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Health Brief

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What Role Could Greater Price Transparency Play in Lowering Health Care Costs?

Policymakers, policy advocates, and other stakeholders have explored many strategies to reduce the cost of American health care, yet costs remain among the highest in the world, without higher performance on many key indicators.[1] One lever that hasn't yet been exploited broadly is price transparency—readily available information on the price of health care services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers. This lever's potential power stems from the fact that health plans and their insured customers, as well as self-pay patients, face widely disparate costs for the same service from different providers—and higher provider cost often does not represent higher quality.[2]

A federal final rule on price transparency is set to take effect on January 1, 2021, which for the first time requires hospitals to share their negotiated prices for shoppable services. Another recently finalized rule requiring health plans to provide consumers with specific information on their costs by service takes effect beginning January 2022, so this is a good time to think about the role price transparency could play in "moving the dial" on health care costs.[3] Greater transparency could enable consumers to shop in more price-conscious ways or could shift the arrangements between health plans, hospitals, other providers, and consumers in ways that result in lower costs.

The rules could change market dynamics across the country, but the ultimate effects are not clear. Because information is power, revealing price information has the potential to change the dynamics between employers, health plans, hospitals, and other health care providers (Exhibit 2). Because health care is a complex system, it's uncertain how and how much these dynamics will change, and whether the result will be lower costs for consumers without reduced quality.[4] Further, the effects of the new rules are likely to vary across markets. The affected organizations within each market differ in their strategies and relative market power, and the consumer populations also vary in their needs and preferences.

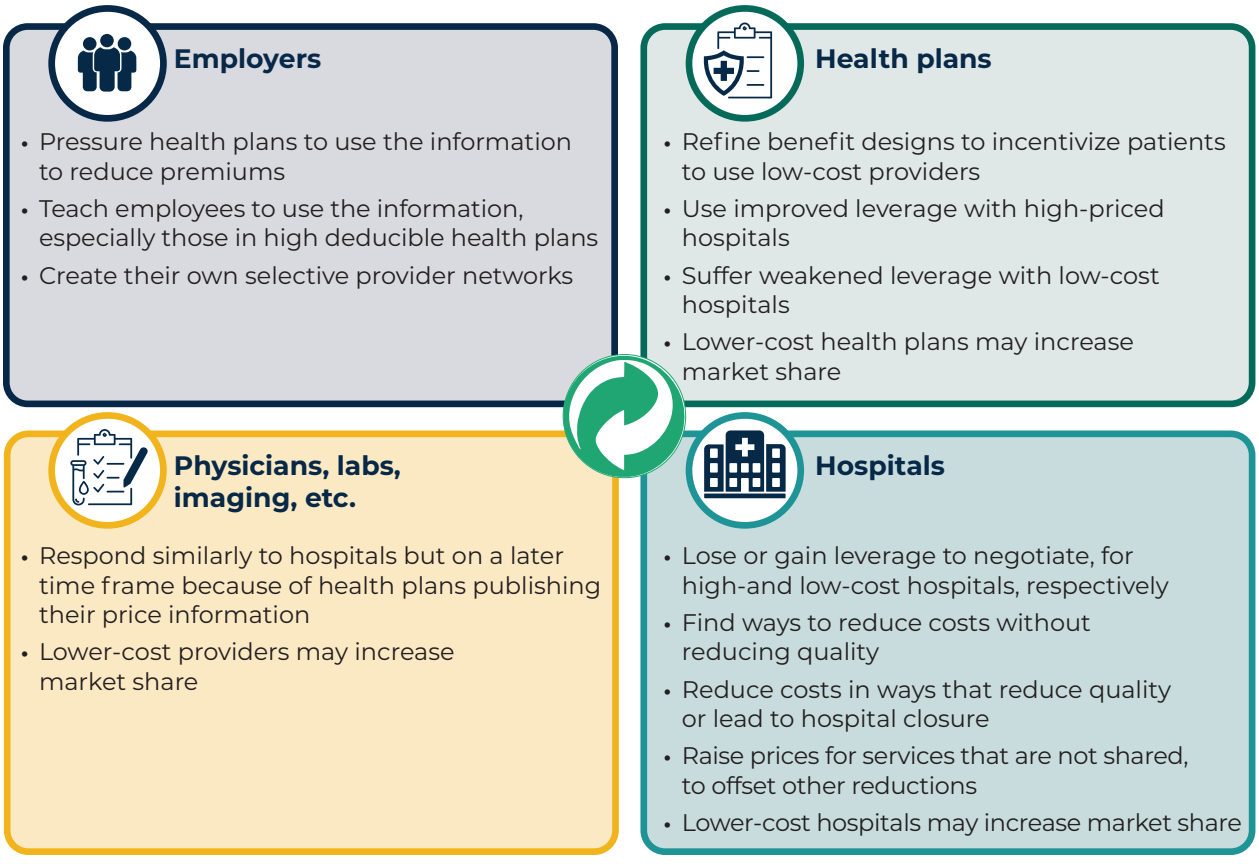
Shoppable services

- These are services for nonurgent situations that allow patients to price shop and schedule for a convenient time.
- Examples include imaging, laboratory services, medical and surgical procedures, and outpatient clinic visits.
- The required list for hospitals is here: https://www.cms.gov/files/document/steps-making-public-standard-charges-shoppable-services.pdf

Exhibit 1. Summary of Centers for Medicare & Medicaid Services (CMS) price transparency rules for hospitals and health plans

	Hospitals (all by January 2021)	Health plans (January 2022–2024)
For consumers, hospitals and health plans must publish the following information:		
For these shoppable services:	70 standard services and 230 that the hospital selects Plain language descriptions, including ancillary services	500 standard services (yet to be specified) by January 2023 All, by January 2024
This price information:	Negotiated prices by health plan product, and cash discounted prices	Personalized, out-of-pocket costs Underlying negotiated rates or fee schedule, including for prescription drugs
For tool developers, researchers, and others, health plans and hospitals must provide this information for cross-comparisons or research:		
	Machine-readable file with gross charges, discounted cash prices, payer-specific negotiated prices, and de-identified minimum and maximum charges	Three machine-readable files by January 2022 with the following: • Negotiated rates for covered services • Historical payments to and billed charges for out-of-network providers • In-network negotiated rates and net prices for covered prescription drugs by plan at pharmacy level

Exhibit 2. Potential for changes in market dynamics



The rules are controversial. CMS characterizes the rules as a victory for consumers and points to supporters such as Healthcare Bluebook and the ERISA Industry Committee (representing many large employers); some influential researchers also support the rules.[5] However, hospitals and health plans/insurers oppose the new rule, with the American Hospital Association's lawsuit against the U.S. Department of Health and Human Services (DHHS) pending in the U.S. Court of Appeals after it lost a lower court ruling in June 2020.[6] Exhibit 3 summarizes concerns expressed by industry members and other sources about the content of the rules. The exhibit also explores possible mitigating factors that might address the concerns and lead to progress toward the desired outcomes.

The price transparency rules will not be a silver bullet for health care cost reduction. The new rules are just a starting point. Implementation could fail in various ways, the first of which is a court ruling adverse to DHHS. However, there are at least two reasons to be modestly optimistic about implementation of the rules:

1. Several prior smaller-scale price transparency initiatives demonstrate reduced costs and shifted dynamics in ways that benefit consumers.
2. Several key trends could help the rules have a greater impact now than in the past, including increased consumer price sensitivity because of exposure to high-deductible health plans, increased provider interest because of participation in alternative payment models, and the move to digital solutions that could use the new data to create customer-friendly comparative tools.

Given the importance of reducing health care costs, policymakers should study the implementation and consequences of the transparency rules and remain ready to make timely adjustments if adverse effects emerge.

Exhibit 3. Concerns about the effects of the rules and potential offsetting considerations

Concern	On the one hand...	But also, watch for this
Consumers might not be interested in using the information.	Consumers have not used price comparison tools much.[7] Typically, patients obtain care from wherever their physician suggests, with one study showing they drove by an average of six lower-priced options to get an MRI from their physician-recommended location.[8] Historically, insured patients have been shielded from most health care costs at the time of service through their health plans. Instead, they bear high costs indirectly through premiums.	Consumers might be increasingly interested in learning about health care costs, as high-deductible health plans have become more prevalent, exposing them to more costs.[9] If the rules work, market dynamics (Exhibit 2) might benefit consumers by resulting in lower costs, even if consumers do not use the information directly.[10, 11]
It might be too difficult for interested consumers to use the information.	Cross-provider and cross-plan comparisons are not part of hospital or health plan rules.	Tool developers and others, such as self-insured employers, can use the machine-readable files to create cross-provider and cross-plan comparisons. For instance, Healthcare Bluebook, an existing developer, is reported to have worked with the Centers for Medicare & Medicaid Services during policymaking.[12]

Concern	On the one hand...	But also, watch for this
Cost information without corresponding quality information might be misleading.	Consumers have been known to mistake high prices for high quality, as with other consumer goods.[13] Quality information for providers exists separately, is incomplete, and does not correspond with many of the listed services.	The new rules could spur efforts to develop more aligned quality measures, or could bring corresponding quality information into view if new tools are developed.
The rules might result in upward rather than downward cost pressure.	Exposing results of health plan negotiations could weaken health plans' leverage with low-cost providers where they have been most effective.[14] At least once, an insurer dropped a price transparency initiative after provider pressure to raise payment rates.[15]	Others believe health plans will use the information to apply downward cost pressure to high-cost providers.[16] Examples exist of successful cost reduction following price transparency initiatives.[17,18,19,20]

Endnotes

[1] https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019

[2] https://www.acpjournals.org/doi/full/10.7326/0003-4819-158-1-201301010-00006

[3] CMS developed the rules pursuant to Executive Order 13877, June 24, 2019. The rules are available at the following links. Hospital rule: https://www.federalregister.gov/documents/2019/11/27/2019-24931/medicare-and-medicaid-programs-cy-2020-hospital-outpatient-pps-policy-changes-and-payment-rates. Health plan rule: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-Transparency-in-Coverage-9915F.pdf.

[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3511782/

[5] https://www.cms.gov/newsroom/press-releases/cms-completes-historic-price-transparency-initiative, and virtual roundtable with Seema Verma, October 29, 2020, sponsored by CMS and Michigan Center for Value-Based Insurance Design, "Discussion of Final Rule on Price Transparency"

[6] https://www.aha.org/system/files/media/file/2020/07/opening-appeals-brief-disclosure-negotiated-charges-7-17-20.pdf

[7] https://www.nejm.org/doi/full/10.1056/NEJMhpr1715229

[8] https://www.nber.org/papers/w24869.pdf

[9] https://www.kff.org/report-section/ehbs-2019-section-8-high-deductible-health-plans-with-savings-option/#:~:text=ENROLLMENT%20IN%20HDHP%2FHRAS%20AND%20HSA%2DQUALIFIED%20HDHPS&text=-Seven%20percent%20of%20covered%20workers,last%20year%20%5BFigure%208.5%5D

[10] https://www.chcf.org/wp-content/uploads/2017/12/PDF-MovingMarketsNewHampshire.pdf

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[12] https://www.benefitspro.com/2020/10/29/cms-finalizes-price-transparency-rule-aimed-at-health-insurers/

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[14] https://www.ahip.org/wp-content/uploads/AHIP-Transparency-in-Coverage-Comment-Letter-Final-1-29-20.pdf, page 32

[15] https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.26.2.w208

[16] https://www.healthaffairs.org/do/10.1377/hblog20200304.157067/full/

[17] https://pubs.aeaweb.org/doi/pdfplus/10.1257/pol.20150124

[18] https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.0168

[19] https://europepmc.org/article/med/25335149

[20] https://www.bakerinstitute.org/media/files/event/01ce2e80/HPF-paper-AHEC-Floyd.pdf

[21] https://www.acpjournals.org/doi/full/10.7326/m18-2223

[22] https://pubmed.ncbi.nlm.nih.gov/25691240/