Consumer Price Shopping in Health Care

Statement of Paul B. Ginsburg, Ph.D.
President
Center for Studying Health System Change

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Mr. Chairman, Representative Brown and members of the Subcommittee, thank you for the invitation to testify about providing consumers with better information about the cost of health care services. My name is Paul B. Ginsburg, and I am an economist and president of the Center for Studying Health System Change (HSC). HSC is an independent, nonpartisan health policy research organization funded principally by The Robert Wood Johnson Foundation and affiliated with Mathematica Policy Research.

HSC's main research tool is the Community Tracking Study, which consists of national surveys of households and physicians in 60 nationally representatives communities across the country and intensive site visits to 12 of these communities. We also monitor secondary data and general health system trends. Our goal is to provide members of Congress and other policy makers with objective and timely research on developments in health care markets and their impacts on people. Our various research and communication activities may be found on our Web site at *www.hschange.org*.

With funding from the California HealthCare Foundation, HSC has conducted research on consumer price shopping for health services, focusing both on self-pay services, such as LASIK, and analyzing the issue of price transparency for medical services that tend to be insured.[1]

My testimony today will make three points:

- Fostering consumer price shopping for health services does have potential for containing costs without sacrificing quality—but some are overselling the magnitude of this potential.

- For most consumers who are insured, their health plan has long been their most powerful asset in shopping for lower prices, and insurers have the potential to become even more effective agents as they develop more sophisticated benefit structures and information tools to support consumers in choosing effective treatments from higher-quality, lower-cost providers.

- Consumers' experiences with markets for self-pay services, such as LASIK, have been romanticized and do not offer much encouragement as a model of effective shopping for health care services without either a large role for insurers or regulation.

BACKGROUND

I perceive the current policy interest in price transparency as essentially a second stage of the evolution of consumer-driven health care. The first stage was financial incentives for consumers in the form of greater cost sharing—high deductibles and greater coinsurance. Now, we are focusing on the tools needed by consumers to make effective decisions on reducing the costs of

[1] Two working papers from this project, "Shopping for Price in Medical Care, " by Paul B. Ginsburg, and "How Consumers Shop for Health Care When They Pay Out of Pocket: Evidence From Selected Self-Pay Markets," by Ha Tu and Jessica H.May, are available by request by contacting HSC.

their care. As insurers compete vigorously to sell consumer-driven products, they seek to differentiate their products on the basis of the tools offered to consumers to compare price and quality across providers. Policy makers are interested in government's role in fostering greater cost-consciousness and a more favorable environment for consumers to make informed choices about health care services.

Traditionally, health insurance has either removed or sharply diluted consumer incentives to consider price in choosing a provider or treatment strategy. It is difficult for consumers to get price and quality information from providers, who have to date shown little interest in competing for patients on this basis. Likewise, there is little information available to help patients examine the effectiveness of treatment alternatives. The lack of quality information understandably makes consumers reluctant to choose a provider on the basis of a lower price. It is one thing to wind up with a low-quality provider when price is not an issue but another to get there as a result of opting for a lower price. Similarly, lack of information on effectiveness of treatment alternatives makes consumers more reluctant to consider price in the choice of treatment.

Unfortunately, much of the recent policy discussion about price transparency downplays the complexity of decisions about medical care and the dependence of consumers on physicians for guidance about what services are appropriate. It also ignores the role of managed care plans as agents for consumers and purchasers in shopping for lower prices. Well-intentioned but ill-conceived policies to force extensive disclosure of contracts between managed care plans and providers may backfire by leading to higher prices.

POTENTIAL FOR MORE EFFECTIVE PRICE SHOPPING

If you define effective shopping as obtaining better value for money spent, then consumers do have the potential to be more effective shoppers for health care services. There are direct and indirect benefits of choosing providers that offer better value. The direct benefits are simply the cost savings, for example, of choosing the lower-cost of two providers of comparable quality.

But the indirect benefits are potentially more important. If enough consumers become active in comparing price and quality, this will lead to market pressure on providers to improve their performance on both cost and quality dimensions. Providers that measure up poorly on the value dimension will lose market share and will be motivated to revamp their operations to remain viable. Our market economy offers many examples of competitors responding to loss of market share by making difficult changes and regaining their edge, and examples are starting to appear in health care as well. The gains from providers improving their operations will accrue broadly to the health care system.

But we need to be realistic about the magnitudes of potential gains from more effective shopping by consumers. For one thing, a large portion of medical care may be beyond the reach of patient financial incentives. Most patients who are hospitalized will not be subject to the financial incentives of either a consumer-driven health plan or a more traditional plan with extensive patient cost sharing. They will have exceeded their annual deductible and often the maximum on

out-of-pocket spending. Recall that in any year, 10 percent of people account for 70 percent of health spending, and most of them will not be subject to financial incentives to economize.

When services are covered by health insurance, the value of price information to consumers depends a great deal on the type of benefit structure. For example, if the consumer has to pay $15 for a physician visit or $100 per day in the hospital, then information on the price for these services is not relevant. If the consumer pays 20 percent of the bill, price information is more relevant, but still the consumer gets only 20 percent of any savings from using lower-priced providers. And the savings to the consumer end once limits on out-of-pocket spending are reached.

In addition to those with the largest expenses not being subject to financial incentives, much care does not lend itself to effective shopping. Many patients' health care needs are too urgent to price shop. Some illnesses are so complex that significant diagnostic resources are needed before determining treatment alternatives. By this time, the patient is unlikely to consider shopping for a different provider.

Some of these constraints could be addressed by consumers' committing themselves, either formally or informally, to providers. Many consumers have chosen a primary care physician as their initial point of contact for medical problems that may arise. Patients served by a multi-specialty group practice informally commit themselves to this group of specialists—and the hospitals that they practice in—as well. So shopping has been done in advance and can be applied to new medical problems that require urgent care. This is a key concept behind the high-performance networks that are being developed by some large insurers.

Even when services are good candidates for shopping by consumers, comparison of prices is not easy. Much treatment is customized. For example, an elective rhinoplasty, more commonly known as a nose reconstruction, is not a commodity, and a plastic surgeon cannot provide an estimate without examining the patient. Often a medical treatment involves an uncertain number of services by a number of separate providers, but few bundled prices are available in the marketplace today. As mentioned above, limitations in useful comparative quality data make patients reluctant to choose a provider based on lower price.

Shifting from choosing a provider to choosing treatment strategies, the absence of neutral financial incentives for providers is a serious problem. The most typical situation today is one where the provider gets paid on a fee-for-service basis, so the incentive is to recommend more services, especially those that have higher unit profitability.[2] Increasingly, physicians have an ownership interest in services, such as imaging, beyond their usual professional services, creating an additional conflict between physicians' interests and those of their patients.

[2] See Paul B. Ginsburg and Joy M. Grossman, "When the Price Isn't Right: How Inadvertent Incentives Drive Medical Care," *Health Affairs*, August 9, 2005.

SELF-PAY MARKETS

Many have pointed to markets for medical services that are not covered by insurance to show the potential of consumer price shopping. Since these services are not medically necessary—the basis for not being covered by insurance—they should be prime candidates for more effective consumer price shopping. HSC has studied markets for LASIK, in-vitro fertilization (IVF), dental crowns and cosmetic surgery by interviewing providers, consultants and regulators in these fields. Our findings are not as encouraging as one hears from advocates of consumerism.

LASIK has the greatest potential for effective price shopping because it is elective, non-urgent, and consumers can get somewhat useful price information over the telephone. Prices have indeed fallen over time. But consumer protection problems have tarnished this market, with both the Federal Trade Commission and some state attorneys general intervening to curb deceptive advertising and poorly communicated bundling practices. Many of us have seen LASIK advertisements for prices of $299 per eye, but in fact only a tiny proportion of consumers seeking the LASIK procedure meet the clinical qualifications for those prices. Indeed, only 3 percent of LASIK procedures cost less than $1,000 per eye, and the average price is about $2,000. I can only wonder about the extent to which policy advocates have themselves been deceived by these advertisements and inadvertently perceived a sharper decline in prices than has been the case.

For the other procedures that we studied, we found little evidence of consumer price shopping. For dental crowns and IVF services, many consumers are unwilling to shop because they perceive an urgent need for the procedure, and other consumers are discouraged from shopping by the time and expense of visiting multiple providers to get estimates. In cosmetic surgery, a limited amount of shopping does occur, facilitated by free screening exams offered by some surgeons. However, quality rather than price is the key concern to most consumers in this market; in the absence of reliable quality information, most consumers rely on word-of-mouth recommendation as a proxy for quality, instead of shopping on price.

ROLE OF INSURERS IN PRICE SHOPPING

Much of the policy discussion about price transparency has neglected the important role that insurers play as agents for consumers and purchasers of health insurance in obtaining favorable prices from providers. Even though managed care plans have lost some clout in negotiating with providers in recent years, they still obtain sharply discounted prices from contracted providers. Indeed, in my experience as a consumer, I often find that the discounts obtained for the PPO network for routine physician, laboratory and imaging services are worth more to me than the payments by the insurer.

Insurers are in a strong position to further support their enrollees who have significant financial incentives, especially those in consumer-driven products. Insurers have the ability to analyze complex data and present it to consumers as simple choices. For example, they can analyze data on costs and quality of care in a specialty and then offer their enrollees an incentive to choose providers in the high-performance network. Insurers also have the potential to innovate in

benefit design to further support effective shopping by consumers, such as increasing cost sharing for services that are more discretionary and reducing cost sharing for services that research shows are highly effective.

Insurers certainly are motivated to support effective price shopping by their enrollees. Employers who are moving cautiously to offer consumer-driven plans want to choose products that offer useful tools to inform enrollees about provider price and quality. When enrollees become more sensitive to price differences among providers, this increases health plan bargaining power with providers. Negotiating lower rates further improves a health plan's competitive position. One thing that insurers could do that they are not doing today is to assist enrollees in making choices between network providers and those outside of the network by providing data on likely out-of-pocket costs for using non-network providers.

The Administration has recently been pushing hospitals and physicians to provide more information on prices to the public. If this is limited to prices paid by those who are not insured or those who are insured but are opting to use a non-network provider, additional price information for the public is likely to be a positive. But if hospitals and insurers are precluded from continuing their current practice of keeping their contracts confidential, this could damage the interests of those who pay for services, especially hospital care.[3]

Antitrust authorities throughout the world have recognized that posting of contracted prices tends to lead to higher prices. In highly concentrated markets, posting of prices facilitates collusion. Even in the absence of collusion, posting would mean that a hospital offering an extra discount to an insurer would gain less market share because their competitors would seek to match it. Of course, this works on both the buying and selling side of the market, but if hospitals tend to be more concentrated than insurers, disclosure will raise rather than lower prices.

The experience in Denmark, where the government, in a misguided attempt to foster more competition in a concentrated market, posted contracted prices in the ready-mix concrete industry is instructive. Within six months of this policy change, prices increased by 15-20 percent, despite falling input prices.[4] Drawing on this and other experience, the Federal Trade Commission in 2004 testified in the California Legislature against Assembly Bill 1960, which would have required the disclosure of certain price information from contracts between pharmacy benefits managers (PBMs) and pharmaceutical manufacturers.[5]

Some health plans are now experimenting with ways to communicate to their enrollees the fact that certain hospitals have particularly high or low negotiated fees, without violating their

[3] I do not have such concerns about physician prices because the physician services tend to be far less concentrated than hospital services in most markets. But information on contracts with physicians would not be particularly useful because prices paid by insurers vary much less.

[4] Albaek, Svend, Peter Mollgaard, and Per B Overgaard, "Government-Assisted Oligopoly Coordination? A Concrete Case," Journal of Industrial Economics, Vol. 45 (1997): 429-43.

[5] Federal Trade Commission, Competitive Effects of California Assembly Bill No. 1960, V040027, (September 7, 2004).

agreements to hospitals and their desire to maintain the confidentiality of their price negotiations. For example, Blue Cross of California, which tends to rely heavily on coinsurance in its benefit structures, has been posting ratings of the costliness of hospitals for PPO enrollees. It follows the approach of Zagat guides to restaurants, where "$" is assigned to the lowest cost hospitals and "$$$$" is assigned to the highest cost hospitals. This approach not only maintains the confidentiality of contracts with hospitals, but it also engages the formidable actuarial resources of the plan to simplify complex and voluminous hospital data for consumers. Humana Inc. has presented hospital price information to some of its Milwaukee enrollees that maintains confidentiality by using ranges and combining hospital costs with physician costs. I expect that insurers will come up with more innovative ways to present price information to enrollees.

CONCLUSION

The need for consumers to compare prices of providers and treatment alternatives is increasing and has the potential to improve the value equation in health care. But we need to be realistic about the magnitude of the potential for improvement from making consumers more effective shoppers for health care. Whatever the gains from increased shopping activity, rising health care costs will, nevertheless, price more consumers out of the market for health insurance and burden governments struggling to pay for health care from a revenue base that is not growing as fast as their financing commitment. For those who have health insurance, their health plan will be a key agent in facilitating their obtaining better value. Government needs to take care not to interfere with this relationship and should focus instead on the needs of those without insurance.