

RESEARCH SUMMARY

How to Increase Transparency and Promote Value in Healthcare: Information plus Incentives

The rising cost of healthcare is a major concern and even prevents some Americans from seeking medical treatment. The COVID-19 pandemic underscores the urgent need to reduce unnecessary spending to allow for more appropriate allocation of limited healthcare resources. In addition, US consumers rarely know what they will pay for medical services before those services are rendered. This prevents patients from making informed decisions about the value of the care they receive and has generated pressure for greater access to meaningful price information. In [“How to Increase Transparency and Promote Value in Healthcare: Information plus Incentives,”](#) John S. O’Shea argues that while increasing price transparency is essential, it addresses only part of the issue. The incentives for consumers, insurers, and providers must change in order to reduce excessive healthcare spending and allow all Americans to get the care they need.

WHY IS US HEALTHCARE SO EXPENSIVE?

It was not until the early 1900s that medicine became the life-changing asset that it is today and something worth paying for. As anesthesia and antisepsis made surgery safer and new technologies, such as X-rays and laboratory tests, improved diagnoses and led to more effective treatments, the public’s demand for, as well as the cost of, medical care rapidly increased. The US response to these rising costs 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.

Efforts to adopt a system of compulsory national health insurance in the United States were defeated in the early decades of the 20th century, and by the 1930s Americans began enrolling in voluntary group prepayment plans, such as the Blue Cross and Blue Shield programs, to help pay growing medical costs. A number of policy decisions, especially during World War II, provided a further stimulus to enrollment in these plans, and by the 1960s more than two-thirds of Americans had some form of health insurance coverage, usually through an employer.

Introduced in the mid-1960s to cover those Americans left out of the employer-based system, Medicare and Medicaid proved to be inflationary from the outset. In the first year of Medicare’s operation, for example, the average daily service charge in US hospitals increased by an unprecedented 21.9 percent. In the following decades, medical costs have continued to increase as policymakers have struggled to rein in the prices of healthcare goods and services.

The current opacity in healthcare pricing parallels the increasing complexity of healthcare and healthcare transactions in the United States. Currently, layers of terminology, as well as complicated and arcane accounting practices, obscure the actual cost of care to consumers.

TRANSPARENCY ALONE IS NOT THE ANSWER

Concern over consumer dissatisfaction with the level of available healthcare cost information has led to increased availability of price information resources. However, despite widespread access to transparency tools and general support for the concept of shopping for healthcare services, few people use the tools, and these tools have so far shown limited ability to reduce healthcare spending significantly. It is clear that simply offering patients access to price information through transparency tools is not enough. Price transparency needs to be combined with compelling incentives to use the information.

A number of innovative healthcare financing arrangements with varying effectiveness and tradeoffs have been developed to influence consumer healthcare choices by giving them “skin in the game” through the “stick” of increased out-of-pocket spending or the “carrot” of direct financial rewards. Examples include the following:

- *high-deductible health plans* that exchange reduced monthly premiums for higher deductibles, exposing consumers to actual medical costs;
- *limited networks*, where consumers are responsible for part of or all the costs for care received outside a defined group of healthcare providers;
- *reference-based pricing*, where an insurer agrees to pay for a healthcare service up to an established maximum price, the reference price, and the patient must pay for any costs above that price;
- *reward-based programs* that offer direct financial rewards for choosing services from lower-cost providers; and
- *direct contracting*, where consumers enter into direct price negotiations, bypassing government or third-party payers.

KEY TAKEAWAY

Excessive spending prevents some Americans from accessing necessary care and wastes resources that could be used to mitigate the strain on the healthcare system during crises such as the COVID-19 pandemic. Because healthcare needs vary greatly across the nation and from time to time, there is no “one size fits all” solution to rising healthcare costs. Because the insurance-based system of healthcare financing in the United States is so entrenched, policymakers must continue to reform traditional insurance structures through enhanced cost information and incentives to shop. However, to maximize the benefit of price transparency and promote competition and value, the US healthcare system needs a longer-term strategy that includes more “forward-looking” policies that disrupt the traditional insurance-based system, giving consumers greater ownership of their healthcare resources and facilitating more direct transactions between consumers and providers.