



AMA Journal of Ethics®

November 2022, Volume 24, Number 11: E1069-1074

POLICY FORUM: PEER-REVIEWED ARTICLE

Necessity for and Limitations of Price Transparency in American Health Care

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Abstract

Price transparency is an ethical and policy imperative for American health care. More transparent pricing would allow patients and families to make better decisions and would allow clinicians to deliver care with greater simplicity and integrity. This article also considers transparency's real-world patient care limitations and the extent to which price transparency is a reliable pathway to service delivery efficiency and market discipline.

Consensus

I pondered a version of this essay in the waiting area of an outpatient surgical center. I was waiting for my wife, who was undergoing endoscopy to rule out a primary cancer that might have produced an anomalous mass detected in the parietal lobe of her brain. Although I teach health economics, I did not comparison shop for these services. I had no idea how much my wife and I or our insurer would be charged. My out-of-pocket bill could be \$100 or \$1000. Who knew? In that difficult moment, we were experiencing the uncertainty of health care as so many others do. We were blessed that no cancer was found.

Cases in which a patient receives emergency services or important surgical care at an in-network hospital—only to later discover that their particular anesthesiologist or surgeon is out of network (ie, not fully covered by their insurance)—demonstrate how daunting billing surprises can be for patients. Nearly 20% of patients undergoing in-network elective surgery or giving birth receive surprise bills,¹ often for thousands of dollars. In many cases, out-of-network prices are not only unexpected but also markedly higher than prices charged for similar in-network services. Such billing practices undermine public confidence in health care, particularly when **surprise billing** becomes a business model used by physician groups to charge more for their services² than patients and payers would likely tolerate in more transparent exchanges. One indicator of Americans' consensus on the value of price transparency is bipartisan support for the No Surprises Act, which went into effect on January 1, 2022.^{1,3,4}

This article discusses variation in health care prices that drives calls for price transparency, the benefits and limits of price transparency, and the extent to which price transparency is a reliable pathway to service delivery efficiency and market discipline.

Pricing Variation

Vast, seemingly random variation across clinicians' and organizations' pricing and billing practices and some hospitals' lack of compliance with the No Surprises Act have attracted widespread media coverage. A 2021 *New York Times* article, "Hospitals and Insurers Don't Want You to See These Prices,"⁵ offered many examples of seemingly irrational variation in what patients covered by insurers are charged. At the University of Mississippi, a colonoscopy costs \$2144 for patients with an Aetna plan, \$1463 for patients with a Cigna plan, and \$782 for patients without insurance. University of Pennsylvania hospitals charged \$93 for a pregnancy test for patients insured by New Jersey Blue Cross PPO, \$18 for Pennsylvania Blue Cross patients, and \$10 for patients with no insurance.

Some pricing variation might be justifiable on economic or policy grounds. It's not surprising that a hospital would charge less to patients who belong to its own vertically integrated health maintenance organization. Some differences might also be justified as helping cross-subsidize care for patients without insurance. Moreover, Medicare and Medicaid pay lower prices than private insurers, which provides a valuable counterweight to hospitals and other provider organizations that leverage their pricing power against fragmented private insurers to charge insurers (and ultimately patients) prices that far exceed marginal costs.

Other species of price dispersion are more difficult to justify. The pastiche of covert discounts, surprise charges, and opaque billing practices hinders individual patients who are seeking to make sensible decisions or simply understand what they will pay, given their insurance and diagnostic realities. The sheer opacity and complexity of health care prices wastes patients' time and, at times, undermines the legitimacy of the health system itself.

Benefits of Price Transparency

Price transparency could help align patient-consumer welfare and **health equity**: more simplicity and transparency would allow patients and payers to comparison shop and to bear predictable costs. For example, health insurance decision support tools that provide personalized out-of-pocket cost estimates across plans could help patients navigate the challenges of managing care costs, and the results of trials of such tools have been reported.^{6,7,8} These tools' developers, however, acknowledge their limitations, noting that "system-level interventions are needed to lower financial toxicity and help patients manage care costs."⁷ One also hopes that transparent pricing would increase competition, thereby lowering prices of services that are amenable to comparison shopping (eg, hip replacement, hernia surgery, colonoscopy).⁹

Limitations of Price Transparency

When price transparency does not lower prices, control costs, or discipline a health care market in other ways, overreliance on it to curb predatory pricing and billing practices might prove disappointing, and it sometimes has unintended consequences.¹⁰ Price transparency can, for example, facilitate collusion,¹⁰ as happened when the Danish government posted prices of concrete.¹¹ Neither would price transparency address

differences in resources or bargaining power between patients and organizations or between affluent and resource-poor patients.

Another limitation of price transparency is that patients don't or can't always make efficient use of price information to advance their interests on their own or without support in interpreting and applying the information.^{12,13} Patients experiencing the greatest financial need are not always well positioned to benefit from transparency. In nursing home markets, for example, proliferation of quality and pricing information hinders equity when more affluent patients and families are positioned to respond more aggressively to such information.^{14,15} Patients with the most serious illnesses also might not be well positioned to benefit from price transparency, as the burden of comparison shopping falls to ill patients or their loved ones who might be already-overworked caregivers.

Although the No Surprises Act seeks to address out-of-network service billing abuses, several organizations, with the backing of bipartisan support, oppose regulating median in-network reimbursement rates to offer benchmarks for out-of-network billing.¹⁶ These groups argue, implausibly, that such regulations unfairly favor insurers by incentivizing them to lower rates paid to in-network providers and thereby lower out-of-network reimbursement to in-network rates. Such pushback provides a timely reminder that physicians and health care organizations are self-interested political and economic actors within our \$4 trillion health sector.¹⁷

Price transparency also requires us to address **diagnostic and procedure upcoding**, a practice that inflates prices, especially when used by noncritical-access hospitals that treat rural Medicare beneficiaries.¹⁸ Upcoding Medicare Advantage enrollees' diagnoses is common, especially in vertically integrated plans.¹⁹ Such overt departures from price transparency exacerbate pressures on public budgets, violate patient-clinician trust, and are financially toxic to patients.

Policy Solutions

Acknowledging all of price transparency's limitations, greater price transparency might nonetheless improve our health care delivery system, bolster its ethical operation, and improve our health care system's public legitimacy if the following actions are taken.

Clinicians and organizations must recognize their economic self-interests. Clinicians and organizational leaders must acknowledge their roles as economic actors who respond to financial incentives that do not always promote health equity or their patients' interests. Organizations that limit services to Medicaid patients and offer more lucrative reimbursement to affluent patients able to pay higher prices²⁰ have great influence on excess expenditures, patients' and communities' well-being, and health equity. Provider organizations should thus exercise their leverage over medical prices transparently—but, more importantly, in a fair and equitable way.

Supplement price transparency with other measures. Measures to promote greater transparency are valuable complements to, not substitutes for, expanding insurance coverage, increasing Medicaid reimbursement rates, and applying pressure to achieve more disciplined pricing and billing practices, promote efficiency, and protect and support vulnerable patients. When health care expenditures account for one-fifth of the US gross domestic product,²¹ American society requires **lower overall prices**, not merely more transparent ones.

Implement effective, fair price transparency regulations. Policymakers must exercise their supply-side leverage in health care marketplaces to promote transparency and economy that do not require or presume individual clinicians' or health care organizations' self-restraint (eg, to not upcode or deny service to patients insured by Medicaid). Public regulation can implement price transparency more reliably and fairly than unilateral action by clinicians and organizations. Health equity demands that we push these levers hardest and first rather than expecting patients, clinicians, and organizations to address this challenge on their own.

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Citation

AMA J Ethics. 2022;24(11):E1069-1074.

DOI

10.1001/amajethics.2022.1069.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.