



## AMA Journal of Ethics®

November 2022, Volume 24, Number 11: E1099-1106

### VIEWPOINT: PEER-REVIEWED ARTICLE

#### What Should “Shopping” Look Like in Actual Practice?

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##### Abstract

In health care, lack of transparency about the cost of health care services to patients during clinical encounters has contributed to increased costs and high out-of-pocket expenses. Federal policy has responded to the need for more transparency and spurred discussion about ethics and the clinician’s role in being transparent with patients at the point of service. This article investigates and encourages state, private market, and federal policy efforts to address what health care costs patients. This article also applies the ethical framework of principlism to cases and considers what a “shoppable service” model would demand of clinicians in practice.

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##### Necessity of Price Transparency

Health care delivery differs from other consumer-facing services, such as dental, legal, or veterinary services, due to limited price transparency at the point of service.<sup>1</sup> This opacity has contributed to increased costs and associated out-of-pocket expenses and affects patients’ health care decisions, as nearly 33% of Americans in 2019 reported that they or a family member delayed treatment due to cost.<sup>2</sup> As a significant portion of health care costs result from physician-driven patient care decisions,<sup>3</sup> clinicians must increasingly consider their responsibility to address cost. Providing high-value care and considering patients’ financial well-being in shared decision making, especially for “shoppable services,” expands the clinician’s role as a steward of health care resources and as an advocate for patient-centered care.<sup>4</sup> In 2017, shoppable services, defined as “service[s] that can be scheduled by a healthcare consumer in advance,”<sup>5</sup> composed an estimated 36% of medical spending and 43% of out-of-pocket spending.<sup>6</sup> Recent policy efforts by the Centers for Medicare and Medicaid Services (CMS) support price reporting for shoppable clinical and diagnostic services to drive innovation; to facilitate informed, price-conscious decision making; and to promote competition.<sup>5</sup>

## The Current Landscape of Price Transparency

Under the Affordable Care Act of 2010, Congress mandated that US hospitals establish and annually update a public list of standard charges.<sup>7</sup> Unfortunately, standard charges as exemplified by the “chargemaster” represent nondiscounted, fee-for-service list prices that bear little resemblance to negotiated prices, making them unhelpful and inaccurate for predicting patients’ out-of-pocket expenses. Accordingly, Executive Order 13877 of June 2019 directed the Secretary of Health and Human Services to propose regulation requiring hospitals to publicly post charges based on negotiated rates for common shoppable items and services.<sup>8</sup> The subsequent CMS Hospital Price Transparency Final Rule of November 2019 required hospitals to publish a consumer-friendly list of the 300 most shoppable services and expanded the definition of standard charges to include discounted cash prices and payer-specific negotiated rates.<sup>5,9</sup>

Similar efforts at the state level have yielded mixed effects. Since 2004, California state law has required hospitals to make public chargemaster data, publish average charges for the 25 most common inpatient and outpatient procedures, and provide price estimates to uninsured patients who request them.<sup>10,11</sup> However, most hospitals do not comply with providing price estimates when requested,<sup>12</sup> and the legislation had minimal effect on hospital prices, at least in the first 18 months.<sup>13</sup> New Hampshire launched a HealthCost price transparency program in 2007, producing an estimated 5-year savings of \$7.9 million for individuals and \$36.0 million for insurers on imaging studies.<sup>14</sup> However, a subsequent analysis found no decrease in price variation for reported services, including imaging, during the first full year of the program.<sup>15</sup>

Some insurance plans have developed cost estimator tools for their members. One study found that, during 2011-2012, users of Aetna’s Member Payment Estimator were more likely to be younger, healthier, and have higher annual deductible spending and to most often search for preventive screenings (eg, mammography and colonoscopy), childbirth, imaging, and nonemergency outpatient procedures.<sup>16</sup> Following implementation of Castlight Health’s price transparency platform, 18 employers demonstrated a \$124.72 (13.2%) reduction in payment for advanced imaging for users of the platform,<sup>17</sup> and Blue Cross Blue Shield’s price transparency intervention reduced costs by \$220 (18.7%) per magnetic resonance imaging scan in 2012.<sup>18</sup> Thus, the benefits of price transparency accrue to patients who generally have higher out-of-pocket spending for shoppable services. Challenges remain, as price transparency has not fully entered the exam room, where **clinical decisions** incurring patient expenses are made.

## Price Transparency Using the Framework of Principlism

Discussion of price transparency regulation must include its intentional and unintentional ethical consequences for patients, physicians, and health systems. We analyze these challenges using the 4 principles of bioethics applied to 4 cases.<sup>19</sup>

*Respect for autonomy.* Respect for autonomy assumes that rational agents (patients) are involved in informed and voluntary decisions. Consider a case of a woman with severe osteoarthritis contemplating a total knee replacement. As she plans financially, she would like to know that accepting the risk of surgery would be “worth it.” She must choose if the risks and benefits of total knee replacement outweigh those of continuing conservative management with medications and exercise. Given the evidence that patients forgo care due to cost,<sup>2</sup> financial risk should be considered in shared decision

making for this elective procedure. Yet, there are 3 barriers to patients being informed about prices.

First, studies reveal poor compliance with the Hospital Price Transparency Rule, with 65% of the 100 largest US hospitals unambiguously noncompliant and only 5.6% of 500 randomly sampled hospitals compliant with all requirements within the first 2 months of the rule taking effect.<sup>20,21</sup> During the first 5 months the rule was in effect, compliance was greater in for-profit, system-affiliated, large, nonurban facilities and those with greater information technology preparedness.<sup>22</sup> This finding is consistent with a June 2022 study of 5239 US hospitals, which reported that only 729 (5.7%) were compliant with requirements after 6 to 9 months and that greater compliance was associated with lower revenue per patient-day and within unconcentrated health care markets.<sup>23</sup> The general lack of industry compliance was likely in part due to the modest maximum penalty for hospitals who failed to comply, set at \$300 per hospital per day, or \$109 500 per year.<sup>5</sup> Hence, the policy was updated in 2022 by scaling the penalty for larger hospitals to \$10 per bed per day and raising the maximum annual penalty to \$2 007 500 per hospital.<sup>24</sup> In addition to recent legal requirements for price transparency, social contract theory suggests that the patient, the physician, and the profession engage in reciprocal agreements with the public, including an emerging fiduciary duty to provide cost-effective care.<sup>25,26</sup> To do so, health systems should support price transparency efforts and further develop their technology infrastructure to assist with effective implementation. In addition, greater scrutiny of concentrated health care markets and refinement of financial determinants of hospital adherence are needed.

Second, for the patient to be appropriately informed, pricing and associated quality information should be easily understandable and applicable to the decision-making process. Most individuals do not seek pricing information even when tools are available.<sup>16,27</sup> For insured patients, copayments can be constant and hospitalizations might exceed the deductible, which shields insured patients from many of the medical costs and price differences. For this reason, price transparency efforts should focus on copayments and out-of-pocket costs so that patients can make decisions using personalized, salient, and consumer-friendly information. In this way, our health system could alleviate unjust or unrealistic burden on patients in navigating a complex system.

Lastly, patients often rely on physicians for advice about where to receive care and are frequently unwilling to go against a clinician's advice for a copayment difference of \$10 to \$35.<sup>28</sup> Price information should thus be available at the point of care. To realize this goal, physicians will require a supportive environment with specific training and reflective practice.<sup>29</sup>

*Nonmaleficence.* Consider a man with chest pain who, suspicious of a heart attack, searches online for a hospital with the cheapest interventional cardiac procedure. This case highlights the need to focus price transparency on shoppable services, a distinction emphasized in the 2019 Hospital Price Transparency Final Rule. Price transparency can reduce the harms of unnecessary tests and procedures. In one study of primary care physicians, displaying the average Medicare reimbursement rate decreased ordering of 5 laboratory tests by 19% and improved physician knowledge of relative costs without increasing adverse events (although there was no metric to determine clinical appropriateness of forgoing a test).<sup>30</sup> Another controlled clinical trial at a tertiary care hospital presented fee data to clinicians at the time of order entry and reduced test

ordering by 8.6%.<sup>31</sup> Regardless of cost, clinicians should act according to standard of care while avoiding wasteful practice.

*Beneficence.* Beneficence emphasizes the duty to benefit the patient, as well as to take positive steps to prevent harm to and remove harm from the patient. Price transparency can potentially reduce cost, especially out of pocket, which benefits patients directly and potentially health care practitioners and systems operating under risk-based contracts or those directly partnered with a health plan. Consider an expectant mother planning a normal vaginal birth who factors price in her decision but would like to ensure a healthy outcome. To uphold the principle of beneficence, price transparency should be paired with transparency of quality and effectiveness data, which can be less accessible.<sup>32</sup> Publicly reporting quality in the context of price would empower this mother to shop for value and has been shown to stimulate quality improvement activity within hospitals.<sup>33</sup> Hospitals and clinicians committed to high-quality, cost-effective care would profit from increased patronage for these services. Policymakers should commit to promoting cost-effectiveness research in conjunction with price transparency.

*Justice.* Justice can be promoted using a variety of factors, including allocation to each person an equal share, or according to need, effort, contribution, merit, or free-market exchanges.<sup>19</sup> Consider an uninsured man with low-back pain and intermittent numbness of his leg who wonders whether he should have an MRI for further evaluation. Empirical evidence suggests that price transparency leads to lower and more uniform prices,<sup>13</sup> which would benefit this man. In theory, price transparency achieves lower and more uniform prices in 2 ways. First, transparency publicizes the practice of price discrimination, or selling a product at different prices to different groups based on willingness to pay, which primarily affects those who are uninsured or are poor. Secondly, transparency would reduce cost through increased price negotiation by providers.

Finally, adoption of “reference pricing” might incentivize patients to be more engaged consumers. In this model, an employer or insurer pays up to an established maximum price (the “reference price”) for a health care service. Several studies have shown an effective reduction in prices paid by patients after implementation of reference pricing.<sup>34</sup> For knee or shoulder arthroscopy, there was \$2.3 million in savings over 2 years for one large retirement system.<sup>35</sup> Over 3 years, out-of-pocket costs were reduced by \$71 508 (13.8%) for computed tomography and magnetic resonance imaging scans<sup>36</sup> and by \$1.05 million (41.5%) for lab testing for one large employer.<sup>37</sup>

It should be noted that price transparency might not prevent discrimination. If displaying prices to clinicians affects ordering, certain patient groups may be systematically unfairly treated, especially if cost of care is higher for certain insurance types (with higher deductibles or out-of-pocket expenses) or for uninsured patients. However, these disparities exist currently, and the goal of transparent prices is to promote price competition and allow for more informed choices.

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**Citation**

*AMA J Ethics.* 2022;24(11):E1099-1106.

**DOI**

10.1001/amajethics.2022.1099.

**Conflict of Interest Disclosure**

Dr Miller is currently a member of the CMS Medicare Evidence Development and Coverage Advisory Committee and served as special advisor at the Federal Trade Commission in 2015. He has received fees unrelated to the submitted work from the Federal Trade Commission, the Health Resources and Services Administration, the Heritage Foundation, and Oxidien Pharmaceuticals, as well as grant support outside the related work from Arnold Ventures. The other authors had no conflicts of interest to disclose.

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