

What Type of Price Transparency Do We Need in Health Care?

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Under new U.S. Department of Health and Human Services rules, hospitals must post prices for all of their services as of 1 January 2019. This federal mandate is just the latest government foray in price transparency. More than one half of states has passed some form of price transparency legislation (1). The growing bipartisan demand for price transparency taps into frustration with high health care prices in the United States, the confusing way prices are communicated, and exorbitant “surprise bills” when a patient inadvertently sees an out-of-network provider. One hope is that communicating prices will cause patients to shop for lower ones, putting downward pressure on price growth.

Are transparency efforts working, and will the Trump administration's new hospital price disclosure rule help? In a word, no. However, this problem has more to do with how these efforts are being implemented than with the idea of price transparency itself. The new rule mandates that hospitals report their chargemaster prices, but a vast gulf unfortunately remains between these prices and what insurers or patients actually pay. On average, Medicare pays 31% of charges (2). Furthermore, patients do not care what insurers pay—they care about their out-of-pocket payment based on their insurance benefit design.

Another problem with chargemaster price disclosure is that it takes place at the individual service and supply level. Even if patients were motivated to shop for the lowest price, they typically would not shop separately for each bandage, scan, or laboratory test. These costs are usually incurred as part of an episode (such as a knee or hip replacement), and patients are not able to select a bandage from one hospital, an imaging service from another, and a laboratory test from a third. Patients need the bundled price for the entire episode, which chargemaster prices do not provide.

Even providing out-of-pocket episode prices may not tame price growth. Studies show that few patients take advantage of information on price transparency (3). One limitation of most price transparency efforts is that they do not include information on quality (4). Another is that the information is overly complex, including such factors as CPT [Current Procedural Terminology] codes, medical jargon, and facility or professional fees. The biggest barrier may be that most patients defer to their physician on where to obtain care and are loath to override that recommendation on the basis of price (5).

If existing mandates for price transparency are not working, how do we move forward? One strategy is to simplify. The goal is not to force patients to navigate the complex health care billing system and shop for care but to slowly shift them to lower-priced providers. This could be done in a more straightforward way with

benefit design. Requiring patients to pay more when they choose providers with prices above a predefined limit (an approach known as *reference pricing*) has been extremely effective at reducing prices, often yielding savings between 20% and 30% (6). A related strategy is to tier copayments for providers on the basis of relative price. Allowing patients to share in their insurers' savings when selecting a lower-cost provider through financial rewards also could drive some patients to these providers (7).

A second strategy is having providers communicate price information instead of an external Web site or after-the-fact billing statements. There is a moral argument for providing information about what patients will need to pay before they receive care. Every other transaction in our economy operates on this principle. If we want patients to play a role in the health system akin to their role in procuring other goods and services, prices must be available before care is delivered, not weeks to months later. The U.S. Department of Health and Human Services Secretary Alex Azar agrees, stating that patients “ought to have the right to know what a healthcare service will cost—and what it will really cost—before [they] get that service” (8).

Patients want their physicians to be the source of price information. Most patients who seek prices turn to their providers first (5). Dentists already provide prices to patients—why should physicians be any different? Ohio has passed legislation that requires providers to give patients good-faith estimates before they begin nonemergency treatment. This law addresses what patients need, which is a timely estimate of their out-of-pocket costs from the source they depend on (9).

There are many complexities and limitations in any such effort. Price ranges may be needed to reflect uncertainty about the intensity of care required, and caveats may need to be provided in case an unexpected circumstance arises. Calculating a patient's out-of-pocket price for a given service is complicated because it depends on coverage, including how much of the deductible (if any) has been paid. Physicians cannot do this on their own. This effort will require a new infrastructure that allows physician offices to obtain an estimate from a patient's insurer, which will lead to new time burdens on physician offices that are already stretched thin. Moreover, it raises questions about who should provide price quotes. If a primary care provider refers a patient to a specialist, who should provide the quote?

These limitations and complexities have yet to be worked out, but doing so is possible. Many health systems, insurers, and private companies are creating tools for physicians to access out-of-pocket costs for drugs at the time of prescribing (10). These efforts

could be expanded to other services directly ordered by physicians (such as imaging studies and laboratory tests). It will take time, upgrades to technology, and a change in culture to begin to move toward the ideal.

The federal government could facilitate these efforts by changing how Medicare pays physicians. Bundling physician and facility fees and moving to site-neutral payments would make comparing prices easier. This would serve as a model for private insurers to follow. An additional benefit is that the price difference between hospital outpatient care that includes facility fees and outpatient care that does not include these fees would be clearer. It would also help address surprise bills that are driven by the unexpected out-of-network professional fee.

Price transparency ultimately is not helpful if irrelevant prices are provided. We need to move to a system in which patients can turn to their physician for out-of-pocket prices or good-faith estimates before they receive care.

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Disclosures: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M19-0534.

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Ann Intern Med. 2019;170:561-562. doi:10.7326/M19-0534

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