[64] GOV'T ACCOUNTABILITY OFFICE, GAO-11-791, 15 HEALTH CARE PRICE TRANSPARENCY: MEANINGFUL PRICE INFORMATION IS DIFFICULT FOR CONSUMERS TO OBTAIN PRIOR TO RECEIVING CARE 1 (2011) [hereinafter GAO REPORT ON PRICE TRANSPARENCY].
[65] Jeffrey C. Lerner et al., *The Consequences of Secret Prices: The Politics of Physician Preference Items*, 27 HEALTH AFF. 1560, 1561 (2008).
[66] GOV'T ACCOUNTABILITY OFFICE, GAO-12-126, MEDICARE: LACK OF PRICE TRANSPARENCY MAY HAMPER HOSPITALS' ABILITY TO BE PRUDENT PURCHASERS OF IMPLANTABLE MEDICAL DEVICES 29-31 (2012).

without an incentive to contain costs by reducing unnecessary tests and treatments.[67] An MFN clause, on the other hand, is a contractual agreement that prohibits a provider from giving any other insurer a deeper discount than the contracting insurer. Both gag clauses and MFN clauses can thwart transparency efforts and have the effect of unnecessarily raising consumer costs.

1. Gag Clauses

While some existing price transparency initiatives circumvent these contractual obligations by disclosing cost ranges or gross prices, these figures are neither specific enough to be useful for consumers or employers in making purchasing decisions, nor to aid in a provider leverage increase at the bargaining table. More specific price information, however, is often subject to "gag clauses" in contracts between insurers and providers that prohibit the contracting parties from disclosing the negotiated prices with third parties. These gag clauses allow insurers to pay "must-have" providers, or anchor providers—that is, essential providers to a health plan—higher than market prices for services, without other providers' knowledge.[68] Further, they prevent payers and consumers from knowing the differences in provider-negotiated rates. Without the ability to compare prices, providers, payers, and consumers cannot be sure they are getting a competitive price. Price transparency initiatives to eliminate gag clauses at the insurer-provider level would allow other insurers and providers, who are not parties to the contract, to know the prices their competitors charge or are being charged for specific services.

Gag clause prohibitions can produce varied effects depending upon specific market dynamics. In markets with high levels of competition, eliminating gag clauses might give insurers more leverage, if consumers gravitate toward low-cost, high-quality providers. Under those circumstances, providers will not be able to insist on higher rates unless they have the cost and

[67] SHANNON BROWNLEE, OVERTREATED: WHY TOO MUCH MEDICINE IS MAKING US SICKER AND POORER 28-42 (2008).
[68] Berenson, *supra* note 24, at 973.

quality measures to support that demand. However, this model assumes that, in highly competitive healthcare markets, cost and quality information is available, easily-accessible, and that patients will use it to make healthcare decisions. To date, no data is available to support this assumption. Even worse, in markets without substantial competition, transparency of prices paid to "must-have" providers may encourage other providers with as good or better quality measures to demand even higher prices, thereby driving up the cost of healthcare in those markets.

Efforts to eliminate gag clauses that target provider and insurer behaviors may translate into lower costs overall. At best, providers might be forced to provide valuable, transparent reasons for charging higher prices, such as quality measures or being the only provider in a healthcare market who offers certain services, or else lower their prices to maintain a profitable patient base. At worst, this might allow competing providers to demand higher prices, driving up costs.[69] But identifying this possibility, and the market conditions that create it, can enable policymakers to design around this concern.

Unfortunately, successful price transparency initiatives to remove gag clauses may prove more elusive when aimed at affecting consumer choice. Unlike insurers and providers who may have a more complete understanding of codes and healthcare pricing structures, consumers on the whole do not and cannot effectively use information they do not understand.[70] In order for disclosure of insurer-provider negotiated prices and quality information to consumers to help lower healthcare costs, the information must be easily accessible and comprehensible, not simply available.[71]

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[69] *See supra* Part II.

[70] Paul B. Ginsburg, *Market Watch: Shopping for Price in Medical Care*, HEALTH AFF. WEB EXCLUSIVE, Feb. 6, 2007, at 208, 211 (citing Hibbard & Peters, *supra* note 38).

[71] Kaiser Family Found., *Transparency & Complexity* (Aug. 13, 2012), http://policyinsights.kff.org/en/2012/august/transparency-and-complexity.aspx (stating that while simplified assumptions make it easier for health plans to

Just as transparency interventions aimed at the insurer-provider level may result in a benefit to consumers by creating lower prices, consumer-level disclosure may, in turn, affect providers and insurers by allowing consumers to demonstrate where their demand lies, thereby creating a more level playing-field for contract negotiations. Returning to the MRI cost example from Part II, a price transparency initiative eliminating the gag clause in the contract between Provider A and Insurer X can create these mutually beneficial results. First, Insurer Y would gain access to the $1,000 rate between Provider A and Insurer X. This would give Insurer Y increased bargaining leverage and allow it to negotiate for a lower rate. Second, eliminating the gag clause would allow individual consumers and employers to comparison shop between Insurer X and Insurer Y. In choosing the insurer with the lowest reimbursement rate, Insurer X, consumers have the ability to increase the demand for Insurer X's rate. This would also give Insurer Y more leverage at the bargaining table to negotiate for a lower rate. Both levels of price transparency, therefore, have the potential to drive down healthcare costs.

While disposing of gag clauses may prevent secret deals and selective discounts that lead to escalating costs, some economists believe that price transparency at the provider-payer level could have the opposite effect of actually raising prices charged to patients. Thus, thorough economic analysis of the effects of this type of initiative in different market settings is necessary.

2. Most-Favored-Nation Clauses

Most-favored-nation (MFN) clauses have also had similar effect on the healthcare market, stifling competition and driving up healthcare costs.[72] In the healthcare market, MFN clauses occur most often when large insurers with substantial market power agree to pay "must-have" providers a higher than fair price to have them in their network. These agreements can have the effect of

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produce coverage illustrations, mis-estimating costs make the price information must less useful to consumers because the effect on the plan differences is masked).

[72] Cutler & Dafny, *supra* note 36, at 894-95.

setting a minimum price for all medical services covered by the contract. "Thus, the cost of such services incurred by a dominant insurer with an MFN clause can become the minimum price for all other competitors in the market that deal with those same providers."[73] As a result, MFN clauses can make it impossible for new insurers to offer a competitive plan in a given market because of the inability to negotiate the same or lower prices with "must-have" providers.[74]

To have a competitive advantage, an insurer must ensure that it pays the lowest price for important providers, not that it pays a low price. As a result, large insurers do not need to use their leverage to negotiate lower costs and can accommodate higher price demands from providers. Any additional costs can be passed on to consumers as premiums. In the healthcare market, the existence of these clauses in insurer-provider contracts has hindered alternative delivery systems and interfered with competition, causing prices to rise.[75] Like MFN clauses, price transparency initiatives would enable large insurers to negotiate to obtain the lowest prices applicable to a "must-have" group of providers. However, this might cause must have providers to charge higher prices overall, rather than lowering them. Further, price transparency initiatives would also allow competitor-providers to see the higher prices other providers have been able to negotiate and demand to be paid those prices as well, which could drive up the cost of healthcare across the board. However, without price transparency, in some markets insurers could continue to offer certain providers lower rates and better contain costs.

Contractual barriers, in the form of gag clauses and MFN clauses, inhibit efforts to increase healthcare price transparency. However, at this stage, economists can only speculate as to the current impact of these clauses on healthcare prices and the effects of prohibiting them on the

[73] James F. Doherty & Monique Ras, Most Favored Nation Clauses in Payor/Provider Agreements, at 3, *available at* http://www.insurance.ohio.gov/documents/MFN6.pdf.
[74] Cutler & Dafny, *supra* note 36, at 894.
[75] *Id.* at 895.

future of the healthcare market. Greater economic analysis of healthcare market conditions and behavior must be conducted before complete price transparency can be implemented by the prohibition of confidentiality clauses.

B. Trade Secret Barriers: Price Information as Trade Secrets

Another hurdle to price transparency that stems from confidentiality clauses in contracts is whether healthcare prices—that is, the negotiated rates in insurer-provider/hospital contracts—are trade secrets, such that insurers could defend against the mandatory disclosure of a price transparency initiative.

Trade secret law is governed by state law. To date, 46 states have adopted the Uniform Trade Secrets Act (UTSA).[76] The UTSA was intended to codify section 757 of the First Restatement of Torts,[77] which defines a trade secret as including "not simply information as to single or ephemeral events in the conduct of the business . . . [but] a process or device for continuous use in the operation of the business." At common law under Section 757, the "continuous use" requirement effectively excludes ephemeral events, such as specific sales price information, from protection. The UTSA, however, eliminated the continuous use requirement. This change, arguably, may broaden the definition of what kinds of information can be afforded trade secret protection, so as to include pricing information.[78] The inclusion of price information, however, ultimately remains uncertain in the healthcare market because it has yet to be resolved by the courts.

[76] James H. Pooley et al., *§ 1.2 Sources of California Trade Secret Law, in* OVERVIEW OF CALIFORNIA TRADE SECRETS LAW, CEB ONLAW (2d ed. 2011). States that have not adopted the UTSA rely on common law based on the Restatement of Torts.

[77] *Commissioners' Comment to Uniform Trade Secrets Act §1, in* TRADE SECRETS: A STATE-BY-STATE SURVEY 3084 (Brian M. Malsberger ed., 3d ed. 2005) (stating that the purpose of the Act is to "codif[y] the basic principles of common law trade secret protection").

[78] Annemarie Bridy, *Trade Secret Prices and High-Tech Devices: How Medical Device Manufacturers Are Seeking to Sustain Profits by Propertizing Prices*, 17 TEX. INTELL. PROP. L.J. 187 (2009) (citing Commissioners' Comment to UTSA § 1, *in* TRADE SECRETS: A STATE-BY-STATE SURVEY, *supra* note 80, at 3084, and stating that the purpose of the omission of "continuous" in the Act is to "extend[] protection to a plaintiff who has not yet had an opportunity . . . to put a trade secret to use.").

The threshold question in trade secret law must be whether the information is a trade secret. Usually the answer is determined when the holder of an alleged trade secret files a misappropriation claim, alleging that someone or some entity has used or disclosed their trade secret information through improper means.[79] If the information is determined to be a trade secret, that information is protected only against misappropriation. If no trade secret exists, an alleged misappropriator is not liable under the state's UTSA, even if the information was improperly acquired.

In terms of possible healthcare price transparency mandates, the analysis will not focus on whether price information has been misappropriated; before such mandates are in place, no possible misappropriation can occur. Rather, this analysis must preempt a misappropriation claim and examine whether a transparency initiative can force insurers and providers to disclose their pricing information without running afoul of their legal ability to protect their alleged trade secrets. This will depend upon whether pricing information meets the definition of a trade secret.

1. Defining Price Information as a Trade Secret

In 1984 California adopted the California Uniform Trade Secrets Act, which defines a trade secret as follows:

> "Trade secret" means information, including a formula, pattern, compilation, program, device, method, technique, or process that: (1) Derives independent economic value, actual or potential, from not being generally known to the public or to other person who can obtain economic value from its disclosure or use; and (2) Is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.[80]

Whether information is a trade secret is a question of fact;[81] the court will objectively determine whether a trade secret exists. A party's belief that information is secret or contractually confidential may be a factor in the analysis, but is not dispositive.[82]

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[79] Cal. Civ. Code § 3426.1(b).
[80] *Id.* § 3426.1(d). This language comes directly from the U.T.S.A. and is not unique to California.
[81] San Jose Const., Inc. v. S.B.C.C., Inc., 155 Cal.App.4th 1528 (2007).

a) First Prong – Unknown information with economic value

The first prong of the USTA definition is more easily understood when broken down into two separate elements: (a) information not generally known, and (b) independent economic value. Each will be discussed separately, followed by the final definitional prong of "secrecy measures," effectively creating a three-part test.

(a) *Information not generally known.* First, the information claimed to be a trade secret must be not be generally known, or readily ascertainable by, business competitors or others to whom the information would have some economic value.[83] A party alleging misappropriation of trade secrets must initially be able to identify the trade secrets with "reasonable particularity" prior to discovery.[84] This flexible standard requires the party to identify the alleged trade secret in a fair, proper, just and rational manner under all circumstances so that the trial court can control the scope of discovery and allow both parties the opportunity to prepare their case.[85] In certain cases, a court may require the party claiming trade secret protection to "separate [the instant subject matter] from matters of general knowledge in the trade or of special knowledge to those persons who are skilled in the trade."[86] A court will often require a party to draw this distinction when the nature of the alleged trade secret makes a detailed description, alone, inadequate to permit the opposing party from learning the limits of the trade secret and developing defenses, or to allow the court to effectively control the scope of discovery.[87]

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[82] Morlife, Inc. v. Perry, 56 Cal. App. 4th 1514, 1522 (1997) (plaintiff's belief); American Paper & Packaging Prods., Inc. v. Kirgan, 183 Cal. App. 3d 1318, 1325 (1986) (contract).
[83] Syngenta Crop Protection, Inc. v. Helliker, 138 Cal. App. 4th 1135, 1172 (2006); DVD Copy Control Ass'n, Inc. v. Bunner, 116 Cal. App. 4th 241, 251 (2004).
[84] Cal. Civ. Code § 2019.210; Neothermia Corp. v. Rubicor Medical, Inc., 345 F. Supp. 2d 1042 (N.D. Cal. 2004).
[85] Advanced Modular Sputtering, Inc. v. Superior Court, 132 Cal. App. 4th 826 (2005) (rehearing and review denied).
[86] Diodes, Inc. v. Franzen, 260 Cal. App. 2d 244, 251, 253 (1968).
[87] Discovery is the pre-trial phase of litigation where each party can obtain evidence from the opposing party, including by the taking of depositions and requesting the production of documents. A court must have a sufficient

(b) *Independent economic value.* The second element of the first prong requires that the information derive value from the fact that it is a secret. The value of the information to a competitor must be substantial; it is insufficient to know that it might have been merely helpful.[88] To determine what value is substantial, it is necessary to compare the alleged secret information to information generally known.[89] This requirement was codified from the common law requirement that a trade secret reflect a "competitive advantage,"[90] which is especially helpful to insurers and providers wishing to keep their negotiated pricing confidential so as to maintain a competitive advantage against the rest of the market participants. The focus, therefore, is on the greater value of the alleged secret information in comparison to information of general knowledge. Any unrelated value or the value of efforts expended to create the information is not conclusive evidence of substantial value, although both are relevant to the analysis.[91]

b) Second Prong – Secrecy measures

The second prong of the test requires the party alleging secrecy of information to show that they have made reasonable efforts to keep the information secret. To satisfy this prong, that party must show that its secrecy efforts make it difficult for a third party to acquire the information, except by improper means.[92] Such efforts include, among others, imposing an obligation of confidentiality, such as a confidentiality clause in a contract, to prevent others from sharing the

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understanding of the parameters of a case in order to rule on what types of information one party may request from the other.

[88] Yield Dynamics, Inc. v. Tea Sys. Corp. (2007) 154 Cal. App. 4th 547, 567 (stating software routines only represented trivial value because they or their equivalents could be recreated).

[89] Pooley et al., *supra* note 79, *§ 1.7(C) Independent Economic Value Requirement.*

[90] Restatement (Third) of Unfair Competition § 39, cmt. d, Reporter's Note (1995).

[91] *Id.* §39, cmt. e (value of the information); Courtesy Temp. Serv. V. Camacho, 222 Cal. App. 3d 1278, 1282 (1990) (development expense).

[92] Clark v. Bunker, 453 F.2d 1006, 1009 (9th Cir 1972) (quoting Restatement of Torts §757, cmt. b (1939)).

information. Contrarily, information easily obtainable, sold on the open market, or discovered by reverse engineering cannot constitute a trade secret.[93]

2. The effect of the Restatement's and the USTA's definition on the courts

Due to the rather amorphous definition provided by the USTA for trade secrets, many courts have referred back to the First Restatement to help narrow what kinds of information can receive trade secret status in other markets. Courts that have decided cases related to commercial transactions and business investments have still invoked the "continuous use" requirement to exclude ephemeral information and align the definition of trade secrets with the legislative intent of the UTSA.[94] One federal district court in New York concluded that although a company had taken all the necessary measures to maintain the secrecy of its pricing information, prices fluctuate over time in any market and cannot receive trade secret protection.[95] However, since New York has not adopted a version of the UTSA, but only the common law definition of trade secret from Section 757 of the Restatement of Torts,[96] this case may inform, but is not binding as to interpretation of trade secret law in states that have adopted the USTA. Courts in USTA jurisdictions may nonetheless find the court's ruling to be persuasive authority in future cases of first impression.

Courts may also deny trade secret designation if the information has been disclosed even to a limited set of individuals. Therefore, price disclosures to customers on an individual basis have been found to evade trade secret protection because of the theory that disclosure would not necessarily end with the individual consumer, but could continue to be disseminated by that

[93] Cal. Civ. Code § 3426.1(a).
[94] Bridy, *supra* note 81, at 203-04.
[95] *Id.* at 204 (citing Ivy Mar Co. v. C.R. Seasons Ltd., 907 F. Supp. 547, 558 (E.D.N.Y. 1995) and quoting: "Price decisions are made on current competitive information which fluctuates over time in any industry. . . . Accordingly, that information is not likely to be accorded trade secret status.").
[96] *Trade Secrets Law in New York*, CITIZEN MEDIA LAW PROJECT (last updated May 6, 2008), *available at* http://www.citmedialaw.org/legal-guide/new-york/trade-secrets-law-new-york.

consumer to other third parties.[97] These courts reason that once the consumer has possession of allegedly confidential information, the seller's competitor can easily obtain that information from the consumer.[98] This case law seems to suggest that proponents of price transparency could successfully defend against trade secret claims if so much as one line of price data was made available to an individual consumer. In particular, the fact that Aetna has made complete price information available to its members on its website may be enough to withstand a trade secret defense asserted by the insurance company.[99]

3. Pricing in healthcare: unanswered by the courts

Two federal district court cases in Minnesota and Pennsylvania attempted to tackle the question of whether healthcare pricing can be protected as trade secrets. In each case, Aspen Healthcare Metrics (Aspen) and Emergency Care Research Institute (ECRI), respectively, urged the court to find that the prices hospitals pay for implantable medical devices manufactured by Guidant Corporation do not qualify as trade secrets as a matter of law.[100] In opposition, Guidant asserted trade secret protections for the "prices paid by hospitals to Guidant for its devices."[101] Each court denied motions for summary judgment, ruling that a genuine issue of material fact remained as to whether Guidant's pricing information met the above three-step analysis.[102] Ultimately, both cases settled on confidential terms before trial, leaving the merits of Guidant's trade secret claims unexamined.

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[97] Bridy, *supra* note 81, at 206.
[98] *Id.* (citing Economation, Inc. v. Automated Conveyor Systems, Inc., 694 F. Supp. 553, 556-57 (S.D. Ind. 1988) (Indiana has adopted the UTSA)).
[99] See further discussion of Aetna's price transparency initiative in Part IV.B.
[100] Cardiac Pacemakers, Inc. v. Aspen II Holding Co., 413 F. Supp. 2d 1016 (D. Minn. 2006); Emergency Care Research Institute v. Guidant Corp., 2007 U.S. Dist. LEXIS 67658 (E.D. Pa. Sept. 12, 2007).
[101] Guidant's First Amended Ans. & Counterclaims, ¶ 30.
[102] *Cardiac Pacemakers*, 413 F. Supp. 2d at 1028; *Emergency Care Research Institute*, 2007 U.S. Dist. LEXIS 67658, at *16. Denial of a motion for summary judgment means that both parties alleged enough conflicting facts that the court could not rule on the merits of the case at the pre-trial stage.

Consequently, the proprietary nature of pricing information in the healthcare context remains unresolved. As for the first prong of the trade secret analysis, healthcare pricing information remains unknown and arguably has substantial independent economic value such that politicians, policymakers, and economists alike have long been advocating for increased price transparency in the healthcare market. However, these cases may serve to strengthen the second prong of the trade secret test. The confidential nature of the settlement agreements may serve as further evidence of the companies' substantial measures to maintain the concealment of their prices, weighing in favor of affording them trade secret protection.

4. Acquiring price information from government agencies

If a state, through legislation or regulation, mandates disclosure or invites voluntary disclosure of pricing information to a government agency, such as its state exchange under the ACA, the state government's ability to share that information with competitor-insurers/providers or the public at large in light of trade secret protections is unknown. In some instances, a company may disclose information to a third party while still maintaining secrecy of the information through contract, such as a gag clause. When the third party is a government agency, however, the analysis becomes more complicated.

In California, for example, Intentional disclosure of proprietary pricing information by a state agency is governed by the California Public Records Act (CPRA).[103] The CPRA provides that public records are open to inspection by members of the public, unless exempted by law, and must be made promptly available upon request.[104] The law allows individuals to bring actions to enforce

[103] Gov. Code §§ 6250-76.48; *see also* San Gabriel Tribune v. Superior Court, 143 Cal. App. 3d 762, 772 (1983). Because the CPRA was modeled after the Freedom of Information Act (FOIA), 5 U.S.C. § 552, federal case law can be relied upon to interpret and apply the CPRA.

[104] Gov. Code § 6252 (b). Members of the public include individual persons, corporations, partnerships, limited liability companies, firms, and associations, as well as public agencies.

disclosure of information if they feel it has been wrongfully withheld.[105] A public record includes any writing retained by any state or local agency, regardless of physical form or characteristics.[106] "This definition is intended to cover every conceivable kind of record that is involved in the governmental process and will pertain to any new form of record-keeping instrument as it is developed."[107] As a result, if the state or local government has negotiated with providers for discounted rates on healthcare services, those contracts may be obtainable via CPRA. Further, if California passes legislation or regulation that mandates disclosure of healthcare price information to a government entity, individuals may be able to enforce disclosure of that information which may, in turn, negate a trade secret claim by the owner of that information.

Some exemptions to CPRA do exist. While no statutory exemption directly applies to information disclosed pursuant to a state transparency initiative, three kinds of exemptions may apply to healthcare pricing information as well as to trade secrets - §6254(q) exemptions, the "trade secret exemption," and the "catchall exemption." Each could be used by insurers and providers wishing to maintain the secrecy of their individual prices.

Section 6254(q) exempts, in part, negotiations with providers of healthcare services by special negotiators who represent the State Medi-Cal program. It also exempts portions of a provider contract with Medi-Cal containing rates of payment for three years from the date of the contract. This, and all other exemptions, must be narrowly construed.[108] Since no such exemption exists for private insurer negotiations or contract provisions with providers, it seems unlikely that private insurance companies and providers could successfully challenge disclosure of pricing

[105] *Id.* § 6258.
[106] *Id.* § 6252 (e) (definitions).
[107] San Gabriel Tribune v. Superior Court, 143 Cal. App. 3d 762, 774 (1983) (citing Assembly Committee on Statewide Information Policy California Public Records Act of 1968, 1 Appendix to Journal of Assembly 7, Reg. Sess. (1970)).
[108] Board of Trustees of California State University v. Superior Court, 132 Cal. App. 4th 889 (2005).

information should it be lawfully retained by the state through a transparency initiative. Furthermore, even if individuals sought to challenge disclosure of information by a government agency, CPRA would not allow them to bring actions to prevent the disclosure. However, the government may appear hypocritical if its agencies collected and disseminated data from private insurance companies, while still maintaining the secrecy of its own healthcare price information.

The trade secret exemption prevents disclosure of all trade secrets under CPRA if their disclosure "is exempt or prohibited pursuant to federal or state law including…the Evidence Code relating to privilege."[109] Although the exemption references only the Evidence Code as basis for trade secret protection, it has been interpreted to incorporate by reference all statutory and common law bases for the protection of trade secrets, including the UTSA.[110] Thus, the analysis returns to the original inquiry to determine whether the information qualifies as a trade secret.

The catchall exemption protects confidential information if "the public interest served by not disclosing the record clearly outweighs the public interest served by disclosure."[111] Private insurers could contend that the risk of healthcare price increases posed by price transparency is high enough that disclosure of healthcare price information does not serve the public's interest. While reputable data and analysis exist about the possible negative outcomes of price transparency, without more conclusive studies in the healthcare market this argument is unlikely to meet the onerous burden of clearly outweighing the benefit of disclosure. Further, recent case law suggests that it is becoming increasingly difficult to protect proprietary information under the catchall exemption.[112]

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[109] Gov. Code § 6254(k).
[110] Pooley et al., *supra* note 79, *§ 5.22 Trade Secret Exemption* (urging that, because the trade secret exemption was enacted prior to the passage of the UTSA, practitioners should not hesitate to argue that the limited the limited scope of the Evidence Code should not apply).
[111] Gov. Code § 6255(a). *See* State Bd. of Equalization v. Superior Court, 10 Cal. App. 4th 1177 (1992).
[112] *See, e.g.*, County of Santa Clara v. Superior Court, 170 Cal. App. 4th 1301 (2009) (demonstrating that any doubt should be resolved on the side of disclosure).

Finally, local city ordinances may provide additional regulations pertaining to disclosure of proprietary information. San Francisco's Sunshine Ordinance, established by Chapter 67 of the San Francisco Administrative Code, is the city's version of the CPRA.[113] Under the Sunshine Ordinance, the Director of Public Health may withhold proposed and final payment rates for managed care contracts for its employees.[114] However, just like the CPRA, this exemption, narrowly interpreted, does not extend to private health insurance contracts with providers and hospitals.

The potential for insurers or providers to claim that the specific prices negotiated in their contracts constitute trade secrets could be a substantial barrier to price transparency initiatives. In general, the courts have left substantial uncertainty as to whether healthcare prices deserve trade secret protection.[115] However, in California, the exemptions to CPRA should support an argument against offering trade secret protections to healthcare price information.[116] Further, private entity negotiations under Section 6254(q), combined with a showing that, on balance, public disclosure of healthcare prices weighs in the public's interest under the catch-all exemption, seem to suggest that those entities seeking trade secret protection will have an uphill battle.[117] If California courts affirmatively denied trade secret protection to healthcare price information, such a decision could serve to clarify muddied precedents in other states as well.

C. Other Barriers

In addition to legal barriers created by gag clauses and trade secrets claims, substantial non-legal barriers exist to improving the transparency of healthcare prices, including provider resistance,

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[113] The San Francisco Sunshine Ordinance (added by Ord. 265-93, App. 8/18/93; amended by Proposition G, 11/2/99), *available at* http://www.sfbos.org/index.aspx?page=5551#67.2 (last accessed Oct. 8, 2012).
[114] *Id.* at Sec. 67.24(e)(2).
[115] *See Cardiac Pacemakers*, *supra* note 103 (where the lawsuit settled before the court could decide the trade secret claim), and Nunes v. The Hospital Committee for Livermore-Pleasanton Areas (Cal. Ct. App., May 29, 2012, A131060) 2012 WL 1925537 (an unreported case where, similarly, the court ruled on a motion for summary judgment before tackling the question of alleged trade secret protection).
[116] *See* Gov. Code § 6254(q), (k) and § 6255(a).
[117] Gov. Code § 6254(q); GAO REPORT ON PRICE TRANSPARENCY, *supra* note 67, at 9.

consumer lack of interest, and complex billing practices. Even if the law mandated providers and insurers to make negotiated prices public, these obstacles have the capacity to render price transparency initiatives ineffective, and therefore should be readily addressed in any price transparency initiative.

1. Provider resistance

Provider resistance to transparent healthcare prices is, and may continue to be, one such substantial barrier to mandating price transparency. Providers may resist price transparency initiatives mandating public reporting and anti-transparency clauses in their contracts.[118] For instance, Aetna's online description of its price transparency initiative cites "provider resistance as limiting the extent to which they can make price information available to their members."[119] This resistance to transparency is logical, if physicians are paid on a fee-for-service basis.[120] In a fee-for-service system without transparency, physicians are financially incentivized to order increasing numbers of tests and procedures because most consumers have no way of knowing the costs or the relative benefit of the procedure. In a value-based purchasing system, which the ACA hopes to achieve, price transparency can actually help improve quality of care while lowering costs. For example, providing greater reimbursements for physicians who provide increased preventative care and follow-up visits after certain procedures can shift provider incentives away from quantity of care and toward keeping patients well and out of the doctor's office.[121]

Not all providers oppose price transparency. Some have spoken out in favor of it. In written comments prepared for the August 25, 2012 California Health Benefit Exchange Board Meeting, insurers, provider groups, and other healthcare advocacy groups who partner with providers

[118] GAO REPORT ON PRICE TRANSPARENCY, *supra* note 67, at 27.
[119] *Id.* at 22; *see also Aetna's Healthcare Cost Transparency Tools*, http://www.aetna.com/producer/e.briefing/2009-02/nat2_09_trans.html (last visited Sept. 24, 2012).
[120] BROWNLEE, *supra* note 70.
[121] BROWNLEE, *supra* note 70.

expressed their support for the exchange staff's recommendation to prohibit anti-transparency clauses (gag clauses) in insurer-provider contracts.[122] Their support for transparency incorporated all of the above-mentioned intended effects, including cost-savings and creating well-informed consumers as a way to drive consumerism and lower prices. Although price transparency has seen some support from provider groups, in most instances, those seeking to advance a price transparency initiative should be prepared for resistance from providers.

2. Questionable consumer usage

Even if a health policy initiative were enacted and survived trade secrets challenges, many health policy experts warn that consumers may not use this information in the ways previously described.[123] If consumers will not comparison-shop for their healthcare like they do for other consumer products, making healthcare prices readily available to consumers will have very limited effects on healthcare spending.[124]

Major changes in healthcare billing practices may need to occur before transparency aimed at consumers can be expected to drive down the cost of healthcare.[125] Uwe Reinhardt, Professor of Political Economy and Economics at Princeton University in the area of health policy, has argued that consumer-directed care cannot positively impact the healthcare industry unless hospital billing practices are reformed to allow consumers to readily understand how and for what services they will

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[122] *Stakeholder Input: Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability*, CALIFORNIA HEALTH BENEFIT EXCHANGE, Aug. 10, 2012, *available at* http://www.healthexchange.ca.gov/BoardMeetings/Documents/August_23_2012/IX_StakeholderConsolidatedCommentsQHPPoliciesandStrategies_8-14-12.pdf. Those expressing support of prohibiting anti-transparency clauses in provider contracts included the California Pan-Ethnic Health Network, Castlight Health, Health Access, VSP Vision Care, Pacific Business Group on Health, Blue Shield of California. However, Blue Shield of California believes it is too soon to address contract regulation because (a) providers will resist, and (b) it is too soon before apps for QHPs are due to change any existing contracts. The lone group in opposition was the California Medical Association, due to a worry about a lack of concomitant provider protections and no way to protect providers from inaccurate and unfair reporting.
[123] GAO REPORT ON PRICE TRANSPARENCY, *supra* note 67 (citing CRS REPORT FOR CONGRESS, *supra* note 9); Ginsburg, *supra* note 73, at 211 (stating consumers will not use information they do not understand).
[124] GAO REPORT ON PRICE TRANSPARENCY, *supra* note 67 (citing CRS REPORT FOR CONGRESS, *supra* note 9); Ginsburg, *supra* note 73, at 211 (stating consumers will not use information they do not understand).
[125] Reinhardt, *supra* note 15; *see also infra* Part IV.A.1.

be charged.[126] The current chaotic system of hospital pricing would, if made completely transparent to the public, be akin to "forcing sick and anxious people to shop around blindfolded for cost-effective care."[127] Because prices negotiated with hospitals vary more than prices negotiated with providers, regulating hospital pricing structures should be a priority.[128] Effective consumer-directed price transparency will require translating the complicated language of healthcare billing into easy-to-understand information, if consumers are expected to utilize that information in their decision-making.[129]

Even then, consumers may not use perfectly accessible and comprehendible billing information when making decisions about where to receive treatment and from whom. Health services research demonstrates that patients are more likely to base treatment decisions on the experiences of friends and family members than cost.[130] Further, in the absence of accessible and comprehendible quality information on providers, lower prices may indicate a lower quality service to many patients, which may defeat the purpose of making prices transparent.

Ultimately, a consumer-directed initiative, alone, cannot change the course of healthcare spending. In the right circumstances, initiatives aimed at increasing transparency of prices at the provider-insurer level are more likely to reduce costs. Therefore, whether consumers become more informed purchasers of healthcare as a result of a price transparency initiative is not dispositive of the effectiveness of price transparency overall. However, a consumer-targeted initiative may be a helpful piece of a larger price transparency strategy only if consumers are able to understand and effectively use price information in their decision-making processes.

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[126] Reinhardt, *supra* note 15.
[127] *Id.* at 68.
[128] Ginsburg, *supra* note 73, at 213
[129] *See* CATALYST FOR PAYMENT REFORM, *supra* note 35, at 1-2.
[130] Anna D. Sinaiko, *How Do Quality Information and Cost Affect Patient Choice of Provider in a Tiered Network Setting? Results from a Survey*, Health Serv Res. 2011 Apr;46(2):437-56, 451; *see also* Henry J. Kaiser Family Foundation, *National Survey on Americans as Health Care Consumers: An Update on the Role of Quality Information*, (Menlo Park, Calif.: Kaiser Family Foundation, 2000).

3. Complex cost-shifting and billing practices

Apart from concerns related to consumer-directed transparency initiatives, complicated healthcare billing practices also pose additional challenges to the implementation of effective price transparency measures. The complex series of cost-shifts in the healthcare industry—from the insurer through multiple providers to the consumer—also contributes to potential difficulties for individual consumers and employers in obtaining complete price information.[131] For hospital procedures, both in- and out-patient services, the billing passes through multiple providers, e.g. the anesthesiologist, surgeon, and the hospital. Provider networks can minimize some complexity, as insurers have access to in-network prices in advance based on their contractual relationship with those providers. But as soon as a patient sees one out-of-network provider in the chain, estimating costs in advance becomes more problematic.

Each of these barriers, contractual barriers, trade secrets protections, provider resistance, consumer usage, and complex billing practices, should be addressed as part of launching an effective price transparency initiative. Depending on which healthcare levels the initiative seeks to target, some barriers may cause more difficulty than others. Contractually, confidentiality clauses limit disclosure of price terms, which may prevent price transparency on all levels unless these clauses are either eliminated in whole or in part. Additionally, any attempt to force price transparency may meet resistance in the form of a trade secret. Since courts have yet to determine whether prices qualify as trade secrets, addressing this barrier will most likely require litigation to resolve. Lastly, other practical barriers in the form of physician resistance, consumers usage, and the existing complexity of healthcare payments also present formidable challenges to implementing effective price transparency initiatives.

[131] CRS REPORT FOR CONGRESS, *supra* note 9, at 8-12.

V. Current Transparency Initiatives

Not dissuaded by the significant barriers to price transparency, state governments, private insurers, and independent private entities have initiated programs relating to price transparency and the disclosure of healthcare charges.[132] This Part examines these existing initiatives to improve disclosure, transparency, and reporting of provider charges and fees. In recent years, California has enacted a range of programs aimed at improving access to healthcare information for consumers. This part will first examine California's combination of efforts, and then examine the initiatives of other states, a private insurer, and independent private entities.

A. California Laws and Current Transparency Initiatives

California currently has four separate transparency initiatives pertaining to healthcare cost, quality or both. Each current initiative has the potential to target all three levels of price transparency – insurers, providers, and consumers. First, this section evaluates the Payers' Bill of Rights, which requires unwaivable mandated reporting by California hospitals of prices for certain procedures.[133] Second is an assessment of California Hospital Compare, a website that gathers data via voluntary reporting of quality measures.[134] Third, this section provides an overview of California legislation aimed at increasing price transparency in the healthcare market: SB 751 allows insurers to disclose price and quality information to their members,[135] SB 1196 allows healthcare claims data to be disclosed to qualified entities.[136]

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[132] Madeline Kreischer, et al., *State Actions Relating to Transparency and Disclosure of Health and Hospital Charges,* NAT'L CONFERENCE OF STATE LEGISLATURES, http://www.ncsl.org/issues-research/health/transparency-and-disclosure-health-costs.aspx (last visited February 11, 2013) (summarizing signed laws and proposed state legislation).
[133] Cal. Health & Safety Code § 1339.52 (waivers prohibited).
[134] CALHOSPITALCOMPARE.ORG, http://www.calhospitalcompare.org/about-us.aspx (last visited Oct. 22, 2012).
[135] Cal. Health & Safety Code § 1367.49.
[136] *Id.* § 1367.50.

1. Payers' Bill of Rights

Sections 1339.50-56 of the California Health & Safety Code, also known as the Payers' Bill of Rights, seeks to prevent hospitals from "gouging patients" and to help inform patients of the cost of healthcare procedures.[137] It requires each hospital to disclose their average billed charges for the twenty-five most common inpatient and outpatient procedures to the Office of Statewide Health Planning and Development (OSHPD).[138] OSHPD then publishes these charges to its website, while hospitals must make the list of procedures and charges available to any person upon request.[139] Any person who believes a hospital is in violation of the Payers' Bill of rights may file a claim with the California Department of Public Health (CDPH), which investigates such claims to determine whether a violation has occurred.[140]

The Payers' Bill of Rights also requires hospitals to make its chargemaster, a list of the hospital's gross billed charges for 25 specific services or items, publicly available.[141] Chargemaster prices are important because they are prices billed regardless of a patient's insurance coverage and are the starting point for discounted prices by insurers.[142] While a step in the direction of price transparency, the chargemaster amounts can represent more than double the actual prices insurance companies pay for the listed services and, therefore, bear little relationship to the actual cost of the healthcare services provided to the insured consumer.[143]

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[137] CRS REPORT FOR CONGRESS, *supra* note 9, at 27.
[138] Cal. Health & Safety Code § 1339.56 (list of charges for common services and procedures).
[139] *Id.* OSHDP publishes both the average and median charges for each service and item.
[140] Cal. Health & Safety Code § 1339.54 (claims of violations; investigation); *see also Healthcare Information Division: Annual Financial Data General Information About the Hospital Chargemaster Program*, OFFICE OF STATEWIDE HEALTH PLANNING & DEV'T (last updated Aug. 8, 2012), http://www.oshpd.ca.gov/HID/Products/Hospitals/Chrgmstr/index.html ("This process would also pertain to any person who has no healthcare coverage and requested a written estimate from a hospital for healthcare services, procedures and supplies or requested information and/or an application for financial assistance or charity care and received no response from the hospital.").
[141] Cal. Health & Safety Code § 1339.51 (charge description master; posting; notice).
[142] CRS REPORT FOR CONGRESS, *supra* note 9, at 19.
[143] Reinhardt, *supra* note 15, at 57-58 (citing American Hospital Association, Hospital Statistics (2005)).

So far, the Payers' Bill of Rights has had little to no observable effect on hospital pricing. Several factors contribute to its ineffectiveness. First, each hospital is allowed to determine which 25 outpatient procedures to report to OSHPD, making comparisons between hospitals' list of charges not always possible.[144] Second, because patients do not pay the prices listed, these prices are not likely to be helpful to the average insured consumer who is insulated from gross charges via their health insurance plan.[145] For example, if the average price for a hospital stay varies significantly between two hospitals, but the out-of-pocket costs to a consumer are the same, access to the average price information on a chargemaster is unlikely to influence a consumer's decision in favor of a lower cost provider, and may even signal the higher priced provider as offering higher quality services. Consumers in high deductible health plans (HDHPs) or with a plan that requires coinsurance payments will, however, benefit from knowing what their provider is charging their insurer, because that, in turn, will determine their out-of-pocket costs. Knowledge of these price figures could allow these consumers to determine whether their insurer is paying more for a particular service from one provider to another, thus giving consumers the capability to provider-shop within their network before even making an appointment. Further, the chargemaster prices are not specific to particular health plans, which may be of no help at all to insured consumers who are only concerned with the price of a service as it relates to their plan. Since the total number of insured individuals is expected to rise dramatically in 2014 when the CHBE takes effect, it will become increasingly important for price transparency initiatives to convey price information based on health plan.

Third, OSHPD's website does not provide an adequate explanation of chargemaster prices to allow the average consumer to decipher the meanings of the listed gross figures. Instead, the

[144] *Healthcare Information Division: Annual Financial Data General Information About the Hospital Chargemaster Program*, OFFICE OF STATEWIDE HEALTH PLANNING & DEV'T, *supra* note 137.
[145] CRS REPORT FOR CONGRESS, *supra* note 9, at 30.

website includes vague disclaimers stating that charges will vary significantly from one patient to the next. These disclaimers tend to negate the transparency initiative altogether since the website has no mechanism for disclosing more consumer-specific prices. The website simultaneously highlights the industries complex billing practices by disclaiming the discrepancies between each patient's cost of care. More successful price transparency initiatives provide supplemental information for consumers to consider along with price when making decisions about a hospital.[146] Aetna's website, for example, provides a more helpful disclaimer to educate consumers that high quality and low price are not mutually exclusive measures.[147]

Lastly, comparable quality data is completely absent from the information presented via the chargemaster. The inclusion of quality data would give the listed prices the necessary context to be meaningful information for consumers.[148] The website does provide volume data, which could be helpful if paired with quality and price data, allowing consumers to choose physicians based on the number of times they have performed a procedure. However, this data alone is not as useful, and is unlikely to have much effect on consumer choice.[149]

2. California Hospital Compare

A second transparency initiative is California Hospital Compare, a website launched by the California Healthcare Foundation, in partnership with the University of California, San Francisco, and the California Hospitals Assessment and Reporting Taskforce (CHART) to compare hospital quality information.[150] This website includes ratings for clinical care, patient safety, and patient experience for over 230 hospitals who voluntarily self-report quality measures related to the most

[146] GAO REPORT ON PRICE TRANSPARENCY, *supra* note 67, at 22
[147] *Id.* at 24. Further examples are provided in Part V.D.2.
[148] GAO REPORT ON PRICE TRANSPARENCY, *supra* note 67, at 22; Hibbard & Peters, *supra* note 38, at 415 (2003).
[149] Hibbard & Peters, *supra* note 38, at 415-16 (stating that pieces of information that do not inherently relate to each other, such as trade-offs, create burdensome cognitive processing that will result in consumers choosing to allow one factor to drive their entire decision making process in order to ease the burden).
[150] CALHOSPITALCOMPARE.ORG, http://www.calhospitalcompare.org/about-us.aspx (last visited Oct. 22, 2012).

common procedures. The inverse of the price data available on OSHPD's website, the quality data presented on CalHospitalCompare.org are not linked to price data. The website provides a link where individuals can go to the OSHPD site to see average pricing data, but without a connection drawn between the two, consumers are likely to find it too challenging to successfully integrate the available cost and quality information for effective use in healthcare decision-making.[151]

3. Enacted and Proposed Legislation to Avoid Contractual Barriers to Transparency

In addition to requiring providers to make price and quality information available, the California Legislature addressed the problem of gag clauses in provider-insurer contracts this year by passing two laws that promote healthcare price transparency—Senate Bills (SB) 751 and 1196. Both laws amend section 1367 of the California Health and Safety Code to prohibit contract provisions that would restrict the transparency of healthcare data, also known as "gag clauses". SB 751, effective January 1, 2012, targets transparency at the consumer level by allowing price and quality information to be made available to enrollees of health plans.[152] SB 1196, signed into law on September 30, 2012 and effective January 1, 2013, pertains to the disclosure of claims data to qualified entities.[153]

SB 751 renders void and unenforceable any contract between an insurer and a licensed hospital or healthcare facility that contains a gag clause.[154]

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[151] There is also a way to search for free and discount payment programs for hospital services. *See California Hospital Free and Discount Payment Programs,* OFFICE OF STATEWIDE HEALTH PLANNING & DEV'T, http://syfphr.oshpd.ca.gov/search.aspx (last visited Oct. 21, 2012).

[152] Cal. Health & Safety Code §1367.49, Section 1 of Stats. 2011, c. 244 (S.B.751) ("It is the intent of the Legislature to ensure that subscribers and enrollees of a health care service plan, and policyholders and insureds of a health insurer, can make informed decisions about their health care choices.").

[153] SB-1196: Claims Data Disclosure, CALIFORNIA LEGISLATIVE INFORMATION (2012), *available at* http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120SB1196 (last visited Oct. 2, 2012).

[154] Cal. Health & Safety Code § 1367.49(a)-(b) (ability of healthcare service plan to furnish information to subscribers or enrollees concerning cost range of procedures or quality of services at hospital or facility; contractual provisions; statement posted on Internet website).

> A contract issued, amended, renewed, or delivered on or after January 1, 2012, by or on behalf of a healthcare service plan and a licensed hospital or any other licensed health care facility owned by a licensed hospital to provide inpatient hospital services or ambulatory care services to subscribers and enrollees of the plan shall not contain any provision that restricts the ability of the health care service plan to furnish information to subscribers or enrollees of the plan concerning the cost range of procedures at the hospital or facility or the quality of services performed by the hospital or facility.[155]

The law does not require insurers to disclose this information, but merely removes any contractual barriers that may prevent insurers from doing so.[156] For example, where previously hospitals would demand confidentiality clauses in insurer contracts, preventing health plans from disclosing prices paid to those providers to their members, hospitals can no longer prevent those health plans from choosing to provide provider price information to consumers on their plans. Although not explicitly stated in the statutory language, SB 751 does not prevent an insurer from using its discretion to refuse to disclose cost range and quality information to subscribers. Thus, the law does not mandate price transparency, but merely removes a contractual barrier to achieving it, should insurers choose to do so.

Two significant limitations of SB 751 are as follows: (1) The law allows only a cost range to be disclosed, and (2) the timing of the intervention by disclosing cost and quality information only to subscribers or enrollees of a health plan limits the potential effects of transparency.

First, by prohibiting contractual barriers to disclosure of the range of costs to consumers, the legislature has created a similar problem to the Payers' Bill of Rights—that a potentially large range of prices for one procedure may provide little, if any, guidance to consumers attempting to select a hospital. Whether or not this information will help consumers make more informed decisions will depend on how narrow the cost ranges are. Disclosure of a larger range of prices for each facility

[155] *Id.* § 1367.49(a)

[156] The law also states that the hospital or facility must be allowed "at least 20 days to review the methodology and data compiled by the health care service plan," as well as "an opportunity to provide an Internet Web site link" with a timely written response to the reported cost and quality information.

will restrict consumers' ability to make comparisons, whereas a smaller range of prices may allow for better comparison of facilities. Further, this bill received substantial opposition from the University of California (UC), the state's fourth largest healthcare delivery system, in its letter to the Assembly Health Committee Chair opposing SB 751. In its letter, UC stated that the bill's lack of built-in "means or assurances that consumers will receive meaningful and relevant information on provider cost and quality" prevents consumers from receiving the most valuable and accurate information in order to make informed healthcare choices.[157] While SB 751 requires insurers to include several risk adjustment factors along with any quality measures they choose to disclose to their members, SB 751 mandates no such risk adjustment factors in conjunction with price information to ensure maximum consumer usability of quality information. Without certain risk adjustment factors, such as severity of condition and type of facility (i.e. community hospital or academic medical center), consumers may be unable to draw meaningful comparisons across hospitals and providers.[158]

The second limitation of SB 751 stems from the elimination of gag clauses as they relate to the disclosure of information to health plan "subscribers and enrollees" only, instead of to consumers prior to choosing a health plan.[159] By only preventing anti-transparency clauses from precluding disclosure to enrollees and subscribers, SB 751 limits the potential for transparency to lower healthcare costs. SB 751 does not bar contracts from preventing disclosure of price and quality measures to non-enrollees; insurers and providers may still keep this information secret from uninsured consumers, preventing consumers from comparing hospital price ranges on different health plans prior to enrollment. If the law required disclosure of price and quality information to consumers prior to enrollment, both providers and insurers could be forced to compete for business

[157] Letter to The Honorable William Monning, Chair, Assembly Health Committee, on behalf of the University of California (June 8, 2011).
[158] *Id.*
[159] Cal. Health & Safety Code § 1367.49(a)

at an earlier stage, thus potentially driving down prices not just for one insurer, but across multiple carriers. Still, these effects depend on whether the healthcare market reacts to price transparency like a traditional economic market.

One positive effect of SB 751 is that it may provide a defense to a trade secrets claim by providers and insurers who wish to challenge any mandated disclosure of price information. The interplay between the California UTSA and SB 751 has not yet been addressed by the courts. The question remains as to whether cost range information furnished to subscribers of a health plan under SB 751would make actual prices that insurers pay to healthcare facilities matters of general knowledge, or whether cost range information is so different from the actual facilities' prices that those prices can still be considered "special knowledge" under the California UTSA. Providers could argue that disclosure of cost range information is so broad, i.e. does not reveal the actual prices of procedures, that actual price information remains secretive and should receive trade secret status. However, the possibility that actual price information could be obtained from the disclosed cost ranges by reverse engineering could cause a trade secret claim to fail.

SB 1196 appears to take SB 751 one step further. Although the law pertains solely to price information, it expands the disclosure of healthcare prices beyond just enrollees of health plans to the public. The law prohibits contracts between a health plan and a provider, including a provider of supplies, from containing any provision that prohibits, conditions, or in any way restricts the disclosure of claims data related to healthcare services provided to enrollees, insureds, or beneficiaries of any self-funded health coverage arrangement to "qualified entities" as determined by the Centers for Medicare and Medicaid Services (CMS). [160] The Secretary of CMS recognizes qualified entities to make evaluations of provider/supplier performance and to agree to meet

[160] Cal. Health & Safety Code § 1367.50 (defining a "qualified entity," pursuant to 42 USC 1395kk, as a public or private entity "that is qualified (as determined by the Secretary) to use claims data to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use").

specific requirements regarding the transparency of their methods and their use and protection of data.

To be certified as a qualified entity, an organization—"either a single public or private entity, or a lead entity and its contractors"—must submit to CMS an application package that includes information demonstrating that the applicant will satisfy the requirements specified in 42 CFR § 401G (401.700–.721), as well as other criteria determined by CMS.[161] Among other requirements, applicants must demonstrate the following: existing expertise and sustained experience (defined as three or more years) in performance measurement, the ability to combine Medicare data with existing claims data, a process for allowing providers to review and correct their performance reports, and adherence to rigorous data privacy and security procedures.[162] If it demonstrated sufficient expertise, an exchange could apply to be a qualified entity; alternatively, a group of healthcare stakeholders organized as a single entity, as required by section 401.703(a), could perform the same function. Once determined to be qualified, a multi-stakeholder organization that represented a range of interests in healthcare could collect price data and determine the best way—in the interest of all stakeholders—to use that information. Such an organization could potentially partner with the Exchange to inform its decisions.

B. Other State Initiatives

In other states, some current transparency initiatives provide access to complete cost information, while others use only limited price data. Complete cost information is the disclosure of a price that incorporates all discounts, includes associated costs such as lab fees, and identifies out-

[161] *Id.*
[162] 42 CFR § 401.700-.721; Qualified Entity Certification Program for Medicare Data, https://www.qemedicaredata.org/SitePages/about.aspx (last visited Nov. 4, 2012) (stating that applications will be accepted on a rolling basis

of-pocket costs.[163] Complete cost information allows them to anticipate all potential costs for a particular procedure that they could be responsible for. On the other hand, limited price data or price averages create the risk that consumers will feel misled by the information or not use the information at all.[164]

While complete cost information can be extremely difficult to obtain due to confidential agreements between insurers and providers, two price transparency initiatives – one public and one private – demonstrate that providing complete cost information is potentially attainable. However, whether transparency will affect consumer decision-making or provider-insurer negotiations will depend on successful implementation.

The first example is the public initiative of the state of New Hampshire: HealthCost. Since 2007, HealthCost has disseminated complete medical cost information by insurance plan and procedure, as well as prices for uninsured consumers.[165] Directed at individual consumers and employers, the website lists specific prices that reflect negotiated discounts and other reductions off the billed charges obtained through access to claims data.[166] Insured users enter their insurance plan, their deductible amount, and their percentage rate of co-insurance, and the website uses that data to calculate their out-of-pocket costs as well as the total cost of the service by provider. The website is updated quarterly to reflect the most recent changes in pricing. However, New Hampshire does not provide quality data as a part of its price transparency initiative. This leaves consumers unable to truly compare providers and leaves open the question of whether higher prices reflect higher quality care.

[163] GAO REPORT ON PRICE TRANSPARENCY, *supra* note 67, at 24.
[164] Sinaiko & Rosenthal, *supra* note 16, at 892.
[165] NH HEALTH COST, http://nhhealthcost.org (last visited Oct. 22, 2012).
[166] GAO REPORT ON PRICE TRANSPARENCY, *supra* note 67, at 24.

Other states have not gone as far in their price transparency initiatives. The Massachusetts initiative, MyHealthCareOptions, provides a median and range of insurers' aggregated payments made to particular provider groups and hospitals based on claims data.[167] While Massachusetts, like New Hampshire, has access to claims data that could be used to provide complete cost transparency to its consumers, it instead provides average prices paid by private insurers for specific services. This is due, in part, to insurers' and providers' concerns about the initiative disclosing insurer-specific information to consumers, as well as a lack of technical capabilities to identify which hospital and physician data should be linked.[168] Consumers, therefore, cannot see a price estimate that is specific to their insurer, much less their specific health insurance plan or their specific treatment.

C. Private Insurer

Similar to New Hampshire's HealthCost, Aetna's "Member Payment Estimator" provides complete cost information to members through access to the insurer's negotiated discounts with providers.[169] Prices for each service are provided as "service bundles." This means that when a member searches for the price of a cesarean section, the generated price includes the costs likely to go along with that procedure, i.e. anesthesia and blood work, giving members a more complete picture of the cost.[170] For calculating estimated out-of-pocket costs, Aetna links member data to its price transparency website, which then automatically updates and calculates the member's estimated costs in real-time.[171] Aetna's transparency initiative also provides consumer education that high price does not always mean high quality, and informs consumers that low cost/high quality

[167] *MyHealthCareOptions*, MASS.GOV, http://hcqcc.hcf.state.ma.us (last visited Oct. 22, 2012).
[168] GAO REPORT ON PRICE TRANSPARENCY, *supra* note 67, at 27 (explaining that since not all insurance plans are consistent in how they report physician fees, the initiative cannot use the available claims data).
[169] *Member Payment Estimator*, AETNA, http://www.aetna.com/individuals-families-health-insurance/tool/member-payment-estimator.html (last visited Feb. 19, 2013).
[170] *Id.*
[171] *Id.*

healthcare does exist.[172] However Aetna's member-only access to complete cost information precludes employers and individual consumers from accessing the Member Payment Estimator until they have already committed to the health plan. Further, member-only access still prevents other insurers and providers from accessing these figures, which does not facilitate competition among health plans.

D. Independent Private Initiatives

Finally, there exist three private, web-based initiatives that are not affiliated with a specific insurance plan. The first of these is Clear Health Costs, a company that gathers data from independent reporting, including from health-care providers, participating consumers, and other databases, to bring transparency to consumers in the healthcare market.[173] The goal of this website is to "empower[] consumers to make informed decisions about costs of their medical care and coverage."[174] The website currently focuses on common procedures and items in the New York City and San Francisco areas, and provides Medicare pricing information for these procedures in all other states.[175] Within the two focus areas, the website provides the highest and lowest cash prices for uninsured consumers per procedure charged by specific providers, in addition to varying price reports from the company's various reporting sources.[176]

Another private transparency initiative has been launched by Compass Professional Health Services ("Compass"). Compass provides healthcare pricing information to employers and individual consumers who pay an annual membership fee.[177] In addition to consumer advocacy and

[172] GAO REPORT ON PRICE TRANSPARENCY, *supra* note 67, at 24.
[173] *The Pros and Cons of Health-Cost Transparency*, CLEAR HEALTH COSTS (Mar. 14, 2011), http://clearhealthcosts.com/blog/2011/03/the-pros-and-cons-of-health-cost-transparency.
[174] *About*, CLEAR HEALTH COSTS, http://clearhealthcosts.com/about (last visited Oct. 22, 2012).
[175] *Id.* The website states the initiative is focused on the New York City area, but recent email exchanges with a company representative revealed that specific pricing information is now available also for the San Francisco area and that the company is planning to expand.
[176] *Id.* Each price is disclosed alongside the provider's full name and address.
[177] COMPASS PROFESSIONAL HEALTH SERVICES, https://www.compassphs.com/index (last visited Oct. 22, 2012).

helping consumers and employers to find low-cost, high-quality healthcare, Compass's website also contains a blog and news reports on the latest changes in the healthcare industry, as well as several white papers directed at helping consumers select the best health plans and save money.[178] For uninsured consumers who are trying to save money on healthcare costs, Compass does not seem to be the best cost-saving solution. However for employers, a few hundred dollars per year in membership fees may be worth the 25% savings proposed by Compass's services.[179]

A third private transparency initiative is Castlight Health. Since 2008 this San Francisco company has been offering an online portal that allows self-insured employers to provide quality assessment and price transparency information to employees.[180] Castlight Health also has partnered with health plans to help deliver cost and quality information directly to plan members, including individuals and small businesses, with the belief that enabling consumers to make better-informed decisions when purchasing healthcare will drive quality up and costs down. While there are no consolidated results of Castlight's efforts on their website, the multitude of positive testimonials suggests that Castlight has successfully enabled employers, employees and individual consumers to realize significant savings.

E. Existing Initiative Effectiveness

Each of the state and private initiatives targeting individual consumers discussed above provide helpful information to consumers, but none provides all the necessary components for what potentially could be the most effective consumer-targeted transparency. For price transparency to be most effective, complete cost information must give customers an accurate and actionable picture

[178] *Keys to Success*, COMPASS PROFESSIONAL HEALTH SERVICES, https://www.compassphs.com/about-compass-white-papers (last visited Oct. 22, 2012). The most recent white papers are entitled, "7 Key Strategies for Effective Cost Containment" and "8 Mistakes To Avoid When Selecting a Health Plan."
[179] COMPASS CASE STUDY (2012), *available at* https://www.compassphs.com/files/casestudies/Compass_Case_Study.pdf. A 6,000 employee company saved $4.5 million dollars in a year by moving to a consumer-directed health plan and enlisting Compass's services.
[180] CASTLIGHT HEALTH, http://www.castlighthealth.com (last visited Oct. 22, 2012).

of their healthcare costs.[181] While the Massachusetts Connector is unable to provide complete costs, both the Aetna and New Hampshire initiatives have demonstrated that this level of disclosure is possible. Bare pricing information, however, like that of New Hampshire's initiative, without providing more explanation and context, may have the effect of misleading consumers into believing that higher price is always indicative of better quality care.[182] Ideally, transparency of healthcare prices alongside quality measures would meaningfully assist consumers, and those making decisions on their behalf (employers, health carriers, and referring practitioners) in making more informed healthcare decisions.[183] Judith Hibbard, a health policy professor and researcher, argues that consumers will not use information they do not understand because of unwillingness to go through the process of trying to make sense of the information and match it up with other factors, such as quality, provider or peer recommendations, and location.[184] The most effective transparency initiative, Hibbard asserts, will reduce the mass of information into an index that consumers can easily understand. Only then can consumer choice have a large enough impact on the healthcare market to actually lower costs.

Theoretically, a more informed consumer population choosing higher-quality and lower-cost healthcare services could force providers and hospitals to not only charge competitive prices for healthcare services, but could also provide an incentive to increase quality of care. Aetna's website is an example of this contextual transparency with cost and quality available in concert, whereas New Hampshire's website discloses only price information without allowing its consumers to realize its connection with quality measures. However, Aetna's transparency falls short of its full potential by limiting disclosure of that information to its members only. Further, all of these initiatives target the

[181] GAO REPORT ON PRICE TRANSPARENCY, *supra* note 67, at 28.
[182] *Id.* at 23.
[183] Ginsburg, *supra* note 73, at 209.
[184] *Id.* (citing Hibbard & Peters, *supra* note 38).

consumer-level only, rather than focusing on initiatives that target transparency at agreements made between providers and insurers in an effort to shift employer purchasing of insurance, rather than individual consumer behavior. At a time when employees and employers have so much more at stake than before, employer-education initiatives like Castlight, will also be an integral part of ensuring effective price transparency.

While state government and private insurers have yet to launch a price transparency initiative that is proven to lower healthcare costs, each of the three independent private organizations have sought to fill the regulatory gap and offer employers and individual healthcare consumers valuable information to help them lower their healthcare costs.

VI. Potential Solutions to Promote Effective Price Transparency

As demonstrated above, price transparency initiatives can be implemented through a variety of methods. This Part examines a range of potential legal and educational initiatives designed to promote price transparency. The legal solutions include antitrust litigation, legislative solutions, and exchange regulations. Next, this Part will explore possible educational initiatives for employers and consumers to promote price transparency. Part VII will then offer recommendations for combinations of potential solutions.

A. Antitrust Litigation

As a supplement to price transparency initiatives, antitrust litigation is a potential way to break down the market power that allows certain providers and insurers to drive up prices and conceal them from consumers. An antitrust suit may help create more price transparency by forcing dominant parties to reveal their competitive prices. In addition, as a result of increased price transparency, certain competitive harms with the potential for antitrust liability may become more apparent to consumers and competitors.

The goal of antitrust law is to protect consumers—rather than competitors—against anticompetitive behavior and to promote competition between different products.[185] In the context of healthcare, anticompetitive behavior can have a greater impact on competition than do similar practices in other markets, due to the fact that the healthcare market does not function like a traditional economic market. Because consumers do not confront prices directly but rather through their insurers, providers with market power—meaning those that are able to control prices in the relevant market—have significant pricing freedom, which allows them to gain greater monopoly profits and to create more lopsided wealth distributions than they would if consumers had a more direct path to price information.[186] In other words, because the current market structure and organization of health insurance do not allow healthcare consumers to adequately respond to prices, providers with market power are able to leverage their dominance without having to answer to consumers for the resulting prices. This contributes to high price variation between hospitals, depending on the extent of their market power.[187]

This section provides an overview of possible antitrust litigation measures that can be taken against dominant healthcare providers and insurers to increase price transparency and thereby prevent further harm to competition. There are two primary theories of U.S. antitrust liability: (1) unlawful agreements in restraint of trade and (2) single-firm monopolization or attempted monopolization. This section describes the basic facts that are necessary to allege an antitrust cause

[185] *See, e.g.*, State Oil Co. v. Khan, 522 U.S. 3, 4 (1997). Antitrust scholar Robert Bork has described the public policy goal of antitrust law as protecting competition, not competitors, *see generally* ROBERT BORK, THE ANTITRUST PARADOX (1978), noting that "[t]he only legitimate goal of American antitrust law is the maximization of consumer welfare," *id.* at 51.

[186] Clark C. Havighurst & Barak D. Richman, *The Provider Monopoly Problem in Health Care*, 89 OR. L. REV. 847, 851 (2011); *see also* Berenson et al., *supra* note 21, at 973 ("Some health care systems, commonly referred to as 'must-have' providers—meaning providers that health plans must include in their networks to attract employers and consumers—have used their clout to raise prices.").

[187] *See, e.g.*, Robert A. Berenson et al., *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, HEALTH AFF., Apr. 2010, at 2; Peter Waldman, *Sutter Health's Market Power Is Questioned*, BLOOMBERG BUSINESSWEEK (Aug. 26, 2010), http://www.businessweek.com/magazine/content/10_36/b4193015983853.htm.

of action and the potential application of these allegations to the healthcare market, looking specifically at antitrust issues arising from provider-payer negotiations.[188] By challenging the lawfulness of these restraints of trade, it may be possible to lessen the ability of powerful actors to conceal prices from other parties—including consumers—and to enable both price competition and closer regulatory scrutiny to help reduce their negotiating leverage.[189] This section first outlines what is necessary to allege a violation of antitrust law and then details two potentially relevant categories of antitrust causes of action to the issue of price transparency: restrictive contracts and unlawful tying arrangements.

1. What Constitutes an Antitrust Violation?

The Department of Justice (DOJ) and the Federal Trade Commission (FTC) enforce antitrust law on behalf of the United States. They share jurisdiction over healthcare industries and allocate cases under a process known as "clearance." The suits they bring may focus on behavior that courts have decided is inherently anticompetitive and thus constitutes a per se violation, or they may look at practices that require more analysis to balance their pro- and anticompetitive impacts. Private individuals who can show that they have been injured by anticompetitive behavior—usually competitors or consumers—can also sue privately for treble damages.[190] To have standing to bring a private antitrust suit, a competitor must show both a tendency of the alleged violation to reduce competition in a certain market and an injury resulting from that decrease in competition (that is,

[188] Two related issues that are outside the scope of this memorandum but which warrant further investigation are (i) the antitrust implications of accountable care organizations and (ii) any potential anticompetitive consequences of price transparency initiatives on providers' and insurers' behavior—most notably, the possibility of an increase in collusive behavior due to the availability of price information.
[189] *See, e.g.*, Berenson et al., *supra* note 21, at 979.
[190] Clayton Act, 15 U.S.C. § 15. The Clayton Act allows a plaintiff to enforce the "antitrust laws," which include the Sherman Act and the Clayton Act, as well as portions of other federal laws. *Id.* § 12.

not from another of the defendant's actions that do not violate antitrust law).[191] Even if not yet injured, however, a plaintiff may seek injunctive relief against the threat of competitive injury.[192]

a) The Sherman Act

The Sherman Act is the primary vehicle for U.S. antitrust enforcement.[193] Section One of the Sherman Act prohibits multiple parties from engaging in a contract, combination, or conspiracy that constitutes an unreasonable restraint of trade.[194] To prove a Section One violation, a plaintiff must prove (1) the existence of a multi-party agreement[195] and (2) that the agreement is an unreasonable restraint of trade.[196] Types of agreements that are illegal under Section One include those that amount to price fixing, market allocation, output restrictions, or stabilizing prices using non-price controls, as well as other agreements that are found to unreasonably restrain trade.

Although some agreements, such as price fixing among competitors, constitute per se antitrust violations, courts generally apply the Rule of Reason when they need to test whether the anticompetitive harm of a particular restraint might be outweighed by pro-competitive benefits.[197] In applying the Rule of Reason to an alleged violation, "the factfinder weighs all of the circumstances" to determine if the agreement is an unreasonable restraint of trade, looking first to the plaintiff's allegations of anticompetitive harm and then to the defendant's arguments about the

[191] Tennessean Truckstop, Inc. v. NTS, Inc., 875 F.2d 86, 88 (6th Cir. 1989).
[192] Clayton Act, 15 U.S.C. § 26.
[193] The Federal Trade Commission Act and the Clayton Act also govern U.S. antitrust law but are not discussed in detail in this memorandum. Substantively, their relevant portions are largely similar to the Sherman Act. Other laws governing merger analysis are outside the scope of this memorandum.
[194] Sherman Antitrust Act of 1890, 15 U.S.C. § 1.
[195] To successfully allege a violation of Section One, it is crucial that there be two parties, because a single party cannot make an agreement with itself. *See* United States v. Colgate & Co., 250 U.S. 300, 307 (1919) ("In the absence of any purpose to create or maintain a monopoly, the [Sherman Act] does not restrict the long recognized right of trader or manufacturer engaged in an entirely private business, freely to exercise his own independent discretion as to parties with whom he will deal. And, of course, he may announce in advance the circumstances under which he will refuse to sell.").
[196] For an agreement to be an unreasonable restraint of trade, either the two parties must be competitors or the agreement must directly affect others in the market. In the context of healthcare, this means that certain agreements between insurers and providers do not constitute unreasonable restraints of trade, because they do not directly impact competition. *See, e.g.*, Royal Drug Co. v. Group Life & Health Ins. Co., 737 F.2d 1433 (5th Cir. 1984).
[197] Leegin Creative Leather Prods. v. PSKS, Inc., 551 U.S. 877, 885 (2007).

pro-competitive benefits that arise from the restraint.[198] Relevant factors in this extremely fact-intensive analysis may include information about the business, the history and nature of the restraint, and the business's market power.[199]

Section Two of the Sherman Act forbids a party with monopoly power from willfully acquiring or maintaining that power.[200] Simply gaining monopoly power by "skill, foresight and industry," however, does not constitute a violation of antitrust law.[201] Attempted monopolization claims require that the plaintiff prove "(1) that the defendant has engaged in predatory or anticompetitive conduct with (2) a specific intent to monopolize and (3) a dangerous probability of achieving monopoly power," which is measured by the defendant's ability to foreclose competition in the relevant market.[202]

The potential antitrust claims discussed in this memorandum all fall under Section One, because, as described in more detail below, many of the inefficiencies caused by hidden prices occur in connection with provider-payer negotiations. Furthermore, under Section Two, a claim against a monopolistic healthcare provider that has not engaged in anticompetitive actions to build or maintain that monopoly would be unsuccessful. If an antitrust suit is brought in concert with one or more of the price transparency initiatives described in this memorandum, the combination of the breakdown of market power and the visibility of prices should alleviate many of the market inefficiencies created during the negotiation process.

[198] Continental T.V., Inc. v. GTE Sylvania Inc., 433 U.S. 36, 49 (1977).
[199] *Leegin*, 551 U.S. at 885 (citing State Oil Co. v. Khan, 522 U.S. 3, 10 (1997); Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752, 768 (1984)).
[200] Sherman Antitrust Act of 1890, 15 U.S.C. § 2.
[201] United States v. Aluminum Co. of Am., 148 F.2d 416, 430 (2d Cir. 1945).
[202] Spectrum Sports v. McQuillan, 506 U.S. 447, 456 (1993).

b) Defining the Market

A key step in bringing an antitrust suit is to first define the market in which a party operates to determine if it has sufficient market power to manipulate prices. To establish whether a party has power in a specific market for purposes of antitrust analysis, it is necessary to first define the relevant product and geographic markets in which the party operates—that is, the smallest set of products and geographic area in which the party would be able to raise and sustain prices. The relevant product market is the group of products that constitute reasonable substitutes for each other, which depends on consumers' cross-elasticity of demand: If the price of the product increases, the products that consumers would replace it with are part of the relevant product market.[203] In the hospital market, courts have tended to view the product market as a single "cluster market" of all inpatient services, rather than viewing each individual service as a separate product.[204]

The geographic market is defined by where the seller operates and where consumers look to purchase the product.[205] In the case of a hospital, the boundaries of the geographic market depend not simply on the hospital's service area, but also on the existence of barriers to entry for competitors, as well as consumers' ability to switch to other hospitals.[206] The geographic market

[203] United States v. E.I. du Pont de Nemours & Co., 351 U.S. 377, 380-81 (1956).
[204] Havighurst & Richman, *supra* note 186, at 868-69 (citing *In re* Hosp. Corp. of Am., 106 F.T.C. 455 (1985), *aff'd*, 807 F.2d 1381 (7th Cir. 1986)). Havighurst and Richman go on to cite Ian Ayres, *Rationalizing Antitrust Cluster Markets*, 95 YALE L.J. 109 (1985), for the proposition that "the cluster-market approach may be justified where goods or services are in some way complementary in production, consumption, or distribution." Havighurst & Richman, *supra* note 186, at 869 n.62. This is especially relevant for analyzing tying claims. *See infra* Part V.A.3.
[205] Tampa Elec. Co. v. Nashville Coal Co., 365 U.S. 320, 327 (1961).
[206] Drs. Steuer & Latham, P.A. v. Nat'l Med. Enters., 672 F. Supp. 1489, 1511 (D. S.C. 1987) ("Because we are concerned only with an area in which competition could be harmed, the relevant geographic market must be broad enough that buyers would be unable to switch to alternative sellers in sufficient numbers to defeat an exercise of market power by firms in the area." (quoting Matter of Hosp. Corp. of Am., 106 F.T.C. 361, 466 (1995), *aff'd*, Hosp. Corp. of Am. v. F.T.C., 807 F.2d 1381, *cert. denied*, 481 U.S. 1038 (1987)). Recent antitrust history, however, has tended to overestimate the size of geographic markets in hospital merger analyses. Prepared Statement of Professor Thomas L. Greaney Before the Committee on the Judiciary United States House of Representatives Subcommittee on Intellectual Property, Competition, and the Internet on "Health Care Consolidation and Competition After PPACA" at 4 (May 18, 2012); *see also* FED. TRADE COMM'N & DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, ch.4, at 6 (July 2004) [hereinafter IMPROVING HEALTH CARE]

may also be measured in part by how the party itself defines it; for instance, the California Health and Safety Code requires that all health plans identify their prospective enrollees' general geographic areas and report the providers available therein.[207] Other measures define geographic areas by using geo-political boundaries, such as by combining zip codes; for example, using the "Geozip" method, the San Francisco area would include all zip codes beginning with 941.[208]

In merger cases, market definition is often tested with the "hypothetical monopolist" test, which asks what the smallest possible set of products and geographic area is in which a profit-maximizing firm with no competition could sustain a "small but significant and non-transitory" price increase.[209] Essentially, this test asks whether the merger creates a danger that the firm could get away with anticompetitive behavior. In hospital mergers, courts use the "Elzinga-Hogarty" test to define a hospital's geographic market, which considers evidence of how many patients leave or enter a specific area for hospital services.[210]

> "[I]f the patient flow data show large numbers of patients coming into or going out of the area for inpatient hospital care, then the geographic market is hypothesized to be broader than originally thought . . . . A geographic market definition is usually described as 'strong' if less than 10 percent of discharged patients from the merging hospitals' area come into or out of the area."[211]

Critics of this methodology, however, point out that patient migration does not necessarily mean that a patient "would respond to a small price increase by using hospitals outside of the merging hospitals' core geographic area," because it ignores the many other reasons a patient might travel for

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(recognizing consistent criticism that the Elzinga-Hogarty test should not be the only basis for defining the geographic market).

[207] Cal. Health & Safety Code § 1367.26(a)(1).

[208] *See, e.g.*, Ingenix Benchmark Products Presentation (Apr. 2005), *available at* http://www.dmhc.ca.gov/aboutthedmhc/org/boards/fssb/notes/050419ipp.pdf. Ingenix (now known as OptumInsight) performs efficiency analyses for healthcare actors and government agencies. It has evaluated California's healthcare market and separated the state into 28 different geographic areas based on its "Geozip" coding system. *Id.*; *see also* OPTUMINSIGHT, http://www.optuminsight.com/government/overview.

[209] IMPROVING HEALTH CARE, *supra* note 206, at 4-5.

[210] *Id.* at 7-8.

[211] *Id.* at 8.

healthcare services.[212] That is, these data do not show how patients would react to an increase in price and therefore do not prove anything about the substitutability of hospitals.[213] In fact, empirical studies have shown that most patients do not "view distant hospitals as close substitutes for most services," but rather that those individuals that do travel have "distinct reasons" and therefore do not "inhibit merging local hospitals from increasing prices substantially."[214] Therefore, in spite of the existence of a number of measures for defining a hospital's relevant geographic market, it is questionable whether these methods provide a fully accurate picture of those markets. As a result, antitrust lawsuits, even if supported by economic evidence about anticompetitive behavior, may be difficult to prove in the context of healthcare.

c) Measuring Market Power

Once the relevant market is defined, the question arises whether the party has market power—that is, the ability to control prices—in that market. The party's market share provides a useful starting point to measure market power, but market share rarely offers a complete picture of actual ability to control prices. Circumstantial factors such as barriers to entry and the ability of competitors to increase output in the short run also prove crucial to measuring market power. In the California healthcare market, for instance, looking just at percentage market share likely underestimates providers' actual market power, due to factors including Kaiser Permanente's role in the market and regulatory barriers to entry controlled by the Department of Managed Health Care.[215] In addition, consumer demand for certain hospitals makes them "must-haves" for insurers

[212] *Id.* These reasons include "perceived and actual variations in quality, insurance coverage, out-of-pocket cost, sophistication of services, and family connections." *Id.*
[213] *Id.*
[214] *Id.* at 9 (quoting CORY CAPPS ET AL., THE SILENT MAJORITY FALLACY OF THE ELZINGA-HOGARTY CRITERIA: A CRITIQUE AND NEW APPROACH TO ANALYZING HOSPITAL MERGERS 1 (Nat'l Bureau of Econ. Research, Working Paper No. w8216, 2001)).
[215] Letter from Blue Shield of California to Federal Trade Commission dated May 27, 2011, at 3. Blue Shield explains some of these factors in a section of its letter to the FTC titled "Need for Stricter Market Share Screens":

to include in their health plans. These hospitals obtain significant leverage, not from market power, but based on their reputation or their provision of specialized services that make it implausible for insurers to threaten not to contract with them.[216] Thus, market power must be analyzed by looking at the whole picture—competitors, regulations, market barriers to entry, and the economic impact of the party in question on overall market competition.

In an effort to uncover the link between increased healthcare prices and market power, the California Attorney General's office has recently been examining healthcare consolidation practices and "probing whether mergers of hospitals and doctor groups are pushing up prices."[217] This attention puts a spotlight on issues including "hospital systems' reimbursement from . . . insurers" and "whether the systems' tie-ups with physicians, as well as ownership of hospitals, have given them the market power to boost prices in a way that violates antitrust law."[218]

The Attorney General's efforts create the potential for increased scrutiny of anticompetitive behavior in the healthcare market, and the A.G.s office should focus on all restrictive practices, not just consolidation itself. Hospital leverage is driven by many "factors unrelated to consolidation."[219] By directly addressing restrictive practices that create anticompetitive effects, it may be possible to prevent the continued amalgamation of market power in dominant parties. As a result, other players in the healthcare market would have more power to demand and respond to competitive and

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> [M]arket shares of providers located in areas near Kaiser facilities are understated because Kaiser's large network is included when their market shares are calculated even though the Kaiser facilities are not available to competing payers. In addition, health plans must obtain advance permission from the Department of Managed Health Care to transfer members from a provider that is being removed from a network. These providers often insist, and sometimes persuade the Department, that alternative providers are not adequate substitutes, leaving the health plan with no choice but to negotiate with the incumbent provider who has been given significant leverage.

Id. Blue Cross also describes hospital systems' practices of negotiating on an "all-or-nothing" basis as contributing to certain providers' market power, despite having "shares well below the 30 percent primary service area" threshold set by the FTC. *Id.*; *see also infra* Part V.A.3.b.

[216] Berenson et al., *supra* note 187, at 4.

[217] Anna Wilde Mathews, *Doctor, Hospital Deals Probed*, WALL ST. JOURNAL, at B1, Sept. 14, 2012.

[218] *Id.*

[219] Berenson et al., *supra* note 21, at 975.

transparent pricing, allowing for an increase in both market-based and regulatory solutions. "Market-oriented approaches are generally based on benefit designs that make consumers more aware of costs and give them direct incentives to select low-cost options. . . . [E]mployers . . . might support more direct regulation of provider rates, perhaps setting upper bounds on permissible rates negotiated between health plans and providers."[220] Thus, it seems that the combination of the threat of antitrust litigation *and* regulatory and/or market-based price transparency initiatives will be the most effective route for California to take. The sections that follow explain how antitrust analysis may apply to providers and payers with market power as a method of increasing price transparency and allowing consumers to exercise control over the healthcare market.

2. Contractual Provisions Between Providers and Payers

One place to look for anticompetitive behavior is in the negotiations between providers and insurers, either of which—or both—may have market power and thus be able to contribute to concealing prices from consumers. These contracts may include provisions that either directly make unavailable accurate price information about services or indirectly contribute to the powerful parties' maintenance of their market power by protecting their position in the market.

In contracts between healthcare providers and insurers, certain provisions may constitute unreasonable restraints of trade under Section One when those terms impact competing parties in the market. Most notably, most favored nation ("MFN") clauses that guarantee insurers they are receiving a provider's best rates, a form of payment parity agreement, open the door for antitrust liability by limiting the prices that providers can charge to other insurers. The Massachusetts Attorney General has argued that MFN clauses have the potential to harm competition by locking in

[220] *Id.* at 979.

payment levels, thwarting innovation, and preventing price competition.[221] The Massachusetts Attorney General's report continues:

> Parity clauses may decrease competition among providers by reducing their incentive to offer lower prices to insurers. Likewise, parity clauses may reduce insurers' incentive to bargain with providers, since rival insurance companies with parity provisions would obtain any price savings. Parity clauses may also deter entry to the marketplace since any discount would have to be passed on to insurers already in the market. . . . [T]hese agreements may have the net effect of allowing insurers to increase payment to providers without concern that they will be at a competitive disadvantage to other insurers.[222]

If factual analysis shows that these effects occur as a result of a specific provision and that the counterbalancing pro-competitive effects of that clause are minimal, there would be a strong case that it is an unreasonable restraint of trade under Section One.

There is potential to bring such a suit against a healthcare provider for accepting an MFN clause in exchange for the insurer paying higher rates. MFN clauses allow insurers to pay certain providers higher rates "in return for the hospitals' charging competing plans even higher rates, potentially raising prices for everyone."[223] The competitive harm to consumers is evident. In addition, the provider loses any incentive it might have had to offer lower prices because it must offer that same low price to all insurers—resulting in an increased equilibrium price.[224] MFN clauses therefore reduce any incentive to make prices transparent.

Challenging providers for their role in accepting MFN clauses, however, would likely only result in an injunctive remedy preventing the MFN clause's enforcement (because it would be difficult to prove competitive harm to other providers), which might not provide sufficient incentive

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[221] OFFICE OF MASS. ATT'Y GEN. MARTHA COAKLEY, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS PURSUANT TO G.L.C. 118G, § 6½(b), at 40-41 (2010), *available at* http://www.mass.gov/ago/docs/healthcare/final-report-w-cover-appendices-glossary.pdf.
[222] *Id.* at 41; *see also* FIONA SCOTT-MORTON, DOJ, CONTRACTS THAT REFERENCE RIVALS 12-13 (Apr. 5, 2012).
[223] Berenson et al., *supra* note 21, at 978.
[224] *See* SCOTT-MORTON, *supra* note 222, at 12.

to effect a change in behavior.[225] The more promising route is for the government and/or competitors to threaten the insurers who demand the inclusion of the clauses in the contracts; if competing insurers can show that they are worse off as a result of the provision (that is, by paying more to providers than they otherwise would have), they can sue for treble damages.[226] In concert with price transparency initiatives that help uncover MFN clauses, increased enforcement by the DOJ may make the threat of antitrust litigation more credible and therefore discourage this kind of anticompetitive behavior. Recently, the DOJ challenged Blue Cross Blue Shield of Michigan's use of MFN clauses on this theory, alleging that it has reduced competition in the market.[227] Aetna subsequently brought a private suit alleging that it was harmed by the reduction of market competition.[228] As of the date of this writing, both lawsuits have survived the defendant's motions to dismiss.[229] To prevail in this and in similar lawsuits, the plaintiffs will ultimately need to prove that the anticompetitive aspects of the MFN clauses outweigh any alleged pro-competitive benefits thereof, which will require intensive economic analysis.

Other contractual provisions might also open up providers or insurers for antitrust liability if they cause harm to competition. Because insurers and providers do not compete with each other, however, it is difficult to prove that agreements that otherwise might appear to restrain trade under Section One cause harm to competition rather than simply being good business tactics.[230] Rather,

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[225] Havighurst & Richman, *supra* note 186, at 879.
[226] *Id*.
[227] United States v. Blue Cross Blue Shield of Mich., 809 F. Supp. 2d 665 (E.D. Mich. 2011) (denying defendant's motion to dismiss).
[228] Aetna Inc. v. Blue Cross Blue Shield of Mich., 2012 U.S. Dist. LEXIS 82621 (E.D. Mich. June 14, 2012) (denying defendant's motion to dismiss).
[229] To survive a motion to dismiss, a claim must allege enough facts so that the court will find the facts plausible and "raise a reasonable expectation" that, in the course of the lawsuit, evidence of an unlawful agreement will be uncovered. Bell Atlantic Corp. v. Twombly, 550 U.S. 544, 556 (2007).
[230] *See* Royal Drug Co. v. Group Life & Health Ins. Co., 737 F.2d 1433 (5th Cir. 1984) (finding no horizontal restraint of trade in an agreement between an insurer and pharmacies, despite the appearance of collusion between the pharmacies as a result of the insurer-pharmacy agreements). In *Royal Drug*, the court rejected the plaintiffs' argument that the insurer, "by engaging in procompetitive conduct in the insurance business, . . . bec[a]me a price-fixer in the retail drug business because its method of competition [sought] to bring its customers the maximum

the terms that might create an antitrust issue are those that affect the prices that competitors of the agreeing parties can set.[231] That is, if a transaction between a provider and an insurer depends on the "specifics of a different buyer-seller relationship involving at least one of the same parties," or if either party needs to "know the details of a rivals contract" to determine the final price or terms of the contract, the clause is potentially anticompetitive.[232] For example, using market power to demand exclusionary discounts has the potential to impact competition and therefore can lead to antitrust liability.[233] As with MFN clauses, courts will carefully analyze these contractual provisions to determine if their pro-competitive impact is outweighed by their anticompetitive effect. Where the anticompetitive impact is more significant, they may be viewed as unreasonable restraints of trade that harm competition; preventing their enforcement may be a step toward increasing incentives to make prices transparent so that the market can respond accordingly.

Most antitrust cases based on contractual provisions, however, end in consent decrees enjoining enforcement of the terms in question rather than threatening offenders with treble damages, as would a private lawsuit alleging competitive harm.[234] Thus, this threat may not be a sufficient incentive to lead to any measurable change; regulatory measures forbidding such clauses may be just as effective as, and less costly than, litigation.

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insurance reimbursement." *Id.*at 1438. Rather, the court found that the insurer and the pharmacies "sit on opposite sides of the bargaining table. Absent any evidence of the presence and abuse of monopoly power, [the insurer] has the clear right to bargain for the lowest price and best deal for itself and its customers/insureds." *Id.*

[231] *See* Jonathan M. Jacobson & Daniel P. Weick, *Contracts That Reference Rivals as an Antitrust Category*, THE ANTITRUST SOURCE (Apr. 2012), http://www.wsgr.com/publications/PDFSearch/jacobson-0412.pdf.

[232] SCOTT-MORTON, *supra* note 222, at 3.

[233] United States v. United Regional Health Care System, Case No. 7:11-cv-0030-O (Sept. 29, 2011) (final judgment prohibiting exclusionary conduct).

[234] Jacobson & Weick, *supra* note 231 (citing United States v. Or. Dental Serv., No. C95-1211 FMS, 1995 U.S. Dist. LEXIS 21042 (N.D. Cal. July 17, 1995); RxCare of Tenn., Inc., 121 F.T.C. 762 (1996)). A consent decree is simply a stipulation by the offending party that it will cease its illegal conduct, in exchange for withdrawal of the lawsuit.

3. Tying Arrangements Between Providers and Payers

A second potential theory of antitrust liability is an unlawful tie under Section One. A tie is prohibited when a company uses its market power in one product to coerce the purchase of a second, separate product.[235] A party is harmed by and therefore has standing to challenge an illegal tying arrangement if it is either a purchaser forced to buy the tied product or a competitor prevented from competing in the tied product's market as a result of the illegal tie.[236]

To prove a tie, there must be (1) two separate products involved, (2) a tie requiring the purchase of the tied product as a condition of buying the tying product, (3) sufficient market power in the tying product to make the coercion possible, and (4) a not insubstantial effect on interstate commerce in the tied product's market.[237] For example, if a supermarket sold flour to customers only if they also bought sugar, that would clearly satisfy the first two elements: (1) flour and sugar are two separate products, and (2) the purchase of flour is a condition of the purchase of sugar. However, a plaintiff must also show that the store has (3) sufficient market power in flour and (4) a significant impact on the sugar market for the tie to be unlawful.

To prove the first element, courts use the separate products test, which asks whether there is sufficient consumer demand for each of the two products such that the supplier will provide each product separately.[238] The second and third elements require a factual determination of the use of market power to coerce the purchase of the tied product, asking to what extent the seller had and exploited its dominance "to force the buyer into the purchase of a tied product that the buyer either did not want at all, or might have preferred to purchase elsewhere on different terms."[239] To

[235] Times-Picayune Publ'g Co. v. United States, 345 U.S. 594, 605 (1953).
[236] Abraham v. Intermountain Health Care Inc., 461 F.3d 1249, 1266 (10th Cir. 2006).
[237] IMPROVING HEALTH CARE, *supra* note 206, at 99; *see also* Eastman Kodak Co. v. Image Technical Servs., Inc., 504 U.S. 451 (1992); Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2 (1984).
[238] *Jefferson Parish*, 466 U.S. at 21-22 (Stevens, J.).
[239] *Id.* at 12.

determine whether there was a substantial enough effect on interstate commerce to satisfy the fourth element, the plaintiff must allege evidence showing the foreclosure of a substantial amount of competition.[240]

Courts tend to analyze the market realities to determine if a tie might be pro-competitive. A tie may be an effective and efficient means of competition and therefore "entirely consistent with the Sherman Act."[241] This distinguishes between engaging in legal business practices to maximize return on the tying product and actually imposing restraints that insulate a "potentially inferior product" from competition.[242] For instance, there is economic evidence that integrating or bundling healthcare services can sometimes be efficient, so courts analyze factors like whether there is a business justification for the tie or whether there is a less restrictive alternative.[243] Only after taking these arguments into consideration will a court find a tying arrangement unlawful. Therefore, for a provider to be liable for an unlawful tie, it must be demonstrated that the tie aims to foreclose competition in the tied market and that it is not outweighed by pro-competitive effects. This section describes two potential theories of tying in greater detail.

a) Bundled Services

One potentially unlawful tie in the healthcare market is hospitals' bundling of services in their negotiations with payers, which effectively masks the prices of individual services. Importantly, a bundling challenge should focus on how a tie between *unrelated* services harms consumer welfare and increases the provider's monopoly power.[244] If services are not used together by consumers, the

[240] Gordon v. Lewiston Hosp., 272 F. Supp. 2d 393, 447 (M.D. Pa. 2003), *aff'd*, 423 F.3d 184 ((3d Cir. 2005) (affirming dismissal in part because plaintiff "failed to present any evidence regarding either the patient volume effect or the dollar volume of business that has been affected by the tied market").
[241] *Jefferson Parish*, 466 U.S. at 12.
[242] *Id*. at 14.
[243] IMPROVING HEALTH CARE, *supra* note 206, at 98, 39-40; Berenson et al., *supra* note 21, at 977; Anna Wilde Mathews, *Doctor, Hospital Deals Probed*, WALL ST. JOURNAL, at B1, Sept. 14, 2012.
[244] *See* Havighurst & Richman, *supra* note 186, at 876 n.86. This ensures that the products are viewed as two distinct products. Economic analysis suggests that it is not profitable for a monopolist to tie a complementary

arguments in favor of pricing them together may be lessened, leaving little justification for a coercive tie.

It can be profitable for a monopolist provider to bundle unrelated services, because doing so allows it to "make a precommitment to tie" that strengthens its hold on the tied market.[245] Bundling has the potential to harm competition by concealing the prices of individual services; separating the prices of discrete services would allow insurers to negotiate the reimbursement rate for each service separately, thereby enabling competitive pricing for services for which good substitutes exist rather than forcing insurers to accept a bundled rate.[246] As a result, as Professors Havighurst and Richman argue, hospitals that want to "fully exploit [their] various monopolies" would be forced to reveal prices for individual services to insurers and to the marketplace.[247] Insurers could then use this information to adopt policies and create incentives that would encourage consumers to seek out lower costs for specific procedures.[248]

One issue with this bundling theory, however, is that hospital services are often viewed as a single product, rather than as individual products. Thus, proving the existence of two separate products capable of being tied together would be a significant legal hurdle. To prevail on this claim would require economic analysis of the markets for each hospital service (or set of related hospital services) and of consumers' demands for those services to establish that they are distinct products.

A second hurdle is proving the element of coercion. In one healthcare case alleging that a hospital required third party payers "to contract for outpatient surgery services on an exclusive basis

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product to its monopolized product, therefore making such a claim unlikely to succeed; however, "where the monopolized product is no longer essential for all uses of the non-monopolized components, tying once again emerges as a profitable exclusionary strategy." Michael D. Whinston, *Tying, Foreclosure, and Exclusion*, 80 AM. ECON. REV. 837, 840 (1990).

[245] Whinston, *supra* note 243, at 839 ("By bundling components of its system together . . . firms can precommit to their marketing strategy.").

[246] Havighurst & Richman, *supra* note 186, at 876.

[247] *Id.* at 876-77.

[248] *Id.* at 877.

as a condition for contracting for general inpatient acute care hospital services on a discounted basis," the court found that there was no coercion because "the exclusive contracts, unreasonably restrictive or not, were the product of negotiation."[249] The court based this on testimony that the insurer had agreed to the contracts, in spite of their restrictive nature, as a business decision to avoid severing its relationship with the hospital.[250] To prove coercion, there will need to be clear evidence that the insurer would not have purchased the tied product but for the unlawful restraint.

A third problem to overcome is the argument that bundling is often pro-competitive and therefore not unlawful. Arguments about the pro-competitive character of bundling arrangements center on the economic efficiencies they create that allow providers to bargain for lower prices that they can then pass on to consumers.[251] For instance, bundling may allow for the cross-subsidization of services that otherwise might be prohibitively expensive.[252] It also helps avoid the problem of fee-for-service payment that can incent overtreatment.[253] In fact, bundling was a focus of the Affordable Care act due to its ability, at least in some cases, to reduce fragmentation in healthcare and thereby improve the coordination of healthcare—in turn lowering overall costs.[254]

On the other hand, if these ties create barriers that prevent competitors from introducing better, cheaper competing products, to the detriment of consumers, they should be considered anticompetitive.[255] If health plans were better able to distinguish between the prices of different services, they would be able to provide better coverage for patients willing to accept narrower

[249] Rome Ambulatory Surgical Ctr. V. Rome Mem. Hosp., 349 F. Supp. 2d 389, 407-08 (N.D.N.Y. 2004).
[250] *Id.*
[251] IMPROVING HEALTH CARE, *supra* note 206, at 100.
[252] *Id.* at 39-40.
[253] *See, e.g.*, BROWNLEE, *supra* note **Error! Bookmark not defined.**.
[254] *See, e.g., Improving Care Coordination and Lowering Costs by Bundling Payments*, HEALTHCARE.GOV (Aug. 23, 2011), http://www.healthcare.gov/news/factsheets/2011/08/bundling08232011a.html.
[255] *See id.*; *see also* ANTITRUST MODERNIZATION COMM'N, REPORT AND RECOMMENDATIONS 96 (Apr. 2007) (describing a de facto tying arrangement as one where the bundled products are priced such that it is better for consumers to purchase them together than separately, resulting in higher consumer costs).

networks.[256] Together with price transparency, this could give consumers significantly more power in the healthcare market than they have now. Analyzing the impact of bundling on consumer costs in a specific market, the availability of alternatives, and the ease of entry into the market—in addition to the initial determination of whether the provider has market power in the relevant market—will therefore be crucial facts to lay out a case for antitrust liability.

b) Geographic Tying

A second potential theory of tying is the tying of a hospital's services in one geographic market where the hospital has market power (the tying product) to its services in a second market (the tied product). In some markets, hospital networks with dominant hospitals have significant negotiating power over even dominant insurers.[257] Blue Shield points out that "an increasing number of provider networks in multiple geographic areas in California have insisted Blue Shield contract with them on an 'all-or-nothing' basis—meaning that Blue Shield must contract with their providers in every geographic location or none at all."[258] Blue Shield argues that this harms competition by allowing providers to increase rates and impose non-price requirements that prevent cost-containment and transparency.[259] In Massachusetts, the Special Commission on Provider Price Reform recommended prohibiting "any contracting practices that require insurers to contract with all provider locations for a multi-location provider, rather than contracting only with the individual provider locations with which an insurer may wish to contract," as well as "any contracting practices that require payers to pay the same or similar prices to all provider locations for a multi-location

[256] Havighurst & Richman, *supra* note 186, at 877.
[257] Berenson et al., *supra* note 21, at 974. "[A] leading form of consolidation is the multihospital system extending across large geographic areas, which in most cases does not lead to antitrust scrutiny. *Id.* at 978-79.
[258] Letter from Blue Shield of California to Federal Trade Commission dated May 27, 2011, at 3.
[259] *Id.* at 4.

healthcare provider where geographic differences in the provider's site do not support charging the same or similar prices."[260]

To warrant a finding of liability for these practices, each element of an unlawful tie must be present. The court must (1) be willing to view the same health service offered in the two geographic markets as separate products that may be tied together, (2) find evidence of a coercive tie, (3) find market power in the first market, and (4) find that the alleged anticompetitive harms create a substantial amount of harm in the secondary market and are neither legal business tactics nor outweighed by pro-competitive effects. Proving each of these elements will require significant economic and legal analysis.

The first element may be the most difficult to prove. If two separate geographic regions attract entirely different groups of consumers, with very few patients traveling to the other location, it seems apparent that health services in each region constitute distinct products. Although this argument aligns with the general justifications for prohibiting tying,[261] the case law is unclear as to whether an unlawful tie can exist where the two products constitute the same services but in different geographic markets. In *Jefferson Parish*, a seminal tying case, the Court wrote that it "follows from the underlying rationale of the rule against tying" that "two distinguishable product markets" must be involved.[262] This definition does not clarify whether the differentiation between product markets can include geographic distinctions, and courts have not directly addressed this question in the context of tying. Furthermore, it is possible that a court might view a hospital network's geographic market as a single, broad market—perhaps covering the entire State of California or even

[260] RECOMMENDATIONS OF THE SPECIAL COMMISSION ON PROVIDER PRICE REFORM 25 (Nov. 9, 2011). The Special Commission is made of members including public health officers, legislators on health committees, officers of insurance and hospital organizations, and health economists. *Id.* at i.
[261] Tying arrangements are forbidden because "[t]hey deny competitors free access to the market for the tied product . . . . [and] buyers are forced to forego their free choice between competing products." N. Pac. Ry. Co. v. United States, 356 U.S. 1, 6 (1958).
[262] Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2, 21 (1984).

the entire country—if the hospital proves that a broad market "reflects the reality of the way in which [it] built and conduct[s] [its] business."[263] In spite of each hospital's local activities, if the network is viewed as operating on a larger scale, courts may see it as a single entity, simply negotiating to get the best deals possible and therefore not engaging in unlawful tying.[264] Nonetheless, if there is economic proof of distinct consumer demand for each geographic market—which may exist as employers often demand providers within a specific geographic region—there is an argument that that should be sufficient to prove the existence of two separate, tie-able products under the separate products test.[265]

The Supreme Court has found similar—though not entirely analogous—situations in violation of antitrust law. In *United States v. Griffith*, four affiliated movie theater companies vastly increased their market share over a period of five years in the late 1930s, seeing an increase from having theaters in 37 towns—57% of which had only a single theater and thus no competition—to 85 towns—62% of which were without competition.[266] The corporations faced allegations that they had used their market power in the closed markets (that is, those without competition) to gain exclusive privileges from movie distributors in other markets.[267] The Court found that this behavior violated antitrust law, but under the (presently disfavored) theory of monopoly leveraging[268] rather than under a theory of unlawful tying, likely because it does not appear that the companies threatened not to deal with the distributors in the towns where they had a monopoly subject to their dealing with them in the competitive markets. Nonetheless, the Court's reasoning is useful:

[263] United States v. Grinnell Corp., 384 U.S. 563, 576 (1966).
[264] *See id.* at 575. In *Grinnell*, the Court found that an accredited central station service operated in a national geographic market because its planning, inspection, certification, rate-making, pricing, and terms were all set on a national level—despite the fact that "rates may be varied to meet local conditions." *Id.*
[265] *See Jefferson Parish*, 466 U.S. at 21-22.
[266] United States v. Griffith, 334 U.S. 100, 101-02 (1948).
[267] *Id.* at 103-04.
[268] *See infra* notes 288-291 and accompanying text.

> A man with a monopoly of theatres in any one town commands the entrance for all films into that area. If he uses that strategic position to acquire exclusive privileges in a city where he has competitors, he is employing his monopoly power as a trade weapon against his competitors. It may be a feeble, ineffective weapon where he has only one closed or monopoly town. But as those towns increase in number throughout a region, his monopoly power in them may be used with crushing effect on competitors in other places. . . . When the buying power of the entire circuit is used to negotiate films for his competitive as well as his closed towns, he is using monopoly power to expand his empire.
> The consequence of such a use of monopoly power is that films are licensed on a non-competitive basis in what would otherwise be competitive situations. That is the effect whether one exhibitor makes the bargain with the distributor or whether two or more exhibitors lump together their buying power, as appellees did here.[269]

The Court went on to note that, though "[l]arge-scale buying" is not unlawful per se because of the potential efficiencies it can create, such conduct for the purpose of either monopolization or "stifl[ing] competition by denying competitors less favorably situated access to the market" is unlawful.[270] This indicates that, despite finding liability under Section 2 in *Griffith*, the Court might be willing to view similar conduct as a restraint of trade under Section 1.[271]

However, another well-known tying case, *Times-Picayune Publishing Company v. United States*, provides an argument that two distinct markets for the same hospital network's services may not be separate products because they belong to the same network. In that case, the Court found that a morning and evening newspaper was the same product in the eyes of advertisers; despite the fact that "readers consciously distinguished between these two publications," the advertisers did not differentiate between the customers but rather generally sought to increase their customer coverage by advertising in both newspapers.[272] Thus, because "two newspapers under single ownership at the same place, time, and terms [sold] indistinguishable products to advertisers," there were no separate

[269] *Griffith*, 334 U.S. at 107-08.
[270] *Id.* at 108.
[271] Although the *Griffith* Court did not expand on its statement, it suggested that the companies, "having combined with each other *and with the distributors* . . . formed a conspiracy in violation of §§ 1 and 2." *Id.* at 109 (emphasis added).
[272] Times-Picayune Publ'g Co. v. United States, 345 U.S. 594, 613 (1953).

tying and tied products.[273] Despite the fact that different readers might purchase the two newspapers, the Court seemed to view the relevant customer base as the advertisers seeking simply to expand their reach and increase the number of (in their view) fungible consumers, without regard for differences between those consumers. This is analogous to an insurer contracting with a hospital network to expand its reach; the insurer does not distinguish between consumers based on geographic location but only seeks to sell to more customers. Under this reasoning, depending on how inherently different a court determines the two markets to be, it might view all of a provider's services as a single product in the eyes of insurers seeking to expand their consumer base.

Another illustrative example is the unreported case *Austrian v. UnitedHealth Group, Inc.*[274] In that case, individual physicians challenged a dominant insurer's practice of imposing an all-or-nothing requirement that the physicians accept all of its health plans.[275] The court held that the tying allegation was too general and that there was no proof of a foreclosure of competition in a distinct product market, finding that "only one market [was] involved."[276] The market in that case included "managed care organizations operating in the [same geographic] market;" despite having different contractual terms, the court decided that their services were "legally indistinguishable."[277] This case offers insight into how difficult it is to prove a tying claim between two similar products—but it leaves open the question of whether two managed care organizations operating in *different* markets would be indistinguishable. Because this issue has not been thoroughly vetted by the courts, to justify a finding of liability a court would have to carefully analyze the pro- and anticompetitive aspects of an all-or-nothing arrangement, as well as the market power and coercive tactics of the provider.

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[273] *Id.* at 614.
[274] In general, unreported cases cannot be cited as authority, but can provide useful examples.
[275] Austrian v. UnitedHealth Group, Inc., 2007 Conn. Super. LEXIS 1949, at *5 (July 17, 2007).
[276] *Id.* at *30.
[277] *Id.*

The second element, coercion, may also be difficult to prove for the reasons described above. That is, the fact that health plans have negotiated and agreed to purchase the tied product may negate any allegation of coercion, because the health plan may not be able to say that it would not have purchased the tied product but for the unlawful tie.

The third element, market power, will require thorough analysis of the control a certain provider has in the alleged tying market. As discussed above, this analysis must not only clearly define the relevant geographic market, but it must also take note of factors beyond just market share such as market-based and regulatory barriers to entry.

The fourth element asks whether a substantial amount of commerce in the tied product has been anticompetitively impacted. This question will depend on the balance of pro- and anticompetitive effects in the secondary market. Such pro-competitive effects might include the fact that these arrangements enable an entire system of hospitals to negotiate with insurers rather than just the ones the insurers find "important,"[278] as well as the efficiency and quality benefits that arise from an integrated system.[279] These may include cross-subsidization between hospitals and better coordination between physicians at multiple locations.[280] The Massachusetts Special Commission noted that its recommendations to prohibit these contracting practices "may not apply" in situations where those practices allow for more efficient delivery and better-managed costs, so they "should be reevaluated" in light of market changes.[281]

The anticompetitive effects of these ties, however, are vast. Geographic ties force health plans to accept providers' rates and thereby cut short the negotiation process. As a result, health plans lose the ability to set market-rate prices for distinct services, and this loss gets passed on to

[278] Berenson et al., *supra* note 187, at 4 (describing how hospital networks leverage the fact that health plans seek out their "must-have" hospitals to negotiate beneficial rates).
[279] *Id*. at 5.
[280] *See, e.g.*, IMPROVING HEALTH CARE, *supra* note 206, at 39-40; Berenson et al., *supra* note 21, at 977.
[281] RECOMMENDATIONS OF THE SPECIAL COMMISSION ON PROVIDER PRICE REFORM 25 (Nov. 9, 2011).

consumers, who lack knowledge about the prices they pay. Thus, if this claim is successful, it may help illuminate the true market value of hospital services and alleviate these market inefficiencies.

c) Alternative Theories of Tying

A slightly different way to frame the ties between healthcare services and/or markets is as a form of tying known as "full-line forcing." Often used in the context of retail distribution, full-line forcing occurs when a seller requires a retailer to "take and display a full or 'representative' line of the seller's products in order to obtain a desired product."[282] This is arguably analogous to the practice of forcing a health plan to purchase all of a provider's services or to contract with all of its hospitals in a region, although most full-line forcing cases involve retail distribution and therefore may be distinguishable from the provision of healthcare services through insurance plans. Courts tend to uphold full-line forcing arrangements, particularly when the arrangements are not exclusive, due to the benefits in distribution efficiency they provide.[283] If the products the retailer is forced to purchase are unrelated to those it initially wanted, however, "the reasonableness of this requirement to buy the whole line would be suspect."[284] For example, in a case involving ties between tractors and haying equipment, the court rejected the defendant's argument that full-line forcing is always permissible, finding that the circumstances under which such an arrangement does not violate the law "probably do not include cases in which coercion is applied to secure compliance with the full-line requirement."[285]

If hospital networks' practice of leveraging their power in one service or market is viewed as full line forcing, the justification for allowing the practice does not hold. As discussed above, when hospital systems coerce the purchase of their services, the factual and economic evidence suggests

[282] 1-22 ANTITRUST LAW AND TRADE REGULATIONS § 22.05(2) (Matthew Bender & Co., 2d ed. 2012).
[283] *Id.*
[284] *Id.*
[285] Earley Ford Tractor, Inc. v. Hesston Corp., 556 F. Supp. 544, 550-51 (W.D. Mo. 1983).

that full-line forcing does not produce the efficiencies that it does in analogous distribution arrangements. On the contrary, if there were proof that these practices result in "higher prices and outlays for medical services,"[286] there would be a strong argument that they are anticompetitive and harmful to consumers. Therefore, in addition to a classical tying argument, full line forcing may—in spite of its disfavor in some courts—be another potential argument.[287]

Alternatively, if this behavior is not enough to constitute an illegal tie, it may give rise to liability under Section Two if it represents a willful acquisition of monopoly power or a willful attempt to monopolize.[288] This may be viewed under a monopoly leveraging theory, under which liability can arise from using one's monopoly power in one market to gain a competitive advantage in another market.[289] However, circuit courts are split as to whether monopoly leveraging can exist without the monopolization or attempted monopolization of the second market,[290] and the Supreme Court recently wrote that proving a monopoly leveraging claim requires evidence that there is a dangerous probability of success of monopolization in the second market.[291] Thus, this claim seems to fall under the same requirements as does a stand-alone Section Two claim for monopolization or attempted monopolization, which would require the difficult factual showing of monopolization or a "dangerous probability of success" thereof in the second market, not just in the first. As a result, this claim is unlikely to succeed without a significant threat of monopolization in the second market.

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[286] AM. BAR ASS'N, ANTITRUST HEALTH CARE HANDBOOK 266 (4th ed. 2010).
[287] *Id.* ("There are no decisions discussing this issue, but full line forcing policies such as this may become a fertile ground for future health care antitrust litigation.").
[288] *See, e.g.*, SmithKline Corp. v. Eli Lilly & Co., 427 F. Supp. 1089, 1127 (E.D. Pa. 1976), *aff'd*, 575 F.2d 1056 (3d Cir. 1978) (finding that, although there was no illegal tie, the defendant engaged in behavior that constituted a willful maintenance of monopoly power and violated Section Two).
[289] United States v. Griffith, 334 U.S. 100, 107-08 (1948).
[290] 2-25 ANTITRUST LAWS AND TRADE REGULATION § 25.04 (2d ed. 2012). Notably, the Ninth Circuit has rejected the monopoly leveraging theory, requiring instead that there be an actual or attempted monopoly in the second market. Alaska Airlines, Inc. v. United Airlines, Inc., 948 F.2d 536, 548-49 (9th Cir. 1991).
[291] Verizon Comm'cns, Inc. v. Law Offices of Curtis V. Trinko, LLP, 540 U.S. 398, 415 n.4 (2004).

4. Antitrust Overview and Requisite Fact-Gathering

Although there are several possible options for antitrust litigation to help increase price transparency, it is crucial to first gather facts about the markets, competition, and contracts at issue to determine which claims might prevail. Based on the information currently available, separating tied services—either using antitrust or regulatory measures—seems to have significant potential to encourage both price transparency and the adoption of pro-competitive policies by insurers. However, any of these suggested claims would require significant economic analysis to succeed in court. In considering whether litigation would be worthwhile, it is also important to consider whether the remedy will be simply an injunction or treble damages, and what the deterrent effect of that remedy would be, both on the specific entity against whom the case were brought and as a societal deterrent. To change widespread behavior, antitrust enforcement may not be most efficient way to enact statewide change, but targeting a small number of dominant parties would demonstrate the state's willingness to challenge anticompetitive behavior and protect consumers in the healthcare market.

At this stage, certain factual questions should be investigated further to better analyze potential claims. These facts should include:

- Contract terms, noting any MFN clauses, explicit price fixing terms, or other provisions that might constitute unreasonable restraints—particularly those that directly affect the dealings of competitors.
- Evidence of the impact of contract provisions on competition. This should include information about who the competitors are and how they have been harmed, which may be measured by, for example, comparing their rates with others in the market or by analyzing any decrease in consumers due to anticompetitive behavior.

- Accurate measures of market power. As described in Blue Shield's letter, measures of market power in the provider market in California are inaccurate due to Kaiser Permanente's impact. This analysis also requires investigation into barriers to entry, whether regulatory, legal, or market-based.
- For a tying claim, there will need to be an economic analysis of the product market demonstrating separate demand for individual hospital services. For a geography-based tying claim, there must be analysis supporting treating the two geographic areas as separate markets that can be tied together. This is a threshold issue for establishing a tying claim and is difficult to prove in many healthcare cases. This question will depend on factors such as the number of patients traveling in and out of the geographic area for services and the other hospitals that patients view as substitutes, as well as, perhaps, the metropolitan statistical area in which the hospital operates and the breadth of the hospital's marketing.
- Evidence of a substantial impact on competition caused by the alleged illegal ties. This should include evidence of a decrease in consumers or a financial loss resulting from the tie.

Once this information has been collected and analyzed, it will be easier to assess the likely success of an antitrust claim and its impact on price transparency.

5. Antitrust Litigation Recommendations

As described above, antitrust litigation may help break down market power and, in combination with price transparency regulation, force dominant parties to make their prices transparent. Despite the competitive harms of certain conduct, however, under current antitrust law it is unclear whether any of these behaviors will lead to liability. This section will analyze three

potential avenues for bringing an antitrust suit to promote price transparency. However, any of the claims proposed herein must be evaluated carefully and supported by strong economic analysis.

a) Prohibiting Most-Favored Nations Clauses

One possible antitrust suit is a challenge to "most-favored nation," or MFN, clauses in insurer-provider contracts. As noted above, these clauses guarantee the insurer is getting the provider's best rates, thereby discouraging providers from offering low prices to other insurers—which raises the equilibrium price in these contracts and restricts competition among insurers.

An MFN challenge would likely be brought against a dominant insurer, as in the case of the DOJ's challenge to Blue Cross Blue Shield in Michigan, which dominates the Michigan insurance market with anywhere from 40% to 80% market share across different geographic areas.[292] The DOJ's arguments have succeeded in surpassing the early hurdles in litigation. Given the California Attorney General's office's demonstrated interest in intensifying antitrust enforcement in the healthcare market, the political climate in California may be ready for such a suit. Proving such a claim will require evidence that insurers have used MFN clauses to force providers to charge competing insurers higher rates, thereby unreasonably restraining trade.

However, despite the anticompetitive harms caused by the enforcement of MFN clauses, it is unclear what the impact of such a suit would be on price transparency. Furthermore, the strongest MFN suit would challenge dominant *insurers*, but the economic literature suggests that dominant *providers* are more of a problem in keeping prices hidden from consumers. Breaking down dominant insurers' market power may also make them less powerful negotiators to challenge these providers. Thus, while such a lawsuit might have some success in breaking down entrenched market power, it may not be the best route to achieve price transparency.

[292] *See* Complaint, United States v. Blue Cross Blue Shield of Mich., No.2:10-cv-14155-DPH-MKM (E.D. Mich. Oct. 18, 2010).

c) Unbundling Services

A second way to address price transparency through an antitrust lens is by unbundling services under a theory of unlawful tying. Such a challenge would address the price issues that arise when providers condition insurers' purchase of services in which they have market power on their purchase of distinct, non-dominant services. By forcing negotiating providers to separate those services that are not functionally related, they will have to reveal discrete values of those services that previously were riding on the coattails of services in which they had market power. As a result, insurers will be better able to negotiate for the true value of each set of related services, and consumer prices should reflect those increased efficiencies.

To prove a claim of unlawfully tying discrete services, there must be evidence of: (1) two separate products, (2) coercion, (3) market power, and (4) a substantial effect. The first element will be difficult to prove; it will require evidence that the demand for each product is discrete, which is in opposition to the popular view in antitrust law that all hospital services constitute a single product. Significant economic evidence regarding consumer demand for distinct services will be necessary. Second, to prove the existence of a coercive tie will require a court to find that a negotiated agreement can still represent a coercive arrangement. Proving this may be particularly difficult if the insurer would have contracted for the services even without the existence of the tie. To prove the third element, market power, will require economic analysis of the provider's power in the market for the tying services. Finally, the fourth element—proving a harmful effect on a substantial amount of commerce in the market for the tied services—will require a finding that the harm caused by these ties outweighs any pro-competitive impact they have on the efficiency of the healthcare insurance and delivery systems. For instance, even if it increases price transparency, unbundling

could potentially result in higher prices for dominant services and thereby harm consumers who need those services.

Each of these four elements requires thorough economic analysis, and the ultimate balance of efficiencies is dependent on these determinations. In addition, proving the existence of two separate products and of a coercive tie will be challenging legal hurdles to surmount. As a result, it is difficult to predict how a court would view an antitrust case alleging an unlawful tie between distinct services. If successful, however, unbundling services may have a significant impact on providers' revelation of prices to health plans, and as a result there is the potential that it may help increase price transparency for consumers. This result becomes significantly more likely if antitrust enforcement is paired with regulatory measures (to ensure the availability of price information) and consumer initiatives (to enable decision making).

d) Breaking Geographic Ties

A second, though less clearly subject to liability, theory of unlawful tying can be drawn in dominant providers' abuse of their market power in one geographic market to coerce the purchase of their services in other geographic locations. To date, such a claim has not been alleged and therefore would have to overcome many legal hurdles—most significantly, proving that separate geographic markets for the same hospital network's services constitute distinct product markets—but, because of this behavior's tendency to harm competition, courts may be willing to apply antitrust liability to this conduct. Challenging these geographic ties, like challenging bundled services, may break up market power and force providers to negotiate rates for their distinct geographic services. When paired with price transparency, this should allow insurers to negotiate competitive rates for non-dominant hospitals, which in turn will enable employers and consumers to engage more fully with price differences in the market.

Geographic tying arguably meets the elements of an unlawful tie, but each element faces difficulty: (1) *Two separate products.* Although patient demand for services in distinct geographic regions may demonstrate that two hospitals in one network are distinct products, a court may nonetheless decide that the network constitutes a single product, with which health plans must negotiate. If a court determines that the hospital network operates as a single company and negotiates on a broad geographic scale—that is, if it defines the geographic market on, for instance, a state or even national scale—it may not be possible to distinguish between separate products offered by the single company. In California, however, because patient demand creates at least two distinct markets—Northern and Southern California[293]— for providers (as well as for employers building networks of hospitals), a court may be more willing to view hospitals in each market as separate products than it would in a smaller state. It will thus be crucial to demonstrate this distinct demand for hospitals in separate geographic areas and to show that the network's administration operates on a local rather than statewide scale.

(2) *Coercive tie.* As with bundled services, even if there are two separate products capable of being tied, there must be evidence that the tie coerced the health plan to purchase the tied product, which is difficult to prove when the purchase is the result of negotiations. If a health plan might have purchased the product regardless of the tie—the difference being only the amount it paid—there may be a strong argument against the existence of a coercive tie. However, studies of provider-insurer negotiations in several metropolitan areas throughout the country have demonstrated that networks with dominant hospitals often exercise significant leverage over health plans, making their negotiations one-sided and forcing the health plans to contract with their non-dominant hospitals as well. If a study demonstrated a similarly anticompetitive impact in California,

[293] For example, Kaiser Permanente separates California into Northern and Southern regions, on the assumption that patients will seek care in one region or the other.

there would be a stronger argument that these ties are coercive. Performing such a study may be a logical starting point to build evidence of the anticompetitive effects of this conduct in California.

(3) *Market power*. Proving market power in the tying product is a factual determination. Given the difficulty in measuring market power in California's healthcare market, due to factors such as regulatory and market barriers to entry, market share alone may provide an incomplete picture of a hospital's market power. Consequently, there needs to be through economic analysis of the actual power held by any given provider.

(4) *Foreclosure of a substantial amount of competition*. Again, this is a factual question, requiring consideration of the overall harmful impact of geographic tying. This requires analysis not only of the harmful effect on competing hospitals, but also of potential pro-competitive justifications that might outweigh the harm to competition. For example, geographic tying may create cross-subsidization efficiencies by balancing costs across different hospitals, and it may contribute to better coordination between both physicians and administrators, thereby decreasing overall costs. Ultimately, the question is whether those benefits outweigh the harm to competition—such as barriers to entry and inefficient negotiation—caused by these ties.

Like bundled services, geographic ties are not necessarily unlawful under antitrust law simply because they may have a negative impact on the healthcare market; there are significant economic and legal challenges to address before concluding that a court would find a provider liable for engaging in this conduct. Therefore, a lawsuit of this type would require significant evidence of harm to competition in order to justify establishing this as a new theory of antitrust liability. However, with price transparency initiatives in place, it may be easier to gather the evidence necessary to bring a suit—and the impact of such a suit would be significantly stronger if accompanied by clear and readily available price information. Therefore, antitrust enforcement and

regulatory or market-based solutions seem to have the most potential if we take both approaches at once.

B. Legislative Solutions

Aside from litigation, states could continue to try to promote price transparency through legislation. Price transparency legislation will have varied effects, depending upon particular conditions in the target market. In urban areas with a higher concentration of providers, less leverage, and greater market competition, price transparency may drive price decreases, while rural areas with fewer providers may actually see healthcare prices increase. The potential for geographically varied outcomes results from provider leverage over certain markets, where more leverage exists for "must-have" providers and providers supplying unique services within a network.[294] As a result, blanket price transparency requirements should not be implemented through legislation. Instead, the legislature should focus on incentivizing price transparency in areas with less leverage and greater competition where its intended effects are most probable. With this in mind, there are three potential avenues for legislating price transparency.

One possible solution may include passing legislation that gives the state authority to certify individual health plans that provide the best value, both within and outside of the exchanges, as "Visible Value" plans. Exchanges could require Visible Value plans to meet specified criteria for lower cost and high quality services. Receiving certification would also signal to consumers that the plan did not result from any anticompetitive tactics such as MFN clauses or geographic tying leverage, and that it has value-based financial incentives for provider payment, rather than fee-for-service. Since complete transparency may not be an ideal solution for all markets, the law should require that insurers only disclose complete price information negotiated with providers to the exchange or other state agency in charge of certification in order to determine certification eligibility.

[294] Berenson et al., *supra* note 24.

By not releasing full price information to competitors, this will prevent collusion in less competitive markets while still allowing the state to direct consumers to those health plans that offer the best quality care for the most competitive price, in the absence of anticompetitive negotiations.

In terms of transparency to the public, only certified Visible Value plans would be required to make provider quality scores and premium rates available to the public. Each certified health plan would be required to maintain quality and cost scores at a minimum level, or else lose its certification status. In addition to facilitating consumers' healthcare decision-making, this legislative transparency initiative may also incentivize providers to deliver higher quality care and insurers to negotiate for lower priced, better quality providers, thereby helping to lower the cost of healthcare statewide.

One challenge of this approach would be gathering and analyzing the cost and quality data needed to certify the health plans. In California, the cost portion of this data could be collected by a qualified entity, designated by CMS to gather and disseminate date on provider performance pursuant to SB 1196,[295] and evaluated in accordance with the legislative criteria to determine which plans are eligible for certification.[296] A state exchange could apply to CMS for designation as a qualified entity for purposes of gathering price and quality data. Other entities, such as a multi-stakeholder group, could also apply for qualified entity status to enable collection of this information for Visible Value plans. The quality evaluation, however, would either require voluntary reporting

[295] See Section V.A.3, *supra* (stating SB 1196, recently signed into law in September 2012, prohibits health plan-provider contracts from preventing disclosure of claims data to "qualified entities" designated by the Secretary of the Centers for Medicare and Medicaid Services).

[296] As part of the ACA, Congress created a new program to make certain healthcare data available to certified "qualified entities." In 2011, CMS launched its Medicare Data Sharing for Performance Measurement program that allows qualified entities to use Medicare claims data, along with publically available data from private insurers, to produce comprehensive reports on provider performance. Using the same certification process, states, like California, could allow qualified entities to access healthcare pricing information for public dissemination.

by health plans, or would need to be collected from a quality comparison website, such as California Hospital Compare[297] or "Health In Sight," a national hospital rankings website.[298]

This process of certifying best-value health plans would differ from the tiered health plans in that tiering is fundamentally based on cost, whereas this certification will be based additionally on quality and competitive activity. Because the success of health plan certification depends on consumer engagement and purchasing of those certified plans, education programs for individual consumers and employers will be absolutely necessary. Similar to the types of consumer education found on Aetna's website regarding provider cost and quality, [299] succinct and usable information must be provided to consumers and employers to ensure full understanding of the certification process.

States could also pass legislation requiring an annual review of all insurance premium increases of 5% or greater. Currently, the Affordable Care Act mandates an annual review of premium rate increases of 10% or more.[300] By mandating an even more strict review, states could monitor rising costs more closely. States could deny and assess penalties on insurance companies that are unable to justify their rate increase by demonstrating quality improvements or increased benefits. If triggered, annual review of premium increases of 5% or greater could also nullify gag clauses, as insurers would be required by law to disclose information negotiated in provider contracts in order to justify their desired increase. Penalties and mandatory disclosures would provide strong additional incentives for insurance plans to keep premium increases below 5%. These mandatory disclosures for auditing purposes would not be disseminated to the public,

[297] See Section V.A.2, *supra*.
[298] Health In Sight, Hospital Performance Rankings, *available at* http://www.healthinsight.org/Internal/Hospital PerformanceRankings.html.
[299] See Section V.C, *supra*.
[300] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1003, 124 Stat. 119 (2010).

however the information may requested under a state's public records law, such as the CPRA, to facilitate public disclosure.

C. Regulatory Solutions

Unlike legislation, which is created by an internal proposal from within a legislative body, voted on by both the houses and then signed by the governor, regulation can be created by any state agency with the power to enforce certain laws. While the most opportune regulations could come from the exchanges, initiatives can also be initiated outside of the exchanges by state departments of insurance.

Recent healthcare reform efforts create new opportunities to address the gap in consumer information through the state health benefit exchanges. The ACA requires states to pass legislation to legally set up an exchange, or else the federal government will administer one for them.[301] The federal law gives states flexibility to set up exchanges in ways that will most benefit each state, within certain federal guidelines. The creation of state exchanges offers two opportunities for states to incorporate price transparency initiatives into these new entities: 1) legislation establishing the exchanges; or 2) regulations created by an exchange to govern qualified health plans offered on the Exchange.

1. Legislation Governing the Exchange

In January 2011, California became the first state to create a health benefit exchange with the passage of Senate Bill (SB) 900 and Assembly Bill (AB) 1602. As the first state-created exchange, this section will use California as a model for analyzing price transparency initiatives at the exchange level.

SB 900 established the Exchange and created a five-member Board of Directors. AB 1602, the California ACA, creates the structural framework of the California Health Benefit Exchange

[301] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1331, 124 Stat. 119 (2010).

(CHBEX), known as Covered California. The statute grants the CHBEX Board the authority to determine both the minimum requirements for carriers to offer a plan on Covered California, as well as the standards and criteria required for designating a plan as a Qualified Health Plan (QHP) eligible to be offered through Covered California. Most notably, section 2(a) calls for the creation of a "transparent marketplace for Californians to purchase affordable, quality healthcare coverage." Incorporating price transparency language into the legislation establishing Covered California opens the door to discussion about ways to implement a price transparency initiative in California, with hopes to pave the way for other states to follow suit.

2. Avenues to Exchange Regulation and Their Uncertainties

Since the California enacted legislation designating Covered California to be an active purchaser, it has the authority to impose requirements, such as price transparency, on health plans that wish to be a part of the exchange. As one of its first steps to actively negotiate with health plans, the CHBEX Board drafted a list of requirements and questions for plans submitting bids to be on the exchange.[302] Covered California asks bidders to describe their current cost, quality, and efficiency programs, including "activities to identify for members/consumers those providers . . . that are more efficient and/or lower cost" and "the web-based cost information that the Plan makes available."[303] Each bidding health plan must also reveal current cost containment strategies, describe methodology used to combine provider cost and quality metrics,[304] and list any contractual agreements with its participating providers that prevent it from making contract terms transparent to

[302] California Health Benefit Exchange, Qualified Health Plans Solicitation Draft (Sept. 25, 2012), *available at* http://www.healthexchange.ca.gov/Solicitations/Documents/QHP%20Solicitation%20DRAFTv%20092512public.pdf.
[303] *Id.* at 70.
[304] *Id.* at 24.

plan members.[305] Based on bidders' responses, the CHBEX Board has the authority to fine-tune its requirements and impose even greater restrictions on insurers. [306]

The CHBEX Board does not currently impose any price transparency requirement on health plans that wish to participate in Covered California. However, increased pressure through stakeholder testimony and written comments at meetings and in webinars may motivate the Board to mandate price transparency on the exchange. The CHBEX Board strongly believes that its efforts should be guided by input from stakeholder groups.[307] As a result, it invites public testimony and submission of written comments at its meetings, allows stakeholders to give panel presentations on particular issues, and holds separate webinars to assess stakeholder values and concerns. This willingness to listen to and incorporate stakeholder feedback provides an opportunity to advocate for incorporation of transparency initiatives within the exchange.

Some uncertainty exists regarding whether additional price transparency initiatives could still be incorporated into existing bids and contracts for plans that initially want to participate in Covered California or whether those initiatives would have to be incorporated at a later date. At this stage, the CHBEX Board appears to have considerable authority to impose requirements on health plans to shape the operation of the exchange.[308] The CHEX Board has already included certain reporting requirements for plans that want to participate in Covered California, but so far they largely focus on

[305] *Id.* at 23.
[306] *Id.*
[307] California Health Benefit Exchange Vision, Mission and Values, *available at* http://www.healthexchange.ca.gov /Pages/HBEXVisionMissionValues.aspx.
[308] California Health Benefit Exchange, Qualified Health Plans Solicitation Draft 23 (Sept. 25, 2012), *available at* http://www.healthexchange.ca.gov/Solicitations/Documents/QHP%20Solicitation%20DRAFTv%20092512public.pdf. The timeline of how the Board will accept bidders' proposals to be part of the Exchange is as follows: A first draft of the Exchange's Qualified Health Plan Solicitation Draft was released on September 25, 2012. The Board invited bidders to submit comments and suggestions by October 4, 2012. Evaluation and selection of winning bidders will take place between January 7 and March 30, 2013. The negotiation of final contract terms and conditions will be completed by March 31, and contracts between the Exchange and selected bidders have a projected execution date of June 1, 2013.

quality reporting.[309] The CHBEX Board should also consider similar reporting requirements for healthcare service, device, and procedure prices prior to Covered California's debut in January 2014. However, Blue Shield of California wrote in comments to the CHBEX Board that while it would favor a prohibition of anti-transparency clauses, it is too late to amend or change their contracts with providers before the bids for Qualified Health Plans were due in January 2013.[310] If the CHBEX Board is reluctant to add requirements to the initial plans, once fully established, Covered California or the California Department of Insurance, which regulates insurance practices within the state, could impose additional regulations to promote price transparency on plans offered within Covered California.

The commitment to transparency in AB 1602, along with Covered California's position as an active purchaser, places it in an influential position to shape the ways health plans and insurance companies disclose price information to consumers on the exchange and to hold insurers accountable for meeting those requirements. But as it stands, the CHBEX Board has not utilized its full authority to promote price transparency on the exchange. Evaluating current transparency initiatives employed by plans seeking inclusion in Covered California should be just the first step. To ensure consumers on the exchange have access to meaningful price and quality information in order to make educated decisions about plan selection, the Board will need to use its regulatory power to require transparency of complete cost information, like the New Hampshire and Aetna initiatives. If key stakeholders can communicate to the Board the importance of such initiatives, it may be feasible for the Board to incorporate them into the design of Covered California before it is launched in 2014. Requiring price and quality reporting as part of health plan certification on

[309] Covered California, Qualified Health Plan Model Contract – First Draft (January 11, 2013), *available at* http://www.healthexchange.ca.gov/Solicitations/Documents/1st%20DRAFT%20QHP%20Model%20Contract%20%201%2011%2013.pdf.
[310] Stakeholder Input: Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability, California Health Benefit Exchange (August 10, 2012).

Covered California has potential to improve consumer decision-making and spur competition in the healthcare market.

3. Potential Exchange Regulatory Initiatives

State regulation can take many forms. First, the largest mandate a state could require would be to mandate price transparency of all plans offered by any insurer, regardless of whether the plan is offered on the exchange. Second, the exchange, through its contracting power as an active purchaser, could implement a certification process for health plans that meet more rigorous cost and quality measures. For these certified Visible Value plans, an exchange could mandate disclosure of complete price transparency, including negotiated prices to providers, by insurers to the exchange only, while allowing the exchange to publish quality and premium information to the public. This type of selective price transparency would serve to protect against over-disclosure of price information that may have unintended consequences, such as collusion, which could raise prices.

A similar model of this type of certification exists currently on the Connector, the healthcare benefit exchange in Massachusetts. The Connector screens each carrier based on a high standard of quality and rates each on a scale of one to four stars consistent with the National Committee for Quality Assurance.[311] One report reviewing the Connector cautions that exchanges must strike the right balance between setting the bar too low and not effecting any change, and imposing too many requirements and running the risk of "be[ing] unable to attract a sufficient mix of the plans that consumers want."[312]

Additionally, an exchange board might consider creating various sub-portals within the exchange based on geographic market. A similar division of healthcare markets could also be implemented by a state Department of Insurance, which may be more equipped to determine which

[311] SABRINA CORLETTE ET AL., GEORGETOWN UNIV. HEALTH POLICY INST., THE MASSACHUSETTS AND UTAH HEALTH INSURANCE EXCHANGES: LESSONS LEARNED 7.
[312] *Id.*

geographic regions would respond most positively to consumer-driven competition.[313] By actively dividing the state into regional healthcare markets, the Board can then choose which regions would respond best to certain transparency initiatives and only implement them in those areas. Currently, the California State Legislature has proposed such a division to partition the state into six regions in 2014 and 13 regions in 2015.[314] In opposition, California's Insurance Commissioner, Dave Jones, has proposed an 18-region plan, arguing that an increased number of regions will lower possible premium increases due to the differing cost of healthcare among communities.[315]

Finally, exchange boards may wish to set up a portal to track which parts of the exchange website consumers visit and what they consider when choosing insurers and providers. If a board creates a price transparency initiative and wishes to track consumer traffic on its website, it should partner with healthcare economists in order to begin generating data on how healthcare consumers respond to certain initiatives in order to continue to fine tune them.

As noted above, a chief concern of implementing transparency initiatives through the exchanges is whether there is enough time before the launch of the Exchange in 2014 to successfully include these initiatives. Regulation suggestions should be presented to the exchange boards as soon as possible to determine feasibility of implementation. If a board cannot implement additional regulations at this stage, these initiatives could be introduced for review and implementation at a later date.

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[313] The California Department of Managed Healthcare invites public suggestions for new regulations on its website. However, each link purporting to invite such suggestions leads to a dead end page stating "[t]here are currently no 'Issues and Regulations for the Upcoming Year.'" *See Laws*, CA.GOV, http://www.dmhc.ca.gov/aboutthedmhc/law/law_default.aspx (last visited Oct. 22, 2012).

[314] A.B. X1-2, 2013-2014 Sess. (Ca. 2013), *available at* http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320141AB2.

[315] California Dept. of Ins., "Insurance Commissioner Jones issues statement to oppose geographic rating proposals that would result in rate increases for California healthcare consumers," *available at* http://www.insurance.ca.gov/0400-news/0100-press-releases/2013/statement017-13.cfm.

Although the effects of regulations and laws, so long as they are not conflicting, are identical,[316] regulations serve to fast-track the above initiatives. While a board can only impact those health plans offered on the exchange, by implementing these initiatives through regulations both the board and the Department of Insurance can begin annual reviews and certifications more immediately, instead of waiting out the long and potentially futile legislative process.

D. Employer and Consumer Education Initiatives

On the other hand, legal and regulatory actions are not the only potential paths. A silver lining to our country's recession and its effect on the healthcare market is that now is likely the most opportune time, on many levels, to implement price transparency initiatives. With employers increasingly shifting more healthcare costs onto their employees via high deductible health plans (HDHPs), and employees' salaries unable to keep up with the growth rate of healthcare, consumers have more incentives to be cost-conscious when purchasing healthcare products and services than ever before. With consumers paying closer attention to healthcare prices, and providers, in turn, taking notice of consumer healthcare trends,[317] both employers and consumers are poised to be target audiences for price transparency initiatives.

1. Employer-level initiatives

Higher spending for hospital, physician, and other clinical services accounted for almost 80 percent of premium increases between 2005 and 2009.[318] As it stands, employer demand for broad provider networks gives providers substantial leverage to contract for higher prices with insurers in

[316] Violations of both regulations and laws can result in similar penalties and fines.
[317] RECOMMENDATIONS OF THE SPECIAL COMMISSION ON PROVIDER PRICE REFORM 13 (Nov. 9, 2011) (reporting that "the use of differential employee health insurance contributions based on provider cost and quality" in Maine and Minnesota led to 100% of Maine hospitals reporting quality data and Minnesota providers strengthening their credentials in direct employer contracting and improving coordination and joint decision making among hospitals and physicians).
[318] JULIE A. SCHOENMAN & NANCY CHOCKLEY, NAT'L INST. FOR HEALTH CARE MGMT. FOUND., UNDERSTANDING U.S. HEALTH CARE SPENDING (2011), 9-10, *available at* http://nihcm.org/images/stories/NIHCM-CostBrief-Email.pdf.

order to participate in their network. In a market with substantial provider leverage for "must have providers", transparency initiatives could cause insurers to pay more for all provider groups, as maintaining the fact that they pay higher prices to dominant providers remained a secret.[319] Once exposed, it is more likely that other providers will demand higher prices, rather than the "must have provider" reducing their prices. Insurers can regain leverage by convincing employers to shift their preferences to narrower, but high quality, networks. With provider payment and quality information transparent to employers, employers would then have the tools and knowledge to demand plans that offer particular low-cost, high-quality providers. This would allow employers to save money on healthcare benefits and, at the same time, to offer employees greater value healthcare.

Narrow and tiered networks have already gained some traction in the small group market, especially when combined with consumer-driven health plans, such as HDHPs.[320] For example, in Indianapolis, where consumer-driven health plan enrollment is high, health plans focus on helping employers see the benefits of choosing those plans that incorporate lower-cost, high-quality services, thereby narrowing the network of providers needed on a given health plan.[321] By educating employers about the value of certain providers, insurers are not only saving money themselves, but they also help employers save money on healthcare costs and provide better value care for their employees. Unfortunately, this strategy has been circumvented, however, by the manipulation of billing codes, whereby providers attempt to convolute insurers' ability to determine which facilities

[319] Berenson et al., *supra* note 24.
[320] Christianson et al., *supra* note 29, at 3 (stating that narrow networks may work better to restrict physician networks over hospitals, because those with negotiating leverage can avoid being placed in a less-preferred tier or excluded from narrow networks).
[321] *Id.* at 4 (stating that, in addition to insurers in the Indianapolis market, BlueCross BlueShield in Syracuse has reduced growth in high-cost imaging by requiring prior-authorization for high-cost imaging centers).

provide lower-cost services.[322] To thwart this potential barrier it will be necessary, as mentioned in Section IV.C.3, to demystify billing codes for employers as well as individual consumers.

Consumer-driven plans not only incentivize individual consumers to stay healthy, but also change the nature of the healthcare market. In theory, consumers enrolled in HDHPs will pay closer attention to the cost of their day-to-day healthcare than those on traditional health plans with copays. Since enrollees of consumer-driven health plans have incentives to be cost-conscious consumers, efforts to introduce employer-level transparency and to educate both employers and consumer would allow employers to choose health plans with smaller networks of high-quality, lower-cost providers and communicate those better value plans to their employees. This employer-based strategy will prove most effective at reducing healthcare costs in geographic markets with a wide range of choices among physicians and hospitals, because it will increase transparency and, therefore, competition among providers to be recognized as lower-cost, high-quality providers that employers should want to direct their employees toward. Those markets with very little selection should not be the target of this type of initiative, as transparency is not likely to positively affect markets without the potential for increased competition.

Shifting the leverage from providers to employers (and individual consumers) may also yield particularly beneficial results in the self-insured employer arena. In order to educate employers about the potential cost-saving power of a price transparency initiative, it is likely that human resources departments, insurance brokers, and private companies, like Castlight Health will need to play a role in helping employers understand their options.[323] For instance, Castlight creates an online space where employees of self-insured employers can shop for healthcare based on price, quality and how much of their deductible is already spent. By educating employers about how to, in

[322] *Id.*
[323] The Massachusetts Connector actually requires that one of its Board members be an insurance broker. CORLETTE ET AL., *supra* note 311, at 5.

turn, educate their employees, data gathered by Castlight demonstrates that helping self-insured employers aid their employees in informed healthcare decision-making can change employee behavior.[324] As the main purchasers of healthcare, employers should exercise some leverage of their own. If large companies demanded price transparency, whether through an intermediary such as Castlight or on their own, providers who once were able to leverage higher prices against blind employers would either need to produce evidence of value or else accept lower payments.

To effectuate this change, self-insured employers may negotiate lower their prices in exchange for incentivizing employees to use the provider, as Lowe's Company has done with the Cleveland Clinic.[325] The North Carolina-based company encourages its employees from all across the country to travel to the Cleveland Clinic for high quality heart procedures at comparatively low prices.[326] Because of the size of Lowe's employee base, the arrangement was beneficial enough for Lowe's that it agreed to pay for all travel and lodging costs for employee-patients and a companion, as well as waive a $500 deductible, among other out-of-pocket costs.[327] Through employer initiative and innovation, Lowe's is able to offer better quality healthcare to its employees at a lower cost. If more self-insured employers can demand services, compare the cost and quality of healthcare nationwide, and incentivize employees to seek out recommended providers, not only may employers realize savings, but individual consumers may also see the effects of transparency on their costs as well. For example, it may be difficult for providers to continue demanding higher payments for

[324] CASTLIGHT HEALTH, http://www.castlighthealth.com/why-castlight (last visited Oct. 22, 2012) (reporting that Castlight Health has helped customers achieve 70% employee engagement rates; that 61% of employees made medical care decisions based on Castlight's recommendations, resulting in a 13% reduction in spending and 38% improved care; and that Castlight users are 40% less likely to go out-of-network for healthcare).
[325] Havighurst & Richman, *supra* note 205186, at 877 n.89.
[326] *Id.*; *see also* Harlan Spector, *Lowe's-Cleveland Clinic Deal Could Be a Model for Health-Care Reform Through Competition: A Medical Checkup Column*, CLEVELAND.COM (Mar. 2, 2010), http://www.cleveland.com/healthfit/index.ssf/2010/03/lowes-cleveland_clinic_deal_co.html (explaining that Lowe's Company analyzed five separate heart centers before striking the deal with the Cleveland Clinic).
[327] *Id.* (citing Harlan Spector, *Lowe's Will Bring Its Workers to Cleveland Clinic for Heart Surgery*, CLEVELAND.COM (Feb. 17, 2010), http://www.cleveland.com/healthfit/index.ssf/2010/02/post_27.html).

individual consumers when their prices and quality information, now transparent to employer-consumers, suggest services are worth less.

2. Consumer-level initiatives

Targeting consumers directly with price transparency initiatives will be harder, and may prove least effective of all possible avenues in lowering healthcare prices overall. Since pricing information varies from consumer to consumer based on insurance carrier, type of health plan, and geographic location, not all price information will be relevant to all consumers. This means that effecting change on a consumer level will require disclosure of pricing information on a variety of levels to incorporate all the necessary variables in order to influence enough consumers to make a difference in healthcare spending. Creating and designing an initiative that would allow consumers to retrieve specified price information based on several variables would cost more than simply mandating that providers disclose their negotiated reimbursement rates. It would require gathering those rates from each provider and insurer contract, as well as quality measures from each provider, and distilling that information into streamlined figures that can be manipulated through an Internet portal based such variables as on insurer, health plan, location, and budget.

The next step in disclosing healthcare costs to consumers is ensuring usability of that information. As they currently exist, hospital billing codes, methods of healthcare service bundling, and the various levels of cost-shifting (from numerous providers, to insurers, to employers) make comprehension of healthcare pricing extremely difficult for the average consumer.[328] But given the trend of enrollment in HDHPs, a growing number of consumers are poised to start paying more attention to healthcare expenditures. Although there is still no guarantee consumers will use available cost and quality information when purchasing health insurance or choosing a provider, there are certain ways of presenting more meaningful cost information that will serve to educate

[328] CRS REPORT FOR CONGRESS, *supra* note 9, at 4, 8, 10.

consumers. Also, a younger generation of healthcare consumers may be more familiar with and willing to use these kinds of online tools to evaluate health plan and provider options.

For any generation, the more meaningful transparency information is to consumers, the more likely it is to influence their healthcare decision-making. Separate disclosure of price and quality information, as is often done, is too disjunctive to be useful for consumers.[329] Rather, presenting cost and quality information either in a side-by-side comparison or a separate scale that is easy to understand may inspire healthcare consumers to act more like consumers in other markets resulting in lower overall healthcare costs.[330]

One solution to promoting usability of transparency information is to develop a website that enables consumers to enter their health plan, medical condition, and geographic location in order to generate a list of available providers and their prices and quality scores. This initiative would require higher start-up costs than other price transparency measures. For instance, it would likely require the development of software to convert of thousands of healthcare products and services, at thousands of facilities, into one state-wide scale of measurement. This initiative, however, is a prime example of a model that may qualify for demonstration grant funding under the ACA, which could alleviate state implementation costs.[331] If consumers begin to use this information in large numbers in favor of lower cost providers, which remains a significant question, could reduce provider leverage and healthcare costs overall.

[329] Hibbard & Peters, *supra* note 38, at 415-16.
[330] *See* Reinhardt, *supra* note 15, at 66-67 (stating also that he proposed a similar hospital rating system for consumers in 1993 that allowed each hospital to maintain their own quality and pricing measurements while assigning each a conversion factor, allowing for a national body of experts to calculate each hospital's cost and quality measures on the same "weight scale").
[331] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3013 and 3015, 124 Stat. 119 (2010).

VII. Recommendations

The most effective combinations of these solutions will include two elements: (1) one that targets provider leverage by discouraging anticompetitive behavior, and (2) another that mandates disclosure of price information. For instance, breaking apart geographic markets, alone, risks only reforming healthcare pricing in the select areas where geographic ties exist. On the other hand, merely requiring price transparency may have the unwanted result of driving up healthcare costs in some markets. In combination, however, these elements have the potential to effectively lower healthcare costs across each state. There are multiple different methods for combining these two elements, which are discussed below.

A. Antitrust Litigation and Legislation/Regulation

The combination of bringing an antitrust suit to break apart and prevent anticompetitive tying and passing legislation or regulation to mandate price transparency has the potential to reduce costs through improving competition. Simultaneously requiring price transparency and reducing anticompetitive behavior could make prices both *visible* and *fair*. The antitrust suit would likely challenge providers' higher prices derived from anticompetitive ties linking geographic markets and/or unrelated services.[332] Even the specter of a successful suit could reduce provider willingness to leverage their power to demand uncompetitive prices.

For this approach to work, antitrust litigation must take place prior to legislative or regulatory change. Although transparent prices would allow the Attorney General to use discovery to gather useful data to inform an antitrust suit, because of the uncertain outcomes of enacting price transparency alone in regions where providers or insurers have leverage,[333] the first step in this process should be using antitrust litigation to break down and discourage anticompetitive uses of

[332] Alessi, *supra* note 203.
[333] *See supra* Part II.

market leverage.[334] The results of the lawsuit could then be used to drive support for potential legislation or regulation.

Despite the potential benefits of this combination of antitrust litigation and legislative or regulatory change, there is a high risk that it may not succeed. The antitrust lawsuit may fail at a number of stages: The Attorney General may not be interested in prosecuting the case; the court may reject the geographic tying claim;[335] or the lawsuit may fail for a number of other reasons, including the inability to obtain price information due to its trade secret status or to gather other requisite facts to establish liability. Notably, filing an antitrust lawsuit does not guarantee the disclosure of healthcare pricing information during discovery, particularly if that information is under a protective order to preserve its confidentiality.[336] This may prove to be a substantial obstacle. Even if the antitrust suit does succeed, which could take a number of years, it may be difficult to achieve the hoped-for legislative or regulatory measures to make prices transparent in a meaningful way. Therefore, although this combination has great potential to benefit consumers, these contingencies suggest those benefits may not be easy to obtain even with a significant investment in data collection. In the end, this approach requires a substantial investment of time, money, and manpower, with uncertain prospects for success.

B. Healthcare Market Regions

A second mechanism for implementing both necessary elements is promulgating regulation through the State Department of Insurance or similar government agency to divide the state into independent healthcare regions and, simultaneously, mandate price transparency in the more competitive regions. The independent regions would represent distinct product markets that would prevent dominant providers from abusing their market power in one market by coercing the

[334] Alessi, *supra* note 203.
[335] *See supra* Part V.A.3.b; *see also* Alessi, *supra* note 203.
[336] *See supra* Parts III.A & B.

purchase of their services in another. Unlike the difficulty of proving distinct markets posed by antitrust litigation,[337] this regulatory initiative would clearly outline each region, eliminating providers' defense that they are merely selling services in a single, state-wide market. The creation of the regions would serve to eliminate the existing geographic ties among regions, thereby breaking up market power and forcing providers to negotiate rates for their distinct geographic services.[338]

The Dartmouth Healthcare Atlas has established regional healthcare divisions throughout the United States and currently collects data on a wide range of factors for Medicare patients living in each region.[339] A state could either use the regions created by the Atlas or set up its own regional division of healthcare communities. The division of a state into separate healthcare markets should be done in a manner to satisfy the antitrust requirements for defining a geographic market, such that buyers would be unable to switch to alternative sellers in sufficient numbers to defeat an exercise of market power by firms in the area.[340] Further, healthcare delivery and other data collected could be reviewed regularly in order to track market power abuses in the future.

The second half of the regulation would mandate disclosure of healthcare price information negotiated by insurers and providers. However, the law would require price transparency only in those regions where "must-have" providers and providers supplying unique services within that market cannot use excessive leverage to demand higher costs.[341] Mandated price transparency in regions with great provider leverage may result in a rise in healthcare costs to consumers. As a result, it will be important to first identify those regions where transparent pricing information would most likely result in lower healthcare costs, and mandate that insurers and providers reveal

[337] *See supra* Part V.A.5.d; *see also* Alessi, *supra* note 203 (arguing that one of the most significant hurdles to establishing a geographic tying claim would be proving that separate geographic markets served by a single hospital network constitute distinct product markets capable of being tied together).
[338] This regulation may not, however, prevent providers from tying services between submarkets.
[339] *Data by Region*, DARTMOUTH ATLAS OF HEALTH CARE, http://www.dartmouthatlas.org/data/region (last visited Nov. 6, 2012).
[340] Hospital Corporation of America, 106 F.T.C. 361 (1985).
[341] See *supra* Part V.B.

their negotiated prices in those regions. A mechanism for monitoring each region by a government entity such as the Department of Insurance may be necessary to determine which regions will require these regulations in the future. For added enforcement the regulation should also include a provision for regulatory sanctions and alert providers to the possibility of antitrust litigation.

Although not as precise as a geographic tying claim in an antitrust lawsuit, the creation of distinct geographic regions can weaken market coercion when accompanied by price transparency initiatives in those regions most receptive to the positive effects of market competition.

C. Employer-Led Leverage Flip

Taking a market-based approach, a third solution would use education initiatives to inform employer healthcare purchasing incentives. This strategy would encourage employers to exercise their leverage as purchasers and demand price transparency from providers and insurers. In geographic markets where consumers have a wide range of choices among physicians and hospitals, initiatives to improve education and make information more widely available would empower healthcare purchasers to force sellers to compete with one another in the market. In those markets, where price transparency is most likely to be effective, this strategy would enable employers to demand the price and quality information they need. In contrast, markets with fewer competing parties would see minimal effects from employer-driven demand for transparency and thus should not be targeted.

Education initiatives should focus on making human resources departments aware of the potential cost savings they can achieve by highlighting and incentivizing lower-cost healthcare options for their employees and offering narrower and more efficient provider networks. Healthcare consumers have grown increasingly cost-conscious in recent years,[342] so they are more likely to be responsive to financial incentives. By encouraging employers to demand smaller, high-

[342] *See supra* Part VI.D.I.

value provider networks, it is possible to harness this cost-awareness and thereby give the employer-purchasers of healthcare an increasing amount of bargaining power against dominant sellers. Self-insured employers are in a particularly good position to lower their costs in this way, by encouraging their employees to make more efficient healthcare purchasing decisions in exchange for lower premiums and out of pocket expenses.

To make these initiatives most effective, the analysis of, and education about, healthcare options should be driven by a multi-stakeholder organization. Including representatives from business, provider, insurer, and consumer groups can ensure an even-handed analysis of healthcare value that fully considers all perspectives and potential costs and benefits. Once appropriately informed with objective information, employers could use their new power as fully informed purchasers to match the negotiating leverage of providers and insurers. Consequently, dominant parties would be less able to hide price information or engage in other anticompetitive tactics like tying the purchase of their services in one market to those in other markets.

D. "Visible Value" Standard Certification

Certification of health plans under the "Visible Value" standard through administrative or legislative action, also has the ability to dismantle geographic tying and implement price transparency. The Visible Value standard would be a set of criteria created by a state exchange or Department of Insurance whereby health plans could voluntarily submit cost, quality, and anticompetitive activities data to the exchange in order to apply for certification. The exchange would then list these criteria on its website and indicate which plans on the exchange were certified under this standard.

To receive certification, a health plan would need to meet three conditions. First, the exchange boards, or other government agencies, would determine a plan's best-value criteria by

evaluating the price and quality measures of each plan. This data could be collected entirely by voluntary disclosure from each health plan as part of the application process. Second, a health plan must demonstrate it is not a product of any anticompetitive tactics, such as geographic tying leverage. This may incentivize providers to refrain from anticompetitive activities in order to be included in a Visible Value standard health plan. Third, a certified health plan must show that provider reimbursement rates are based on value-based payment systems, rather than on a fee-for-service basis. These three conditions, along with the subsequent criteria, could be made transparent to consumers via publication on a state exchange website. With the proper consumer education, this initiative not only incentivizes health plans to meet these best-value standards, but also has the added benefit of helping to usher consumers toward these plans.

Through these mandated disclosures, the certification process stands to provide California with health plans of great value and integrity. If a large number of consumers purchase Visible Value standard plans, more insurer-provider partnerships may be motivated to follow suit.

E. Conclusion

The above recommendations combine the breaking apart of geographic regions and the requirement of price transparency to create an effective attack on rising healthcare prices. In addition to each of these recommendations, other solutions discussed in Section V could also be implemented separately to further ensure the greatest level of success. The first of these two solutions is stringent evaluation of all insurance premium increases of 5% or more by the Department of Insurance. The second solution is the implementation of consumer-education initiatives. The most important aspect of any price transparency initiative will be the education provided to employers and consumers about the newly available price and quality information made available to them. Without an understanding of how this information can help each group make

more informed healthcare decisions and save on healthcare costs, simply making prices and quality scores available to the public will not have the desired effect of lowering the cost of healthcare. But, by providing employers and consumers with meaningful and transparent information about their healthcare choices and ensuring that those choices are not exploitative, a well-crafted price transparency initiative can begin to reduce the inefficiencies that characterize the healthcare market and make healthcare more affordable.

CATALYST FOR PAYMENT REFORM

HEALTH CARE INCENTIVES IMPROVEMENT INSTITUTE INC

Report Card on State Price Transparency Laws

July 2015

Dear Colleagues,

In this third installment of the Catalyst for Payment Reform (CPR) - Health Care Incentives Improvement Institute (HCI^3) Report Card on State Price Transparency Laws, you will find little progress since last year and, in some cases, regression. For this reason, this year's report is concise, sharing information only on the handful of states that received new grades.

However, this bleak picture masks the recent legislative and regulatory activity that has sprung up around the country, spurred in part by our prior Report Cards. In fact, many states highlight this report when introducing bills for pricing transparency. As a reminder, when we assess each state, we base the grade on legislation passed during the prior year's legislative session; this year's report is based on legislation enacted in 2014.

Legislative sessions are still underway and some proposed bills may still pass. Many won't due to pressure from providers, payers and other suppliers to the industry who still benefit from price opacity. That pressure often rests on spurious arguments about price as a trade secret and/or the potential for a state law on price transparency to violate contracted terms between payers, providers, and suppliers—arguments legislators and the media often accept.

To outline the legal arguments raised against price transparency and how best to address them, we teamed with the University of California San Francisco and University of California Hastings Consortium on Law, Science & Health Policy. These experts host The Source on Healthcare Price & Competition. We believe it is important for the public, including the media, to understand what legal arguments are valid and question the others. A crucial point for legislators and the media is that states who take efforts to ensure price transparency seriously have successfully brushed aside the spurious arguments, and not one plan or provider has sought a challenge in the nation's highest court. Many of the arguments against price transparency -- including that it leads to higher prices and breaks laws—are toothless. We hope the legal analysis helps legislators and the media focus on the right considerations (see Appendix I).

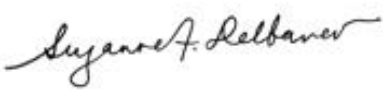
For states that enact laws on price transparency, there is much work to be done. Our report illustrates whose lead to follow. One state returned to a high score this year after a brief hiatus due to an inactive website last year: New Hampshire. Its rebound shows that even small states with few resources can develop and maintain a useful and consumer-friendly website on health care prices. Conversely, Massachusetts' grade dropped precipitously due to shutting down MyHealthCareOptions, the website that had publicly posted price information.

In this year's Report Card, as we did with the 2014 report, we review whether states had passed laws or regulations requiring health care price information be made public. In addition, we examined how well those laws were being put into action by providing residents with access to meaningful price information through public websites and the use of all-payer claims databases (APCDs) as data sources for those sites. We discuss the important role for APCDs in Appendix II. The results of our analysis show few changes since last year's report: 90% of states fail to provide adequate price information to consumers.

But it wouldn't take much to change this result. States like Connecticut and New York are still assembling their all-payer claims databases and working on consumer-facing websites. Maryland is in the process of embarking on a significant effort to publish prices on health care services, and Washington State just enacted new laws. We expect continued progress, even if at a slow pace.

Neither CPR nor HCI^3 receives funding to support the development and publication of this Report Card. We do it because we believe that markets cannot function properly without freely accessible information on price and quality. Those who oppose transparency are a shrinking minority, and we hope our efforts diminish it further.

Sincerely,



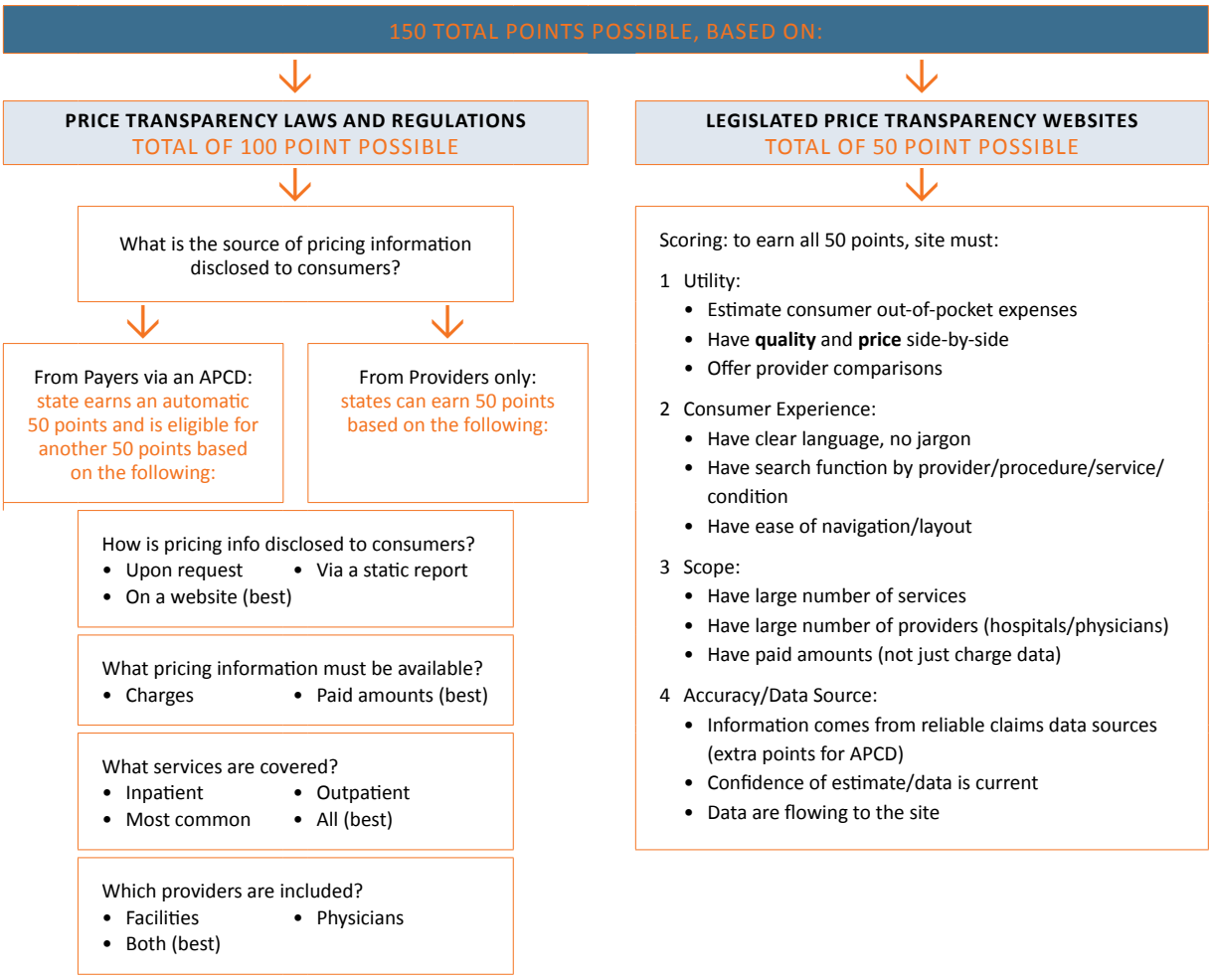
Suzanne Delbanco, Ph.D.
Executive Director
Catalyst for Payment Reform

Francois de Brantes, MS, MBA
Executive Director
Health Care Incentives Improvement Institute

I. METHODOLOGY

For a refresher on the methodology the team uses to assess state grades please refer to our 2014 Report Card on State Price Transparency Laws. A snapshot appears below in Figure 1.

Figure 1: Scoring Methodology for Laws, Regulations, and State-Mandated Websites



II. GRADE CHANGES IN 2015

New Hampshire

In our 2014 report, we gave New Hampshire an "F" grade due to the lack of a functioning public price transparency website. However, its new website, NH HealthCost, is now a prime example of a price transparency website built with consumers in mind. The site accounts for both insured and uninsured patients and provides great details on the methodology in consumer-friendly terms. We commend New Hampshire for the effort it has put into the site and urge other states to use NH HealthCost as a model when developing price information for their residents. This year, using the same grading methodology as last year, we gave the state an "A."

Massachusetts

Massachusetts has traditionally been a leader in health care transparency. In fact, in past report cards we gave the state high honors. However, in 2014, legislation went into effect that placed the responsibility of transparency on health plans and the government

ACKNOWLEDGMENTS

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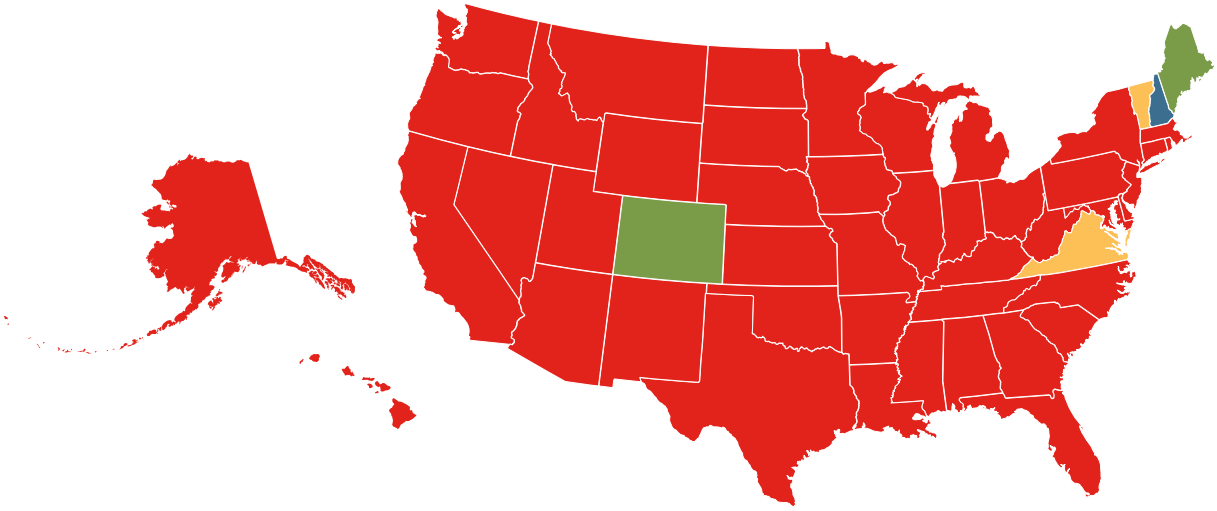
mandated website went dark. While we believe that health plans play an important role and should assist patient members in estimating costs, the lack of a public website with price information leaves out entire populations of consumers, especially the uninsured. In addition, the health plan websites vary in the amount of information they provide. A statewide transparency tool creates uniformity. Since we awarded a possible total of 50 points to states with a mandated state website, and Massachusetts no longer has one, the state lost 50 points and dropped to an "F" in this year's Report Card.

Colorado

When we released last year's report, Colorado was on the verge of releasing a new public price transparency website. Because the site was just in the process of being launched, the state received a "C." This year we were pleased to revisit Colorado and see that the public website is indeed up and running, and consumers can look up price information for episodes of care. However, the website is still in a nascent stage, and so far consumers can only search for maternity care and "hip replacement" and "knee replacement." The site also indicates information may not be consistent across hospitals in some cases. For these reasons, this year we gave the state a "B."

50 STATE REPORT CARD ON PRICE TRANSPARENCY LAWS, 2015



STATE	GRADE	STATE	GRADE	STATE	GRADE	STATE	GRADE
Alabama	F	Indiana	F	Nebraska	F	South Carolina	F
Alaska	F	Iowa	F	Nevada	F	South Dakota	F
Arizona	F	Kansas	F	New Hampshire	A	Tennessee	F
Arkansas	F	Kentucky	F	New Jersey	F	Texas	F
California	F	Louisiana	F	New Mexico	F	Utah	F
Colorado	B	Maine	B	New York	F	Vermont	C
Connecticut	F	Maryland	F	North Carolina	F	Virginia	C
Delaware	F	Massachusetts	F	North Dakota	F	Washington	F
Florida	F	Michigan	F	Ohio	F	West Virginia	F
Georgia	F	Minnesota	F	Oklahoma	F	Wisconsin	F
Hawaii	F	Mississippi	F	Oregon	F	Wyoming	F
Idaho	F	Missouri	F	Pennsylvania	F		
Illinois	F	Montana	F	Rhode Island	F		

We wish we had seen more progress since our last report, but are heartened that many legislatures were still in session at the time this was published, and we hope to see more change soon. Given changes to state laws and regulations were insignificant since our last published report card, we did not update our appendix of laws and regulations in this year's report card. Readers interested in reviewing specific state laws and regulations can refer to our 2014 report card starting on page 18.

APPENDIX I An Analysis of Popular Legal Arguments Against Price Transparency

INTRODUCTION

Efforts to advance price transparency in health care often run into legal obstacles that make it difficult to obtain and share the information with consumers, other health care entities, or government agencies. Health care providers and insurers often argue that pricing information may not be made public because it is (1) confidential by contract, or (2) protected as trade secret. Market dynamics exacerbate the extent to which these entities are able to keep the information out of third parties' hands—i.e., the bigger the provider or insurer, the better chance it has of holding onto its price information. In response to these legal barriers to disclosure, states have begun to prohibit the inclusion of certain contractual provisions that inhibit transparency. In addition, antitrust enforcement provides a means to promoting price transparency. This appendix details these legal barriers to price transparency and the best ways to address them.

This Appendix was prepared by the team behind The Source on Healthcare Price & Competition

CONTRACTUAL BARRIERS

In health care provider-insurer contracts, three types of clauses inhibit price transparency: (1) non-disclosure agreements, or "gag clauses;" (2) anti-tiering/anti-steering clauses; and (3) most favored nation clauses. These clauses, which typically allow a provider or insurer to mandate how pricing information is determined and/or shared, are best understood in context. Typically, the amount of market leverage a provider or insurer has is directly correlated with its ability to impose these contractual provisions on other parties.

Non-Disclosure Agreements/"Gag Clauses"

Non-disclosure agreements ("NDA") or "gag clauses" are frequently used in contracts between insurers and health care providers to require that both parties keep the negotiated provider rates confidential, i.e., any party that shared the information would breach the contract. NDAs have two main effects. First, they deny third parties, including the government and individual consumers, access to pricing information that could influence their choice of providers and insurers. Second, they facilitate the ability of "must-have" providers to negotiate above-market rates, driving up costs overall.[1] Further, NDAs between hospitals and medical device manufacturers can keep valuable price information from physicians that prescribe device use, which can lead to inefficient treatment choices.[2]

Anti-Tiering/Anti-Steering Clauses

Anti-tiering or anti-steering clauses in insurer-provider contracts also inhibit price transparency. Provider organizations often use these clauses to prevent insurers from creating incentives for their insureds to choose high value alternatives. Although anti-tiering and anti-steering clauses do not directly prohibit the disclosure of price information, they limit the overarching goal of price transparency initiatives – to enable patients to choose providers based on cost and quality.

1 Robert A. Berenson et al., *The Growing Power of Some Providers to Win Steep Payment Increases from Insurers Suggests Policy Remedies May Be Needed*, 31 Health Aff. 973, 973 (2012).

2 Government Accountability Office. GOA-12-126, Medicare: Lack of Price Transparency May Hamper Hospitals' Ability to Be Prudent Purchasers of Implantable Medical Devices 29–31 (2012).

Most-Favored Nation ("MFN") Clauses

In an insurer-provider contract, a most-favored nation clause promises that the provider will not give an equal or more favorable price to any other insurer. Insurers often request a MFN clause as part of an agreement to pay a dominant provider organization an above-market rate. Although these clauses have less to do with price transparency than with the prices themselves, they raise transparency concerns in a couple of key ways. First, MFN clauses often mandate the disclosure of rates negotiated with competing insurers, so that the insurer holding the protection can ensure it is receiving the best price. Second, they hinder rate disclosure to consumers, as neither party wants to reveal the above-market rate. Lastly, unless these clauses are eliminated from provider-insurer contracts, price transparency measures will not be able to reduce health care costs because the MFN's control over pricing will trump consumers' ability to affect prices by shifting demand.

How to Address:

Legal challenges to these contractual provisions come in two forms: (1) statutory bans on their use, and (2) antitrust enforcement that either specifically targets these clauses, or more generally addresses the market imbalances that give rise to their use by dominant firms. States have begun to outlaw these clauses in a variety of ways. For example, California banned gag clauses relating to cost information in insurer-hospital contracts in 2011, and expanded that prohibition in 2013 to cover all healthcare providers.[3] More recently, a gag clause ban[4] was introduced in Missouri, but failed to pass in February 2014. Elsewhere, including in New Mexico[5], consumer groups are advocating gag clause bans as part of a price transparency agenda. As for MFN clauses, 18 states have already enacted bans, and two have pending legislation.[6] MFN clauses have also been the subject of several successful antitrust suits brought by the Department of Justice against dominant insurers. Antitrust enforcement aimed at curbing anticompetitive mergers also must be used to prevent dominant firms from using their leverage to demand contract terms that stymie transparency and competition. The government should be especially wary of the potential for dominant providers to skirt statutory bans and specific enforcement efforts by imposing implied or outside-the-contract arrangements for best pricing guarantees.

TRADE SECRETS PROTECTION

In addition to contract-based confidentiality provisions, providers and insurers often assert that negotiated price information is a protected trade secret under the law. Whether information is a trade secret is a matter of state law; but, because forty-seven states have adopted the Uniform Trade Secrets Act, some level of consistency in legal principles exists across those states. To qualify as a trade secret, (1) the secrecy of the information must provide a competitive advantage to its owners, and (2) the owners of the information must make an effort to maintain its secrecy. Whether information qualifies under these elements is a fact-specific determination left to the courts. In other words, unilateral designations made by the owners of the information do not guarantee protection. The types of information courts often protect as trade secret include formulas, techniques, designs, and processes not generally known or easily ascertainable by others.[7] Only under very limited circumstances do courts grant trade secret protection to price information.[8] Generally, those circumstances involve courts providing trade secret protection to promote vigorous competition between rivals; not, as we see in health care, to take advantage of the consumer's lack of pricing information.

Like patent law, trade secret protection developed as a means to encourage innovation and to promote competition and economic growth. Unlike patent law, trade secret protection lasts indefinitely (until disclosure). Historically, trade secret protection furthered its policy goals by preventing employees from disclosing valuable information to the competition, protecting companies' ability to develop new and innovative products, and promoting entry into the market place by new competitors. None of these goals

3 *See* SB 751 and SB 1340, creating and amending CA Health & Safety Code § 1367.49 of and CA Ins. Code § 10133.64
4 SB 847.
5 *See* http://www.thinknewmexico.org/homepage.html.
6 "Legislative Topics: Most Favored Nations Clauses," The Source Blog, March 19, 2015 (available here).
7 *See, e.g., Minnesota Mining & Mnfg Co. v. Pribyl*, 259 F.3d 587 (7th Cir. 200
8 *See, e.g., Pepsico v. Redmond*, 54 F. 3d 1262 (7th Cir. 1995).

is served by concealing health care prices from consumers, government agencies, or preventing disclosure more generally. Indeed, concealing negotiated price information serves little purpose other than protecting dominant providers' ability to charge above-market prices and insurers' ability to avoid paying other providers those same elevated rates. Accordingly, there has been a growing recognition that trade secret protection in health care is being misused—raising health care prices without offering any upside.

How to Address:

As with contractual barriers to transparency, trade secret barriers to negotiated health care prices may be addressed through both legislation and litigation. First, states should avoid codifying confidentiality or conferring any specific trade secret protection for negotiated health care prices in provisions of health related legislation. Second, states should establish a public interest exemption to trade secret protection through legislation, which would permit the state to require disclosure of information when necessary to promote the public good. Access by states to negotiated rate information that has profound effects on their citizens' well-being would fall clearly within such an exemption. As for private litigation, plaintiffs should challenge and courts should continue to scrutinize assertions of trade secret protection with a reluctance to spread the doctrine to health care prices.

BEST PRICE TRANSPARENCY LEGISLATION

Over the last several years, numerous states have passed legislation designed to make health care prices more accessible to patients. The most effective patient-focused legislation provides price information that is directly relevant to the patient's decision. Averages, median billed prices, charge master amounts, and usual and customary charges often vary widely from what an individual patient will actually be expected to pay, which substantially lowers the utility of the information.

The most promising price transparency legislation requires that health care providers and insurance plans provide patients with:

- A good-faith estimate of the patient's out-of-pocket expenses that are specific to the patient's insurance plan, health care needs and health care provider.
  The estimate should include patient and plan specific co-pay or coinsurance and deductible information, as well as an explanation of standard prices and the potential range of variable expenses. If the patient is uninsured, the estimate should include both the average allowable reimbursement the provider accepts for the procedure from a third party, as well as the amount the particular patient will be billed.[9]
- Quality information on individual physicians and providers.
  The utility of price information increases greatly when paired with quality assessments of providers. As quality measurement improves and more information becomes available, states should collect and disseminate this information to patients to facilitate health care decision-making.
- Access to this information in real time via a website, personal electronic device, or Electronic Medical Record (EMR) system.
  Price and quality information is only useful if patients can access it easily and in real-time. States should either provide or require insurance companies to provide this information to patients through a website with personal device capability and interoperability with electronic medical record systems.

States currently offer or propose to offer this information to patients in many different ways. Some states, including Washington and Massachusetts (WA SB 6228, MA Ch 224), have passed laws that require insurance companies to provide this information directly to patients. Kansas requires insurance companies to provide all patient cost and provider reimbursement information to providers upon request in the form of a "real time Explanation of Benefits" (HB 2688). Whereas, Colorado offers this information to patients via its All Payer Claims Database.

9 (Minn. Stat. § 62J.81)

CONCLUSION

Over the last several years, states have become more aware of the problems associated with a lack of price transparency in health care. In order to be effective, price transparency initiatives must provide accessible and actionable information to decision-makers in a timely manner. While legal barriers hindered initial efforts to promote price transparency, states can address many of these barriers through legislation and litigation. Legislation can prohibit clauses in provider-insurer contracts that would obscure health care prices, as well as ensure that trade secret protection is not used in ways that harm the public interest. Patient-focused price transparency legislation can help ensure that all patients have real-time access to a good-faith estimate of the expected costs of the procedure to the patient based on his or her health care needs, insurance plan and choice of health care providers.

Litigation can be used to challenge anticompetitive practices that lead to the occlusion of health care prices. State efforts to promote price transparency must also be accompanied by efforts to reduce the market leverage and anticompetitive behaviors that enable dominant providers and insurers to drive up health care costs overall.

APPENDIX II Use of All-Payer Claims Databases (APCD) for Provider Performance Reporting and Transparency

In this year's report card we see New Hampshire regaining its "A" grade and Massachusetts falling several grades. The difference between the two is that the former has a comprehensive statewide website that uses the information in its APCD to inform consumers, while Massachusetts has shut down its statewide website and delegated to health plans the responsibility of making health care prices transparent. There are several reasons why statewide websites that leverage APCDs have an advantage when it comes to sharing information about the price and quality of health care.

1. The importance of sample sizes

   Most commercial health plans across the country have only a portion of the market for health insurance. While it is not necessary to have the totality of a market to determine, with reliability, the average price and the quality of care, larger sample sizes help significantly to differentiate performance. Figures A through F plot the average price of an episode (on the X axis of each chart) for facilities with a minimum of 30 episodes, or physicians with a minimum of 100 episodes. We set these minima to avoid the biasing effect, even after severity adjustment, of too few cases. While a health plan might have a sample size adequate to evaluate the performance of some of the physicians or hospitals in its network, it is highly unlikely to have a large enough sample to evaluate all of them. Only the combination of data from most or all the commercial plans operating in a market can provide an adequate sample size for the majority of providers in a state.

   In Figures A through F, the average market price includes an interval equal to one standard deviation above and below the average. Within that zone, it is not possible to distinguish one provider's price from another. And the smaller the sample size, the wider the distribution and the interval. When observing a single commercial plan, virtually all differences in average price are, statistically speaking, undifferentiated. In many of these figures, it is not possible to differentiate the average price per provider. In others, where the observations come from very large datasets covering multiple commercial and/or Medicaid payers in a single state, differentiation is possible.

2. The importance of multiple payers

   A key element of most APCDs is that they carry claims data from commercial payers and public payers, particularly Medicaid. Figures A through F show the differences in average costs and rates of avoidable complications, for an episode type, by payer type – commercial or Medicaid.

   Potentially avoidable complications are a construct developed by HCI[3] to help more formally link price and quality by counting, for any episode, the occurrence of these complications and their associated costs. Measures of avoidable complications have been endorsed by the National Quality Forum and are also, in a derivative form, used by Medicare for various quality reporting and value-based payment models. For example, Medicare has instituted a penalty on hospitals that have excessive readmission rates. Medicare also requires hospitals to report on patient safety errors.

   Figures A and B show the average price and rate of complications for routine vaginal deliveries. While the average price of deliveries in Medicaid varies little by provider because Medicaid fixes the prices for certain services, there is significant variability in complication rates, with some providers having rates as high as 1 in 10. Conversely, in the same state, the average cost of deliveries for the commercially insured is four times higher than Medicaid and varies quite significantly. However, rates of complications are significantly lower with almost no variability. What explains these differences,

especially after adjusting for patient severity? Why are mothers delivering babies in this Medicaid program facing far higher rates of avoidable complications than mothers in commercial plans? The point, of course, is that barring an APCD, this question could and would never be asked.

Figures C and D show results that are diametrically opposite to that of vaginal deliveries. There are significant differences in price and almost no differences in avoidable complications for colonoscopy episodes in Medicaid, but somewhat less variability in price and far more variability in avoidable complications for commercial plan members.

Figures E and F show variability in the price and rate of avoidable complications for low back pain episodes for both Medicaid and commercial plan members.

3. The importance of an independent reporting mechanism

Reporting the price and quality of health care is challenging for any organization, but particularly so for individual health plans. While a plan member can only be a member of one health plan at a time, surveys continue to indicate that consumers lack confidence in the independence of health plans when it comes to their reports on the price and quality of providers. In fact, most consumers fear the health plans are simply trying to drive them to less expensive providers rather than "the best" or highest-value.

Furthermore, there are no existing national standards for measuring the price of a medical episode of care, which can create significant heterogeneity from health plan to health plan in how they report prices. Most health plans have chosen to focus their price reporting on individual services, such as an office visit or a lab test. However, the total potential price that might be due for a specific medical episode, such as a colonoscopy or a vaginal delivery, or the treatment of low back pain, ultimately has far greater impact on patients.

Figure F shows the average price and the rates of potentially avoidable complications for the management of low back pain, a common medical episode for patients under age 65. Given that for an average health plan member the deductible is over $1,500 and the out-of-pocket maximum is over $5,000, the plan member will pay a significant percentage of the average costs of managing low-back pain. If a payer simply provides prices on individual services, it might be very difficult for a plan member to select a provider. Consider this table derived from Figure F and representing four different physicians:

	PHYSICIAN 1	PHYSICIAN 2	PHYSICIAN 3	PHYSICIAN 4
Average Price	$2,175.00	$4,173.00	$6,481.00	$8,500.00
PAC %	21.50%	37.00%	5.50%	13.15%

Some of the difference between these providers stems from the quantity of services delivered, but some from the price. Furthermore, price, without some indication of quality, could lead to different conclusions. Each episode of low-back pain consists of dozens of services, from office visits to primary and specialty care, to diagnostic imaging and even procedures. As a result, to make an informed decision, and to compare one provider to another, a consumer should know the extent to which a physician operates on patients with low-back pain, the nature and seriousness of adverse events and other complications, and the reason for the significant differences in price.

HCI[3] generated the results in Figures A through F using its ECR Analytics on an APCD, and stratifying the results by payer type. They illustrate the importance of tying together meaningful price and quality information to help consumers better gauge the relative value of providers in a state, and they also illustrate how these types of data can help policymakers and providers gain insights on the disparity in care between different types of payers. In a prior report with CPR, we delved into many of the methodological pitfalls in reporting price to health plan members, and most of those can be avoided when states take on the important leadership role of assembling data across payers in an APCD, applying a consistent set of rules to those data, and releasing the results of those consistent analyses to the general public.

Figure A: Vaginal Deliveries Medicaid

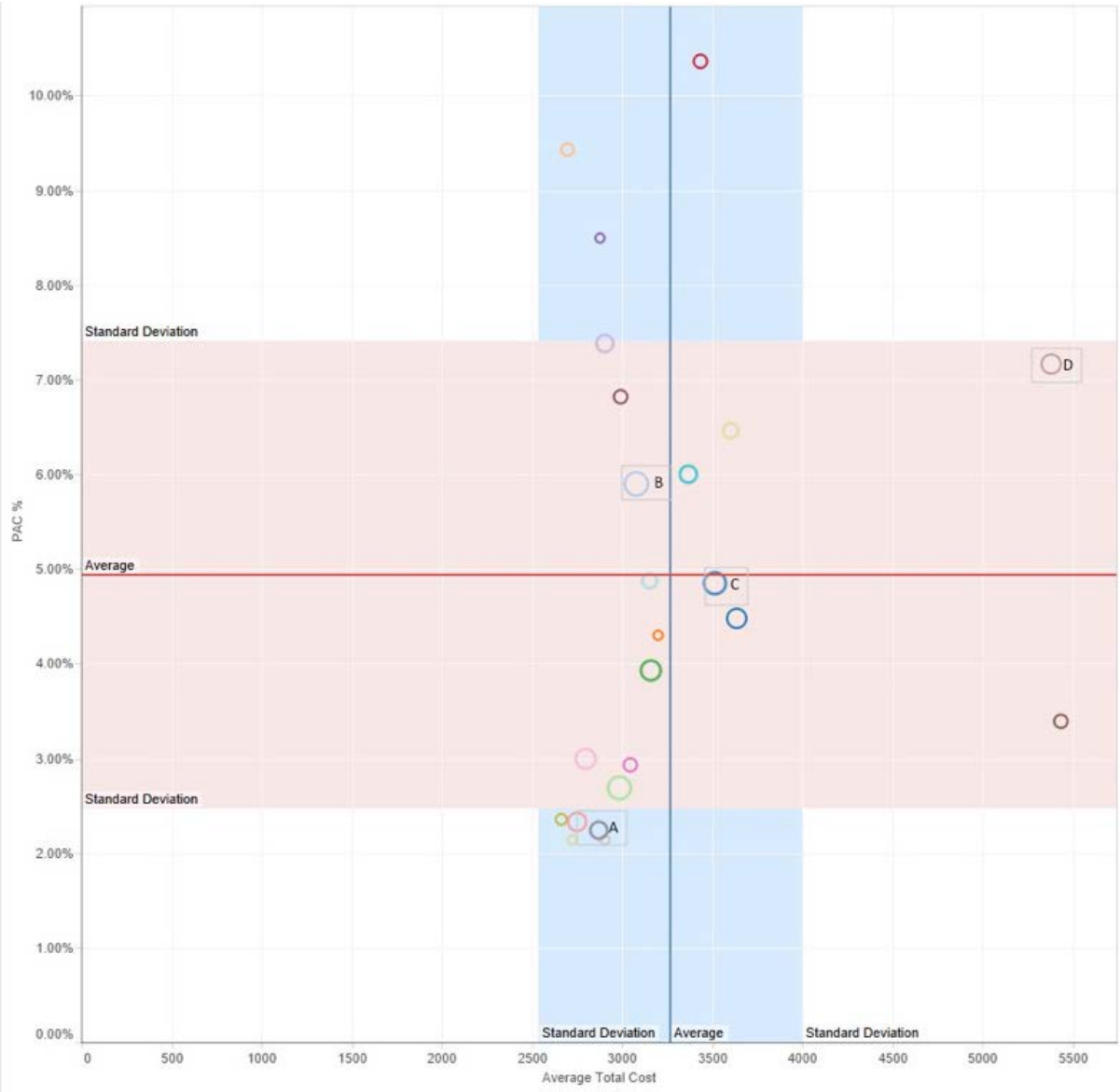


Figure B: Vaginal Deliveries Commercial

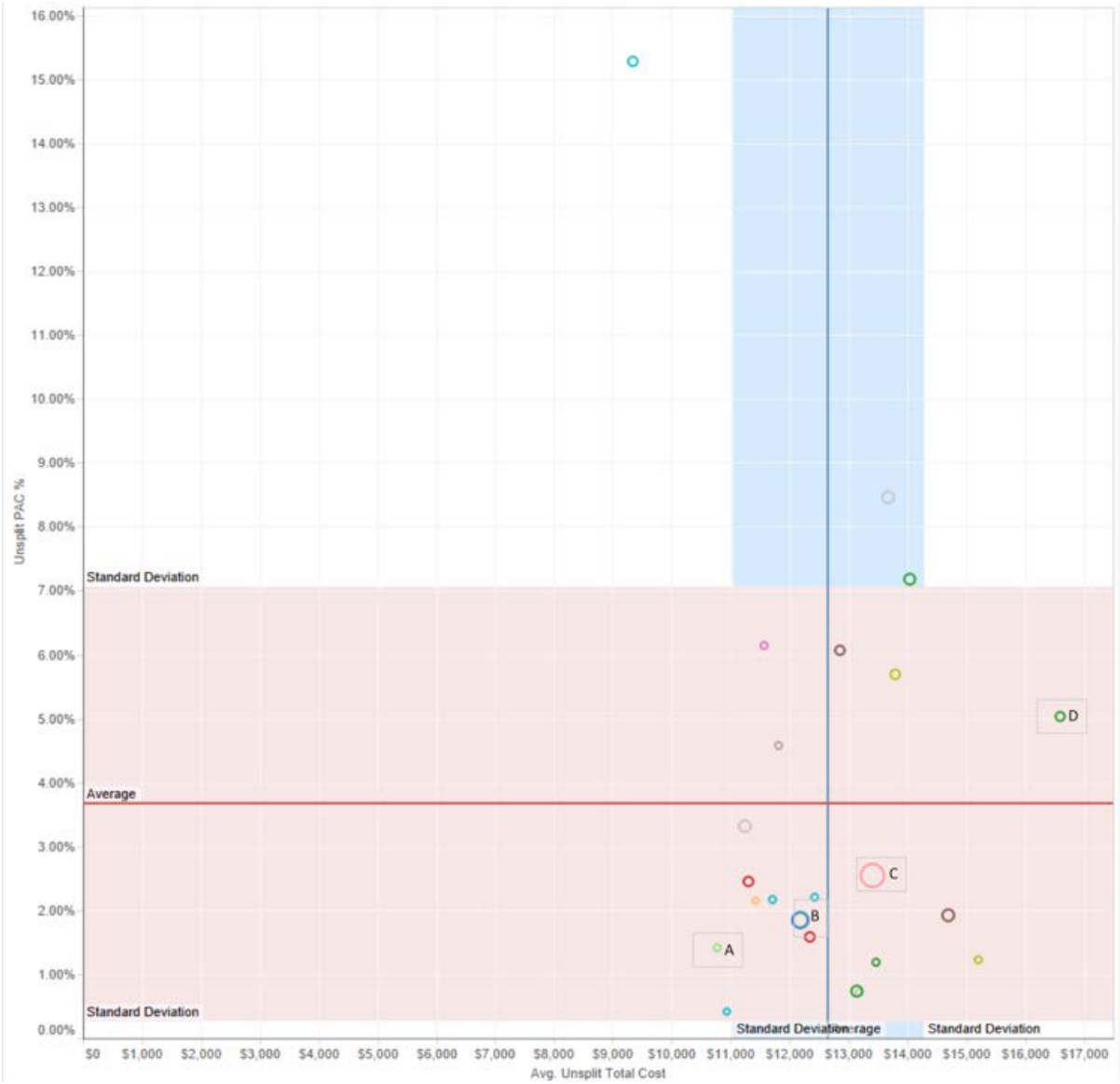


Figure C: Colonoscopy Medicaid

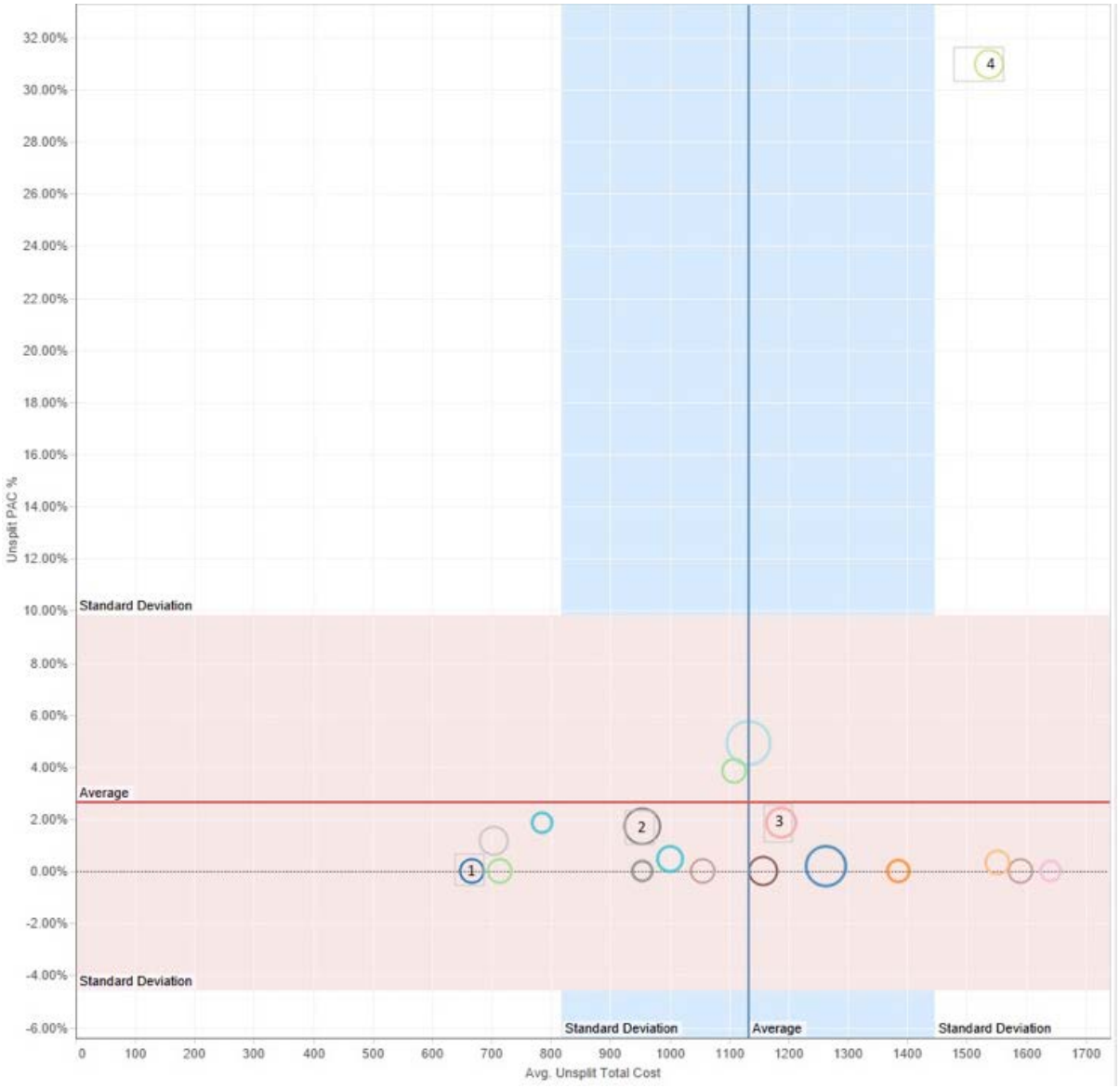


Figure D: Colonoscopy Commercial

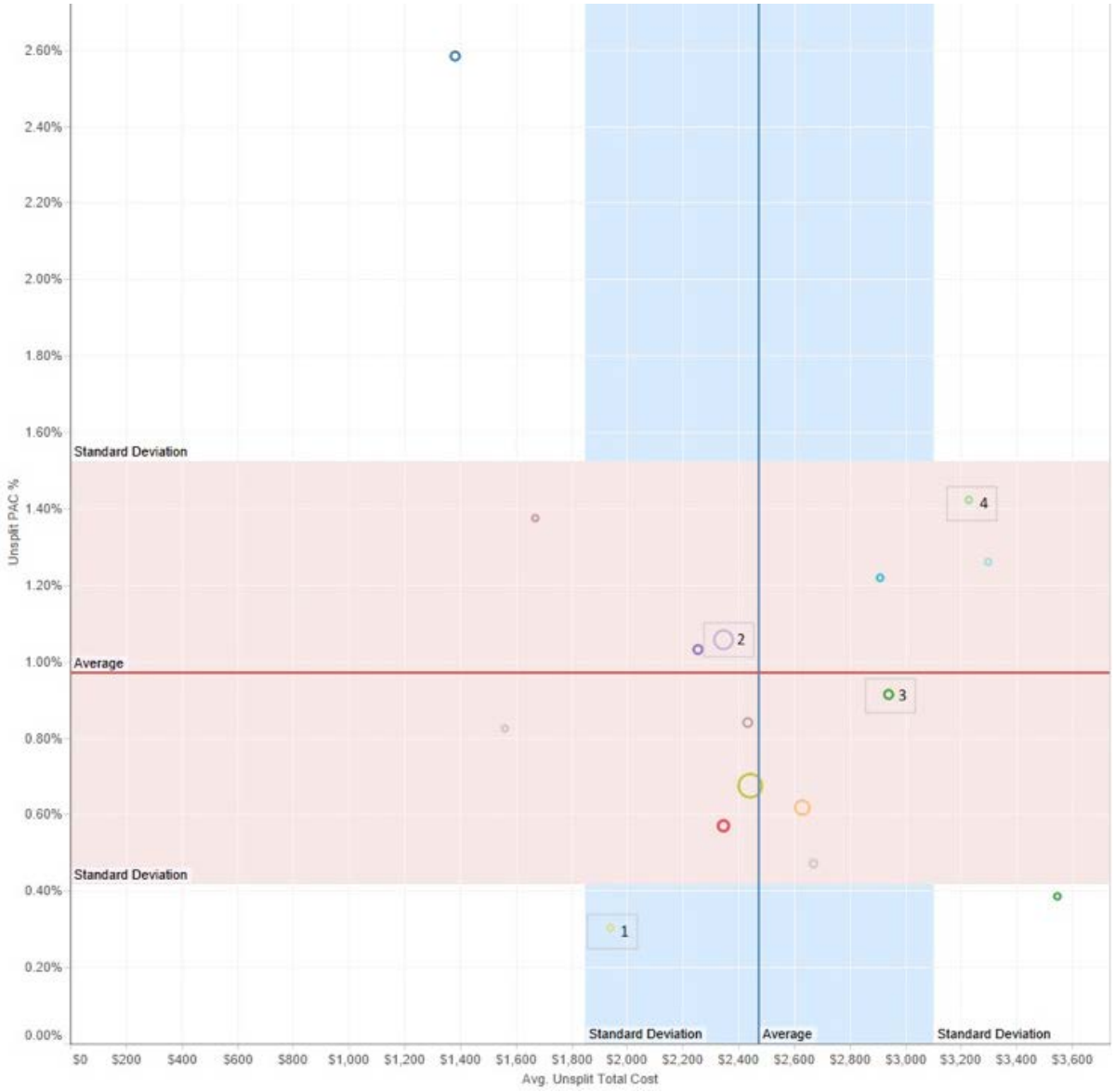


Figure E: Low Back Pain Medicaid

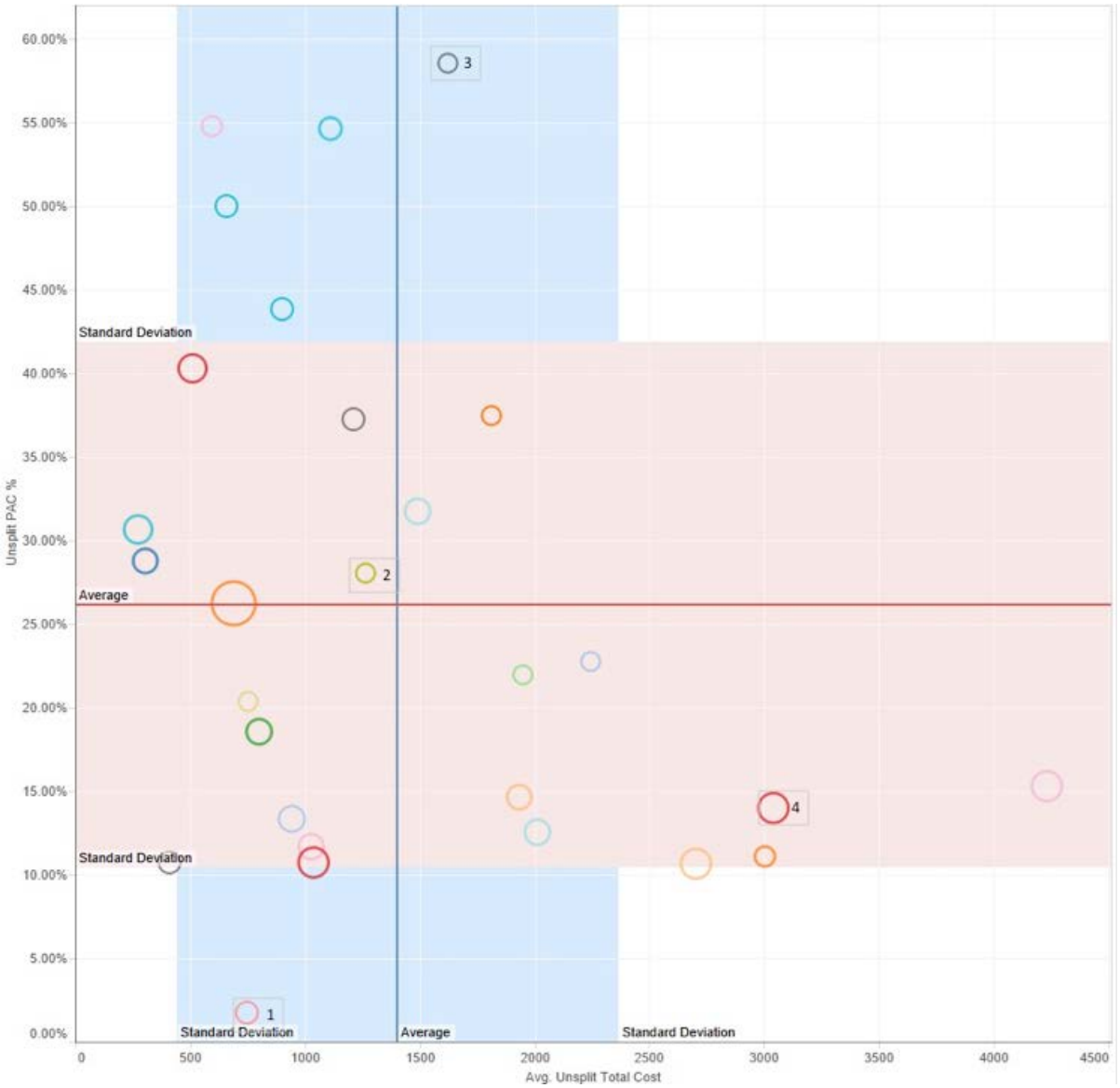


Figure F: Low Back Pain Commercial