How to Increase Transparency and Promote Value in Healthcare

Information plus Incentives

John S. O'Shea

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Abstract

The cost of healthcare in the United States is a major concern, and the prices of goods and services are a key contributing factor to excessive healthcare spending. However, patients in the United States rarely know what services cost beforehand, preventing them from making informed decisions about the value of the care they receive. Although price transparency tools are widely available, barriers such as a lack of awareness and the current structure of health plan benefits limit their use and effectiveness. Price transparency could have a large impact on the healthcare marketplace and lead to greater competition, increased value, and more efficient allocation of resources, but only if designing a robust incentive structure for consumers is a primary concern. In addition to reforming the current insurance-based system, policymakers should pursue "forward-looking" policies that disrupt the status quo by allowing consumers greater ownership of their healthcare resources and facilitating more direct transactions between consumer and provider.

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Author Affiliation and Contact Information

John S. O'Shea
1301 M Street NW #720
Washington, DC 20005
jsoshea4413@me.com

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How to Increase Transparency and Promote Value in Healthcare:

Information plus Incentives

John S. O'Shea

Introduction

The cost of healthcare in the United States is a major and growing concern for patients, payers, and policymakers alike. National health expenditures are projected to grow at an average annual rate of 5.4 percent over the next decade (2019–2028) and will represent 19.7 percent of GDP by 2028, with price growth for medical goods and services expected to accelerate during the same period.[1] Surveys have reported that roughly 3 in 10 Americans have delayed or forgone seeking medical treatment because of costs.[2] In addition, estimates of the potential additional costs and demand for services from the COVID-19 pandemic underscore the urgent need to reduce unnecessary spending to allow for more appropriate allocation of limited healthcare resources.[3]

Several studies support the claim that the prices of goods and services are a major contributing factor to growing healthcare costs.[4] The *Health Care Cost and Utilization Report* for 2018 shows that from 2014 to 2018, spending grew 18.4 percent, and about three-quarters of the increase was owing to growth in service prices.[5] In the face of this increased spending, patients in the United States rarely know what they will pay for services beforehand, which

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[1] Sean P. Keehan et al., "National Health Expenditure Projections, 2019–28: Expected Rebound in Prices Drives Rising Spending Growth," *Health Affairs* 39, no. 4 (April 2020): 704–714.
[2] L. Saad, "Delaying Care a Healthcare Strategy for Three in 10 Americans," Gallup, December 17, 2018.
[3] Sarah M. Bartsch et al., "The Potential Health Care Costs and Resource Use Associated with COVID-19 in the United States," *Health Affairs* 39, no. 6 (forthcoming, June 2020).
[4] I. Papanicolas, L. R. Woskie, and A. K. Jha, "Health Care Spending in the United States and Other High-Income Countries," *Journal of the American Medical Association* 319, no. 10 (2018): 1024–39. See also Gerard F. Anderson, Peter Hussey, and Varduhi Petrosyan, "It's Still the Prices, Stupid: Why the US Spends so Much on Health Care, and a Tribute to Uwe Reinhardt," *Health Affairs* 38, no. 1 (2019).
[5] Health Care Cost Institute, *2018 Health Care Cost and Utilization Report* (Washington, DC: Health Care Cost Institute, February 13, 2020).

prevents them from making informed decisions about the value of the care they receive. Prices for the same service can differ widely, not only between geographic regions but also because of negotiations between providers and payers.

Because of this variation in pricing, there is renewed interest and intensified pressure for greater price transparency, with the hope that transparency will allow patients to make informed choices, encourage competition among providers, and lead to a more efficient provision of healthcare goods and services. Most empirical studies from other industries find that greater price transparency leads to lower and more uniform prices. However, this evidence may not be directly applicable to healthcare, given the special characteristics of the healthcare market.[6]

Survey results have shown that many Americans, frustrated with the cost of healthcare, are receptive to the concept of price shopping. Although most payers and an increasing number of state legislatures have made price transparency tools available, barriers such as a lack of awareness that the information is available and the current structure of health plan benefits limit their use and effectiveness.[7] It is also clear that simply providing consumers with a list of prices, without changing the current incentive structure, will not change the behavior of consumers or providers and will not lead to greater competition, better value, or more efficient use of healthcare resources.

This paper gives a comprehensive analysis of healthcare price transparency in relation to competition and value in the healthcare marketplace. It begins with a brief overview of the evolution of healthcare financing in the United States and then discusses the current opacity in

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[6] D. Andrew Austin and Jane G. Gravelle, *Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Health Sector* (Washington, DC: Congressional Research Service, July 24, 2007).
[7] Hannah L. Semigran et al., "Patients' Views on Price Shopping and Price Transparency," *American Journal of Managed Care* 23, no. 6 (2017).

healthcare pricing, past and current efforts to make price information available, and incentives to encourage consumers to shop.

The key findings of this analysis are as follows:

- The evolution of healthcare financing in the United States has helped shape a system where escalating prices are the main driver of increases in healthcare spending, while at the same time the system has been remarkably opaque in terms of price information.
- Although price information is becoming more available, few consumers use this information to shop for healthcare that offers better value.
- Shopping for healthcare responds to the type of insurance coverage. Coverage that is more comprehensive provides less incentive to shop.
- Insurance reform using value-based insurance design (VBID), when combined with price transparency, has the potential to encourage the use of high-value care. However, VBID approaches differ substantially in their effectiveness, and all come with varying degrees of tradeoffs.
- Price transparency could have a large impact on the healthcare marketplace and lead to greater competition, increased value, and better allocation of finite resources, but only if designing a robust incentive structure for consumers is a primary concern.

Finally, although excessive healthcare costs present a complex challenge without a simple solution, this paper suggests various policy approaches that need to be considered to enhance transparency in a way that leads to increased competition and greater value in healthcare, including the following:

- Access to enhanced information that goes beyond lists of charges for individual services to include real-time estimates of out-of-pocket costs for an episode of care based on a patient's real-time insurance circumstances.
- Incorporation of meaningful quality measures to help patients make decisions based on value and not price alone.
- Access to information on price and quality at the time of the clinical encounter to promote shared decision-making that includes both the health and financial well-being of the patient.
- Support for private-sector initiatives, such as VBID and direct contracting, that could obviate the need for government intervention.
- Awareness that policies to enhance transparency, competition, and value need to be consistent with larger trends in health reform, such as the development of alternative payment models.
- Urgent reform of the current insurance-based system combined with the development of "forward-looking," consumer-based policies that disrupt the status quo, allow consumers greater ownership of their healthcare resources, and facilitate more direct transactions between patient and provider.

Historical Overview of Healthcare Financing in the United States

The ability to offer a sick or injured person a reasonable chance of survival, let alone a cure following an encounter with a hospital or healthcare "professional," is a relatively recent development. As late as the mid-19th century, for example, much household medicine was identical to hospital treatment, and for those not destitute and alone there was little reason to

pay strangers for the same care that could be provided by family and friends in the comfort of the patient's home with the same or better results.[8]

The introduction of surgical anesthesia, first publicly demonstrated at the Massachusetts General Hospital in 1846, along with the development, beginning in the 1860s, of antisepsis and asepsis, allowed the performance of surgical operations that were considered too complex to be done in the home. With safe and effective operations for common conditions such as appendicitis and tonsillitis, along with specialized obstetrical care and the addition of ancillary diagnostic services such as X-rays and laboratory testing, the hospital was no longer seen as a "place of last resort," and by the 1920s, in an increasingly consumer-oriented society, patients who were more affluent were willing to pay for these services.[9]

Initially, concern about wages lost because of illness was more of an issue than paying for medical care. However, as medicine and especially surgery gained more widespread acceptance, concerns grew over the rising cost of care, prompting the American Association of Labor Legislation to draft a bill for universal health insurance in 1915. In the end, opposition from organized medicine, labor, insurance companies, and business, as well as anti-German sentiment engendered by the entry of the United States into World War I,[10] checked the early efforts to realize compulsory national health insurance.[11]

Although serious discussions about compulsory national health insurance waned during the 1920s, concerns over the cost and distribution of medical care continued. In 1927, the

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[8] Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987), 5.
[9] Rosemary A. Stevens, *In Sickness and in Wealth* (Baltimore: Johns Hopkins University Press, 1989), 107–9.
[10] The first broad-based compulsory health insurance law was enacted by the state of Prussia in 1854 and was extended to workers throughout Germany in 1883 under Chancellor Otto von Bismarck.
[11] R. L. Numbers, *Almost Persuaded: American Physicians and Compulsory Health Insurance, 1912–1920* (Baltimore: Johns Hopkins University Press, 1978), 77.

Committee on the Costs of Medical Care (CCMC) was formed and was charged with conducting a comprehensive study of medical economics. In its final report, issued in 1932, the CCMC cited an increasing inability of middle-class people to pay the cost of modern scientific medicine and made a number of recommendations. Although it endorsed group payment, the CCMC's stance on compulsory health insurance fell far short of endorsement and proposed that individual fee-for-service arrangements should be available for those who preferred them.[12]

The American Medical Association (AMA) treated the CCMC report as a radical document promoting socialized medicine, and Morris Fishbein, editor of the *Journal of the American Medical Association*, called it "an incitement to revolution."[13] Headlines in major newspapers echoed the AMA, and the extreme reaction to the CCMC report left the new administration of Franklin D. Roosevelt feeling that taking on health insurance could jeopardize other New Deal reforms. Consequently, a medical insurance program was not included in the Social Security Act of 1935.[14] However, the private sector responded to the policy vacuum, and the movement for voluntary group prepayment of hospital costs eventually resulted in the establishment of the Blue Cross program, along the lines of the CCMC recommendations.

In 1929, Justin Ford Kimball developed a health insurance plan for Baylor Hospital in Dallas that would become the first expression of the Blue Cross movement, an idea that quickly caught on. At the end of 1933, there were six plans nationwide and 11,500 members, and by the end of 1935, 17 plans were in existence and nearly 213,000 people enrolled.[15]

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[12] Committee on the Costs of Medical Care, *Medical Care for the American People*, Report No. 28 (Chicago: University of Chicago Press, 1932).
[13] Committee on the Costs of Medical Care, "Editorial and Abstract Summary," *Journal of the American Medical Association* 99, no. 23 (1932): 1950–52, 1954–58.
[14] J. S. Ross, "The Committee on the Costs of Medical Care and the History of Health Insurance in the United States," *Einstein Quarterly Journal of Biology and Medicine* 19 (2002): 132, 133.
[15] R. Cunningham and R. M. Cunningham, *A History of the Blue Cross and Blue Shield System* (Dekalb: Northern Illinois University Press, 1997), 19.

The acceptance and rapid growth of prepayment for hospital services quickly created public demand for a complementary system for doctors' services, and in 1939, the California Medical Association created a plan for voluntary private coverage. The California Physicians' Service (operating as Blue Shield of California) became the first prepayment plan for physician services.[16]

Although the depression of the 1930s was a major factor in the initial growth of prepayment for healthcare, developments during and shortly after World War II had the longest-lasting impact on prepayment and provided the basic employment-based health insurance infrastructure that still dominates in the United States. The war created both an expanding economy and a labor shortage as a result of war mobilization. In 1942, Roosevelt created the Office of Economic Stabilization, which imposed wage and price controls that made it difficult for employers to compete for scarce workers. However, through a 1943 executive order, the National War Labor Board approved increases in tax-deductible employee benefits, including health insurance. In 1948 and 1949, the National Labor Relations Board provided a further stimulus to workplace coverage by ruling that health insurance and other employee welfare plans were subject to collective bargaining. Finally, in 1954, the IRS clarified the status of employer-sponsored insurance regarding its exemption from income tax.[17]

Between 1940 and 1960, the total number of people enrolled in health insurance plans grew sevenfold, and by the mid-1960s, approximately 65 to 70 percent of Americans had some

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[16] Cunningham and Cunningham, *A History of the Blue Cross and Blue Shield System*, 45–49.
[17] Thomas C. Buchmueller and Alan C. Monheit, "Employer-Sponsored Health Insurance and the Promise of Health Insurance Reform" (NBER Working Paper No. 14839, National Bureau of Economic Research, Cambridge, MA, April 2009).

form of health coverage.[18] Nevertheless, private insurance remained unaffordable or simply unavailable to many, including poor, unemployed, and elderly individuals. Consequently, interest in creating public health insurance for those left out of the private marketplace persisted.

Before the implementation of the Medicare and Medicaid programs, health expenditures were financed largely by private payers, with out-of-pocket and private health insurance spending accounting for just over two-thirds of all healthcare expenditures. From 1960 to 1965, much of the growth in nominal personal healthcare spending resulted from nonprice factors (such as use and intensity of services), as healthcare prices grew at just 2.1 percent per year on average.[19]

Given a political window of opportunity with a Democratic majority in both houses of Congress, President Lyndon B. Johnson signed the Medicare and Medicaid programs into law in 1965, creating publicly financed insurance for elderly and poor individuals. Medicare was later expanded to cover people with disabilities, end-stage renal disease, and amyotrophic lateral sclerosis (ALS). Medicare was enormously popular from the start. Of the approximately 19 million Americans 65 or older, 93 percent, or 17.7 million, were enrolled in Medicare by the end of the first year.

From the outset, Medicare also proved to be inflationary. For example, in the year between enactment of the Medicare law and its initial operation, the rate of increase in physician fees more than doubled, and in the first year of Medicare's implementation, the average daily

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[18] Robin A. Cohen et al., *Health Insurance Coverage Trends, 1959–2007: Estimates from the National Health Interview Survey* (Atlanta, GA: National Center for Health Statistics, July 1, 2009), 4, table A.
[19] Aaron C. Catlin and Cathy A. Cowan, *Health Spending in the United States, 1960–2013* (Baltimore, MD: Centers for Medicare and Medicaid Services, November 19, 2015), 8.

service charge in America's hospitals increased by an unprecedented 21.9 percent.[20] Growth in healthcare prices accounted for more than 60 percent of the growth in nominal personal healthcare spending (which averaged 14.1 percent annually) each year from 1974 to 1982.[21]

Over the ensuing decades, healthcare spending has fluctuated but has steadily increased as a share of GDP, and policymakers have struggled to rein in healthcare costs, with much of the effort involving the control of prices.

The Role of Pricing in Healthcare

There are a number of factors that have influenced the prices for healthcare goods and services over the years, including consumer demand, provider supply, changes in technology, legislative and regulatory actions, and changes in the wider economy, such as fluctuations in the rate of inflation.

Joseph P. Newhouse has stated that although pricing affects resource allocation and economic efficiency, it cannot be assumed that standard economic models of pricing apply in the medical industry.[22] In addition, payment models are evolving rapidly in an attempt to move away from the traditional fee-for-service model, which reimburses providers a fixed amount for each individual service, to models that aggregate payments to one or more providers for a bundle of services over a period of time or during an episode of care, increasingly linked to some measure of the quality of care. It follows that the ideal basis for determining prices for healthcare is still far from settled. As this transformation evolves, healthcare will often be reimbursed by a

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[20] T. R. Marmor and J. Oberlander, "Medicare at Fifty," in *The Oxford Handbook of US Health Law*, ed. I. Cohen, A. K. Hoffman, and W. M. Sage (New York: Oxford University Press, 2017), 14.
[21] Catlin and Cowan, *Health Spending in the United States, 1960–2013*, 12.
[22] J. P. Newhouse, *Pricing the Priceless: A Healthcare Conundrum* (Cambridge, MA: MIT Press, 2002), 1.

combination of payment arrangements, all with their own set of characteristics and tradeoffs, further complicating the setting and interpretation of prices.

The special features of healthcare point to price being a less important signal than it typically is in other markets, although prices should become more important as the market shifts to insurance arrangements where consumers confront higher out-of-pocket spending. Healthcare by its nature cannot be easily standardized, making price dispersion difficult to evaluate. For example, the process for determining what is included even in common, routine episodes of care, such as vaginal delivery or lower-extremity joint arthroplasty, is not consistent throughout the industry. The need to treat patients as individuals is a basic medical principle. However, the principle conflicts with an idea of "uniform" or "standardized" care, and this resistance to standard definitions makes it difficult to improve transparency to help consumers and other stakeholders meaningfully compare provider prices.[23] An additional consideration is that, as time passes, it is likely that healthcare will become progressively less standardized and more personalized, further challenging an already complicated pricing system.

The organizational complexity of healthcare is another confounding factor. For example, attributing the costs of employing nurses, pathologists, accountants, and billing clerks to specific procedures or patients and the assignment of these costs to specific "cost centers" is not straightforward, and whereas published prices in many other markets may signal the true economic value of goods and services in other parts of the economy, the complexity of many healthcare billing practices complicates consumers' understanding of and response to price differences, inhibiting economic efficiency.[24]

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[23] François de Brantes, Frank Opelka, and Suzanne F. Delbanco, "Embracing Standard Episode Definitions: An Industry Imperative," *Health Affairs* (blog), March 28, 2019.
[24] Austin and Gravelle, *Does Price Transparency Improve Market Efficiency?*

The issue of risk adds another dimension of uncertainty to healthcare markets, since illness is for the most part unpredictable. As noted by Kenneth J. Arrow in 1963, "When there is uncertainty, information or knowledge becomes a commodity. Like other commodities, it has a cost of production and a cost of transmission, and so it is naturally not spread out over the entire population but concentrated among those who can profit most from it." Furthermore, according to Arrow, all the special features of the medical industry that render it unlike other markets stem from this prevalent uncertainty.[25]

Current Opacity in Healthcare Pricing

The reason for the current opacity in healthcare pricing is multifaceted, and the development of this opacity parallels the increasing complexity of healthcare and healthcare transactions in the United States. For one thing, the "true costs" of delivering care are shrouded in layers of terminology, such as cost,[26] price,[27] and reimbursement,[28] as well as complex accounting practices.[29]

Not just patients have been in the dark about healthcare price information. A 2013 study found that only about 16 percent of 102 hospitals contacted between May 2011 and July 2012 were able to give a complete price estimate for a commonly performed elective surgical procedure (total hip arthroplasty). The success rate increased when the hospital and provider

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[25] Kenneth J. Arrow, "Uncertainty and the Welfare Economics of Medical Care," *American Economic Review* 53, no. 5 (1963): 946.
[26] For providers, this is the expense incurred to deliver healthcare services to patients; for payers, it is the amount they pay to providers for services rendered; and for patients, it is the amount they pay out of pocket for healthcare services.
[27] The amount asked by a provider for a healthcare good or service, which appears on a medical bill.
[28] The payment made by a third party to a provider for services.
[29] Vineet Arora, Christopher Moriates, and Neel Shah, "The Challenge of Understanding Health Care Costs and Charges," *American Medical Association Journal of Ethics* 17, no.11 (November 2015): 1046–52.

were contacted separately, but only to about 50 percent.[30] The authors of the study then repeated the survey from June to August 2016 and reported the "sobering evidence" that despite government and industry efforts to improve pricing transparency, they found no evidence of improvement in hospitals' ability to provide price estimates.[31] Regardless of the slow progress, the demand to make healthcare price transparency meaningful has only increased.

Transparency Tools: Access and Use

Surveys show that consumers consider price transparency a major unmet need in the US healthcare system. Of primary interest are prices for hospital services (major procedures and diagnostic tests), physician services, and insurance premiums.[32]

Access

Price transparency sources are widely and increasingly available today. More than half the states require or will require that either insurers or providers make prices available to consumers,[33] and it is estimated that at least half the commercially insured population now has access to some form of healthcare price information.[34] As noted earlier, healthcare pricing is complex, and there is wide variation in how meaningful, useful, or even comprehensible the

[30] J. A. Rosenthal, X. Lu, and P. Cram, "Availability of Consumer Prices from US Hospitals for a Common Surgical Procedure," *Journal of the American Medical Association, Internal Medicine* 173, no. 6 (2013): 427–32.
[31] Safiyyah Mahomed et al., "Changes in Ability of Hospitals to Provide Pricing for Total Hip Arthroplasty from 2012 to 2016," *Journal of the American Medical Association, Internal Medicine* 178, no. 8 (2018): 1132–33.
[32] Paul Keckley, "Price Transparency in Healthcare: What We've Learned, What's Ahead," *Keckley Report*, July 9, 2018.
[33] Lovisa Gustafsson, Shanoor Seervai, and David Blumenthal, "The U.S. Can't Fix Health Care without Better Price Data," *Commonwealth Fund*, May 30, 2019.
[34] Kathryn A. Phillips and Anna Labno, "Private Companies Providing Health Care Price Data: Who Are They and What Information Do They Provide?," *Journal of Managed Care Medicine* 17, no. 4 (October 1, 2014): 75–80.

available price data are for the average consumer. At least half of consumers are not satisfied with the level of healthcare cost information available.[35]

Out-of-pocket costs are most relevant to patients, and the more sophisticated transparency tools attempt to provide this information. However, determining out-of-pocket costs, especially for an episode of care rather than an individual service, presents a greater challenge than simply providing a list of prices. To report out-of-pocket costs accurately requires access to a provider's prices specific to an individual health insurer and real-time access to both the benefit design of the insurer and the patient's health spending to date during the year (e.g., how much of their deductible they have already paid).

In an effort to enhance the quality of the available data and meet the data needs of healthcare consumers, many states are using all-payer claims databases (APCDs), which are centralized data repositories for Medicaid, Medicare, and commercial health insurance membership and claims records, as the basis for their transparency reporting. It is estimated that by 2022 more than half the states will have an APCD or APCD-like database.[36] In 2016, a Supreme Court decision ruled that under the Employee Retirement Income Security Act (ERISA), self-insured plans are exempt from any requirement to submit medical claims data to state APCDs. Although data on a large portion of the population covered under employment-based plans are omitted under the ruling, alternative strategies to preserve the usefulness of APCDs, including providing incentives for voluntary data contributions by payers, are being discussed.[37]

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[35] P. Garg, "Overcoming the Great Price Transparency Divide," *Oliver Wyman*, May 17, 2017.
[36] Joel Ario and Kevin McAvey, "Transparency in Health Care: Where We Stand and What Policy Makers Can Do Now," *Health Affairs* (blog), July 11, 2018.
[37] Gregory D. Curfman, "All-Payer Claims Databases after *Gobeille*," *Health Affairs* (blog), March 3, 2017.

Use

Despite widespread access to transparency tools and general support for the concept of shopping for healthcare services, few people use the tools. Largely because of this, the tools have so far shown limited ability to influence patients to switch to lower-priced providers or to significantly reduce healthcare spending. An analysis of employees at two large companies found that, in the first 12 months after being offered a price transparency tool, only 10 percent of employees used it at least once.[38] Another study found that only 12 percent of employees and retirees in the California Public Employees Retirement System (CalPERS) who were offered a transparency tool used it at least once in the first 15 months after it was introduced. The study found that 2.4 percent searched using the transparency tool at least three times and 3.9 percent searched at least twice. With the exception of the small number of enrollees who searched for prices for imaging services,[39] introduction of the tool failed to meaningfully reduce healthcare prices or spending.[40]

However, according to the 2019 United Healthcare Consumer Sentiment Survey, 37 percent of respondents used the internet or a mobile app to comparison shop for healthcare services. This represents a 257 percent increase from 2012, a trend that is driven in large part by millennials, 50 percent of whom comparison shop. Furthermore, 39 percent of comparison shoppers said the process prompted them to change the healthcare provider or facility (or both) for the service.[41]

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[38] Sunita Desai et al., "Association between Availability of a Price Transparency Tool and Outpatient Spending," *Journal of the American Medical Association* 315, no. 17 (2016): 1874–81.
[39] Only 1 percent of imaging claims were preceded by a search.
[40] Sunita Desai et al., "Offering a Price Transparency Tool Did Not Reduce Overall Spending among California Public Employees and Retirees," *Health Affairs* 36, no. 8 (2017): 1401–7.
[41] United Healthcare, *UnitedHealthcare Consumer Sentiment Survey 2019*, September 24, 2019.

State Initiatives

Since states regulate health insurance and pay for healthcare for many of their residents, it is not surprising that a number of states consider healthcare transparency a major policy concern and provide access to transparency tools, albeit with mixed results.[42] New Hampshire has one of the oldest and most sophisticated tools, which goes beyond posting average APCD-based prices. The New Hampshire Comprehensive Health Information System (CHIS) provides comparative information about the estimated amount that a hospital, surgical center, physician, or other healthcare provider receives for services on an interactive website called New Hampshire HealthCost.[43] The information is specific to that person's health benefits coverage and gives estimates of health costs for uninsured patients as well. Since implementing the program in 2007, the state has seen a modest drop of 1–2 percent in prices for MRIs and other imaging services, which has contributed to a 3 percent reduction in spending for imaging services listed on New Hampshire HealthCost compared to those not listed on the site. The impact of the initiative, however, has been dampened by its low utilization rate (8 percent), prompting the launch of an online advertising campaign aimed at increasing visits to the website.[44]

Launched in spring 2018, CompareCare provides Massachusetts healthcare consumers access to payer-specific provider payment data for 295 common healthcare services, basic

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[42] National Council of State Legislatures, "Transparency of Health Costs: State Actions," March 2017, https://www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx.
[43] NH HealthCost, "Compare Health Costs & Quality of Care in New Hampshire," accessed June 1, 2020, https://nhhealthcost.nh.gov.
[44] "New Hampshire Has Bet Big on Hospital Price Transparency. What Does Its Experience Mean for Trump's Plan?," *Advisory Board*, July 3, 2019. See also Zach Y. Brown, "An Empirical Model of Price Transparency and Markups in Health Care" (Working Paper, University of Michigan, Ann Arbor, August 2019).

quality information about providers, and decision support tools.[45] However, in a 2019 examination of healthcare cost trends, the Massachusetts Office of the Attorney General reported that online cost estimators have had a limited impact on patient selection of high-value healthcare options in the state.[46]

In an attempt to directly engage consumers in a conversation about healthcare costs, Maryland has also launched an ambitious initiative, Wear the Cost, which includes T-shirts with the prices of common procedures such as hip replacement, hysterectomy, and vaginal delivery.[47] Other states have also made substantial progress toward greater availability of healthcare price information, including Colorado, Maine, Minnesota, and Virginia.[48] Recently, several states, including Colorado, Connecticut, Montana, and North Carolina, have introduced or were planning to introduce reference-based pricing designs for select populations.[49]

Recent Trump Administration Initiatives

In 2018, the Centers for Medicare and Medicaid Services (CMS) finalized a rule that went into effect on January 1, 2019, requiring hospitals to make publicly available their "standard charges" for all "items and services."[50] Most hospitals responded to this rule by posting their hospital charge description or "chargemaster" rates. A chargemaster contains the prices of all goods and services, including procedures for which a separate charge exists. However, the

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[45] Center for Health Information and Analysis, Commonwealth of Massachusetts, "Transparency Initiatives," accessed May 13, 2020, https://www.chiamass.gov/transparency-initiatives/.
[46] Office of the Attorney General, Commonwealth of Massachusetts, *Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 12C, § 17*, October 17, 2019.
[47] Robert E. Moffit et al., "The Next Chapter in Transparency: Maryland's Wear the Cost," *Health Affairs* (blog), October 19, 2017.
[48] A. D. Sinaiko, A. T. Chien, and M. B. Rosenthal, "The Role of States in Improving Price Transparency in Health Care," *Journal of the American Medical Association Internal Medicine* 175, no. 6 (2015): 886–87.
[49] Leslie Small, "States Experiment with Health Care Rate Setting," *AIS Health*, October 29, 2019.
[50] 83 Fed. Reg. 41144, 41686 (August 17, 2018).

sheer size and complexity of the chargemaster data, as well as the lack of uniformity in presenting it (spreadsheets for thousands of items), make it nearly impossible for consumers to compare prices for the same service at different hospitals or figure out how much they will have to pay out of pocket. Furthermore, the average price that insurers and patients pay is only a fraction of the charge listed by hospitals.[51] Trying to compare prices using chargemaster rates has been compared to trying to figure out the cost of a car when all you have are widely different prices for individual car parts.[52]

Prompted by an executive order seeking to enhance patients' ability to make informed decisions about their healthcare through greater price and quality transparency,[53] on November 27, 2019, CMS finalized its price transparency requirements for hospitals to make standard charges public.[54] The new rule builds on previous efforts, and for the first time hospitals will be required to make public payer-specific negotiated charges, the amount the hospital is willing to accept in cash from a patient for an item or service, and the minimum and maximum negotiated charges for 300 common "shoppable" services (including 70 CMS specified and 230 hospital selected). The charges are to be posted in a "consumer-friendly" file that must include additional information such as common billing or accounting codes used by the hospital (such as Healthcare Common Procedure Coding System codes) and a description of the item or service to be provided. In addition, the charges are to be bundled whenever possible, meaning they are grouped with charges for any ancillary services the hospital customarily provides with the primary shoppable service. The information must be made public in a prominent location online

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[51] Uwe E. Reinhardt, "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy," *Health Affairs* 25, no. 1 (2006): 57.
[52] R. Pear, "Hospitals Must Now Post Prices. But It May Take a Brain Surgeon to Decipher Them," *New York Times*, January 13, 2019.
[53] Exec. Order No. 13877, 84 Fed. Reg. 30849 (June 24, 2019).
[54] Centers for Medicare and Medicaid Services, *CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates*, November 27, 2019.

that is easily accessible at no cost, is searchable, and describes services in "plain language." To ensure that hospitals meet the requirements, the final rule gives CMS authority to impose civil monetary penalties of $300 per day for noncompliance.[55] Shortly after the rule was finalized, a number of hospital groups filed a lawsuit citing the burden of compliance and challenging the authority of the Department of Health and Human Services (HHS) to enforce the rule.[56] Unless delayed by the legal challenges, the rule will take effect on January 1, 2021.

At the same time that the rule on hospital transparency requirements was finalized, CMS released a proposed rule that set forth recommended requirements for group health plans and health insurance issuers in the individual and group markets to disclose cost-sharing information to enrollees, including an estimate of cost-sharing liability for covered items or services furnished by a provider, in order to give patients a better understanding of their out-of-pocket expenses and promote shopping for items and services. The proposed rule would also require plans to disclose negotiated rates for in-network providers and historical out-of-network allowed amounts. Also included is an incentive program that would allow issuers offering group or individual health insurance coverage to receive credit in the claims and quality-improvement portion of their medical loss ratio calculations for savings they share with enrollees that result from the enrollee's shopping for and receiving care from lower-cost, higher-value providers.[57]

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[55] Centers for Medicare and Medicaid Services, *CY 2020 Hospital Outpatient Prospective Payment System (OPPS) Policy Changes: Hospital Price Transparency Requirements*, November 15, 2019.
[56] Complaint, Am. Hosp. Ass'n v. Azar, No. 1:19-cv-03619 (D.D.C. Dec. 4, 2019); Justine Coleman, "Hospital Groups File Lawsuit to Stop Trump Price Transparency Rule," *The Hill*, December 4, 2019.
[57] The Affordable Care Act (ACA) requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the medical loss ratio. The medical loss ratio provision requires insurance companies that cover individuals and small businesses to spend at least 80 percent of their premium income on healthcare claims and quality improvement, leaving the remaining 20 percent for administration, marketing, and profit. If an issuer fails to meet the minimum standards, it is required to provide a rebate to its customers. See Center for Consumer Information and Insurance Oversight, "Medical Loss Ratio," July 24, 2018, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio; Transparency in Coverage, CMS- 9915 -P, RIN 0938-AU04 (proposed November 12, 2019) (to be codified at 45 C.F.R. pts. 147, 158), https://www.hhs.gov/sites/default/files/cms-9915-p.pdf.

In his February 4, 2020 State of the Union Address,[58] President Trump highlighted the importance of his administration's transparency regulations and the potential of transparency to save money and improve care. It was reported that during the negotiations leading to the coronavirus stimulus package, the administration tried unsuccessfully to include the transparency regulations in the bill.[59] However, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act),[60] which became law on March 27, 2020, does include a provision requiring providers of COVID-19 testing to post their cash prices online.

Can Transparency Lead to Competition and Better Value in Healthcare?

The ultimate goal of price transparency should be to promote competition and more efficient allocation of high-value healthcare services. There are at least two ways that price transparency could achieve this goal. One is that, given the right information, patients will shop for better-value (high-quality, lower-priced) care, and the other is that providers will then compete for patients, not only on the basis of price but ideally also on the quality of care they provide. It is reasonable to think that, given the appropriate set of policies and incentives, greater transparency can be the foundation for greater competition and reduced spending. A 2014 analysis from the West Health Policy Center estimated that implementing a series of transparency policies aimed at physicians, employers, health plans and policymakers, as well as consumers could save as much as $100 billion over a decade.[61] However, it has also been suggested that increased transparency will benefit consumers and lead to better-informed

[58] White House, "Remarks by President Trump in State of the Union Address," February 4, 2020, https://www.whitehouse.gov/briefings-statements/remarks-president-trump-state-union-address-3/.
[59] Peter Sullivan, "White House Pushing to Include Health Price Transparency in Coronavirus Package," *The Hill,* March 24, 2020.
[60] Coronavirus Aid, Relief, and Economic Security Act of 2020, Pub. L. No. 116–136 (2020).
[61] C. White et al., "Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending" (Policy Analysis, West Health Policy Center, Washington, DC, May 2014).

decisions only if the right kinds of information are disclosed. The Federal Trade Commission has raised concerns that too much transparency can harm competition and actually lead to higher prices in any industry, including healthcare.[62]

Whether the concerns about unintended anticompetitive consequences of increased price transparency will be realized is as yet unclear. However, there is ample evidence that simply offering patients access to price information through transparency tools does not lead to lower spending and greater competition. In addition to access, the information needs to be on shoppable services, and patients need an incentive to shop.

Shoppable Services

For a healthcare service to be "shoppable," it must be a common healthcare service that can be researched in advance, multiple providers of that service must be available in a market, and sufficient data about the prices and quality of services must be available.

A study from the Health Care Cost Institute that looked at spending by individuals younger than age 65 who were covered by employer-sponsored insurance found that, at most, 43 percent of the $524.2 billion spent on healthcare by these individuals in 2011 was spent on shoppable services. More relevant for potential healthcare "shoppers" was the finding that shoppable services totaled 48 percent of the out-of-pocket portion of the healthcare bill.[63] Although this represents almost half of out-of-pocket spending, it is a small fraction (7 percent) of total healthcare spending.[64] Based on these findings, the authors of the study concluded that,

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[62] Tara Isa Koslov and Elizabeth Jex, "Price Transparency or TMI?," Federal Trade Commission, July 2, 2015, https://www.ftc.gov/news-events/blogs/competition-matters/2015/07/price-transparency-or-tmi.
[63] A. Frost and D. Newman, "Spending on Shoppable Services in Healthcare" (Issue Brief No. 11, Health Care Cost Institute, Washington, DC, March 2016).
[64] Out-of-pocket spending was 15 percent of total healthcare spending.

overall, the potential gains from the consumer price shopping aspect of price transparency efforts are likely to be modest.

A 2014 study from the National Institute for Health Care Reform that analyzed private insurance claims data from 2011 for about 528,000 active and retired nonelderly autoworkers and their dependents estimated that shoppable services accounted for about one-third of their total healthcare spending if both inpatient and ambulatory services were included. Spending on shoppable services occurred primarily in hospital outpatient departments and physician offices (18.0 percent of total spending) and in imaging and laboratory facilities (9.2 percent of total spending).[65] The authors of the study point out that although the prices of individual ambulatory services are generally far lower than the price of an inpatient hospital stay, ambulatory services collectively are much more common and more substantial from an overall spending perspective, and the potential savings from shopping for outpatient services are greater, than for shoppable inpatient stays.

Adding Incentives to Transparency: Giving Patients "Skin in the Game"

Although making meaningful price information available is a basic and necessary step toward changing behavior, price transparency needs to be combined with compelling incentives to use the information. An additional consideration is that both financial and nonfinancial factors influence consumers' healthcare choices and their willingness to shop. For example, a study from the Yale Institution for Social and Policy Studies found that despite significant out-of-pocket cost exposure, fewer than 1 percent of privately insured individuals used a price

[65] Chapin White and Megan Eguchi, "Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle" (Research Brief No. 18, National Institute for Health Care Reform, Washington, DC, October 2014).

transparency tool to search for the price of lower-limb MRI scans in advance of care and that the influence of referring physicians was significantly greater than the effect of patient out-of-pocket expenses.[66]

There are a number of possible reasons why the use of price transparency tools to shop for better value is so much lower in healthcare than in other industries. One reason is that the structure of health insurance for most patients does not incentivize price shopping. For patients who face little or no out-of-pocket costs, the price at the point of care is largely irrelevant and taking the time to shop for the best price might not be worth the effort. Copayments are generally small and provide little incentive for patients to shop, especially if the copay does not vary depending on the provider chosen. In theory, increasing consumers' exposure to out-of-pocket costs should make them more willing to compare prices, and there is some evidence to support this hypothesis. For example, an analysis of an insured population of nonelderly adults with access to Aetna's member payment estimator, a web-based tool that provides real-time, personalized, episode-level price estimates, showed that patients who incurred higher annual out-of-pocket spending were more likely to use the tool.[67]

There are two main ways that "skin in the game" can be used to influence consumer choices in healthcare: the "stick" of increased out-of-pocket spending through deductibles, limited networks, and reference pricing or the "carrot" of direct financial rewards.

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[66] Michael Chernew et al., "Are Health Care Services Shoppable? Evidence from the Consumption of Lower-Limb MRI Scans" (ISPS Working Paper No. ISPS18-016, Institution for Social and Policy Studies, Yale University, New Haven, CT, July 30, 2018).
[67] Anna D. Sinaiko and Meredith B. Rosenthal, "Examining a Health Care Price Transparency Tool: Who Uses It, and How They Shop for Care," *Health Affairs* 35, no. 4 (2016).

Deductibles

The belief that increasing the amount of out-of-pocket costs that a patient will face will incentivize shopping for healthcare has driven the rapid growth of high-deductible health plans (HDHPs) in recent years. Among persons with private health insurance, enrollment in HDHPs has increased from 25.3 percent in 2010 to 45.8 percent in 2018. Of these enrollees, 20.4 percent were enrolled in a consumer-directed health plan (CDHP), an HDHP with a health savings account (HSA), and the remaining 25.4 percent were enrolled in an HDHP without an HSA.[68]

Although increasing deductibles can encourage the use of a price transparency tool, the evidence that this results in reduced spending is inconsistent, and it is not clear that any spending reductions are the consequence of better healthcare choices. A National Bureau of Economic Research (NBER) study found that although switching enrollees to an HDHP resulted in reduced spending (by as much as 13.8 percent), the spending reduction was not the result of patients shopping for better value, but rather it resulted almost entirely from outright reductions in the quantity of services used.[69] A 2016 analysis of US adults between 18 and 64 years of age who used medical care in the previous year compared rates of shopping for care between HDHP enrollees and people in traditional plans. It found that HDHP enrollees were no more likely than enrollees in traditional plans to consider going to another healthcare professional for their care or to compare out-of-pocket cost differences across healthcare professionals. The authors suggested that simply giving enrollees "skin in the game" by increasing a deductible appears insufficient to

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[68] National Center for Health Statistics, "NCHS Health Insurance Data," July 2019, https://www.cdc.gov/nchs/data/factsheets/factsheet_health_insurance_data.pdf.

[69] Zarek C. Brot-Goldberg et al., "What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics" (NBER Working Paper No. 21632, National Bureau of Economic Research, Cambridge, MA, October 2015), 50.

facilitate price shopping and that if encouraging price shopping is viewed as an important policy goal, innovative approaches to engage enrollees with this information are also needed.[70]

However, after disentangling the effects of HDHPs on provider choice from their effect on negotiated prices,[71] a 2018 study that compared the change in prices for enrollees who switched to HDHPs versus enrollees who remained in traditional plans suggested that HDHPs may shift some enrollees to lower-cost providers, resulting in modest savings.[72] The results also support the findings of other studies that patients are more likely to switch providers for services that they view as a commodity, such as laboratory tests, as opposed to office visits, where they are more likely to have a relationship with a personal physician.

Tiered Networks

According to the 2019 Kaiser Family Foundation Annual Survey of Employer Health Benefits, 14 percent of firms with 50 or more workers that offer health benefits include a high-performance or tiered provider network in their health plan with the largest enrollment.[73] In some markets, the figure may be as high as 27 percent.[74]

In tiered networks, plans designate groups of network providers into levels, or tiers, based on the value—cost, quality, or efficiency—of the care they provide and offer different out-of-pocket costs for consumers according to tier as a way of incentivizing patients to choose high-

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[70] A. D. Sinaiko, A. Mehrotra, and N. Sood, "Cost-Sharing Obligations, High-Deductible Health Plan Growth, and Shopping for Health Care: Enrollees with Skin in the Game," *Journal of the American Medical Association, Internal Medicine* 176, no. 3 (March 2016): 395–97.
[71] Since patients in HDHPs face significant cost sharing and thus might be more price sensitive, providers may be more willing to offer discounts to insurance carriers that predominantly offer HDHPs.
[72] X. Zhang et al., "Does Enrollment in High-Deductible Health Plans Encourage Price Shopping?," *Health Services Research* 53, Suppl. 1 (August 2018): 2718–34.
[73] Kaiser Family Foundation, *2019 Employer Health Benefits Survey*, September 25, 2019, 15.
[74] A. D. Sinaiko, M. B. Landrum, and M. E. Chernew, "Enrollment in a Health Plan with a Tiered Provider Network Decreased Medical Spending by 5 Percent," *Health Affairs* 36, no. 5 (2017): 871.

value providers. In principle, some degree of choice is maintained by allowing the consumer to evaluate the tradeoffs between the selection of a provider and the cost of care, whereas providers may be motivated to improve the value of their care to upgrade their tier status and maintain market share. Tiered networks may be relatively straightforward for consumers to understand compared with some other arrangements, such as reference pricing. But although these networks have shown some promise in incentivizing competition, they are also subject to some limitations.

A study published in the journal *Health Services Research* evaluated the impact of the three-tiered hospital network of Blue Cross Blue Shield of Massachusetts (BCBSMA) that employs large differential cost sharing to encourage patients to seek care at hospitals on the preferred tier. It found that from 2009 to 2012, tiered-network members were more likely than nontiered members to receive care at preferred and middle-tier hospitals. In addition, 44 percent of hospitals changed tiers, mostly from middle to preferred, nearly all because they decreased their prices. The authors proposed that tiered-network designs that feature large enough cost differences between tiers can be successful at steering patients toward preferred hospitals while preserving some degree of provider choice.[75] In a separate analysis, BCBSMA's tiered networks of providers (physicians and hospitals) were associated with a 5 percent decrease in total adjusted medical spending per member per quarter compared to similar plans without a tiered network.[76]

Another study from Massachusetts that assessed the impact of tiered physician networks also produced several important findings. Perhaps not surprisingly, physicians ranked by the plan in the bottom tier (least preferred in terms of value), particularly certain specialists, had a lower

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[75] Matthew B. Frank et al., "The Impact of a Tiered Network on Hospital Choice," *Health Services Research* 50, no. 5 (October 2015): 1628–48.
[76] Sinaiko, Landrum, and Chernew, "Enrollment in a Health Plan with a Tiered Provider Network," 870–75.

market share of new patient visits than physicians with higher tier rankings.[77] However, the effect of tiering appeared to be mainly among patients who chose new physicians, particularly at the lower end of the tier structure. Tier ranking did not appear to persuade patients to switch from physicians they had seen previously, suggesting that loyalty of patients to their "personal doctor" is a stronger consideration than tier ranking.[78]

Although tiered networks show some promise, the cost differentials between tiers need to be large enough to affect consumer choices, and, depending on the market, there may not be enough providers to make the tiers meaningful. For example, it may be difficult to place dominant providers into lower tiers.

Narrow Networks

In contrast to tiered networks, where some degree of consumer choice is maintained, with narrow networks insurers use cost and quality criteria to select healthcare providers from a broader provider network. This effectively limits consumer choice to receiving care from a defined group of healthcare providers or facing very high out-of-pocket costs or even denial of coverage. Narrow networks are less confusing to consumers than reference pricing or even tiered networks, since generally the consumer's main consideration is whether a provider is in or out of network. One possible advantage to providers in narrow networks is a greater ability to manage and coordinate care since patients are less likely to receive care out of network.[79]

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[77] Survey results find that a significant majority of nonelderly US adults do not equate higher prices with higher-quality care. See Ateev Mehrotra et al., "Americans Support Price Shopping for Health Care, but Few Actually Seek Out Price Information," *Health Affairs* 36, no. 8 (2017): 1398, exhibit 4.

[78] Anna D. Sinaiko and Meredith B. Rosenthal, "The Impact of Tiered Physician Networks on Patient Choices," *Health Services Research* 49, no. 4 (August 2014): 1348–63.

[79] For an overview of tiered networks and narrow networks and how they relate to other payment methods and benefit designs, see Suzanne F. Delbanco et al., *Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care* (Washington, DC: Urban Institute, April 2016).

Narrow networks have gained considerable traction in Medicare Advantage (MA), where they include more than one-third of enrollees,[80] and they dominate the Affordable Care Act (ACA) exchanges, where in 2018 they accounted for almost three-quarters of that market.[81] Narrow network plans have shown that they can save money for enrollees, mainly through lower premiums. A 2017 study in *Health Affairs* found that a plan with narrow physician and hospital networks was 16 percent cheaper than a plan with broad networks for both, and that narrowing the breadth of just one type of network was associated with a 6–9 percent decrease in premiums.[82]

However, a survey from the McKinsey Center for US Health System Reform found that 26 percent of the respondents who indicated they had enrolled in an ACA plan were not aware of their selected product's network breadth. In addition, the respondents who reported having selected a narrow network product were more likely than other respondents to have indicated that they picked the lowest-priced product in a given tier, which suggests that price was the key factor affecting their choice.[83]

In contrast to MA and the ACA exchanges, employers have not yet embraced narrow networks to a similar degree, with only 8 percent of firms offering a product that they considered to be a narrow network plan in 2017.[84] One reason for this is the concern about access to care, particularly for patients who live in rural areas or require specialized care. There is good

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[80] Gretchen Jacobson et al., *Medicare Advantage: How Robust Are Plans' Physician Networks?* (Washington, DC: Kaiser Family Foundation, October 5, 2017).
[81] Caroline F. Pearson, Elizabeth Carpenter, and Chris Sloan, *Plans with More Restrictive Networks Comprise 73% of Exchange Market* (Washington, DC: Avalere, November 30, 2017).
[82] Leemore S. Dafny et al., "Narrow Networks on the Health Insurance Marketplaces: Prevalence, Pricing, and the Cost of Network Breadth," *Health Affairs* 36, no. 9 (2017): 1606–14.
[83] Noam Bauman et al., "Hospital Networks: Updated National View of Configurations on the Exchanges" (Center for U.S. Health System Reform, McKinsey & Company, Washington, DC, June 2014).
[84] Kaiser Family Foundation, *2017 Employer Health Benefits Survey*, September 19, 2017.

evidence that, in general, consumers do not understand health insurance plans.[85] Furthermore, the need for healthcare is unpredictable, and if a relatively healthy person chooses a narrow network plan based primarily on the premium without full knowledge of the plan, they could find the network inadequate if faced with a serious illness.[86] There is also concern that narrow networks could exclude high-quality providers, such as academic medical centers, which are often more expensive.[87]

Reference Pricing

Reference-based pricing (RBP), a type of defined contribution for medical services rather than for insurance premiums, has shown considerable promise in terms of motivating patients to shop and stimulating competition among providers. With RBP, an insurer agrees to pay for a healthcare service up to an established maximum price, the reference price. The patient must pay for any costs above that price, so RBP provides incentives for patients to be more involved in their choice of provider. The reference price is ideally set at a level that allows patients to receive care from multiple providers without incurring additional out-of-pocket costs, and insurers also typically provide a list of providers willing to offer the healthcare service at or below the reference price. However, the plan does not contract with a network of providers, and if there is no formal agreement on the reference price, there is no prohibition on balance

[85] George Loewenstein et al., "Consumers' Misunderstanding of Health Insurance," *Journal of Health Economics* 32 (2013): 850–62.
[86] Stephen M. Schleicher, Samyukta Mullangi, and Thomas W. Feeley, "Effects of Narrow Networks on Access to High-Quality Cancer Care," *Journal of the American Medical Association, Oncology* 2, no. 4 (April 2016): 427–28. See also Rimal H. Dossani et al., "Is Access to Outpatient Neurosurgery Affected by Narrow Insurance Networks? Results from Statewide Analysis of Marketplace Plans in Louisiana," *Neurosurgery* 84, no. 1 (January 2019): 50–59.
[87] Les Masterson, "Could Narrow Networks Be the Next Big Cost Cutter?," *Health Care Dive*, January 9, 2018.

billing by physicians and hospitals.[88] For example, the reference price for a nonurgent surgical procedure commonly applies to the institutional portion of costs (the facility fee) but, unless the treating physicians are employed by the hospital, may not include the professional fee for the surgeon and anesthesiologist.[89]

RBP is most appropriate for shoppable services such as drugs, laboratory tests, diagnostic radiology, and some scheduled ambulatory procedures, which are discrete and can be easily priced and compared and where there is little variation in quality. It is inappropriate for emergency services and is not easily employed for more complex conditions requiring multiple services from different providers, such as management of diabetes or complicated surgical procedures.

Unlike plans with deductibles, where patients face out-of-pocket costs from the first dollar, with RBP patients are responsible for the marginal costs when they receive care from a provider whose charges are above the reference price. One potential advantage with RBP is that by shifting the cost responsibility, the anticipated spending reductions will be the result of patients choosing lower-priced providers rather than deciding not to receive services, as may be seen with HDHPs. Theoretically, RBP also gives patients a broader choice of providers than with limited networks, since the patient, rather than the plan, plays a greater role in deciding whether a particular provider is worth the extra cost. However, to avoid potentially catastrophic out-of-pocket costs, patients are likely to need substantial education and support when making those decisions in a complex system.

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[88] Balance billing occurs when patients are billed the difference between the provider's total billed charges and what the health insurance plan allowed and paid.
[89] Peter Boland and David Gibson, "The Promise and the Pitfalls of Reference Pricing," *Managed Care*, May 13, 2014.

Several studies have analyzed the experience of CalPERS, an early adopter of RBP, and the results suggest that RBP can reduce spending not only by incentivizing patients to switch to lower-cost providers but also by incentivizing high-priced providers to lower prices to remain competitive.[90]

James C. Robinson, Timothy Brown, and Christopher Whaley evaluated the ability of RBP to incentivize patients to choose less expensive ambulatory surgical centers (ASCs) rather than higher-cost hospital outpatient departments. After analyzing data from 2009 to 2013 on 2,347 CalPERS cataract surgery patients following implementation of RBP and comparing them to a control group of non-CalPERS patients not covered by RBP, the authors reported that in the RBP group ASC use increased by 8.6 percent, and total employer and employee payments declined by 19.7 percent, compared to the controls. Total savings to CalPERS were $1.3 million in the two years following implementation of the program.[91] Similar findings from the CalPERS experience have been reported for the impact of RBP on other elective procedures, such as total joint arthroplasty and colonoscopy.[92]

Although price transparency tools, even when combined with HDHPs, have had little effect, there is evidence that combining robust price transparency with RBP can amplify patients' incentive to shop and could result in lower prices and an overall reduction in spending. A recent study looked at the experience of the Safeway reference pricing program and compared the

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[90] Ateev Mehrotra, Michael E. Chernew, and Anna D. Sinaiko, "Promise and Reality of Price Transparency," *New England Journal of Medicine* 378, no. 14 (2018): 1351.
[91] James C. Robinson, Timothy Brown, and Christopher Whaley, "Reference-Based Benefit Design Changes Consumers' Choices and Employers' Payments for Ambulatory Surgery," *Health Affairs* 34, no. 3. (March 2015): 415–22.
[92] Dane Brodke et al., "Impact of Reference Pricing on Cost and Quality in Total Joint Arthroplasty," *Journal of Bone and Joint Surgery* 101, no. 24 (December 18, 2019): 2212–18; Marion Aouad, Timothy T. Brown, and Christopher M. Whaley, "Reference Pricing: The Case of Screening Colonoscopies," *Journal of Health Economics* 65 (2019): 246–59.

effects of price transparency alone with the effects of price transparency combined with RBP.[93] Although there was essentially no evidence of price shopping with only the price transparency tool, when RBP was introduced there was a sizable reduction in prices for laboratory tests (27 percent) and imaging (13 percent). However, as the authors of the study point out, they did not specifically examine how use of the price transparency tool influenced the reference pricing results, and they were also unable to estimate the effects of the reference pricing program decoupled from price transparency.[94]

Another study looked at the CalPERS data on prices for colonoscopy, cataract surgery, and some types of joint arthroscopy in order to determine whether providers respond to the shift in consumer demand induced by reference pricing. It found some evidence that providers did respond by lowering prices in order to remain competitive. In addition, as the authors point out, an important aspect of their findings is that the vast majority (over 75 percent) of the provider price reductions that occurred passed to the population that was not covered by reference pricing, which suggests a possible spillover effect and a wider role for increased price transparency.[95] According to Robinson, Brown, and Whaley, the greatest short-term impact of RBP appears to be the ability to shift patients from hospital-based facilities to lower-cost freestanding surgical, diagnostic, imaging, and laboratory facilities. However, over time, RBP may increase pressures for price competition and lead to further innovative cost-reducing approaches.[96]

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[93] In 2010, Safeway provided access to an online price transparency tool for employees and their dependents. In 2011, it added reference pricing for laboratory tests and diagnostic imaging tests.
[94] Christopher Whaley, Timothy Brown, and James Robinson, "Consumer Responses to Price Transparency Alone versus Price Transparency Combined with Reference Pricing," *American Journal of Health Economics* 5, no. 2 (Spring 2019): 227–49.
[95] Christopher Whaley and Timothy Brown, "Firm Responses to Targeted Consumer Incentives: Evidence from Reference Pricing for Surgical Services," *Journal of Health Economics* 61 (2018): 111–33.
[96] James C. Robinson, Timothy T. Brown, and Christopher Whaley, "Reference Pricing Changes the Choice Architecture of Health Care for Consumers," *Health Affairs* 36, no. 3 (2017): 524–30.

Enthusiasm for RBP among payers generated by the CalPERS experience has not translated into widespread implementation of similar initiatives. Surveys by Aon Hewitt reported that only 5–6 percent of employers were using RBP in 2015–2016.[97]

Notable among the concerns is the increased complexity of the program for patients as well as plan administrators. Unlike with narrow networks, where patients can easily find out whether a provider is in or out of network, RBP plans do not contract with a network of providers. Patients need to know whether and to what extent a provider is above the reference price and then decide whether choosing that provider is worth the marginal cost. Ideally, the patient would also have meaningful quality data on the providers under consideration, including hospitals and individual providers.

The potential financial exposure to patients is also a concern. Given the increased complexity of the model, successful implementation of RBP requires a substantial investment in communication and decision support on the part of the plan. Otherwise, if an unwary patient receives services from a provider who does not accept the price set by the plan and balance-bills the patient directly, the patient would need to contest the bill or possibly face substantial out-of-pocket costs. Other considerations are geographic limitations on competition as well as possible exemptions for special-needs patients.[98]

Recent state efforts to introduce RBP for select populations bear watching. In 2016, Montana transferred its state employee health plan to a reference-based reimbursement model with hospital rates set at the reference price of 220–245 percent of Medicare rates. All 11 acute-care hospitals in the state signed on to the plan, and, according to Marilyn Bartlett, who managed

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[97] Aon, *2016 Aon Health Care Survey: Overview of Key Findings*, 2016.
[98] Anna D. Sinaiko, Shehnaz Alidina, and Ateev Mehrotra, "Why Aren't More Employers Implementing Reference-Based Pricing Benefit Design?," *American Journal of Managed Care* 25, no. 2 (2019): 85–88.

the transition and is now senior policy fellow at the National Academy for State Health Policy, Montana's state employee plan went from a projected $9 million deficit to $112 million in reserves by the end of 2017.[99]

An effort to implement similar reforms to the state health plan in North Carolina that would pay hospitals on average 177 percent of Medicare rates has faced considerable challenges. In contrast to Montana, only five hospitals and 28,000 independent providers signed on to the plan, and the initiative has also faced legislative opposition seeking to delay implementation until at least 2022.[100]

Rewards Programs

Some payers are now offering direct financial rewards to incentivize the use of lower-priced providers. If patients choose a designated low-cost provider, they receive a reward that varies according to the service and the provider they choose. In January 2018, a Maine law went into effect requiring some insurers to offer direct rewards initiatives.[101] Several other states, including Ohio, Virginia, and West Virginia, are considering similar proposals.[102] This "carrot rather than a stick" approach should be more attractive to patients and policymakers since, in contrast to initiatives such as reference pricing, it avoids exposing patients to potentially substantial out-of-pocket costs. The Maine legislation has met opposition from insurers, the Maine Hospital Association, and MaineHealth, the largest integrated healthcare system in the

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[99] Sara Hansard, "Insurance Payments Tied to Medicare Intrigue States, Employers," *Bloomberg Law*, August 22, 2019.
[100] Will Doran, "Lawmakers Want to Block a Change That's About to Save State Workers Millions at Hospitals' Expense," *Raleigh News & Observer*, March 1, 2019.
[101] An Act to Encourage Maine Consumers to Comparison Shop for Certain Health Care Procedures and to Lower Health Care Costs, Pub. L. Chap. 232, 128th Maine Legislature (January 2018), https://www.mainelegislature.org/legis/bills/bills_128th/chapters/PUBLIC232.asp.
[102] J. Appleby, "Need a Medical Procedure? Pick the Right Provider and Get Cash Back," *Kaiser Health News*, March 5, 2018.

state. Critics cited concerns that the law could result in patients receiving care of lesser quality or that efforts to coordinate care could be undermined.[103]

Little is currently known about whether rewards programs can steer patients to low-cost providers, pressure providers to lower prices, or reduce spending. One study looked at the impact of the first 12 months of a rewards program implemented in 2017 by 29 employers with 269,875 eligible employees and dependents to augment the telephone and online price transparency tools that were made available to all enrollees. The comparison population was composed of employees (and their dependents) of 45 self-insured employers who did not introduce the rewards program until 2018. Those enrollees in the intervention group who accessed the transparency tools and received care from a designated lower-priced provider for selected services received a check ranging from $25 to $500, depending on the provider's price and the service.[104] In the 12 months after the program was introduced, 8.2 percent of patients in the intervention population used a price shopping support tool, compared to 1.4 percent of patients in the comparison population, and 1.9 percent of services (23.2 percent of patients who used a price shopping support tool) resulted in a reward payment. Overall, the modest 2.1 percent reduction in prices paid for services targeted by the rewards program in the first 12 months following implementation resulted in savings of $2.3 million, or roughly $8 per person, per year. The largest reductions in price were seen in MRIs (4.7 percent) and ultrasounds (2.5 percent), with no observed price reduction among other types of imaging, endoscopy, or surgical procedures. The findings suggest that the "carrots" of rewards programs are less effective in reducing spending

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[103] Colin McHugh, "Testimony in Opposition to LD 445, 'An Act to Encourage Maine Consumers to Comparison Shop for Certain Health Care Procedures and to Lower Health Care Costs'" (Testimony before the Maine State Legislature Insurance and Financial Services Committee, Augusta, ME, April 13, 2017), https://legislature.maine.gov/legis/bills/getTestimonyDoc.asp?id=68659.

[104] There were 131 reward-eligible services, ranging from imaging and minor surgeries to moderate and major surgical procedures.

than the "stick" of, for example, reference pricing. However, rewards programs may be more appealing to employers who want to avoid exposing their employees to possible financial hardship.[105]

Value: It Is Not Just the Price

Convincing consumers to switch providers primarily on the basis of price may not lead to better-value healthcare. Ideally, consumers need meaningful quality data as well. However, easily accessible combined cost and quality data are currently exceedingly rare. According to the Catalyst for Payment Reform's 2017 state report cards on healthcare price transparency and physician quality transparency, only two states, Maine and Oregon, even got passing grades in both the price transparency and quality categories, and there were no states that scored well in both areas.[106] A major factor that contributes to the difficulty of assessing value in healthcare is the general misalignment of quality measures, which burdens providers and often results in quality information that does not help patients make better decisions or help clinicians provide better care.[107] Quality information needs to be aligned with what is most important to patients, which means outcome measures for episodes of care and not an assessment of individual providers on fragmented processes of care. However, the science of healthcare performance measurement has proven to be challenging. For one thing, capturing the necessary information for an episode of care requires the ability to link data from multiple sources, such as electronic health records (EHRs), clinical registries, administrative databases, and patient-reported

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[105] Christopher M. Whaley et al., "Paying Patients to Switch: Impact of a Rewards Program on Choice of Providers, Prices, and Utilization," *Health Affairs* 38, no. 3 (2019): 440–47.
[106] States were graded from A to F. Thirty-seven states received an F in both categories. See François de Brantes et al., *Price Transparency and Physician Quality Report Card 2017* (Ann Arbor, MI: Catalyst for Payment Reform/Altarum, 2017).
[107] Government Accountability Office, *Health Care Quality: HHS Should Set Priorities and Comprehensively Plan Its Efforts to Better Align Health Quality Measures*, October 13, 2016.

outcome surveys. Additional challenges include assigning accountability when there are multiple providers involved in a patient's care and avoiding gaming of the system. Although there are ongoing efforts to overcome these barriers, very little progress has been made in the development of meaningful episode-based quality measures.[108]

Physicians as Patient Advocates

It is absolutely essential to understand how patients respond to efforts to incentivize their choice of lower-cost providers through the use of initiatives such as price transparency and financial incentives, since these decisions can result in reductions in the average price paid per service, even if providers do not respond by reducing their prices. However, in terms of generating meaningful competition, it is at least as important, if not more so, to know how providers respond to these initiatives. Theoretically, if providers respond to patient demand for lower-priced services by lowering their own prices, these reduced market prices could result in further competition and even greater spending reductions, since any reduction in prices will apply to the entire population, not just those using transparency tools to shop.[109] However, while consumer responses to price transparency are becoming better understood, provider responses remain less well studied. Providers may also have intrinsic nonfinancial reasons to respond to information on the cost and quality of their care that reflect professional commitment and go beyond profit maximization.[110]

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[108] Peter S. Hussey et al., "Episode-Based Approaches to Measuring Health Care Quality," *Medical Care Research and Review* 74, no. 2 (2017): 127–47.
[109] Timothy T. Brown and James C. Robinson, "Reference Pricing with Endogenous or Exogenous Payment Limits: Impacts on Insurer and Consumer Spending," *Health Economics* 25, no. 6 (June 2016): 740–49.
[110] Jonathan T. Kolstad, "Information and Quality When Motivation Is Intrinsic: Evidence from Surgeon Report Cards," *American Economic Review* 103, no. 7 (2013): 2875–2910.

A major characteristic that distinguishes healthcare from other markets and influences the consumer response to transparency is the relationship between patients and providers. For example, although patients searching for a new doctor may be more likely to consider cost in their choice, once the relationship is established, patients are reluctant to switch. In a nationally representative survey of nonelderly adults, among respondents who did not consider going to another physician the last time they received medical care, 77 percent reported that this was because they had gone to their provider in the past.[111] Physicians can be thought of as patient advocates and even "purchasers" of healthcare services on behalf of their patients. This is especially true with primary care providers, who order tests and procedures, make referrals, prescribe drugs, and tend to have longer and more personalized relationships with patients.[112]

There have been some efforts to influence physician behavior by making price information available at the point of service (i.e., during the patient-doctor encounter) or at the time the provider orders the service, with mixed results. A 1990 study found that displaying the charges for diagnostic tests in an academic primary care medical practice significantly reduced the number and cost of tests ordered, especially for patients with scheduled visits.[113]

More recent studies have not duplicated those findings. Results from the Pragmatic Randomized Introduction of Cost data through the Electronic health record (PRICE) trial found that displaying Medicare *allowable fees* for inpatient laboratory tests in the EHR did not lead to a

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[111] A. Mehrotra et al., "Americans Support Price Shopping for Health Care, but Few Actually Seek Out Price Information," *Health Affairs* 36, no. 8 (2017): 1397.
[112] Anna D. Sinaiko, "Clinicians and Health Care Price Transparency—Buyers vs Sellers?," *Journal of the American Medical Association Internal Medicine* 178, no. 8 (2018): 1133–34.
[113] William M. Tierney, Michael E. Miller, and Clement J. McDonald, "The Effect on Test Ordering of Informing Physicians of the Charges for Outpatient Diagnostic Tests," *New England Journal of Medicine* 322, no.21 (1990): 1499–1504.

significant change in overall clinician ordering behavior or associated fees.[114] Another study found that displaying *paid-price* information did not alter how frequently primary care and specialist clinicians ordered imaging studies and procedures within an accountable care organization (ACO).[115]

In the first nationwide study to examine how healthcare providers respond to online price transparency tools, Christopher Whaley examined changes in provider prices for two common healthcare services: laboratory tests and office visits. Similar to findings for consumer responses, there was only a small price change for office visits but a meaningful price reduction for laboratory tests. For every 10 percent increase in access to an online price transparency platform, there was a 1.7 percent decrease in laboratory test prices but no significant change in prices for office visits.[116]

Although the results appear to show only a modest ability for price transparency tools to lower provider prices, it is important to note that the provider response occurred even though only a very small share of the population was engaged in active shopping. Furthermore, the provider response (lower prices) passed to the population as a whole, not just to the shoppers. This supports the notion that even if the consumers who are actively shopping and making provider decisions based on their shopping results constitute a small share of the overall market, their price shopping behavior could disproportionately influence provider pricing. This suggests that price transparency may have the potential to promote competition beyond what is reflected in the numbers.

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[114] M. S. Sedrak et al., "Effect of a Price Transparency Intervention in the Electronic Health Record on Clinician Ordering of Inpatient Laboratory Tests: The PRICE Randomized Clinical Trial," *Journal of the American Medical Association Internal Medicine* 177, no. 7 (2017): 939–45.
[115] Alyna T. Chien et al., "A Randomized Trial of Displaying Paid Price Information on Imaging Study and Procedure Ordering Rates," *Journal of General Internal Medicine* 32, no. 4 (2017): 434–48.
[116] Christopher Whaley, "Provider Responses to Online Price Transparency," *Journal of Health Economics* 66 (July 2019): 241–59.

Policy Considerations

Advancing the use of healthcare price transparency to promote competition and greater value will require a multifaceted policy approach. The primary goal of transparency should be patient centered: it should enable patients to make choices that will improve the value of the care they receive. Additional implied benefits include greater competition in the healthcare marketplace and more efficient allocation of healthcare resources. Efforts to improve transparency also need to consider overall trends in clinical medicine as well as healthcare payment and delivery reforms.

Better Information for Better Choices

To paraphrase Kenneth Arrow, the most fundamental commodity for making better choices in an uncertain environment such as the healthcare marketplace is better information.[117]

Given the concerns over the current opacity in healthcare pricing, the wide disparity in prices for the same service, and the evidence that private-sector efforts to address the problem so far have produced modest results at best, government intervention seemed inevitable. The recently finalized hospital transparency rule from the Trump administration (see note 53) makes an important advance over the previous effort by moving beyond the requirement to post largely unhelpful chargemaster rates for all goods and services to posting prices that are more useful to healthcare consumers and focusing on shoppable services. But the rule faces legal challenges that could delay its implementation, and even if implemented, it will do little to promote competition or reduce healthcare spending unless it is accompanied by additional measures to incentivize healthcare consumers to shop for better value. However, the rule could serve as a disruptive

[117] Arrow, "Uncertainty and the Welfare Economics of Medical Care," 946.

force that will stimulate private-sector approaches that can supplant the need for further government intervention.

Beyond the Price List: Adding Incentives

The evidence to date clearly shows that in addition to price information, consumers need compelling incentives to use the information to shop for high-value care. As discussed earlier, a number of insurance reform initiatives have attempted to engage consumers and encourage shopping for healthcare with variable, but mostly modest, results, and all come with their own set of tradeoffs (see table 1). The critical challenge for policymakers in designing an incentive-based model is to include a large enough incentive to get consumers' attention while not exposing them to disproportionate and possibly unexpected financial risk.

Table 1. Value-Based Insurance Design Models

Model	Pros	Cons	Adoption	Potential to promote competition/reduce spending
High-deductible health plans	• Easy to administer • Increase price sensitivity • Can encourage shopping for some services (lab tests, not office visits)	• Effect on quality of care is unclear	• Rapidly growing (45.8% in 2018)[a]	• Good potential, but results are inconsistent • Spending reductions may be owing to forgoing care rather than making better health decisions
Tiered networks	• Straightforward for consumers to understand • Maintain some consumer choice	• Need a large cost differential between tiers to be effective • Need enough providers to make tiers meaningful	• As high as 27% in some markets[b]	• Modest potential for hospital choice • For physician choice, effect mainly among patients who choose new physicians, particularly at the lower end of the tier structure

(continued on next page)

Model	Pros	Cons	Adoption	Potential to promote competition/reduce spending
Narrow networks	• Easier for consumers to understand than tiered networks or RBP • Easier for providers to manage and coordinate care (most patients stay in network) • Reduce costs for consumers (premiums)	• Limit consumer choice/shopping • May limit access, e.g., rural areas and specialized services • Could exclude high-quality, higher-cost providers (teaching hospitals) • Hard to exclude a dominant provider	• High in MA (>33%)[c] and ACA exchanges (~75%)[d] • Otherwise low (8%)[e]	• Limits consumer shopping to in-network providers • Potential for reductions in spending through increased payer negotiating leverage
Reference-based pricing (RBP)	• Unlike deductibles, no front-end costs • Patients responsible only for marginal costs above reference price • Preserves consumer choice • Incorporates price transparency	• Complex for plans to administrate and consumers to understand • Patients need education and support • Potential risk of sizeable unexpected out-of-pocket costs	• Low (5–6% of employers)[f] • Some adoption at the state level[g]	• Good potential for increasing patients' incentives to choose less expensive providers • Some potential to increase providers' incentives to lower prices • Spending reductions are more likely because of choosing lower-cost providers rather than forgoing care
Rewards programs	• More attractive to patients and policymakers • Avoid exposure to increased out-of-pocket costs	• Could result in patients receiving care of lesser quality or undermine care coordination efforts	• Low • Recent legislation in several states could increase adoption[h]	• Modest potential • Limited data

Sources: [a] National Center for Health Statistics, "NCHS Health Insurance Data," July 2019, https://www.cdc.gov/nchs/data/factsheets/factsheet_health_insurance_data.pdf.
[b] A. D. Sinaiko, M. B. Landrum, and M. E. Chernew, "Enrollment in a Health Plan with a Tiered Provider Network Decreased Medical Spending by 5 Percent," *Health Affairs* 36, no. 5 (2017): 871.
[c] Gretchen Jacobson et al., *Medicare Advantage: How Robust Are Plans' Physician Networks?* (Washington, DC: Kaiser Family Foundation, October 5, 2017).
[d] Caroline F. Pearson, Elizabeth Carpenter, and Chris Sloan, *Plans with More Restrictive Networks Comprise 73% of Exchange Market* (Washington, DC: Avalere, November 30, 2017).
[e] Kaiser Family Foundation, *2017 Employer Health Benefits Survey*, September 19, 2017.
[f] Aon, *2016 Aon Health Care Survey: Overview of Key Findings*, 2016.
[g] Sara Hansard, "Insurance Payments Tied to Medicare Intrigue States, Employers," *Bloomberg Law*, August 22, 2019.
[h] J. Appleby, "Need a Medical Procedure? Pick the Right Provider and Get Cash Back," *Kaiser Health News*, March 5, 2018.

RBP may have some advantages over other incentive-based benefit designs and seems to show the greatest potential to generate savings, by motivating consumers to shop and even incentivizing providers to lower prices. Unlike HDHPs, spending reductions under RBP are likely to reflect consumers switching to lower-cost providers rather than reducing utilization of possibly beneficial services. As a type of defined contribution arrangement, RBP also stresses consumer choice over plan choice and encourages patients to take an active role in their healthcare decisions. As discussed, a number of states have implemented or are planning to implement RBP for select populations. However, before considering wide-scale implementation, policymakers need to address the complexity of administering an RBP program as well as the potential financial risk to patients. "Standardizing" and pricing clinical services, especially for episodes of care, and making sure that providers adhere to reference prices without a formal agreement are major challenges. James C. Capretta has proposed a mechanism whereby the federal government could implement RBP on a national scale by establishing a federally required price list for standardized medical services and requiring providers to comply with the price list as a condition of Medicare participation.[118]

Sinaiko, Alidina, and Mehrotra conducted a qualitative study of employers' views of RBP and suggested strategies that could support wider adoption, including reducing the complexity of the program for consumers by exempting certain categories of procedures or low-cost providers,[119] establishing out-of-pocket maximums for RBP so that patients are not at risk

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[118] James C. Capretta, "Toward Meaningful Price Transparency in Health Care" (AEI Economic Perspectives, American Enterprise Institute, Washington, DC, June 26, 2019).

[119] For example, a procedure done at a freestanding ambulatory surgical center (ASC) is generally significantly less costly than the same procedure done at a hospital-based outpatient department (HOPD). If patients choose to have an outpatient procedure, such as a colonoscopy or cataract surgery, at a lower-cost ASC, they would know that all costs would be covered and they would not need to know the reference price. A procedure done at an HOPD would be subject to the reference price limit.

of catastrophic costs, and enhanced education and decision support, especially in the early phase of implementation.[120] However, private-sector employers facing increased competition for workers may need to consider approaches such as tiered networks or rewards programs that, although they have less potential to reduce savings, are also less likely to be viewed negatively by prospective employees.

The insurance-based system of healthcare financing in the United States is well entrenched and is unlikely to be completely discarded in the near term. Therefore, policymakers should continue to refine initiatives that attempt to add incentives by reforming traditional insurance structures. However, as a longer-term strategy to maximize the benefit of price transparency and promote competition and value, policymakers should pursue more "forward-looking" policies that disrupt the traditional insurance-based system by allowing consumers greater ownership of their healthcare resources and facilitating more direct transactions between consumer and provider.

Direct Contracting

The low utilization rates and efficacy of transparency tools, even among their employees who have some "skin in the game" through HDHPs, have prompted some employers to cut out the middleman and contract directly with providers in order to secure lower prices and reduce spending.[121] The experience of the Amish community has been used to illustrate how, by negotiating directly with providers without the intervention of government or third-party payers, they have been able to obtain and use clear and competitive pricing from providers to

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[120] Sinaiko, Alidina, and Mehrotra, "Why Aren't More Employers Implementing Reference-Based Pricing Benefit Design?," 88.
[121] Stephen Miller, *Direct Contracting with Health Providers Can Lower Costs* (Alexandria, VA: Society for Human Resource Management, October 12, 2018).

pay for healthcare. Although the Amish represent a small segment of the population, with a strong sense of community, and their experience may not be generalizable to the larger population, the example should prompt policymakers to take full advantage of the potential of transparency by supporting financing arrangements that give consumers greater control of their healthcare resources and allow them to disrupt the status quo and enter into innovative direct contracting arrangements with providers.[122]

Leveraging the Patient-Doctor Relationship

Increased price transparency has the potential to incentivize consumers to choose lower-cost providers, although, as noted, once the choice of provider is made, patients are reluctant to sever the relationship. However, the patient-doctor relationship needs to be seen as a true asset, not as a barrier to competition in the healthcare marketplace. A positive patient-provider relationship has been linked to better clinical outcomes because patients are more likely to adhere to recommended treatments and maintain continuity of care.[123]

Transparency should ideally lead to enhanced shared decision-making that considers not only patients' clinical well-being but also their financial security. Along with patients' clinical information, the EHR should include real-time insurance information, including benefits, copays, coinsurance, and where patients are in meeting their deductible. This information would give patients and their personal healthcare providers greater ability to fully assess treatment options. Since the healthcare industry is currently at least several years away from providing access to

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[122] K. Rohrer and L. Dundes, "Sharing the Load: Amish Healthcare Financing," *Healthcare* (Basel) 4, no. 4 (2016): 92.
[123] David H. Thom, Mark A. Hall, and L. Gregory Pawlson, "Measuring Patients' Trust in Physicians When Assessing Quality of Care," *Health Affairs* 23, no. 4 (2004): 124–32.

this type of information, policymakers should explore ways to incentivize coordinated efforts to make this information available.[124]

Transparency in the Context of Payment and Delivery Reform

In addressing the current deficiencies in price (and quality) information, policymakers, both public and private, need to develop strategies in the context of overall trends in the healthcare system. Both Alex Azar, HHS secretary, and Seema Verma, administrator for CMS, have stated a commitment on the part of the Trump administration not only to improve healthcare transparency but also to continue the movement to value-based healthcare by moving away from traditional fee-for-service arrangements toward alternative payment models (APMs) of coordinated team-based and population-based care, with aggregation of payments to support those care delivery models.[125] According to the Health Care Payment Learning and Action Network (HCP-LAN), 35.8 percent of total US healthcare payments were tied to category 3 and 4 APMs in 2018, having steadily increased from 23 percent in 2015.[126]

In order for transparency efforts to be consistent with this trend, several things are needed. First is a standardized way to define episodes of care. Although efforts are under way to create episode definitions through the use of "grouping logic" that uses administrative claims

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[124] For a further discussion of how this information could be incorporated into the EHR, see B. J. Miller, J. M. Slota, and J. M. Ehrenfeld, "Redefining the Physician's Role in Cost-Conscious Care: The Potential Role of the Electronic Health Record," *Journal of the American Medical Association* 322, no. 8 (2019): 721–22.

[125] Alex M. Azar II, "Remarks on Value-Based Transformation to the Federation of American Hospitals," March 5, 2018, https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-on-value-based-transformation-to-the-federation-of-american-hospitals.html; Seema Verma, "Remarks by Administrator Seema Verma at the America's Health Insurance Plan's (AHIP) 2019 National Conference on Medicare," September 24, 2019, https://www.cms.gov/newsroom/press-releases/remarks-administrator-seema-verma-americas-health-insurance-plans-ahip-2019-national-conference.

[126] APMs in categories 3 and 4 are models that make a significant transition away from traditional fee for service and include, for example, shared savings, shared risk, bundled payment, population-based payments, integrated finance, and delivery system payments. Health Care Payment Learning and Action Network, "2019 APM Measurement Effort," accessed May 14, 2020, https://hcp-lan.org/apm-measurement-effort/.

data to assign payments to episodes of care, standardized definitions are still lacking even for routine care, let alone more complex treatment episodes involving patients with multiple chronic conditions.[127]

Current price transparency tools do not adequately capture the costs of care in the context of alternative payment models, although there is increasing awareness of the importance of providing that information.[128] Importantly, the new hospital price disclosure rule requires that, whenever possible, charges be bundled to help patients determine the cost of an episode of care.

In models such as ACOs, patient-centered medical homes, or bundled payment arrangements, which emphasize team-based, coordinated care as a path to better outcomes, incentivizing patients to shop for individual services from providers who may have no relationship with each other is likely to be counterproductive. Meaningful price transparency will need to anticipate the evolution of payment and delivery models that move away from traditional fee for service.

Conclusion

There is considerable evidence that the prices of healthcare goods and services are the main driver of rising healthcare costs in the United States. Prices have escalated to a point where some patients are forced to make the difficult decision to forgo necessary care because of the cost. Furthermore, the ultimate impact of the COVID-19 pandemic, although uncertain, will place an additional burden on the healthcare system that is likely to be substantial.

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[127] De Brantes, Opelka, and Delbanco, "Embracing Standard Episode Definitions."
[128] For example, for the Massachusetts experience, see Office of the Attorney General, Commonwealth of Massachusetts, *Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 12C, § 17*.

The evolution of healthcare financing in the United States is in many ways unique and includes critical choices that have led to the system we have today, such as the resistance to universal health insurance, the rise of voluntary insurance, the entrenchment of employment-based coverage, and the implementation of Medicare and Medicaid to cover those not included in the workforce. The result is a patchwork of healthcare coverage and an inflationary system where price is a less important signal than it typically is in other markets. In addition, healthcare by its nature resists standardization.

In the face of rising healthcare costs driven by the prices of goods and services, patients as well as providers have found it difficult to access meaningful price information to help them make better healthcare choices. This opacity in healthcare pricing has many causes and has spawned various public and private policy initiatives to address the problem. Over half of all states require or will require that either insurers or providers make prices available to consumers, and it is estimated that the majority of the commercially insured population now has access to some form of healthcare price transparency.

The Trump administration recently finalized a price transparency rule that, although it is an improvement over previous efforts, will not change behavior, stimulate competition, or reduce spending unless it is accompanied by compelling incentives for consumers to shop. However, the rule could serve to revise the current system and prompt innovative strategies that use the information to improve value in healthcare.

A number of approaches have been used to give consumers "skin in the game" in order to incentivize price shopping and promote competition among providers, including HDHPs, tiered and narrow networks, RBP, and rewards programs. RBP appears to show the greatest potential to generate savings, by motivating consumers to shop and incentivizing providers to lower prices.

However, policymakers need to address the complexity of administering an RBP program and safeguard patients against potentially substantial financial risk before considering implementation on a wide scale. Recent state-level initiatives to introduce RBP to select populations bear watching.

Since physicians act as patient advocates, and the recommendation of a personal physician may be more likely to influence a patient's choice than financial incentives, price transparency should be used to influence those choices at the point of service. Although efforts to influence provider behavior by incorporating price information into the EHR have had mixed results, transparency policies need to leverage the important relationship between patients and providers and facilitate enhanced shared decision-making.

Certain populations have shown that, by contracting directly with providers, they have been able to negotiate lower prices and reduce spending. Policies should be aimed at disrupting the status quo of the current insurance-based system by giving consumers greater control of their healthcare resources to enable innovative direct contracting arrangements with providers.

Price transparency policies also need to be flexible enough to reflect evolving healthcare system trends, such as personalized medicine, as well as payment and delivery reforms. Meaningful quality measures will need to be incorporated as well, so that consumers can make decisions based on value and not just price.

No single policy will achieve all the anticipated goals of healthcare transparency. Various approaches tailored to specific situations will be needed, with private-sector innovation obviating the need for government intervention. With the right information and the appropriate set of incentives, transparency can guide patients to make better choices, stimulate greater competition, reduce spending, and lead to more efficient allocation of healthcare resources. Reducing

unnecessary spending takes on an even greater sense of urgency as additional resources are needed to mitigate the strain on the healthcare system of providing the capacity to manage unanticipated health crises such as the COVID-19 pandemic. Given these concerns over escalating healthcare costs and the current opacity in healthcare pricing, pursuing these policies is imperative.