Weekly Checkup

Price Fixing in the Private Market

JACKSON HAMMOND | JULY 28, 2023

Last week, Senator Bernie Sanders (D-VT) introduced the Primary Care and Health Workforce Expansion Act, which would, among other things, enact price controls in private health care and place onerous restrictions on prior authorization requirements. Both these issues deserve attention, but for simplicity's sake, let's focus on the price control aspect of this legislation.

Section 802 of the legislation would prohibit a health care provider or facility from "charging a fee that exceeds the qualifying payment amount, calculated in accordance with section 2799A1(a)(3)(E), for items and services provided in an office setting." Simply put, Section 802 would apply the surprise billing qualifying payment amount – the median in-network plan rate – to services provided at an outpatient department that could be reasonably provided in an ambulatory (read: non-hospital) setting. **In other words, Senator Sanders would place price caps on health care services in the private market.**

Despite the left's claim that market failures require price controls, we have, paradoxically, routinely seen price controls *cause* market failures. The latest example of this is the Inflation Reduction Act's (IRA) price controls (termed "negotiation" by its authors) on the prescription drug industry. The IRA's price control scheme heavily disfavored small molecule drugs, and as noted in a previous Weekly Checkup, both Eli Lilly and Alnylam Pharmaceuticals pulled the plugs on a cancer drug and a rare eye-disease drug, respectively, because of the IRA's price controls. As my colleague Laura Hobbs has discussed, the United Kingdom's National Health Service (NHS) is facing a crisis wherein their price control scheme is expected to *increase* costs due to the constriction of supply and has already caused both Eli Lilly and AbbVie to leave the scheme. Worse, the NHS further expects reduced generic and biosimilar competition that will cause further price increases.

Price controls are the ultimate feel-good policy. "These greedy health care providers won't decrease prices! Let's just ban them from raising them!" The problem is **price controls don't set a ceiling but instead set a floor from which real prices will only go up while simultaneously disincentivizing other providers from trying to compete.** If there's a limit to how much a company can charge, that company isn't going any lower than that limit, even if a competitive market would normally encourage that. Plus, why establish a new health clinic or hospital in an area if it's guaranteed you can't charge more (and, functionally speaking, won't charge less) than the competitor for one service while undercutting their price on another? **Without that competition, we instead get consolidation, which research has shown time and again raises prices for everyone. Better options for reducing the cost of care would be eliminating certificate-of-need laws, cracking down on hospital mergers and monopolies, enacting site-neutral payment reforms, and allowing for physician ownership of hospitals.** All of these policies would work to more efficiently and effectively reduce prices than government diktats.

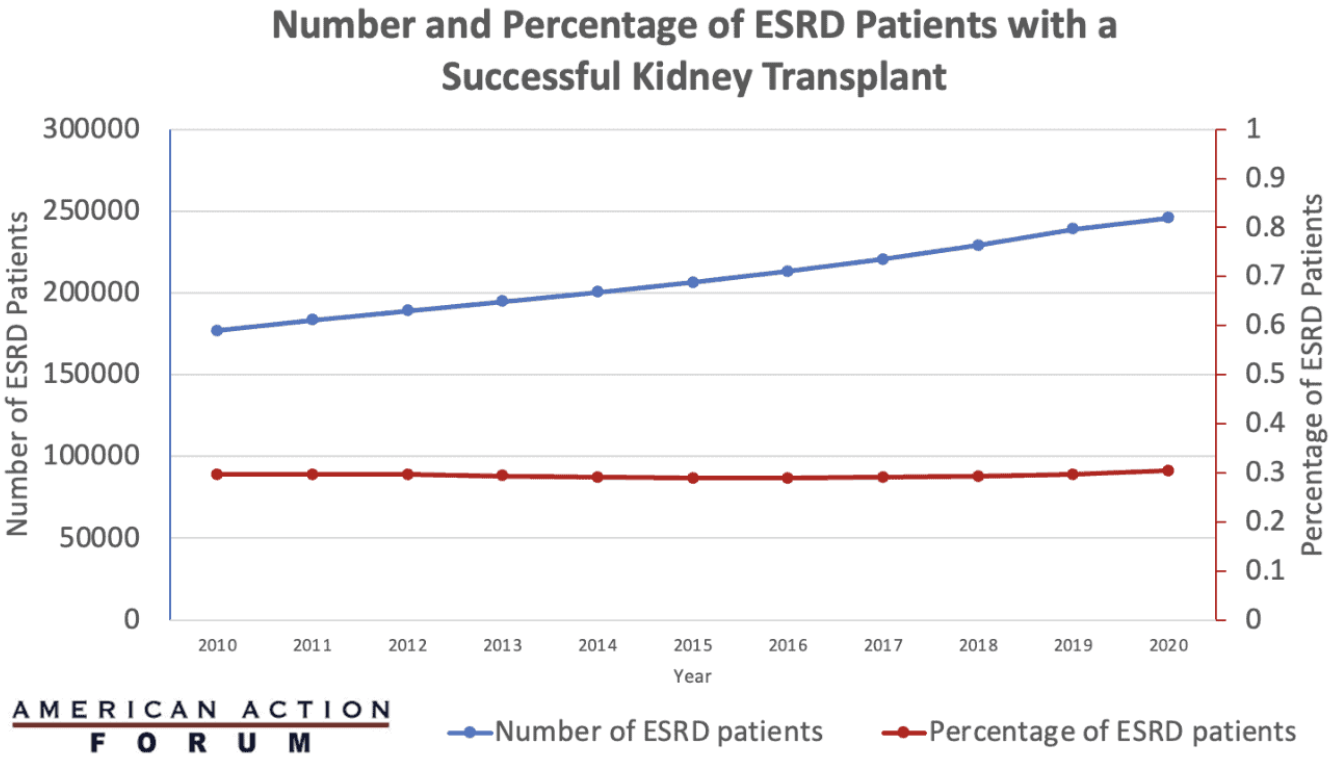
There's also another issue to consider here: Price controls in the private market are steps on the creeping march toward a socialized, single-payer system. Crucial to any socialized system is government price-setting – it's fundamental to the NHS' cost control efforts and for other socialized medical systems around the world. As we've seen with drug pricing bills, it starts with one segment and expands into others. This first bill is a price control for outpatient departments. Soon it will be inpatient departments, and then non-hospital settings, including physician offices. Combine those efforts with the undermining of the private insurance market (which I've discussed here), and it's hard not to see the left laying the groundwork for a socialized, single-payer health care system, and all the problems that come with it.

CHART REVIEW: QUESTIONING THE LAG IN SUCCESSFUL KIDNEY TRANSPLANTS FOR END-STAGE RENAL DISEASE PATIENTS

Sophia Marasco, Health Care Policy Intern

Last week, the Senate Finance Committee's Subcommittee on Health Care highlighted flaws in the practices of the United Network for Organ Sharing (UNOS)—a non-profit under contract with the federal government responsible for managing the nation's transplant waitlist and database—in a hearing titled "The Cost of Inaction and the Urgent Need to

Reform the U.S. Transplant System." This week, H.R. 2544: Securing the U.S. Organ Procurement and Transplantation Network Act, which would allow the Health Resources and Services Administration to run a competitive process for contractors to staff different national Organ Procurement and Transplantation Network functions, was unanimously passed out of the House Energy and Commerce Committee. To further highlight the inefficiencies of the current UNOS-run system, the chart below shows the rates of successful kidney transplants among patients with end-stage renal disease (ESRD)—the most common reason for needing a kidney transplant. As the chart demonstrates, while the number of ESRD patients with a successful kidney transplant increased to more than 245,000 in 2020, the percentage of ESRD patients with a functioning kidney transplant remained unchanged at approximately 30 percent. This suggests that the current transplant program has not produced significant improvements for the ESRD population over the last decade. Time will tell if this new legislation could lead to a greater proportion of ESRD patients receiving successful kidney transplants.



Sources: USRDS