FROM THE EDITOR'S DESK

Will More Transparency Help Us Lower the Cost of Health Care?

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The cost of health care in the United States is the highest among developed countries, with little apparent benefit; compared with 11 other wealthy nations we are the worst in life expectancy and infant mortality. A recent study in *JAMA*[1] found that the main cause was not higher utilization rates, which were largely similar in the United States and the other nations. Rather, "prices of labor and goods, including pharmaceuticals, and administrative costs appeared to be the major drivers of the difference…" For example, an MRI that costs $1,150 in the U.S. is $140 in Switzerland. It would be hard to argue that Swiss health care is only one-eighth as good!

But the problem is more complicated than simply higher prices here, as we also have striking disparities in charges from one region of the U.S. to another, and even among hospitals in the same region.

Fortunately, analysis of claims data is improving transparency and making useful information about these disparities more widely recognized. The Health Care Cost Institute (HCCI),[2] a nonprofit funded by four major health insurers (Aetna, Humana, Kaiser, and United Healthcare), with access to claims data on approximately 25% of the commercially insured market, recently published a study of commercial health care prices that shows regional price differences even for relatively standardized procedures like MRIs and ultrasounds.

Analyzing 3 billion medical claims from 2012 and 2013, they looked at prices actually paid to hospitals and doctors—rather than prices charged. Notably, prices paid can be difficult or even impossible to obtain due to gag clauses in contracts.

They found that the national average price for 242 common services—from lab tests and X-rays to hip replacements and angioplasties—varied extensively across states as well as within metropolitan areas. In an example from one insurer, the average price paid for a knee replacement in South Carolina was almost $47,000, while the average price for the same bundled procedure in New Jersey was $24,000.

In Cleveland, the average price paid for a pregnancy ultrasound was $522, but 60 miles away in Canton, Ohio, the average price was $183.

States with the highest average prices, compared with a national benchmark, included Alaska, Minnesota, New Hampshire, North Dakota, and Wisconsin. Arizona, Florida, Maryland, and Tennessee had medical services that were priced much lower than the national average.

And though it is appropriate to wonder about the HCCI's objectivity since it is the creation of the largest private health insurers, similar regional disparities were found in a separate study funded by the independent Robert Wood Johnson Foundation, and carried out by the Network for Regional Healthcare Improvement (NRHI),[3] a voluntary national organization representing more than 30 regional health improvement collaboratives (RHICs) and state/regional affiliated partners. The NRHI study looked at a somewhat different list of states/regions than HCCI, but found, for instance, that Colorado's hospital prices were 31% higher than average, while St. Louis' prices were 23% lower than average.

The HCCI study did not analyze the root causes of price variations, but as pointed out by David Newman, executive director of HCCI, in an article in Modern Healthcare,[4] geographic variations in cost-of-living certainly play a role. Alaska has high charges, Newman said, but "everything in Alaska, other than snow, is more expensive than elsewhere in the country." And though variations in housing, rent, and salaries partially explain the price differences, Newman continued, "the remaining variation is most likely due to differences in underlying market dynamics, such as varying market power, a lack of transparency, or the availability of alternative treatments." Others have suggested that hospital consolidation also often drives up prices.

At the very least, Newman said, employers, payers and consumers could save money if they knew just how different the prices were. He joked that employers or insurers could drive knee-replacement patients from Palm Bay on the east coast of Florida down to Miami, give them a couple of thousand dollars in casino chips, and then drive them back home—and save money. The average bundled knee replacement price in Palm Bay

was $44,237, compared with $27,115 in Miami. The Blue Cross and Blue Shield Association published similar findings on price variations for angioplasties.[5]

Even as transparency improves, the impetus for changes will likely have to come from private and government payers because individual consumers usually get to choose only which insurer to sign up with – assuming that even that choice hasn't already been made by their employer. As I pointed out in a recent editorial,[6] individual consumers generally lack crucial information, are often in an urgent situation that precludes shopping around, and are more likely to be motivated by quality than by cost, since they are usually insulated from the full cost of their care. People usually search for highly rated institutions and surgeons, not for the cheapest ones. Even if a consumer wanted to prioritize cost, it's likely they could not decipher a hospital's encyclopedia of codes for its services, and would be unable to predict the cost of the care they need.

Overall, pharmacy prices show less variability than other health care prices because they are often determined by negotiations among payers, pharmacy benefit managers, and pharmaceutical manufacturers. Since cost-of-living factors should be less important when spread out over millions of pills, the large price differences that do exist are particularly troubling. Though a high cost of living can partly explain the high prescription drug prices in cities like New York and San Francisco, other cities with high costs, such as Washington, D.C., have below average drug prices. And Raleigh, NC, with a lower than average cost-of-living, has higher than average drug prices.

Notwithstanding all these issues, doctors must daily make decisions that have important financial implications. When a drug can cost $80,000 per year, the simple act of writing a prescription raises questions not only about its value for the individual patient, but about its justification in a health care system that no longer has unlimited resources.

For a patient who needs an anticoagulant after a myocardial infarction, is Ticagrelor (Brilinta), at about $7 a pill, 28 times as good as generic Plavix at about 25 cents a pill? High prices are explained as being necessary to support research, but as I've previously discussed, pharmaceutical manufacturers spend far more on advertising than on research.[7] What is a doctor to do when patients who are largely insulated from a drug's full cost demand expensive new drugs that have little advantage? It is a small consolation that the federal government has finally issued a requirement that all drug advertising must include the price of drugs.[8]

We've always thought it likely that the price of new drugs was determined mainly by what the market would bear, but it now appears that even the prices of many generic drugs have been manipulated. Forty-four states, led by Connecticut, are suing Teva, one of the largest manufacturers of generic drugs, over price fixing.[9]

Finally, in the category of "the more things change, the more they stay the same," is the recent saga of Gilead and Truvada, the drug Gilead markets for Pre-exposure Prophylaxis of HIV-1. A month's supply of Truvada costs roughly $6 to make and sells for more than $1,600 in the United States.[10] Furthermore, Truvada was developed largely with taxpayer dollars.[11]

As a public relations gesture, Gilead has announced that it will donate enough Truvada to treat 200,000 patients a year through 2030. But as the New York Times reported, the major beneficiary may be the company and its stockholders because Gilead is likely to receive a generous tax break for its donation.[12] If the value of that donation is set by Truvada's list price, rather than its manufacturing cost, Gilead could reduce its tax liability by about $1 billion. The donated drugs will cost the company less than $10 million to produce.

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