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# What to Expect from Uniform Pricing of Health Care Services

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## Introduction

Competing health insurance companies usually do not pay the same doctor the same price for the same procedure. Quite often a doctor will get paid one rate from Medica and another from HealthPartners; people who pay out of pocket are charged yet another rate. Large health plans can use their size to negotiate lower prices, which some people argue restricts competition and results in an unfair advantage. To level the playing field, some policymakers suggest that the state should prohibit doctors from charging varying prices and require uniform prices for all payers, with the exception of government health care programs and charity care.[1]

Uniform pricing hopes to fix a number of problems, yet any positive effect may be limited because uniform pricing fails to address their root cause. Moreover, as will be explained here, uniform pricing can lead to unintended consequences, including higher average prices, reduced access, underutilized health care facilities, and more aggravating health plan policies.

## Variable Pricing and Consumer Welfare

Given the right market conditions, variable pricing can benefit consumers. Variable pricing allows sellers to correlate their prices with consumers' demand for products. People with less demand pay less; people with more demand pay more. Rebates, coupons, and sales are traditional methods that businesses use to vary prices among individual consumers. Through these methods, output and consumer welfare are maximized. Variable pricing also allows sellers to reward buyers who agree to reduce the costs associated with transactions, for instance, by buying in volume or by guaranteeing prompt payment.

Despite these good reasons to vary price, providers do not necessarily vary prices in the interest of consumers. Providers mainly offer lower prices in return for higher volume. Yet volume discounts may be more related to a health plan's concentrated buying power than to efficiencies gained from higher-volume transactions. In economic terms, a health plan that has

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concentrated buying power is said to have monopsony power.[2] It's like monopoly power, only in reverse—the buyer holds the power. Like monopoly power, monopsony power allocates resources inefficiently, resulting in less output and what economists call a dead weight loss to society. Practically speaking, this means there are fewer health benefits for consumers or lower quality health benefits.[3] Judge Richard Posner, an expert in applying economics to the law, notes another inefficiency: "The purchaser to whom the [price] discriminating seller sells at a lower price may be no more efficient than the competing purchaser who is charged a higher price."[4] Thus, the main reason that providers vary price may actually harm consumers.

## Monopsony in Minnesota?

Does a monopsony problem exist in Minnesota? National research does find an association between larger discounts and larger market share for Blue Cross Blue Shield (BCBS) plans.[5] Because BCBS maintains a large market share in both the individual (64.4 percent) and small group (44.3 percent) markets in Minnesota, it's reasonable to conclude that BCBS also negotiates larger discounts.[6] Still, discounts alone do not necessarily mean a monopsony problem exists. There needs to be some proof that BCBS plans offer lower quality or fewer health care services—and that proof is a difficult thing to show.[7] Nonetheless, considering BCBS's market share, there's certainly reason to believe a monopsony problem might exist.

## Possible Advantages to Uniform Pricing

Even if a monopsony problem does not exist, proponents of uniform pricing believe the requirement can address a number of difficult problems in the health care market, and they anticipate the following positive effects:

- **Heightened price consciousness.** Uniform pricing can help consumers shop more cost-consciously for health care services by increasing price transparency.
- **Less cost shifting.** Uniform pricing can eliminate cost shifting that occurs when providers charge higher prices to health plans, usually health plans with less market share, to make up for lower prices negotiated by other health plans.
- **Lower administrative costs.** Uniform pricing can reduce administrative costs by eliminating the negotiation process and reducing the number of fee schedules that providers administer.
- **Renewed focus on quality.** By removing a key cost-cutting advantage, uniform pricing can encourage health plans to focus on quality as the mechanism to maintain a competitive advantage.
- **Increased competition among providers.** Uniform pricing can increase competition among providers by encouraging more price competition and by deflating the pressure to consolidate to build up bargaining power against the large health plans.
- **Increased competition among health plans.** Uniform pricing can encourage more health plans to enter Minnesota's market by eliminating existing health plans' price negotiation advantages.

## Intended Advantages May Not Materialize

Upon closer inspection, many of the advantages may not materialize because uniform pricing does not change the fundamental dynamic in the health care market that causes these problems in the first place.

Most of the problems mentioned above, including, limited cost consciousness, high administrative costs, less attention to quality versus cost, and lack of competition, stem from

consumer dependence on employers or government for health coverage. Because employers and the government make the decisions, health plans respond to them, rather than to consumers.

Without changing this market dynamic, familiar problems will remain under uniform pricing. Consumers will not become more cost conscious as long as employers or the government cover most of the costs. Employers and the government—with an eye on global budgets and stock values—will continue to focus on cost far more than on quality. If cost remains the focus, then administrative savings achieved by eliminating the negotiation process would likely be replaced by new administrative costs related to identifying new cost-cutting measures.

Further, removing the incentive to bargain for a lower price does nothing to change providers' unequal bargaining position, and health plans will continue finding ways to exploit it.[8] Thus, providers may continue consolidating to maintain a bargaining position on other important issues, like payment methods, practice guidelines, and physician evaluations.

## Unintended Consequences of Uniform Pricing

Even if uniform pricing can successfully prevent health plans from exercising monopsony power and even if there is some merit to other hoped for advantages (which there is), there are a number of unintended consequences that weigh against uniform pricing.

**Uniform pricing may result in higher average prices.** Instead of being set to the current average, the uniform price may be set higher than the current average. Some studies of uniform gas price regulations arrive at exactly that conclusion.[9] However, the economic literature on price discrimination suggests prices can go up or down depending on the market's structure.[10] The point is that higher prices are a real possibility.

**Increased transparency can facilitate collusion.** Uniform pricing would increase price transparency, which proponents believe would help consumers compare competing services, but it might also lead to collusion among health care providers to maintain higher prices.[11]

**Price increases can disproportionately affect poor people.** Some prices must inevitably level up as other prices level down, and if a larger integrated health care system must charge a uniform price to everyone they serve, then prices for services in lower-income neighborhoods may level up.

**Large integrated health-care systems may leave lower-income neighborhoods.** If uniform pricing results in higher prices at low-income neighborhood clinics operated by large-integrated health care systems, then demand for the clinics' services may decline and the clinics might struggle to maintain a profitable client base.[12]

**Medical facilities may become underutilized.** Uniform pricing can restrict medical facilities from offering lower prices to people willing to use a particular service at a time when facilities are traditionally underutilized, like evenings, weekends, and holidays.[13]

**Health plans may expand the use of aggravating cost-control policies.** Unable to compete on low negotiated prices, health plans may direct their energies to other, often aggravating cost-cutting strategies—like preauthorization requirements, physician evaluations, and treatment guidelines. Worse, health plans might be more tempted to act in bad faith by denying coverage, denying payments, and delaying payments.[14]

This is by no means a comprehensive list. The trouble with unintended consequences is that they're usually unforeseen. Consequently, the

negative impact could be much larger. That said, unintended consequences can also be positive. Furthermore, some of the forgone benefits of variable pricing, such as the ability to encourage efficient utilization of health care facilities, would not be a great loss because few providers actually vary prices for the reasons given here. Nonetheless, as consumers take more control of their health care, providers may find advantages to offering holiday sales for knee surgery and evening discounts for CT scans. Uniform pricing would restrict these innovative pricing strategies.

## Conclusion

Uniform pricing takes aim at a number of serious problems in today's health care market. In many respects, it's a tempting antidote against the power that large health plans wield in the market. Unfair cost shifting might be reduced, smaller health plans might compete on a more level playing field, and health plans might focus more on quality. Consumers might also benefit from additional and higher quality health benefits if a uniform price restrained large health plans from exercising monopsony power. In addition, uniform pricing is simple to legislate and has no direct impact on the state budget. It's easy to see why policymakers take the idea seriously. Yet like most health care issues, uniform pricing is complex and requires policymakers to weigh possibilities, not certainties. Because uniform pricing fails to address the root problem, many desired advantages may not materialize. Moreover, economists have not measured the efficiency loss due to monopsony power or confirmed whether monopsony power exists in the first place. Thus, uniform pricing may be a solution in search of a problem. In light of these uncertainties and in light of possible unintended consequences, uniform pricing may result in substantial harm.

That said, uniform pricing is not a dead-end idea. Judge Posner writes, "If systematic [price] discrimination is a source of net social costs, an effective and inexpensive prohibition would increase social welfare."[15] But Posner acknowledges the limits to knowing if social costs do exist and, therefore, recommends "deferring, probably for a very long time, a decision on whether to institute ... a general ban on systematic price discrimination."[16] Similarly, uniform pricing in Minnesota should be deferred to another day when economists can offer more concrete answers to the issues addressed here.

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## Notes

[1] Minnesota Health Care Transformation Task Force Recommendations, January 2008 available at http://www.health.state.mn.us/divs/hpsc/hep/transform/ttfreportfinal.pdf (accessed April 4, 2008). To be clear, the proposal doesn't call for the government to actually set a price; it just prohibits doctors from varying the price they freely set. So it's not like the government is setting a price floor or ceiling that will lead to surpluses or shortages like price ceilings on gasoline in the 1970s.

[2] *See generally* Herbert Hovenkamp, *Antitrust Law, Vol. XII*, pp. 123-60 (2nd Ed. 2005); Peter J. Hammer and William M. Sage, "Monopsony as an Agency and Regulatory Problem in Health Care," *Antitrust Law Journal*, Vol. 71, No. 3 (2004): 949-88 ("In the classic monopsony model, the buyer faces an upward-sloping supply curve and obtains lower input prices by suppressing the level of its purchases. There is no gain in productive efficiency. A monopsonist health insurer therefore purchases fewer physician services at a lower cost, and lowers output in the final product market (i.e., health insurance benefits)."); and Mark V. Pauly, "Managed Care, Market Power, and Monopsony," *Health Services Research*, Vol. 33, No. 5, Pt. II (December 1998): 1439-60.

[3] Pauly (1998) at 1451.

[4] Richard A. Posner, *Antitrust Law*, p. 203 (2nd Ed. 2001).

[5] Stephen E. Foreman, John A. Wilson, and Richard M. Scheffler, "Monopoly, Monopsony, and testability in Health Insurance: A Study of Blue Cross Plans," *Economic Inquiry*, Vol. 34, No. 4 (October 1996): 662-77; Killard W. Adamache and Frank A.

Sloan, "Competition Between Non-profit and For-profit Health Insurers," *Journal of Health Economics*, Vol. 2, No. 2 (1983): 225-43; Roger Feldman and Warren Greenberg, "The Relation Between the Blue Cross Market Share and the Blue Cross 'Discount' on Hospital Charges," *The Journal of Risk and Insurance*, Vol. 48, No. 2 (June 1981): 235-46. *But see* Michael Staten, William Dunkelberg, and John Umbeck, "Market Share and the Illusion of Power: Can Blue Cross Force Hospitals to Discount?," *Journal of Health Economics*, Vol. 6, No. 1 (March 1987): 43-58.

[6] Minnesota Department of Health, Minnesota Health Care Markets Chartbook, updated July 2007 at http://health.state.mn.us/divs/hpsc/hep/chartbook/index.html (accessed April 7, 2007).

[7] Posner (2001) at 204 ("The limitations of economic science and judicial process make me question how capable antitrust enforcement is of distinguishing systematic price discrimination ... from cost-justified price differences[.]"); and Pauly (1998) at 1451.

[8] Roger Feldman and Warren Greenberg, "Blue Cross Market Share, Economies of Scale, and Cost Containment Efforts," *Health Services Research*, Vol. 16, No. 2 (Summer 1981): 175-83 (finding that high market share increases the probability Blue Cross plans utilize concurrent review and second opinions for surgeries to contain costs).

[9] *See* Michael C. Keeley and Kenneth G. Elzinga, "Uniform Gasoline Price Regulation: Consequences for Consumer Welfare," *Int. J. of the Economics of Business*, Vol. 10, No. 2 (July 2003): 157-68; and William S. Comanor and Jon M. Riddle, "The Cost of Regulation: Branded Open Supply and Uniform Pricing of Gasoline," *Int. J. of the Economics of Business*, Vol. 10, No. 2 (July 2003): 123-43.

[10] *Compare* Daniel P. O'Brien and Greg Shaffer, "The Welfare Effects of Forbidding Discriminatory Discounts: A Secondary Line Analysis of Robinson-Patman," *Journal of Law, Economics, & Organization*, Vol. 10, No. 2 (October 1994): 296-318 *with* Patrick DeGraba, "The Effects of Price Restrictions on Competition Between National and Local Firms," *RAND Journal of Economics*, Vol. 18, No. 3 (Autumn 1987): 333-47; and Michael L. Katz, "The Welfare Effects of Third-Degree Price Discrimination in Intermediate Good Markets," *American Economic Review*, Vol. 77, No. 1 (March 1987): 154-67. *See also* James Langenfeld, Wenqing Li, and George Schink, "Economic Literature on Price Discrimination and its Application to the Uniform Pricing of Gasoline," *Int. J. of the Economics of Business*, Vol. 10, No. 2 (July 2003): 179-93.

[11] Margaret K. Kyle and David B. Ridley, "Would Greater Transparency and Uniformity of Health Care Prices Benefit Poor Patients?," *Health Affairs*, Vol. 26, No. 5 ( September/October 2007): 1384-91 citing George J. Stigler, "A Theory of Oligopoly," *Journal of Political Economy*, Vol. 72, No. 1 (1964): 44-61.

[12] *Id.*

[13] *See* Burton A. Weisbrod, "Some Problems of Pricing and Resource Allocation in a Non-Profit Industry," *The Journal of Business*, Vol. 38, No. 1 (January 1965): 18-28.

[14] Though UnitedHealth Group did not admit to wrongdoing, they agreed to pay $12 million to settle payment disputes in 37 states in September 2007 and they may be on the hook for another $1.3 billion in fines in California. Chen May Yee, "Insurer Settles Case with 37 States," *Star Tribune*, September, 7, 2007, p. D1; and Chen May Yee, "An Angry California Fines UnitedHealth $3.5 million," *Star Tribune*, January 30, 2008, p. A1.

[15] Posner (2001) at 204.

[16] *Id.* at 205. This recommendation was given in the context of using tie-ins—conditioning (tying) the sale of one product to the sale of second product—to facilitate price discrimination. The economic analysis and the limits of that analysis in the context of price discrimination arising from health insurer buying power is similar.