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Which Price Should Be Transparent and Why?

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Abstract

Prices private insurers negotiate with health care organizations and clinicians have historically been confidential. Since the early 2000s, privately insured patients have faced increasing out-of-pocket costs and demanded more information about variability in negotiated prices, some of which has slowly become available. This article argues that fragmentation in US health care delivery streams and shortcomings in formal quality measures mean that the value of making prices transparent is in its usefulness as a tool for policymakers and regulators rather than for patients.

Federal Action on Price Transparency

Price transparency in health care has long been a goal of consumer advocates. In 2019, the Trump administration promulgated 2 regulations enabled by the legal authority afforded under Section 1311(e)(3) of the Affordable Care Act and Sections 2715A and 2718 of the Public Health Act to promote price transparency.[1,2] The first rule, which went into effect in January 2021, requires heath care organizations to reveal negotiated prices in a consumer-oriented display and to produce a machine-readable file of these prices. Initial studies have found uneven compliance overall and evidence of selective compliance among the highest revenue heath care organizations.[3,4,5] The second rule, which has been delayed by 6 months but is expected to take effect in July 1, 2022, requires insurers to make publicly available standardized and updated machine-readable data files of negotiated prices, including in-network and out-of-network allowed amounts and billed charges.[6] Effective January 1, 2023, insurers will also be required to offer an online shopping tool for consumers to access both negotiated rates and personalized estimates of out-of-pocket costs for 500 of the most shoppable health care services (ie, services that can be scheduled in advance and are routinely conducted in nonurgent situations).[7]

This article argues that fragmentation in US health care delivery streams and shortcomings in formal quality measures mean that the value of making prices transparent is in its usefulness as a tool for policymakers and regulators rather than for patients.

Why Price Transparency Now?

Although the opaque nature of health care prices has long been noted as problematic,[8] the use of price transparency as a strategy to address rising health care costs is a relatively new development.[9] The rising profile of price transparency reflects changes in the structure of private health insurance plans. Under 1990s style-managed care contracts, patients' out-of-pocket liability was either transparent—fixed copayments for specific services—or limited by relatively low deductibles and out-of-pocket maximums. In the early 2000s, tax policy began to encourage the adoption of high-deductible insurance plans. Under these plans, patients' potential liability for the cost of care increased substantially.[10] By 2020, average deductibles for single coverage in employer-sponsored plans were 4.6 times higher than in 2000 after adjusting for inflation (see Table 1).[11,12,13]

Table 1. Average Annual Deductible for Single Coverage in 2000 and 2020

Deductible	2000	2020	Fold Increase
Average annual deductible, single coverage	$239[11]	$1644[12]	6.879
Inflation-adjusted amount (2020 dollars)[a]	$358	$1644	4.595

[a] Using the CPI inflation calculator from the US Bureau of Labor Statistics, $239 in December 2000 was estimated to have the same buying power as $357.78 in December 2020.[13]

In response to concerns that patients could not appropriately balance the costs and benefits of care without further information, insurers and self-insured employers began in the 2010s to provide price transparency tools within their health plans. While available evidence suggests low utilization of these tools, they offered a proof of concept for the idea of price transparency in the context of empowering consumers.[14,15,16]

The potential value of price transparency was confirmed by an analysis of data on health care prices published in 2013. As part of the Affordable Care Act, a committee of the Institute of Medicine was tasked with analyzing geographic variation in health care spending. The committee identified significant variation in the negotiated prices paid to physicians and health care organizations by commercial insurers across the country.[17] This study spurred a series of such analyses, which showed that negotiated prices varied substantially, even within narrow geographic regions, and often even for the same service provided in the same hospital.[18,19] Moreover, prices were systematically higher in concentrated markets where a few health professionals had stronger negotiating power. This evidence of price variation suggested that reinforcing price-shopping behavior would have the potential to reduce overall health expenditures. It also suggested that unless price was correlated with real differences in quality, markets are not competitive and alternative price-setting mechanisms should be established.

As this history suggests, there can be different rationales for promoting price transparency. Some posit that awareness of prices might lead consumers to budget appropriately and make more efficient choices about service utilization or to favor lower-cost clinicians and health professionals.[20] Others argue that price transparency might improve the negotiating position of private insurers in markets with few clinicians (ie, concentrated provider markets).[21]

Which Price Should Be Transparent?

Different rationales for price transparency imply that different kinds of prices need to be made transparent. If price transparency is intended to help consumers with household

budgeting or with choosing whether to use a given service or not, knowledge of the average cost of a bundle of services might be sufficient for consumers to make decisions about how to finance their care. For all but the simplest health care services, a consumer's out-of-pocket liability will depend on prices of a series of products and services, suggesting the need to make transparent a single price for a predefined bundle of services, which might include inpatient services, clinician time, laboratory tests, diagnostic services, anesthesia, and postacute care. This level of transparency would be very difficult to achieve unless there is a consensus on which services are included in each of a defined set of bundles that combine the services needed to appropriately address a health condition (see Table 2).[22,23,24] While there are efforts to create such bundles (for example, in the Medicare program),[25,26] more typically the components of treatment for specific conditions are offered by different health care professionals, the exact components of an individual patient's care are not fixed in advance of a treatment or procedure, and alterations in the course of treatment during an episode of care will affect a patient's out-of-pocket liability.

Table 2. Cost Components of a Typical Bundle of Services for a Surgical Episode

Hospital Services
Facility costs
Room and board
Supply costs
Operating room
Prescription drugs
Intensive care unit
Blood
Durable medical equipment
Implant
Physical therapy
Recovery room
Laboratory
Radiology
Professional fees
Postacute Care
Inpatient rehabilitation facility
Skilled nursing facility
Home health agencies
Long-Term Acute Care Facilities
Outpatient visits
Professional and physician fees
Hospital readmission

However, if price transparency is intended to enable patients who plan to go ahead with a course of care make an informed choice among provider organizations, they need information on actual prices, or negotiated reimbursement rates, that different provider

organizations will ultimately charge across various services. An out-of-pocket price faced by an individual insured patient in the United States (in most situations) will depend on that patient's insurance plan at a specific point in time (eg, whether the clinician performing the service is in-network, co-insurance and copayment structures, or whether the patient has met a deductible amount or out-of-pocket maximum). Even among patients with the same insurance plan, net out-of-pocket costs can vary significantly.

Finally, if the goal of price transparency is intended to inform public policy (eg, by providing information to policymakers who might impose regulatory limits on unusually high prices), prices of specific services (rather than bundles) might be most informative. Prices at this level can inform our understanding of the effects of market consolidation, competition across geographies, and price-setting behavior.

Unintended Consequences

Although the obstacles to releasing meaningful price information are daunting, analysts also have qualms about the consequences were such data indeed available.[27,28] Patients have more difficulty judging the quality of health care services than the quality of most other goods and services for which they shop. If reliable quality information is not available, patients may inappropriately prioritize low prices over the quality of the services offered by different physicians or heath care organizations. The opposite possibility is also a concern: some patients may interpret high prices as indicative of high quality (as they have been shown to do in other low-information contexts), which would subvert the cost-reduction goals of price transparency initiatives.[29,30] Price transparency thus must be integrated with meaningful quality information to enable informed and patient-centric choices.[31]

A second concern is that information about stand-alone prices may lead to price *increases*. Under current standards, physicians and health care organizations are likely unaware of the precise rates their competitors have negotiated with commercial insurers. Access to new information on their competitors' rates might lead some high-priced physicians and health care organizations to lower their rates, as has been observed in some studies,[32,33] but it could also lead lower-priced physicians and health care organizations to raise their rates, as is evident in other studies.[34] Economists are also concerned that revealing price information could enhance health care systems' efforts to collude in rate setting, as violators of implicit rate-setting agreements will be easily identifiable if negotiated prices are transparent.[35]

What We Need

Under optimal price transparency, patients would have ready access to information on the personal cost of a bundled treatment for a given condition across a range of local physicians and health care organizations, combined with trusted information regarding relative quality. The price transparency rule mandating that insurers compute member- and plan-specific out-of-pocket prices[7] would provide patients with one component of this information. Although information about comparative quality of services would remain limited and contested, patients might be able to combine plan-specific and clinician- and provider-specific price information with external sources of quality information (eg, advice from a primary care physician).

A big worry, from a patient perspective, is uncertainty about how much a bundle of services will cost. It is possible to imagine a hospital offering a binding, pretreatment price for a bundle of services—for example, in England, some heath care organizations

offer an all-inclusive fixed price for knee replacement surgery to private paying customers, including postdischarge care encompassing outpatient care and treatment of complications for 30 days postprocedure[36,37]—but this is not currently the norm in the United States, except under a few demonstration programs of public and private payers.[38,39,40] Construction and pricing of bundles, or episode payment models, involve complex decisions and calculations and requires adequate infrastructure and data, along with constant monitoring and patient education.

Without binding prices for bundles of care, it is hard to see how price transparency will meaningfully change patient behavior. Even for this purpose, rules making negotiated prices transparent will not be a panacea and may have significant side effects. Negotiated health care prices are an imperfect measure of the underlying costs of producing health care goods and services. Prices reveal little about the quality of services or access to care for varied populations. There will likely be substantial variation in the ability of patients to make use of these data. The availability of new data, however, should enable researchers to uncover information on price variation, better understand the pricing structure of the commercial insurance market, and identify potential policy levers to address the costs of care.[41] Regulations on price transparency would likely be most useful in providing information that can be used by public policymakers seeking to address price variation resulting from market inefficiencies rather than by patients struggling with high out-of-pocket costs.

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