

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Might Patients and Physicians Use Transparent Health Care Prices to Guide Decisions and Improve Health Care Affordability?

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Abstract

Many Americans face high cost-sharing demands from their health insurers. While there is hope that prices for health services are becoming more and more transparent, even increased availability of price information will not always translate into optimal, equitable health and financial outcomes for patients. This commentary on a case argues why transparent pricing is an ethical imperative and identifies steps that health sector stakeholders should take to help patients and clinicians use pricing information to inform health decision making.

Case

NN is a 54-year-old woman with congestive heart failure, type 2 diabetes, hypertension, and chronic kidney disease who is enrolled in a marketplace health insurance plan with a \$6000 annual deductible. Last year, NN was hospitalized for decompensated heart failure. Her out-of-pocket (OOP) expenses for this hospitalization were high, which led to increased credit card debt and required her to spend less on food. Thus, even when NN experiences shortness of breath and leg swelling, she is reluctant to refill her prescribed diuretic. Furthermore, because of her concerns about the costs of her care, she often does not attend follow-up appointments with her physicians and only occasionally completes the laboratory testing they recommend. In her local newspaper, NN reads that hospitals are now required to publicly report to patients their negotiated prices for health care services. She is curious about this information and wonders if it could help with her financial concerns, but she isn't sure where to find this information or how to use it.

Commentary

To benefit from **price transparency**, NN and the clinicians caring for her should discuss NN's insurance deductible, confirm indications for and the necessity of recommended services, canvass which necessary services should have their quality and prices compared in NN's regional market, and consider challenges that could emerge if NN were to receive services at different locations. Using OOP cost estimates from NN's health plan for medications, routine labs, and nonurgent imaging studies (eg, transthoracic echocardiograms), NN's clinicians could revisit her hesitancy to pursue treatment in light of the affordability of available options. Although the kind of

“shopping” needed to take advantage of pricing and quality information that is available and interpretable would not be practical in the case of unpredictable, urgently needed, expensive hospital services, potential benefits of comparing costs for nonurgent services is likely worthwhile.

Health care price information is now more available than ever. A 2019 executive order requiring hospitals to publicly report negotiated prices for health care services became effective on January 1, 2021, and motivates 2 major policy goals.^{1,2,3} First, greater price transparency would allow patients to better predict OOP costs and to decrease OOP spending and might mitigate surprise billing. Second, greater price transparency could have supply-side effects (eg, higher-cost services drop in price to match lower-cost services) and demand-side effects (eg, patients gravitate toward lower-cost services). Both could help constrain health care spending. Regardless of its capacity to further these policy goals, transparent pricing is, we argue, an ethical imperative. We also identify steps that health sector stakeholders should take to help patients and clinicians use this information to inform health decision making. We also identify steps that health sector stakeholders should take to help patients and clinicians use this information to inform health decision making.

Ethics and Equity

Ethical reasons to support greater transparency about what health care services cost patients are numerous and include those discussed here.

Deferred care. As of 2017, nearly half of privately insured adults aged 18 to 64 in the United States were enrolled in a high-deductible health plan (HDHP).⁴ Enrollees in HDHPs who have **chronic conditions** like NN face high OOP costs and commonly delay or forgo necessary services; in 2020, patients experiencing worse health were twice as likely as patients in better health to delay or forgo care due to cost.⁵

Inequitable cost burden. Prior to federal rules mandating price transparency, it was routine for patients to receive a health service without knowing how much it would cost. Financial burdens are disproportionately borne by members of historically marginalized groups, especially patients with low income, no insurance, and multiple chronic conditions.^{5,6} For example, Hispanic adults are more likely to delay or forego care than other groups.⁵ Requirements to disclose services' prices would promote equity by requiring what is a fundamental aspect of transactions in other sectors: people who will pay wholly or partially for a service will know in advance what it will cost.

Financial harm as iatrogenic harm. Physicians are key brokers of a patient's access to health services and should act in a patient's best interest.^{7,8} In the landscape of modern US health care, beneficence requires incorporating **financial information in health decision making**, since ignorance of a patient's financial situation and treatment options' potential financial consequences can result in adverse outcomes.⁹ For example, informed consent to novel therapeutics requires consideration of clinical benefits and harms, a patient's goals and values, and risk of financial toxicity.¹⁰ Health care organizations and insurers—who influence OOP costs and seek payments from patients—should inform patients about services' prices and quality before patients consent to a service.¹¹

Limitations of Price Disclosure

Despite an ethical imperative for transparency, simply providing price information to patients is not enough to reduce OOP cost to patients or decrease overall health spending.^{12,13,14,15} Although the 2019 executive order improved on a prior one that only required charges (rather than payer-specific negotiated rates) to be publicly reported, price comparison tools already offered in many health insurance plans were sparsely used.¹² This finding suggests that patients need user experience support to take advantage of price information that is listed.

Imagine diagnosing a patient with diabetes and recommending medications, supplies, and lifestyle changes without counseling that patient about how to implement those recommendations; we could hardly blame the patient for failing to meet their hemoglobin A1c and self-management goals without adequate support. Aside from direct effects on patients, transparency rules have an as-yet unknown influence on price negotiations and aggregate health care spending. Notably, fiscal transactions in the health sector are more complex than in other areas of commerce. Moreover, price negotiations have ramifications for costs patients face and therefore how much patients spend, regardless of whether patient demand prompts competition in local markets (eg, through patient shopping).¹⁶

Applying Transparency to Practice

The possible market impacts of price transparency, while important, are difficult to predict and will not be discussed further here; we focus instead on price transparency as an opportunity for clinicians and patients to work together to reduce OOP spending, enhance equity, and improve patient-centered outcomes. To realize the promise of greater price transparency, changes will be needed in health care at multiple levels.

Macro-level changes. Patient education initiatives must encourage patients to shop for nonurgent care. One study identified “not having considered” price and quality comparisons as the most common barrier to patient engagement in consumer behaviors.¹⁷ Importantly, after January 1, 2023, health plans will be required to provide personalized OOP cost information and negotiated rates for 500 “shoppable” interventions (eg, prescription drugs, laboratory tests, imaging) that tend to vary little in quality but substantially in price. In January 2024, this requirement will be extended to all health services, necessitating availability to patients and clinicians of quality metrics and aids for interpreting them.¹⁸ Guidance on how to use available metrics—particularly when decisions are made at a point of service during nonemergent clinical encounters—is critical to patients’ ability to maximize the value of their OOP spending. Clinicians-in-training, patient navigators, and social workers should learn to become more comfortable in conducting cost conversations.^{19,20}

Micro-level changes. Cost discussions and price comparison tool use should be incorporated routinely into clinical workflows and service delivery streams. In the absence of new tools created by health care organizations to meet federal transparency requirements,²¹ clinicians should investigate prices for labs and interventions on a case-by-case basis, facilitated by business units responsible for billing and insurance contracts—from which price information for specific interventions by specific clinicians in specific organizations is drawn—so that they can efficiently incorporate relevant, up-to-date cost information in health decision making with patients. Electronic health records should be enhanced to leverage publicly available price information, payer-specific organizational negotiated costs, and insurance plan information to yield accurate,

personalized OOP costs estimates at the point of service. Quality metrics and interpretive guides should be provided, along with price information, so that patients and clinicians can assess costs and benefits of services, given a patient's needs and a clinician's judgment. Such point-of-care assessment will likely influence clinician ordering practices to help reduce costs.²²

Conclusion

In a health system in which patients with minimal health literacy or financial literacy and few resources struggle to afford health care, federal price transparency rules alone are unlikely to reduce financial burdens of care for patients who do not already use price information when care planning.²³ As HDHP enrollment continues to rise and as health services' prices become more transparent, organizations and clinicians should support patients in making cost-informed decisions to maximize affordability of service. By constraining OOP spending, HDHP enrollees' chronic conditions can be more adequately managed to delay, if not prevent, the need for more expensive interventions or hospitalizations.

Clinicians who help patients access needed services have a duty to support patients' access to and interpretation of price and quality information. As interventions to enhance patients' experiences of using transparent information are implemented, data on patients' responses to greater price transparency will be generated; such data should be evaluated to refine transparency strategies. For now, leveraging newly transparent price and quality information to improve access to health services and adherence to recommendations is a step toward promoting equity and affordability of care for all US residents.

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Editor's Note

The case to which this commentary is a response was developed by the editorial staff.

Citation

AMA J Ethics. 2022;24(10):E1034-1039.

DOI

10.1001/amajethics.2022.1034.

Acknowledgements

Dr Kullgren acknowledges grant funding from the National Institutes of Health, the US Department of Veterans Affairs Health Services Research and Development Service, the Veterans Health Administration, the Robert Wood Johnson Foundation, the Donaghue Foundation, the Healthwell Foundation, and the State of Michigan Department of Military and Veterans Affairs. Dr Fendrick acknowledges research support from the Agency for Healthcare Research and Quality, the Gary and Mary West Health Policy Center, Arnold Ventures, the National Pharmaceutical Council, the Patient-Centered Outcomes Research Institute, Pharmaceutical Research and Manufacturers of America, the Robert Wood Johnson Foundation, the State of Michigan, and the Centers for Medicare and Medicaid Services.

Conflict of Interest Disclosure

Dr Kullgren reports receiving consulting fees from SeeChange Health, HealthMine, and the Kaiser Permanente Washington Health Research Institute and receiving honoraria from the Robert Wood Johnson Foundation, AbilTo, the Kansas City Area Life Sciences Institute, the American Diabetes Association, the Donaghue Foundation, and the Luxembourg National Research Fund. Dr Fendrick reports having been a consultant for AbbVie, Amgen, Centivo, the Community Oncology Association, Covered California, EmblemHealth, Exact Sciences, Freedman Health, GRAIL, Harvard University, Health & Wellness Innovations, Health at Scale Technologies, MedZed, Penguin Pay, Rialto, Sempre Health, the State of Minnesota, the US Department of Defense, the Virginia Center for Health Innovation, Wellth, and Zansors. Annika Brakebill had no conflicts of interest to disclose.

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ISSN 2376-6980