

Testimony of:

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Examining State Efforts to Improve Transparency in Healthcare Costs for

Consumers

Subcommittee on Oversight and Investigations

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Summary of Testimony

The United States currently spends more than any other nation on healthcare, as a percentage of gross domestic product and per capita. Our healthcare markets suffer from high levels of consolidation, a lack of clear price and quality signals for consumers, and an inability to access price, utilization, and quality data. Price transparency initiatives, like all payer claims databases, can improve healthcare market functioning in all these areas by providing relevant information to decision-makers, including patients, providers, payers, and policymakers, at key decision points. Historically, most price transparency initiatives have focused on changing consumer behavior to encourage them to select providers and services that provide the greatest value at the lowest cost. Unfortunately, these initiatives have not been successful at bending the cost curve due to limited usage and mixed levels of effectiveness. Price transparency initiatives that provide patient, provider, procedure, and plan level of specificity on price and quality to consumers, accompanied by a financial incentive, like reference pricing or tiering, have proven more effective. However, even with these potential improvements, legal barriers including contractual provisions, ERISA preemption, and trade secrets laws continue to hinder the utility of many existing price transparency initiatives.

Congress, more than any other entity, has the ability to address the most significant barriers to price transparency in healthcare and maximize the tremendous untapped potential of existing state initiatives, in particular APCDs. To do so, Congress should narrow ERISA preemption to exclude state health reform efforts that do not unduly burden ERISA's goal of uniformity for employer-based benefit plans, while also granting states sufficient flexibility to achieve their health reform goals.

Testimony of Jaime S. King

Committee Chairman Walden, Subcommittee Chairman Harper, Committee Ranking Member Pallone, Subcommittee Ranking Member Degette, and Members of the Subcommittee on Oversight and Investigations, I very much appreciate the opportunity to testify on the role of price transparency in the healthcare market. I am a professor of law and the Bion M. Gregory Chair in Business Law at the University of California, Hastings College of the Law. I have written and taught in the field of health law and policy for the last ten years. I am also the Associate Dean and Co-Director of the UCSF/UC Hastings Consortium on Law, Science and Health Policy, and the Co-Founder and Executive Editor of The Source on Healthcare Price and Competition, a free and independent academic website that posts news, academic articles, legislative developments, litigation documents, original analysis, and guest commentary on healthcare price and competition. I owe a great deal of thanks to Katherine Gudiksen, Laura Hagen, Erin Fuse Brown, Anna Sinaiko, and everyone at The Source on Healthcare Price and Competition who contributed their time, effort, and research to this testimony.

Introduction

The cost of healthcare in the United States currently threatens the economic stability of our citizens, our businesses, our state and local governments, and our nation. The United States spends more on healthcare than on any other sector of the economy, including defense, transportation, education, or housing. A 2018 Gallup poll found that a greater percentage of Americans (55%) stated that they worry “a great deal” about the availability and affordability of healthcare than fourteen other major social issues, like crime, the economy, unemployment, terrorist attacks, and the availability of guns.¹ In 2017, projected U.S. spending on healthcare

¹ Jeffrey Jones, *U.S. Concerns About Healthcare High; Energy, Unemployment Low*, GALLUP (March 26, 2018), <https://news.gallup.com/poll/231533/concerns-healthcare-high-energy-unemployment-low.aspx>.

goods and services approached \$3.5 trillion.² This amounts to more than any other economically developed country, both as a percentage of GDP and per capita.³ Despite this, the health of Americans is not significantly better than that of our counterparts in countries like the U.K. or Canada. In fact, on many key metrics we are falling behind.⁴

When faced with how to address growing healthcare costs, academics and policymakers frequently focus on ways to address market inefficiencies and failures. One market failure that has received a great deal of attention in recent years is the lack of price transparency in the healthcare market. Nearly every day a news story reveals the plight of Americans facing astronomical healthcare bills that seem to have little to no relation to the cost of providing the services received and come as a complete shock to consumers. For instance, Peter Drier of New York was blindsided by a medical bill of about \$117,000 from an “assistant surgeon” who the primary surgeon called in while Mr. Drier was receiving neck surgery. Each surgeon billed for each step of the procedure. The primary surgeon billed \$74,000 for removing two disks and an additional \$50,000 for placing the hardware, while the assistant billed \$67,000 and \$50,000 for those tasks. The primary surgeon accepted a negotiated fee determined through Mr. Drier’s insurance company which was about \$6,200. However, because the assistant surgeon was out-of-network, he charged \$117,000. Had Mr. Drier been a Medicare beneficiary, the assistant would have only been able to bill 16% of the primary surgeon’s fee – roughly \$800, less than 1% of

² CENTERS FOR MEDICARE AND MEDICAID SERVICES, NATIONAL HEALTH EXPENDITURES FACT SHEET, <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html> (last modified Apr. 17, 2018).

³ ORGANIZATION FOR ECONOMIC COOPERATION AND DEVELOPMENT, SPENDING ON HEALTH: LATEST TRENDS, June 2018, <http://www.oecd.org/health/health-systems/health-data.htm>.

⁴ Irene Papanicolas et al., *Health Care Spending in the United States and Other High-Income Countries*, 319 JAMA 10, 1024-39 (2018); Austin Frakt, *Medical Mystery: Something Happened to U.S. Health Spending After 1980*, N.Y. TIMES (May 14, 2018), <https://www.nytimes.com/2018/05/14/upshot/medical-mystery-health-spending-1980.html>.

what the assistant surgeon was actually paid.⁵ In an effort to protect patients like Mr. Drier from these astronomical fees, and twenty-four states enacted legislation prohibiting surprise billing of patients.⁶

Economic theory suggests that if consumers had better access to price information prior to choosing providers and receiving healthcare services, they would choose less expensive providers and services, and thereby lower overall healthcare spending. Empirical studies on price transparency in other markets show that transparency initiatives tend to lead to more consistent, lower prices.⁷ As a result, price transparency has become a “cornerstone of the consumer-directed healthcare model,” with policymakers, insurers, private entities, state and local governments, and consumer advocacy organizations investing significant time, resources, and capital to promote consumer-focused price transparency in healthcare.⁸ Yet, health services research examining the impact of these efforts suggests that most of them have not engaged patients in a sufficient way to curb healthcare spending.⁹

Controlling healthcare spending requires engagement from all stakeholders in the healthcare market – patients, providers, payers, and policymakers. Price transparency initiatives, such as all payer claims databases (APCDs), have great potential to provide critical data to guide

⁵ Elisabeth Rosenthal, *After Surgery, Surprise \$117,000 Medical Bill from Doctor He Didn't Know*, N.Y. TIMES (Sept. 14, 2014), <https://www.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html>.

⁶ See Kevin Lucia et al., *Balance Billing by Health Care Providers: Assessing Consumer Protections Across States*, THE COMMONWEALTH FUND (June 13, 2017), <https://www.commonwealthfund.org/publications/issue-briefs/2017/jun/balance-billing-health-care-providers-assessing-consumer> for a description of 21 states that had balance billing laws in 2017. Since the report was issued, Tennessee (HB 1935/SB 1969), Minnesota (SF 3480), and Missouri (SB 982) have passed balanced billing laws and Colorado (SB 146/HB 1282), New Hampshire (HB 1782/HB 1809), and New Jersey (AB 2039) have strengthened theirs.

⁷ D. ANDREW AUSTIN & JANE G. GRAVELLE, CRS Report for Congress: Does Price Transparency Effect Market Efficiency? Implications of Empirical Evidence in Other Markets for the Healthcare Sector (2008) [hereinafter CRS Report for Congress].

⁸ A. Mehrotra et al., *Promise and Reality of Price Transparency*, 378 N. ENGL. J. MED. 14, 1348 (2018).

⁹ See, e.g., A. Mehrotra et al., *Use Patterns of a State Health Care Price Transparency Web Site: What Do Patients Shop For?*, 51 INQUIRY: THE J. OF HEALTH CARE ORG., PROVISION, AND FINANCING, 0046958014561496 (2014); S. Desai et al., *Association Between Availability of a Price Transparency Tool and Outpatient Spending*, 315 JAMA 17, 1874-81 (2016).

healthcare reform efforts, inform analysis on the drivers of healthcare costs, and help patients and providers choose high-value/lower-cost treatment options. However, currently the amount and quality of data available to patients and their doctors and laws restricting data collection limit even premier price transparency tools.

My testimony today will provide an overview of existing price transparency tools, and then focus on how improved transparency can benefit healthcare decision-making by targeting different information to stakeholders. I will then discuss why many prior attempts at improving price transparency have not achieved their goals, and what Congress can do to promote price transparency in healthcare.

Summary of Key Points

- Price transparency initiatives can improve healthcare market functioning by providing relevant information to decision-makers, including consumers, providers, insurers, employers, and policymakers, at key decision points.
- Historically, most price transparency initiatives have focused on changing consumer behavior to encourage them to select lower priced providers and services. These initiatives have had limited usage and mixed results.
- Price transparency initiatives that provide patient, provider, procedure, and plan level of specificity on price and quality to consumers, accompanied by a financial incentive, like reference pricing or tiering, have proven more effective.
- Legal barriers including contractual provisions, ERISA preemption, and trade secrets laws hinder the effectiveness of many existing price transparency initiatives.
- Congress has a range of options in how it can promote price transparency to improve healthcare decision-making and lower costs, but the most important and effective act it

could take is to leverage existing state efforts and resources by amending ERISA to narrow its preemption of state health reform efforts, especially those targeting transparency.

Overview of State Price Transparency Initiatives

Over the last ten years, states have passed laws to reduce the barriers to price transparency and developed statewide databases of healthcare claims data to allow for comparison and analysis of healthcare price, quality, and utilization data. State governments have refined their transparency tools over time to improve their utility and to respond to particularly pressing issues. So far in 2018, state legislatures have introduced 163 healthcare price transparency bills (see Appendix A). A large percentage of these bills focused on addressing transparency in pharmaceutical drug prices, but states have also introduced a wide swath of non-pharmaceutical price transparency bills. Recent state-based efforts include implementing and expanding APCDs, giving consumers new tools to access and compare prices for both insurance plans and healthcare services, and incentivizing patients to shop for higher-value services. Finally, many states recently passed laws protecting patients from surprise or balance billing practices, and laws prohibiting anti-competitive contract terms like gag clauses and anti-tiering/anti-steering clauses. This section will highlight some of the most common state transparency initiatives.

All Payer Claims Databases

All Payer Claims Databases (APCDs) are the cornerstone of many comprehensive price transparency initiatives. Their importance to developing consumer shopping tools, public informational tools, healthcare cost control efforts, and overall competition in healthcare markets cannot be overstated. An APCD is a comprehensive collection of medical claims data from both

public and private payers with information specific to individual plans, patients, and procedures. Consumers can use the data in APCDs to shop for higher value health services or providers. In addition, data from APCDs can be used to inform state policymakers about the operation of healthcare markets in the state.

While APCDs are instrumental tools for consumer shopping, they typically collect information on the services provided and the *amounts paid* for those services, rather than the *fees charged*. Insurance companies negotiate significant discounts from retail or “chargemaster” rates, and so such rates rarely provide the critical pricing information that patients and policymakers need. Providing both negotiated prices and amounts paid, on the other hand, paints a much clearer picture, though they are notoriously difficult to access.

To obtain such information, many states have mandated health plans to report their prices to the state APCD, while others permit them to submit the information voluntarily. Maine established the first statewide APCD in 2003, and twenty states now have or are implementing statewide APCDs with mandatory submission, and seven more states have APCDs with voluntary submission.¹⁰ States with mandatory reporting requirements have more comprehensive data. States with only voluntary reporting mechanisms only receive a portion of the picture, which will, almost assuredly, not prove representative of the entire population. For example, Oklahoma’s voluntary APCD covers only 1 million people, or approximately 25% of the population,¹¹ and therefore risks giving misleading information.

The demand for more reliable information about costs is growing and experts predict that over half the states will have an APCD or APCD-like database by 2022 that will cover at least

¹⁰ The states with APCDs that require submission are: AR, CO, CT, DE, FL, HI, KS, ME, MD, MA, MN, NH, NY, OR, RI, TN, UT, VT, WA, WV. The states with voluntary APCDs are: CA, MI, OK, SC, VA, WI, WY. <https://www.apcdouncil.org/>.

¹¹ *Oklahoma*, APCD COUNCIL, <https://www.apcdouncil.org/> (last visited July 11, 2018).

two-thirds of their populations.¹² States will continue to improve and refine their APCDs. However, the reliability and utility of state APCDs are compromised by their inability to obtain a comprehensive set of claims data because ERISA preempts any state law requiring self-insured employers to submit healthcare claims data. Nonetheless, the experience of many states demonstrates the power of APCDs to both help patients shop for higher value care and strengthen analysis of a state's healthcare market.

Price Comparison Tools

Once established, states can use the data collected in their APCD to create price comparison tools and incentives for patients to find the best value providers. For example, NH Health Cost, New Hampshire's APCD-based consumer-facing website, allows consumers, health plan enrollees, and employers to select different carriers while comparing prices.¹³ Importantly, because NH Health Cost has access to the insurer's negotiated prices with in-network providers, it can provide consumers with personalized out-of-pocket cost information for a particular procedure with a particular provider. New Hampshire's website is also one of the few publicly available sites that allows employers or payers to compare their rates to the median rate for a given service at a particular provider (e.g., a colonoscopy at the same hospital for each major insurer). Even with the desire and expertise, New Hampshire has struggled to offer this level of detailed information for each patient as benefit designs evolve to include options like value-based payments.¹⁴

¹² Joel Ario & Kevin McAvey, *Transparency in Health Care: Where We Stand And What Policy Makers Can Do Now*, HEALTH AFFAIRS BLOG (July 11, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180703.549221/full/>.

¹³ NH HEALTH COST, <https://nhhealthcost.nh.gov/> (last visited July 11, 2018).

¹⁴ Ario & McAvey, *supra* note 13.

Massachusetts, another pioneer in building and refining APCDs, also requires mandatory submission of healthcare claims data and records of services provided from public and private payers, including commercial health plans, Medicare, and MassHealth.¹⁵ However, Massachusetts' APCD, maintained by the Center for Health Information and Analysis (CHIA),¹⁶ does not offer the same connectivity with specific insurance plans as New Hampshire's APCD does. Instead, CHIA's healthcare transparency tool, MassCompareCare, includes a procedure pricing tool. This tool uses data extracted from the state's 2015 APCD and displays, by insurer, the median payment to any provider for any of 295 services. Additionally, it supplies quality information about different providers.

While these consumer-facing websites offer patients pricing information for different providers and services, few patients have engaged with them, for reasons I discuss below, and states have begun to try to incentivize patient engagement.

Right to Shop Laws

"Right to Shop" laws attempt to engage patients by giving them the ability to benefit financially when they choose lower-cost care. In New Hampshire, for example, consumers who successfully select a provider/service at a lower price receive a share of the savings in cash.¹⁷ Maine adopted a similar Right to Shop law in 2017 with transparency provisions that require insurers to give patients access to anticipated charges and estimated out-of-pocket charges in advance of receiving care. The law also requires carriers with small business group plans to offer plans that give financial incentives to patients who choose a high-quality, low-cost provider, and

¹⁵ In Massachusetts, Medicaid and Children's Health Insurance Program (CHIP) are combined into one program called MassHealth. *MassHealth*, MASS.GOV, <https://www.mass.gov/topics/masshealth> (last visited July 11, 2018).

¹⁶ CHIA, <http://www.chiamass.gov/> (last visited July 11, 2018).

¹⁷ N.H. REV. STAT. ANN. § 420-G:11, G:11-a (2018); Josh Archambault & Nic Horton, *Right to Shop: The Next Big Thing in Health Care*, FORBES (Aug. 5, 2016, 12:12 PM), <https://www.forbes.com/sites/theapothecary/2016/08/05/right-to-shop-the-next-big-thing-in-health-care>.

to require all non-HMO plans to cover out-of-network providers with rates that are lower than the state average.¹⁸ In order to implement Right to Shop laws, states and/or providers must first build comprehensive databases, such as APCDs, and implement shopping tools necessary to allow consumers to accurately and adequately shop between providers and services.

Restrictions on Surprise and/or Balance Billing

Other efforts to improve price transparency focus on providing patients access to prices when they seek care and protecting them from surprise bills. When an insured patient sees an out-of-network provider, the provider can bill the patient for the difference between the provider's charges and the insurer's payment. These surprise or balance billing practices can result in astronomical out-of-pocket costs for patients, as Peter Drier of New York found out when he got the bill for \$117,000 from the assistant surgeon that he never met. These practices often affect patients in their weakest moments when they have little control over their care (e.g., in a hospital where they receive care from an out-of-network doctor at an in-network facility). In response, states have begun taking action to restrict surprise and balance billing.

Currently 24 states offer some protection from balance billing, but only less than half offer comprehensive safeguards.¹⁹ While some states, including Florida,²⁰ California,²¹ and, more recently, New Jersey,²² ban balance billing altogether, many states instead require some form of disclosure of potential balance or surprise billing. States have done this in different ways. For example, some states require providers to disclose that a patient might receive a bill

¹⁸ L.D. 445, 128th Leg., Reg. Sess. (Me. 2018).

¹⁹ See footnote 6. According to Lucia 2017, some states prohibit provider balance billing, while others require insurers to hold enrollees harmless from balance billing charges by paying the entire charge if necessary, and some do both. In states that have adopted both approaches, out-of-network providers are directly prohibited from balance billing consumers for additional charges beyond what the health plan pays. In addition, insurers must guarantee that the consumer is held harmless from, and is not liable for, balance billing charges.

²⁰ H.B. 221, Reg. Sess. (Fla. 2016).

²¹ A.B. 72, Reg. Sess. (Cal. 2018).

²² A.B. 2039, Reg. Sess. (N.J. 2018).

for charges from out-of-network providers or that certain types of providers are not employed by the facility. For example, Tennessee requires health facilities to have patients sign the following statement before receiving care: “Anesthesiologists, radiologists, emergency room physicians, and pathologists are not employed by this facility... Before receiving services, the patient should check with his or her insurance carrier to find out if the patient's providers are in-network. Otherwise, the patient may be at risk of higher out-of-network charges.”²³ These type of disclosure laws, however, do little more than cover the providers from liability, as patients often have little choice of emergency room physician or anesthesiologist. Without adequate information and viable options, patients have little ability to plan for or avoid such costs. The goal of price transparency initiatives is to reduce expenditures by allowing patients to shop for higher value care. Patients will be unable to meaningfully shop for care if they cannot know the prices before getting that care, they do not have a choice in providers, or if they may be charged excessively high fees that they could not anticipate.

Some states require disclosure of cost estimates. Minnesota requires providers to give patients good faith estimates of the payment the provider has agreed to accept from the consumer's health plan and to disclose any fees, including facility fees, that an insurer does not typically pay.²⁴ Some states have gone a bit further and passed “hold harmless laws.” For example, Colorado requires a provider to accept payment that is equal to the rate the insurer would pay to an in-network provider.²⁵ Colorado, however, does not prohibit providers from sending bills to patients who might not understand that they do not have a responsibility to pay

²³ H.B. 1935 & S.B. 1869, 110th Leg., Reg. Sess. (Tenn. 2018) (codified at TENN. CODE ANN. § 56-7-120 (2018)) requires written consent for both the charges and the out-of-network statement.

²⁴ Minnesota Senate Bill 3480, which recently passed, requires provider to provide the consumer with information regarding other types of fees or charges that the consumer may be required to pay in conjunction with a visit to the provider, including but not limited to any applicable facility fees. S.F. 3480, 90th Leg., Reg. Sess. (Minn. 2018).

²⁵ S.B. 06-213, 65th Leg., 2nd Reg. Sess. (Colo. 2006).

those bills.²⁶ By prohibiting surprise billing practices and requiring providers and insurers to negotiate out-of-network rates, at least for emergency services, states can protect patients from financially devastating and unavoidable healthcare bills.

Prohibitions on Anti-Transparency Contract Provisions

States have also begun to prohibit insurers and providers from including certain types of provisions in their contracts that might prevent disclosure of healthcare prices or price shopping. First, non-disclosure provisions, also known as “gag clauses,” often prohibit providers and insurers from disclosing negotiated prices, methods of cost-sharing, or more affordable treatment options. In 2017, Maine passed a law prohibiting gag clauses in pharmacy contracts, which states “if information related to an enrollee's out-of-pocket cost or the clinical efficacy of a prescription drug or alternative medication is available to a pharmacy provider, a carrier or pharmacy benefits manager may not penalize a pharmacy provider for providing that information to an enrollee.”²⁷ In other instances, higher-priced providers have used anti-tiering or anti-steering contract provisions to prevent insurers from incentivizing patients to choose lower-cost providers. For example, insurers could signal which providers offer higher value care through the use of “tiered networks” by offering lower copays or other cost-sharing reductions to patients who use providers in preferred tiers. Most famously, North Carolina and the Department of Justice recently sued the Carolinas HealthCare System in an antitrust suit, claiming that the provider’s anti-tiering and anti-steering provisions violated Section 1 of the Sherman Act.²⁸ California is currently considering a bill to ban these contract provisions, but it has not yet passed.²⁹

²⁶ Lucia, *supra* note 6.

²⁷ L.D. 6, 128th Leg., Reg. Sess. (Me. 2017) (codified at ME. REV. STAT. ANN. tit. 24-a, § 4317 (2018)).

²⁸ *United States and the State of North Carolina v. The Charlotte-Mecklenburg Hosp. Auth., d/b/a Carolinas Healthcare System*, 248 F. Supp. 3d 720 (W.D.N.C. 2017). *See also United States v. Am. Express Co.*, 838 F.3d 179 (2d Cir. 2016).

²⁹ S.B. 538, Reg. Sess. (Cal. 2018).

Naming and Shaming Laws

In contrast to transparency laws that encourage or enable patients to make more cost-effective decisions about healthcare, laws that publicly display and/or fine entities with high healthcare prices aim to alert the public as to which entities are charging the highest prices and potentially shame them into lowering prices. In “naming and shaming laws,” states may also explicitly define price gouging, often saying if prices increase higher than some threshold without a reasonable justification, the state Attorney General can prosecute the entity for price gouging. In 2018, most naming and shaming laws focused on addressing drug prices; however, states could apply similar laws to non-pharmaceutical healthcare services in the future.

The states have demonstrated a keen interest in addressing healthcare costs and promoting healthcare price transparency. State laws have evolved over time to better satisfy consumer and governmental needs to access healthcare pricing data, yet there is still a long way to go.

The Unrealized Potential of Consumer-Focused Transparency Tools

With all the interest in state price transparency initiatives, one would think they had been quite successful at lowering healthcare spending. Despite growing efforts at both the state and federal level to increase transparency as a means of facilitating price shopping, so far these tools have been ineffective at substantially reducing costs. Studies examining these tools repeatedly demonstrate that simply offering patients access to price transparency tools alone has little effect on healthcare spending.^{30, 31, 32}

³⁰ Ethan M.J. Lieber, *Does It Pay to Know Prices in Health Care?*, 9 AM. ECON. J.: ECON. POL’Y 1, 154-79 (2017).

³¹ Sunita Desai et al., *Offering a Price Transparency Tool Did Not Reduce Overall Spending Among California Public Employees and Retirees*, 36 HEALTH AFFAIRS 8, 1401-7 (2017).

³² Anna D. Sinaiko et al., *Association Between Viewing Health Care Price Information and Choice of Health Care Facility*, 176 JAMA Internal Medicine 12, 1868-70 (2016).

Initially, price transparency tools offered patients provider retail rates, known as “chargemaster” rates. These provide little utility for insured patients attempting to know their out-of-pocket costs for a particular procedure by a particular provider within their particular plan. Patients also found the information on these websites confusing, as the terms and procedures were not standardized, the billing mechanisms were highly complex, and the prices often were broken out across a range of providers, services, and devices, making it impossible for a patient to fully anticipate his or her costs. Not surprisingly, consumers did not use these tools very often.

Over time, states and insurers offering consumer-facing price comparison tools, like NH Health Costs or United Healthcare’s MyUHC Cost Estimator,³³ began to offer consumers information on their out-of-pocket prices that that were patient, provider, procedure, and plan specific. For a price transparency tool to be useful for consumers, it must tell them how different choices of providers will affect *their* costs. When a patient uses a price transparency tool, studies have typically found savings between 10 and 17% for that patient.^{34, 35} These results are promising, but research demonstrates that the effect on overall spending is minimal due to lack of consumer engagement with these tools.

Overwhelmingly, studies reveal patients’ reluctance to use price transparency tools when shopping for medical procedures, with approximately 2-20% of patients using available tools to

³³ *MyUHC Cost Estimator*, UNITED HEALTHCARE, <https://www.uhc.com/individual-and-family/member-resources/health-care-tools/cost-estimator>. (last visited July 14, 2018).

³⁴ Lieber, *supra* note 31.

³⁵ C. Whaley et al., *Association Between Availability of Health Service Prices and Payments for these Services*, 312 *JAMA* 16, 1679-76 (2014).

search for price information, depending on the intervention.^{36, 37, 38, 39, 40} For example, in a 2016 study, only 3.5% of Aetna enrollees used an available online, personalized, episode-level price comparison tool, but costs for enrollees that used the tool to search for diagnostic services were 12% less than those who did not use the tool.⁴¹ Further, a study by Desai et al. showed that access to a price transparency website led to only a 1% decrease in medical spending because less than 10% of eligible patients even logged into the online tool to search for any procedure or provider.⁴² Mehrotra et al. attempted to understand how patients seek out price information by interviewing 3,000 non-elderly Americans with recent out-of-pocket spending on medical services.⁴³ The researchers found that 13% of the interviewees had searched for price information before their care, but in most cases the patients had only called their physician or plan to determine their out-of-pocket costs, rather than use the online tool to compare prices and select a provider. Specifically, only 3% of the interviewed patients compared prices between different providers. Because so few patients use these tools, consumer-focused price transparency tools, even those that can provide provider specific and plan specific information, have generally demonstrated minimal savings.⁴⁴

The question is: why aren't these tools more widely used? First, most insurance benefit designs do not incentivize patients to shop for costs. For example, if a patient has a flat copay,

³⁶ Lieber, *supra* note 31.

³⁷ Whaley et al., *supra* note 36, at 1670-76.

³⁸ Anna D. Sinaiko & Meredith B. Rosenthal, *Examining a Healthcare Price Transparency Tool: Who Uses It, and How They Shop for Care*, 35 HEALTH AFFAIRS 4, 662-70 (2016).

³⁹ Desai et al., *supra* note 32.

⁴⁰ A. Mehrotra et al., *Americans Support Price Shopping for Health Care, but Few Actually Seek Out Price Information*, 36 HEALTH AFFAIRS 8, 1392-400 (2017).

⁴¹ Sinaiko et al., *supra* note 33.

⁴² Desai et al., *supra* note 10.

⁴³ Mehrotra et al., *supra* note 41.

⁴⁴ Mehrotra et al., *supra* note 9, at 1348-54.

she has little financial incentive to search for a cheaper provider.⁴⁵ Second, decisions about medical care are critically important and patients are often forced to make these decisions at particularly vulnerable and challenging times. Patients often simply do not have the stamina and energy to track down different provider prices, identify those with the lowest cost rates, make numerous phone calls to see which ones are actually taking patients and still remain in their network, and then wait for their appointment. They would much prefer to receive a short list of providers recommended by their primary care doctor or loved one and seek treatment from them. Finally, since patients have so much at stake, price is often not the determining factor when making medical decisions. For shoppable services, i.e., non-urgent and interchangeable services like laboratory or diagnostic tests, patients are more willing to shop based on price, but patients are much less likely to do so for services where the quality is harder to assess, like provider selection. Detailed interviews with patients with access to the Castlight price transparency tool⁴⁶ highlighted that factors other than price are most important when choosing a provider; patients described how their relationship, trust, and loyalty to their current providers was more important than cost.⁴⁷ Patients also face significant switching costs associated with becoming a patient at a new practice, including long wait times for appointments, additional paperwork, having to recount their medical history, and loss of provider knowledge about the patient's personal and medical history. As a result, the most opportune time to offer information about costs and value to patients is when they choose new insurance coverage or new providers.

All these factors mean that healthcare services differ substantially from most other items individuals purchase. Choosing to compare prices and change providers is not like choosing to

⁴⁵ Lieber, *supra* note 31.

⁴⁶ CASTLIGHT HEALTH, <https://www.castlighthealth.com/> (last visited July 14, 2018).

⁴⁷ H.L. Semigran et al., *Patients' Views on Price Shopping and Price Transparency*, 23 AM. J. OF MANAGED CARE 6, e186-92 (2017).

shop at a different car dealership or department store. The consequences of choosing a lower quality provider can be catastrophic and patients are often hesitant to shop for a better price, especially when making these choices without guidance and support. Furthermore, the lasting relationship patients often have with their primary care provider builds trust, and if their provider refers them to a particular specialist, patients often choose to see that particular provider without considering cost. Even individuals with high-deductible health plans (HDHPs), who seemingly have the highest financial incentives to shop for higher-value, lower-cost services, rarely switch providers or seek out lower-cost services. A study of people in the first two years of coverage under an HDHP found a 15% reduction on spending for healthcare services for these individuals.⁴⁸ Detailed economic analysis, however, showed that nearly all the savings came from reducing the amount of care the individuals received, not from price shopping or switching providers.⁴⁹

Collectively, these studies provide evidence that, when used effectively, price transparency tools can reduce the cost of health services. These studies also show, however, that to broaden the use and impact of these tools, we need to do more than simply provide patients with access to lists of providers and prices. We must engage other actors in healthcare markets by providing them access to relevant healthcare pricing information at critical decision-making points.

Maximizing the Potential of Price Transparency Tools

The current lack of price transparency in healthcare not only confounds patient decision-making, it also hinders provider treatment decisions, payer price setting, and governmental

⁴⁸ Zarek C. Brot-Goldberg et al., *What does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics*, 132 THE Q. J. OF ECON. 3, 1261-1318 (2017).

⁴⁹ *Id.*

reform efforts and policy analysis. This section provides suggestions for how various price transparency initiatives can promote more cost effective decision-making and help bend the cost curve by providing patients, providers, payers, and policymakers essential information at critical decision points.

Patients

To maximize the effectiveness of consumer-facing price transparency tools, patients need actionable information from trusted sources and incentives to act on that information. For example, a study by Wu et al. demonstrated that when a representative of their insurer called patients, informed them about a lower-cost location for their MRI, and, if desired, helped reschedule their appointment at a high-value provider, the average cost for an MRIs decreased by 18.7% as patients shifted away from more expensive hospital-based facilities.⁵⁰ Furthermore, the authors found that prices at hospital-based facilities dropped over 10% and price variation in the metropolitan regions studied decreased by 30%, indicating that price transparency also encouraged providers to lower their price to remain competitive.⁵¹ Perhaps most encouragingly, the authors found that all patients in these areas experienced the benefits of lowered prices through competition.⁵² Entire communities benefit when the market encourages high-cost providers to lower their prices or justify higher prices with higher quality for their services.

Reference pricing provides another means of encouraging patients to use price transparency tools. When using reference pricing, an employer or insurer pays up to an established maximum price, the reference price, for a healthcare service. The reference price is typically set at a level that allows patients to receive a healthcare service from multiple high-

⁵⁰ S.J. Wu et al., *Price Transparency for MRIs Increased Use of Less Costly Providers and Triggered Provider Competition*, 33 HEALTH AFFAIRS 8, 1391-98 (2015).

⁵¹ *Id.* The intervention was implemented in Atlanta, GA; Cincinnati, OH; Cleveland, OH; Indianapolis, IN; and St. Louis, MO.

⁵² *Id.*

quality providers without additional contribution. The patient must pay for any costs of the service above that price, so reference pricing encourages patients to be more engaged consumers. For instance, if the reference price for an office visit to a provider is \$200, the patient will receive full coverage for providers that charge \$200 or less, but they will need to pay \$50 extra for a provider that charges \$250. Unlike HDHPs, where patients might be forced to forgo care if they cannot afford the procedure, reference pricing lowers costs while ensuring that patients can access care from a range of covered providers.

Reference pricing thus preserves a patient's ability to choose higher-priced providers if she values their services enough to pay the higher rate, and simultaneously encourages providers to drop their price to the reference price. A study by Robinson and Brown found that price transparency tools coupled with reference pricing effectively directed patients seeking orthopedic surgery to lower-cost providers and, similarly to the study by Wu et al., the costs of the procedure at high-priced facilities decreased by 30% due to price competition.⁵³ Studies of two of the leaders in adopting reference pricing, the California Public Employees' Retirement System (CalPERS) and the grocery firm Safeway, demonstrate the potential of coupling reference pricing and consumer price shopping. These organizations reduced spending by 20% for joint replacement,⁵⁴ 18% for cataract removal,⁵⁵ 21% for colonoscopy,⁵⁶ 17% for arthroscopy,⁵⁷ 12%

⁵³ J.C. Robinson & T.T. Brown. *Increases in Consumer Cost Sharing Redirect Patient Volumes and Reduce Hospital Prices for Orthopedic Surgery*. 33 HEALTH AFFAIRS 8, 1392–97 (2013).

⁵⁴ *Id.*

⁵⁵ J.C. Robinson et al., *Reference-Based Benefit Design Changes Consumers' Choices and Employers' Payments for Ambulatory Surgery*, 34 HEALTH AFFAIRS, 415-22 (2015).

⁵⁶ J.C. Robinson et al., *Association of Reference Payment for Colonoscopy with Consumer Choices, Insurer Spending, and Procedural Complications*. 175 JAMA INTERNAL MEDICINE, 1783-89 (2015).

⁵⁷ J.C. Robinson et al., *Consumer Choice Between Hospital-Based and Freestanding Facilities for Arthroscopy: Impact on Prices, Spending, and Surgical Complications*. 97 THE J. OF BONE AND JOINT SURGERY, 1473-81 (2015).

for computed tomography,⁵⁸ and 32% for laboratory assays⁵⁹ using reference pricing. Montana also used reference pricing to control healthcare costs for beneficiaries in the state employees' health plan⁶⁰ and agreed to pay an average of 234% of Medicare rates for hospital services.⁶¹ Since the program started in July 2016, the state has saved \$15.6 million⁶² and will save an estimated \$25 million by the end of 2018.⁶³ A study by researchers at the University of California, Berkeley, estimated that if the insurers Aetna, United Healthcare, and Humana all implemented reference pricing for laboratory testing services for their commercially insured patients, collectively they would save \$7.6 billion annually, or about 8% of the total spending for this population.⁶⁴

Taken together, these studies demonstrate the potential of price transparency tools when coupled with other mechanisms to encourage their use. They further demonstrate the potential of price transparency between providers to leverage competitive forces to drive down prices. An important caveat, however, is that these studies focus on “shoppable” medical services, ones that are generally standardized and relatively interchangeable, like laboratory tests and generic drugs. In other words, they are not relationship-based services; they do not require patients to switch providers.

⁵⁸ J.C. Robinson et al., *Reference Pricing, Consumer Cost-Sharing, and Insurer Spending for Advanced Imaging Tests*, 54 MEDICAL CARE, 1050-1055 (2016).

⁵⁹ J.C. Robinson et al., *Association of Reference Pricing for Diagnostic Laboratory Testing with Changes in Patient Choices, Prices, and Total Spending for Diagnostic Tests*, 176 JAMA INTERNAL MEDICINE, 1353-59 (2016).

⁶⁰ Julie Appleby, *Holy Cow' Moment Changes How Montana's State Health Plan Does Business*, THE WASHINGTON POST (June 20, 2018), https://www.washingtonpost.com/national/health-science/holy-cow-moment-changes-how-montanas-state-health-plan-does-business/2018/06/20/92b3693c-746a-11e8-bda1-18e53a448a14_story.html?utm_term=.df1a721650a1.

⁶¹ Appleby, *supra* note 60.

⁶² *Id.*

⁶³ Press Release, State of Montana Government, Governor Bullock Announces State Health Plan Change Will Save Taxpayers More Than \$25 Million By End of 2018 (July 8, 2016), <https://news.mt.gov/governor-bullock-announces-state-health-plan-change-will-save-taxpayers-more-than-25-million-by-end-of-2018>.

⁶⁴ J.C. Robinson et al., *Reference Pricing Changes the 'Choice Architecture' of Health Care for Consumers*, 3 HEALTH AFFAIRS, 524-30 (2017).

To bend the cost curve, however, patients need to choose lower-priced providers. As noted above, consumers have been more reluctant to use price transparency tools to select providers. Trust and relationships are paramount for most patients, especially sick ones. A survey of people with HDHP insurance coverage showed that, while the majority of these enrollees believed there were large differences in price between providers, and that higher-cost providers were not necessarily of higher quality, they were no more likely than enrollees in traditional plans to considering switching providers or to compare out of pocket costs for a new provider.⁶⁵ Simply put, patients are reluctant to switch providers, even when it might mean substantial out-of-pocket savings.

Furthermore, the burden of lowering healthcare costs should not be placed solely on the weakest and most vulnerable link in the healthcare chain, patients. Those who can most benefit from price transparency tools are often too sick and overwhelmed to appropriately advocate for themselves and navigate the complicated labyrinth of insurance networks, plan benefit design, and healthcare prices. The stakes are simply too high for individuals – one misstep could result in financial ruin, loss of a home, or bankruptcy. Other actors in the healthcare market, including providers, employers, insurers, and policymakers, should also leverage price transparency tools to lower costs.

Providers

Primary care providers are uniquely well-positioned to use price transparency tools to guide patients toward lower-cost providers when making decisions about which specialist to see and which treatment options to consider. Patients often want an informed referral or recommendation from a trusted provider that takes price into account. One survey of insured

⁶⁵ A.D. Sinaiko et al., *Cost-Sharing Obligations, High-Deductible Health Plan Growth, and Shopping for Health Care Enrollees with Skin in the Game*. 176 JAMA INTERNAL MEDICINE 3, 395–97 (2016).

patients found that more than 80% wanted to discuss costs with their doctor, and 75% of patients reported they wanted their physician to consider out-of-pocket costs before making decisions for their care.⁶⁶ This kind of consultation between patient and provider reflects the most complete form of informed consent, known as shared decision-making, in which the provider and patient jointly consider all of the relevant information about a particular treatment decision – including the costs, risks, and benefits of various treatment options – and use that information to make a treatment choice that best reflects the patient’s preferences.⁶⁷ The same survey that demonstrated that patients want their doctors to consider costs found that less than half of the surveyed patients could find information about healthcare costs when needed.⁶⁸ Since primary care physicians occupy a sentinel role in connecting patients to other services, they can successfully steer patients to lower-cost facilities and providers, and offer guidance on lower-cost alternatives *if* they have access to a particular patient’s insurance network, pricing, and cost-sharing obligations when recommending treatment.

Implementation of this kind of sophisticated interaction, however, faces many challenges. Foremost among them is that providers need price information that is patient, procedure, provider, and plan specific at the time of decision-making, i.e., during a patient’s appointment. Few providers know what their patients will have to pay for the care they recommend. Currently, physicians often struggle to find out if a particular provider is in a patient’s insurance network at the time a referral is made, so developing tools that give providers the necessary detailed information through coordinated infrastructure and interoperability between electronic medical

⁶⁶ N.B. Henrikson et al., *Communication with Physicians about Health Care Costs: Survey of an Insured Population*, 21 THE PERMANENTE J. 2, 16–070 (2017).

⁶⁷ Jaime S. King & Benjamin Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 AM. J. L. & MED. 429 (2006).

⁶⁸ Henrikson, *supra* note 66.

records (EMRs) and insurers will require substantial systematic changes. However, health systems, especially those with an insurance arm, have begun offering providers such information via EMRs, and data reporting practices to APCDs could help facilitate the integration of price and insurance information into EMRs. Even if EMRs could systematically incorporate patient insurance information, provider network lists and information on which providers currently accept new patients would need to be consistently updated to reflect accurate information, so that patients do not inadvertently seek treatment from an out-of-network provider. Further, the short duration of most physician visits, typically 15 minutes, limits the amount of time that can be spent on treatment choice and provider selection. Engaging a patient in a meaningful discussion about the potential risks and benefits, including financial risks and benefits, of different treatment options requires time, and providers should be paid for providing this service.

Payers

Payers for healthcare in the U.S., mostly insurers and employers, also have much to gain from increased price transparency. Approximately half of Americans receive their health insurance through their employer,⁶⁹ and as a main conduit to healthcare, employers have a strong incentive to steer their employees to high-value, lower-priced care. Employers provide health insurance to their employees by either selecting an insurance provider and contributing to premiums or by self-insuring their patients and paying directly for their care, often through a third-party administrator. When choosing an insurance plan, employers need information on the premiums, benefit design, breadth of the provider network, and the cost of services when employees must go outside of the network. When self-insuring, employers need data on the

⁶⁹ *Health Insurance Coverage of the Total Population*, KFF.ORG, <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited July 14, 2018).

negotiated prices that health plans pay for a wide range of services to ensure they are obtaining reasonable rates. They also need information on the size of the provider network needed to ensure that patients can stay in-network for most care. Employers must have a sense of the range of rates for out-of-network care to predict their overall exposure. Having access to an APCD to analyze benchmarks for insurer negotiated rates would prove very helpful to employers seeking to self-insure their employees.

While insurers generally have access to the rates they negotiate with providers, they can also benefit from having access to benchmarks for insurer negotiated rates in a particular geographic area when negotiating their own rates. While making negotiated rates entirely transparent presents some risks of price collusion,⁷⁰ using claims data from an APCD to establish average pricing benchmarks for average to high quality providers should encourage, rather than threaten competition. Further, health plans can benefit from being able to encourage patients to select higher-value/lower-cost providers through tiering and reference pricing tools. Price transparency initiatives that prohibit anti-tiering/anti-steering contract provisions also can facilitate use of those tools.

Policymakers

Finally, policymakers probably have the most to gain from improved transparency of healthcare prices. As noted above, state governments have shown a great deal of interest in obtaining healthcare price data for a variety of uses. States can use healthcare claims data reported to an APCD to examine the drivers of healthcare costs over time, the effectiveness of various reform efforts, the impact of mergers, acquisitions, and other affiliations on healthcare price and quality, and other factors that might hinder competition and efficiency in the healthcare

⁷⁰ Erin C. Fuse Brown & Jaime S. King, *The Double-Edged Sword of Health Care Integration: Consolidation and Cost Control*, 92 IND. L. J. 55 (2016).

market. For example, Oregon recently published a report summarizing 54 use cases for its APCD, the Oregon All-Payer All-Claims Database.⁷¹ Identifying Oregon’s APCD as “an integral component of the state’s ongoing healthcare improvement efforts,” the report outlined numerous uses for the APCD data in analyzing and monitoring healthcare spending and cost trends, healthcare delivery system performance, healthcare utilization, population health, disease prevention, and insurance coverage.⁷² Oregon, Colorado, and Maryland have used their APCD data to analyze geographic variations in price and utilization of healthcare services to detect unwarranted variations due to overutilization and market consolidation.⁷³ Massachusetts’ APCD provides essential information to the Massachusetts Health Policy Commission to track healthcare spending trends and inform policy and legal decisions regarding consolidation and payment reform.⁷⁴ Finally, New York views its developing APCD, the NYS Connector, as a central hub of health information that will collect and synthesize all varieties of health data from the entire state. According to the New York Department of Health, “the APD [all payer database] is creating new capability within the Department, including more advanced and comprehensive analytics to support decision-making, policy development, and research, while enhancing data security by protecting patient privacy through encryption and de-identification of potentially identifying information.”⁷⁵ Perhaps state health policy experts, Joel Ario and Kevin McAvey,

⁷¹ OREGON ALL-PAYER ALL-CLAIMS DATABASE USE CASE DOCUMENT (2017), <https://www.oregon.gov/oha/HPA/ANALYTICS/APAC%20Page%20Docs/APAC-Use-Cases.pdf>.

⁷² *Id.*

⁷³ A. COSTELLO ET AL., APCD COUNCIL, INFORMING HEALTH SYSTEMS CHANGE - USE OF ALL-PAYER CLAIMS DATABASES (2018), <https://www.apcdouncil.org/publication/informing-health-system-change-use-all-payer-claims-databases>.

⁷⁴ *Massachusetts Health Policy Commission*, MASS.GOV, <https://www.mass.gov/orgs/massachusetts-health-policy-commission> (last visited July 14, 2018).

⁷⁵ *New York State All Payer Database*, HEALTH.NY.GOV, https://www.health.ny.gov/technology/all_payer_database/ (last visited July 14, 2018).

said it best in their recent Health Affairs Blog post, “APCDs are very much a work in progress, with tremendous unrealized potential.”⁷⁶

Legal Barriers to Price Transparency

Yet a range of laws and contractual provisions currently hinder the potential of APCDs and other price transparency initiatives. Many states currently lack access to a complete set of claims data in their APCDs because federal laws, trade secret protections, and contract provisions limit what data they can demand from insurers. First and foremost, the Federal Employee Retirement Income Security Act of 1974 (ERISA) preempts any state law that “relates to an employee benefit plan.”⁷⁷ ERISA’s preemptive reach is limited by the “savings clause” which saves all laws that regulate insurance from preemption,⁷⁸ but ERISA does not deem self-insured employer plans to constitute insurance for purposes of regulation. Therefore, ERISA preempts any state insurance law that relates to an employee benefit plan provided by a self-insured employer.⁷⁹ Consequently, many state transparency laws that target health plans do not apply to self-insured employers’ plans, including laws requiring reporting or disclosure of healthcare claims data, drug pricing methodologies, provider network status, and billing information.

Most crippling, in 2015, the Supreme Court in *Gobeille v. Liberty Mutual Insurance Co.* held that ERISA preempts state APCD reporting requirements with respect to self-insured employer health benefit plans.⁸⁰ Specifically, self-insured employers and their third party

⁷⁶ Ario & McAvey, *supra* note 13.

⁷⁷ ERISA § 514(a) (1974); 29 U.S.C. § 1144(a) (2006).

⁷⁸ *Kentucky Ass’n of Health Plans v. Miller*, 538 U.S. 329, 341-42 (2003). The savings clause will save state insurance regulations from preemption so long as they are “specifically directed at entities engaged in insurance,” and the state law “substantially affect[s] the risk pooling arrangement between the insurer and the insured.”

⁷⁹ 29 U.S.C. § 1144(b)(2)(B) (2006).

⁸⁰ *Gobeille v. Liberty Mutual Insurance Co.*, 136 S. Ct. 936 (2015).

administrators, which cover approximately two-thirds of all workers with employer-based health insurance, are exempt from submitting their claims data to the APCD, significantly limiting the number of plans that must report to the APCD and the percentage of employee claims data included in the database. As such, the loss of self-insured employees' claims data deprives state APCDs from having the essential information needed to provide robust analysis on healthcare cost, quality, utilization, and geographic variations within the state.

Second, as noted above, providers and insurers often include specific provisions in their contracts designed to keep healthcare prices secret, such as “gag clauses” or anti-tiering/anti-steering provisions. These types of contract provisions greatly hinder patients' ability to choose high-value services, and policymakers' ability to know and understand how to best reform the healthcare system. States have passed laws prohibiting these and other similar provisions in provider-insurer contracts, but the impact of these laws has been limited due to claims that negotiated healthcare prices constitute trade secrets.

Third, providers and insurers have successfully used trade secrets protections to prevent disclosure of negotiated healthcare price information in the absence of the contract provisions above. Historically, the states have governed trade secret laws, but Congress passed the federal Defend Trade Secrets Act of 2016 (DTSA) to establish a floor for trade secrets protection. The DTSA allows businesses and individuals to keep information confidential if 1) “the owner has taken reasonable measures to keep such information secret”; and 2) “the information derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable through proper means by, another person who can obtain economic value from the disclosure or use of the information.”⁸¹ Some states, like California, Illinois, and

⁸¹ The Defend Trade Secrets Act, 18 U.S.C.A. § 1839(3) (2016).

Oregon have broader protections of trade secrets that would enable more information to constitute a trade secret.

Historically, courts did not consider prices eligible for trade secret protections, but in our modern economy where business-to-business transactions are more common, this question is not so straightforward. Many healthcare organizations now claim trade secrets protections to avoid disclosure of their negotiated prices, rebates, discounts, and other pricing information. This jealous guarding of prices compromises the decision-making of nearly every stakeholder in the healthcare market and contributes significantly to the ever-rising price of healthcare goods and services. Ironically, no court has affirmatively decided that negotiated healthcare prices constitute a trade secret.⁸² Trade secret cases are highly fact specific, such that even if a court found in a particular case that the confidentiality of such prices should be protected, it would not be generalizable to other cases. Yet, the mere claim that negotiated price information constitutes a trade secret has seemingly been sufficient to stop many who seek the data from continuing to do so or taking the issue to court, allowing provider and insurer organizations to use legal protections to avoid disclosure of information that has the potential to lower their revenues.

Ultimately, ERISA, contract provisions, and trade secret laws form a formidable obstruction to price transparency in healthcare that require federal intervention.

What Can Congress Do?

For transparency initiatives to achieve their full effect at the state level, the federal government must make changes. Despite the need for federal policy to maximize healthcare

⁸² A number of courts have discussed how negotiated price lists may be considered trade secrets, but none have ruled squarely on the issue. *See, e.g., Synthes, Inc. v. Emerge Med., Inc.*, 25 F. Supp. 3d 617, 706 (E.D. Pa. 2014), *In re Maxxim Med. Grp., Inc.*, 434 B.R. 660, 669 (Bankr. M.D. Fla. 2010), *Emergency Care Research Inst. v. Guidant Corp.*, No. CIV.A. 06-1898, 2007 WL 2702455, at *5 (E.D. Pa. Sept. 12, 2007) and *Emergency Care Research Inst. v. Guidant Corp.*, No. 06-1898, 2006 WL 3541776, at *3 (E.D. Pa. Dec. 5, 2006).

transparency efforts, policymakers should craft changes to preserve state flexibility and innovation. Fortunately, Congress, more than any other entity, has the ability to address the most significant barriers to price transparency in healthcare and maximize the tremendous untapped potential of existing state initiatives, in particular APCDs.

1. Address ERISA Preemption Challenges

APCDs have the greatest potential of any price transparency initiative to inform consumers and policymakers in ways that can help control healthcare costs. Unfortunately, following the *Gobeille* decision to allow ERISA preemption of state APCD reporting requirements as applied to self-insured employer plans, many data reporters have reduced or ceased their submission of healthcare claims data to state APCDs, depriving state governments, researchers, and the public from access to essential information on healthcare costs, quality, and utilization.⁸³

The omission of self-insured employer claims data greatly limits the accuracy and utility of APCDs. Essentially for health policy analysts, trying to analyze the healthcare landscape using an APCD without the self-insured employer population is akin to trying to use GoogleMaps with one-third of the roads missing – you don't have the whole picture. Enabling APCDs to collect the full set of healthcare claims data would dramatically increase the utility and reliability of these initiatives.

Congress can pursue several paths to relieving the burden of ERISA preemption on APCDs. It could pass legislation creating a federal APCD that required reporting on all claims from all healthcare payers. While a federal APCD would standardize reporting requirements,

⁸³ See NATIONAL ACADEMY FOR STATE HEALTH POLICY, COMMENTS ON DEPARTMENT OF LABOR NOTICE OF PROPOSED RULEMAKING 1 (2016), <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB63/00030.pdf>.

streamline, and simplify reporting mechanisms, and create one complete dataset for the entire country, such an initiative would further entrench the federal government's role in healthcare and require significant human and capital resources. A federal APCD would also fail to capitalize on the investment made by nearly half the states to develop state APCDs.

Rather than reinvent the wheel, Congress should invest its efforts in facilitating the already significant strides made by state APCDs. The most effective and direct manner of doing so would be to amend ERISA to narrow preemption to exclude state health regulations that do not unduly burden ERISA's goal of uniformity for employer-based benefit plans, while also granting states sufficient flexibility to achieve their health reform goals.⁸⁴ Amending ERISA's preemption scheme to replace broad preemption with conflict preemption would permit the states to experiment with a variety of health reform proposals, including price transparency initiatives, while permitting ERISA to preempt any state law that directly conflicts with the federal law.⁸⁵

Alternatively, Congress could pass legislation that affirms the Department of Labor's authority to collect healthcare claims data from ERISA plans and allow them to partner with state APCDs under ERISA § 506, such that the Department of Labor could require ERISA plans to submit claims data to state APCDs.⁸⁶ For states that have not yet created an APCD, the Department could require ERISA plans to submit claims data to a third party contracted to perform the APCD functions for those states, similar to the federal marketplace created by the Patient Protection and Affordable Care Act of 2010. The Department of Labor could facilitate

⁸⁴ Erin C. Fuse Brown & Jaime S. King, *ERISA as a Barrier for State Health Care Transparency Efforts*, TRANSPARENCY IN HEALTH AND HEALTH CARE (Holly Fernandez Lynch, I. Glenn Cohen, & Barbara Evans eds., Cambridge University Press, forthcoming 2019) (manuscript at 10-11), <https://ssrn.com/abstract=3214173>.

⁸⁵ Elizabeth Y. McCuskey, *Body of Preemption: Health Law Traditions and the Presumption Against Preemption*, 89 TEMP. L. REV. 95, 103 (2016); Erin C. Fuse Brown & Ameet Sarpatwari, *Removing ERISA's Impediment to State Health Reform*, 378 N. Eng. J. Med. 5, 7 (2018).

⁸⁶ 29 U.S.C. § 1136 (1996).

the collection of this additional claims data with minimal financial investment and also develop the ability to request reports from the state APCDs on claim information from employee benefit plans.⁸⁷ On the other hand, this approach would leave ERISA's broader preemption scheme in place, which would still hinder other state transparency initiatives like surprise billing protections, pharmacy benefit transparency laws, and anti-tiering and anti-steering prohibitions, making a direct amendment of ERISA the preferred approach for promoting price transparency initiatives overall.

Under either approach, Congress should require that state APCDs request claims data in a standardized manner to minimize the burden for multi-state employers and to facilitate data comparisons across states. State APCDs have already developed and agreed upon a standardized set of healthcare claim and related data that can be collected from all health plans – the Common Data Layout.⁸⁸ The Common Data Layout creates a uniform system of reporting across all state APCDs that will ease the reporting burden on employers, third-party administrators, and insurance companies, satisfy ERISA's uniformity requirements, and facilitates analysis of claims data across states. Further, the depth of information reported in the Common Data Layout could strengthen the Department of Labor's ability to monitor ERISA plans well beyond any information the Department currently collects.

Overall, addressing ERISA preemption of state health reform laws is *the* most important action Congress could take at this time to promote price transparency to bring down healthcare costs, but additional actions by Congress could also further illuminate healthcare prices.

⁸⁷ See Fuse Brown & King, *supra* note 84, at 8-9.

⁸⁸ See NATIONAL ACADEMY FOR STATE HEALTH POLICY, COMMENTS ON DEPARTMENT OF LABOR NOTICE OF PROPOSED RULEMAKING (2016), <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB63/00030.pdf>.

2. Encourage Consumer Pricing Shopping Initiatives

Congress should seek to encourage consumer price shopping initiatives like reference pricing, rewards, and tiered networks to provide patients with further incentives to select high-value/lower-priced providers. Congress could promote reference pricing by implementing reference pricing schemes into Medicare and funding pilot projects to test reference pricing in a variety of settings. Congress could also facilitate insurers' attempts to signal lower-priced providers to patients by prohibiting anti-tiering/anti-steering provisions in contracts or prohibiting them in ERISA plan contracts.

3. Create a Public Interest Exemption to Trade Secrets

Trade secrets protections were designed to encourage and protect innovation, not protect exorbitant prices that take advantage of consumers, bankrupt businesses, and bleed government coffers. Congress should pass a public interest exemption to the Defend Trade Secrets Act of 2016 that clearly establishes that trade secret protections will not apply to information being kept secret in ways that harm the public's interest. In the case of negotiated healthcare prices, keeping negotiated rates secret from competitors in highly concentrated markets where disclosure might drive costs up might serve the public interest, but keeping those same rates secret from the government, employers who pay them, or consumers would not. Evaluation of this standard would be a highly fact-specific analysis, performed on a case by case basis, yet it would provide a clear opportunity to better define the specific contours of trade secret protections in healthcare and raise questions about whether trade secrets protections apply to all or any negotiated healthcare prices.

4. Mandate Interoperability of Electronic Medical Records Systems

Similar to the Common Data Layout, Congress should require manufacturers of electronic medical records and insurance companies to establish uniform standards of interoperability and data reporting practices, such that a patient's insurance information can load into a provider's electronic medical record to enable the provider to access meaningful network, out-of-pocket cost, and quality information for patients when making provider and medical service referrals during appointments. Placing relevant cost information into the hands of both patients and providers when they are selecting a treatment or provider will significantly increase the odds that patients will incorporate such information into their healthcare choices.

5. Develop Billing Codes to Pay for Physician Time for Shared Decision-Making

Congress should develop billing codes and other payment mechanisms within Medicare to pay for physician time in discussing treatment selection, including information on which providers are "in-network" and what the cost to the patient would be of different treatment choices. Shared decision-making that includes a discussion of the out-of-pocket costs to the patient not only encourages physicians to provide a robust form of informed consent to patients, but it also has the added benefits of encouraging patients to shop for healthcare services and potentially decreasing overutilization of services that patients would not choose if they knew all the risks and benefits.

Thank you for your time and your consideration of these important issues.

APPENDIX A

2018 Legislative Session

During the 2018 legislative session, state legislatures have attempted to pass laws related to healthcare price and quality transparency. In 2018 the legislatures have focused particularly on lowering drug prices, and as such, have constructed their legislation to target drug manufacturers, pharmacy benefits managers (PBMs), formularies, and other pharmaceutical-related entities and tools. The vast majority of these bills target consumers' access to healthcare price and quality information, rather than other stakeholders.

<u>Focus of Bill*</u>	<u>Number of Bills Introduced in 2018**</u>	<u>Number Passed in 2018**</u>	<u>Number Died in 2018**</u>
<u>Pharmacy Gag Clauses, Clawback Prohibitions, and Mandatory Disclosure of Cheaper Drug Alternatives</u>	55	25	17
<u>Price Comparison (Right to Shop, the Right to Know, and Transparency Website/Tools)</u>	46	5	23
<u>Prohibition on Price Gouging</u>	43	2	21

(Continued on next page)

<u>Focus of Bill*</u>	<u>Number of Bills Introduced in 2018**</u>	<u>Number Passed in 2018**</u>	<u>Number Died in 2018**</u>
<u>“Pricing Report” Laws (Mandatory Disclosure of Drug Prices, Increase in Costs, or Pricing Mechanisms)</u>	41	8	16
<u>Surprise and/or Balance Billing Laws</u>	34	7	15
<u>All Payer Claims Databases (APCD)</u>	9	2	4
<u>Reference Pricing Laws</u>	8	2	4
<u>Chargemaster Laws</u>	4	0	3
<u>Price/Claim Request</u>	3	0	3

* Some categories of transparency bills not included in this summary as there are too few bills or do not specifically target price/quality, though they may impact either.

** All data as of July 3, 2018.