Center for American Progress

Shining Light on Health Care Prices

Steps to Increase Transparency

By Maura Calsyn April 3, 2014

Introduction and summary

As a nation, we pay too much for health care, in large part because of the excessive prices charged by health care providers, manufacturers, and suppliers. A key reason why those prices are so high is because almost all health care prices are hidden, which hinders market competition and keeps patients and their health care providers from making fully informed decisions.

Imagine receiving a bill for $8,000 for car or home repairs without having first had a chance to receive a price estimate or the opportunity to comparison shop. That scenario is preposterous, yet it is exactly how we pay for our health care. Each year, our nation spends more than $8,000 per person on health care,[1] but patients have little to no idea how much each procedure, medication, or hospital stay actually costs. And unlike many other goods and services, higher health care prices do not necessarily reflect higher quality.[2]

In the rare cases in which prices are publicly available, they are usually of little value to patients. For example, listed prices are not the same as a patient's out-of-pocket costs, and the listed price most likely reflects only one part of a patient's treatment. In order to lower health care costs, we must fix each of these problems—health care prices must not only be transparent, they must also be easy to understand.

Secrecy in health care pricing distorts the market in other ways, and it is not just patients who are kept in the dark about health care prices. For instance, doctors make referrals without knowing the prices charged by other providers; they select medical devices for use in procedures without knowing the costs of the products or whether less-expensive alternatives may produce similar or even better outcomes. A recent study found that orthopedic surgeons correctly estimated the cost of a device only 21 percent of the time.[3]

In fact, at almost any point in the health care delivery system, the lack of meaningful, readily available price information raises costs.

Fortunately, policymakers across the political spectrum as well as private-sector entrepreneurs are starting to focus on this issue. More than 30 states now require disclosure of at least some minimal level of health care price information, and last year, the Centers for Medicare & Medicaid Services released large amounts of Medicare claims data for the first time.[4]

Even with these promising changes, health care prices are still maddeningly opaque. This report outlines specific recommendations to increase price transparency in health care, including immediate steps that the Obama administration can take:

- The Department of Health and Human Services, or HHS, must ensure that the Affordable Care Act's, or ACA's, requirement that insurers provide cost-sharing information is implemented in a consumer-friendly way.
- The ACA's cost-sharing disclosure requirements should be modified so that the plan's quoted costs for episodes of care are guaranteed.
- HHS should encourage the development of statewide, all-payer claims databases.
- Hospitals and other institutional health care providers should provide uninsured and out-of-network patients with episode-based costs, which would also be guaranteed.
- Insurers' provider directories should include rankings of higher-value providers to encourage patients to seek out their services.
- Medicare's Compare websites' star rating systems should include an overall "value" score for each health care provider, calculated using both quality and price data.
- Federal law should increase price transparency in the device industry, allowing hospitals and physicians to comparison shop without revealing prices to competitors.

Enacting these recommendations will significantly improve price transparency and improve the value of the health care services patients receive.

Why price transparency matters

Masking the price of health care items and services prevents competition based on price and value at numerous points in the health care system.[5] This lack of competition can artificially inflate prices, which in turn increases the nation's health care spending.[6] Price increases above inflation also contribute to the system's excessive rate of growth.[7] One study estimates that the system's lack of transparency adds about $36 billion in system-wide costs each year.[8]

For example, hospitals are able to charge private health care payers—insurers and employers—different prices based in large part on the hospital's relative market power, and higher prices do not necessarily reflect the quality of its services.[9] This contributes to vast price differences and unnecessarily high prices for hospital services in parts of the country. The Institute of Medicine has found that in the commercial insurance market, "regional differences in price mark-ups, not utilization, are the prime influence on geographic variations in spending."[10] If more cost and quality data were available, private payers could select high-value providers more easily.

But at the same time, hospitals also pay inflated prices due to a lack of price transparency. Not only do device manufacturers keep their prices secret, but they may also bar a hospital from sharing price information with physicians who perform procedures at the hospital.[11] For many cardiac and orthopedic procedures, the cost of these devices is the most expensive part of the patient's care.[12] As a result, doctors and hospitals are unable to work together to identify high-value devices, which disadvantages hospitals during negotiations with device manufacturers.

Access to price and quality information is critical to doctors for other reasons. For example, doctors participating in new payment models such as accountable care organizations, or ACOs, that hold providers responsible for the overall costs of a patient's care need this information in order to refer their patients to high-value specialists.

The lack of price transparency is now becoming an increasingly visible consumer issue. While uninsured patients are responsible for paying the full price of various health care services, the impact of higher prices on insured consumers has, in the past, generally been limited. Excessive prices raise premiums, but insured consumers had otherwise been largely shielded financially from inflated prices.[13] Patients may have paid more for out-of-network providers, but otherwise insurers absorbed price differences.

Today, all patients—not just the uninsured—are responsible for a larger share of health care costs. Nearly one-third of all privately insured adults are enrolled in high-deductible health plans, and employers and insurers continue to design plans with larger deductibles and increased cost-sharing.[14] Many plans offered through the ACA's marketplaces have higher deductibles, and consumers selecting new marketplace plans must consider those expenses in addition to premium amounts. Uninsured individuals also continue to need price information.

Patients are also becoming increasingly likely to encounter benefit structures that insurers and employers design to channel them to high-value providers. For example, tiered insurance plans specify providers who achieve high quality and low costs, and patients who choose these providers have lower cost-sharing. Employers or insurers may also set a reference price for elective procedures—the amount that an employer or insurer agrees to pay for that service—and if a patient chooses a provider

that charges more than the reference price, the patient must pay the difference. For example, the California Public Employees' Retirement System set a reference price of $30,000 for joint replacement surgery, which saved California $6 million and saved patients $600,000 in two years.[15] These efforts can only succeed if patients have clear price and quality information.

Of course, there will always be emergencies and other situations in which patients need immediate treatments and have little or no control over what hospital or doctor they use. But for the many procedures and treatments that are scheduled in advance, consumers should have access to meaningful, user-friendly information.

Price transparency challenges

Unfortunately, simply publishing health care prices is not as straightforward as listing the prices of other consumer goods and services. There are a number of reasons why these efforts are complicated and some approaches to transparency are far more helpful than others.

Operational challenges

There is not a single price for different health care services. Health care providers set a charge for each item and service, which are essentially the wholesale or "list" prices. They bear little relation to the amount that public and private payers and insured patients pay for health care services. Charges listed in a hospital's chargemaster—the comprehensive list of prices for every item or service—are more than twice as high as the actual prices paid by insurers, and physicians also set extraordinarily high list prices for their services.[16] These list prices have limited use because private insurers negotiate far lower prices with providers. Traditional Medicare also pays significantly lower prices based on formulas set by law. However, providers will still bill the full charge amount in two situations, for treating uninsured patients and out-of-network patients.[17] Low-income uninsured patients are likely to receive some level of discount.[18]

The lower prices insurers pay based on their agreements with different health care providers are still of little help to patients because patients with different insurance benefits and cost-sharing structures will pay a different portion of the medical bill. Even if two patients have the same insurance, they may still pay vastly different amounts for the same procedure performed by the same doctor at the same facility. For example, if an insurance policy has a $1,000 deductible and then 20 percent co-insurance for outpatient procedures, a patient who has only paid $200 of the deductible will pay $800 more for the exact same care than a patient who has already paid the entire annual deductible.

Patients will also pay higher amounts for the exact same procedure if it is performed by out-of-network providers or, in yet another variation, if the patient needs a higher level of care and therefore the procedure occurs in a hospital operating room instead of an outpatient surgery center.

Efforts to present price information in a consumer-friendly format are thwarted by another feature of the current payment system. For each encounter with the health care system, a patient will likely receive more than one bill. For example, patients will usually receive separate bills from a hospital as well as from the doctors who treated the patient.

How each of those bills is generated by health care providers further complicates this issue. Instead of charging one price for an entire episode of care, such as all of the costs associated with a hospital stay to undergo hip replacement surgery, health care providers submit claims to insurers with prices for different codes that describe individual, specific items and services furnished to the patient as part of their care. Hospitals may have charges for 12,000 to 45,000 specific items and services.[19] Depending on the patient's actual treatment, those codes may vary, and providers cannot always accurately predict each needed service in advance, particularly if the patient faces complications.[20]

This payment structure, combined with the need for patient-specific insurance information, makes it very difficult for patients to track down relevant, user-friendly information. Researchers who called more than 100 hospitals for the price of a hip replacement found large variations in responses from the hospitals and in some cases did not receive any response.[21]

Researchers only received complete price information—including both hospital and doctors' costs—from 12 of 20 top-ranked hospitals. Of those 12, 9 were able to give a single, bundled price, but for the remaining 3, researchers needed to have separate discussions with the hospital and doctor before finding the total cost.[22] Overall, only 16 percent of randomly selected hospitals could give a complete, bundled price. Researchers also found that the estimated prices varied from about $10,000 to well over $100,000 at the selected hospitals.[23]

Additional challenges

Price transparency efforts must also navigate other obstacles, including legal barriers that protect industry stakeholders. For example, hospitals' contracts with insurers may contain gag clauses, which prevent the insurers from disclosing negotiated rates. Device manufacturers include similar prohibitions in their contracts with hospitals.[24] And in some states, these prices might be considered trade secrets, which could make some disclosures of this information unlawful.[25]

The health care market has become increasingly consolidated and has very high barriers to entry. Therefore, reforms must also protect against the possibility that these efforts at transparency could raise prices as competitors become aware of each other's prices.[26] The U.S. Department of Justice, or DOJ, and the Federal Trade Commission, or FTC, have raised these concerns, stating in a 1996 joint opinion about price transparency in the health care industry that without appropriate safeguards, price transparency could result in providers colluding to set "mutually acceptable" prices.[27] Industry stakeholders repeatedly cite the possibility of collusion to create a useful straw man argument to oppose transparency.

But there are ways to mitigate any such risk, and this concern should not block necessary reforms. In their 1996 opinion, DOJ and FTC created an antitrust "safety zone," wherein price and cost information:

- Must be managed by a third party
- Must be at least 3 months old
- Must have a data collection with at least five providers contributing, with no individual provider's data accounting for more than 25 percent of the information[28]

These conditions were "intended to ensure that an exchange of price or cost data is not used by competing providers for discussion or coordination of provider prices or costs."[29]

These "safety zone" requirements are nearly two decades old, and since then there are new approaches to increase price transparency that can protect against collusion without the need for DOJ and FTC's strict conditions. For example, insurers could disclose price information only to their enrollees or to employers purchasing insurance for their employees. In both situations, price transparency can lead to selecting higher-value, lower-cost providers, but providers will not be able to directly compare their prices with their competitors. Providers could also publish average prices in highly concentrated areas,[30] although that would be less helpful for patients.

The last hurdle facing policymakers is the public's perception that higher costs mean higher quality. The health care market does not function like the markets for other consumer goods, and quality and price are not necessarily correlated.[31] When consumers review prices, they should also have access to quality information. Information such as mortality rates, complication rates, and average length of stay for common procedures are examples of the types of consumer-friendly quality indicators that should accompany price information.[32]

Current efforts to increase transparency

Despite these numerous challenges, policymakers at the state and federal levels have taken a variety of approaches to shine light on health care prices. Private-sector innovators are also actively engaged in this issue. These efforts vary in their scope and success—some focus on making information available to consumers, while others focus on disclosing more detailed health care data to employers, other health care payers, and health care researchers.

Federal efforts

Federal efforts to increase price transparency are slowly gaining momentum. Prior to the Affordable Care Act, there was some price and quality information available to Medicare beneficiaries. For example, beneficiaries can compare premium prices of prescription drug plans, and over the past decade, Medicare has slowly built its Compare websites, which include Hospital Compare, Physician Compare, and Nursing Home Compare. These websites allow beneficiaries to review quality rankings of hospitals, doctors, and other health care providers.[33]

The Affordable Care Act includes a limited number of new price transparency requirements. Insurers and other health care payers must disclose certain cost and quality information, including information on out-of-network cost-sharing, consumer rights, and claims payment policies.[34] Health care plans must also provide in-network cost-sharing information—including deductibles, copayment, and co-insurance—so that consumers can make informed decisions when selecting health care providers.[35] At a minimum, insurers and other plan sponsors must make this information available through a website while also offering another way for individuals without Internet access to find these materials.[36]

These new requirements offer promise for patients, but the Department of Health and Human Services has yet to focus enough attention on implementing these provisions. The department's regulations restate the language in the law, which is insufficient to ensure that consumers have access to this information.[37] Strong enforcement and more specific guidance on how plans should calculate cost-sharing amounts are also needed to ensure that information is timely, complete, and easy to understand.

HHS has made greater progress toward implementing other transparency initiatives aimed at sharing more technical data. This can help health care purchasers such as insurers and businesses, as well as health care researchers.

The Affordable Care Act's Medicare Data Sharing for Performance Measurement Program now allows the Centers for Medicare & Medicaid Services to disclose Medicare claims to qualified entities, which are public or private organizations that are approved by the secretary of health and human services to use claims data to evaluate provider performance. The groups that have received approval to participate in the program to date are regional and state organizations with significant experience working with large amounts of health care data.[38] These entities will then combine this information with data from other payers to allow them to more accurately evaluate quality and costs as well as to prepare public reports about providers' performance.[39]

Qualified entities must enter into a data-use agreement and pay a fee for the cost of providing the data, and the law places several other limits on the use of the data and how research using these data must be presented.[40] In addition to these limited disclosures of claims data, the ACA also requires hospitals to release and update their standard charges annually.[41]

Separate from the health reform law's requirements, the Centers for Medicare & Medicaid Services is taking additional steps to release Medicare data. In 2013, the agency released charge data for the 100 most common inpatient hospital services and 30 common outpatient hospital services for more than 3,000 hospitals.[42] Not surprisingly, the data showed significant variations between hospitals, even within the same area.[43] More recently, after a federal court lifted an injunction that previously prohibited Medicare from releasing information about the amount it pays to individual doctors, the agency decided to release these data on a case-by-case basis in response to requests for this information.[44]

State efforts

Federal efforts to increase price transparency are moving forward, but more reform is occurring at the state level. Thus far, 31 states have enacted price transparency legislation.[45] These state laws are not consistent, however, and in many states the publicly available information is not user-friendly.[46] For example, there are numerous patient-oriented, state-based websites, but most report only prices of inpatient care and fewer than 15 percent post quality data.[47] In addition, most states list only average prices or, even less helpful, charges.[48]

Massachusetts and New Hampshire, in comparison, have robust, consumer-friendly price transparency initiatives that differ from most other states' efforts in a number of critical ways. New Hampshire's public website displays the median, provider-specific price for a procedure—taking into account negotiated discounts—for each commercial insurer.[49] The website's cost information is organized by service, geographic location, the insurance plan type, and cost-sharing information.[50] This approach is not perfect—it lists only median prices as negotiated by the insurers, not an individual's out-of-pocket costs—but it is still a valuable tool for consumers, providers, and employers.

Massachusetts' law takes a slightly different approach; the state requires insurers and health plan administrators to offer consumers provider-specific estimates of their out-of-pocket costs for specific hospital stays or procedures.[51] These prices, like those posted on New Hampshire's website, include costs of both doctors and health care facilities, instead of discrete services. Importantly, these estimates are binding, unless the patient receives additional, unanticipated services.[52] The law also requires providers to give patients information that their insurer might need to calculate their out-of-pocket costs, and in-network providers must give patients information about how to access the website and toll-free number.

In addition to these consumer-focused requirements, providers must also disclose their estimated charges. And the law includes other initiatives aimed at studying prices and increasing access to quality and cost data—an 18-member commission will study price variation, and all health care organizations must submit annual cost and quality data to the commission. A public website will then list data about the relative costs of different providers.

Massachusetts and New Hampshire are also two of a growing number of states that combine data from all payers into an all-payer claims database.[53] All-payer claims databases generally collect medical claims, pharmacy claims, and dental claims, as well as additional information about the provider and patient demographics from most public payers—including Medicare and Medicaid—and private payers.[54] These collections are large enough to allow policymakers and health care payers to consider quality, utilization, and cost trends across the health care system, a significant change from the fragmented data sets that these groups have typically relied upon in the past. Although the raw data in these collections are not immediately understandable to patients, their contents allow health care payers and policymakers to evaluate cost and quality, which ultimately benefit patients.[55]

Legislation

Pending federal legislation would expand federal initiatives and require states to do more to encourage transparency. The bipartisan Medicare Data Access for Transparency and Accountability Act would require the secretary of health and human services to disclose all Medicare claims and payment data in a searchable format.[56]

The bipartisan SGR[57] Repeal and Medicare Provider Payment Modernization Act includes a section that would expand access to Medicare claims data by requiring the secretary to include utilization and payment data for physicians and other health care professionals on Medicare's Physician Compare website.[58] This information would be searchable and include the number of services provided, as well as provider-submitted charges and payments.[59]

This legislation would also modify the Medicare Data Sharing for Performance Measurement Program's qualified entity program in a number of ways, most importantly by allowing entities to provide or sell nonpublic analyses and claims data to third parties, including providers, insurers, and in certain cases, to self-insured employers. And the proposal would also allow qualified clinical data registries to access claims data.[60]

Other proposals would require greater transparency by hospitals, other health care providers, and insurers, although the specifics vary. For example, the Health Care Price Transparency Promotion Act would require states to have in place laws that compel hospitals to disclose the price of certain procedures and compel insurers to provide enrollees with information about their estimated out-of-pocket costs for those services. But this proposal explicitly allows insurers to charge patients with higher cost-sharing after the fact and includes only limited hospital-based services.[61]

The Hospital Price Transparency and Disclosure Act requires reporting by hospitals and ambulatory surgery centers to HHS on the frequency of certain procedures and the average charges for both insured and uninsured patients. The secretary would then post this information online along with quality data.[62] This link between cost and quality is very helpful, although a patient's specific costs will vary from the posted averages.

Private initiatives

With only piecemeal, targeted federal and state price transparency efforts in place, some private businesses have tried to fill this gap. A few insurers—in part due to interest from employers—have set up websites for their customers to compare prices between different providers.[63] For example, both Aetna and Anthem offer their members price information that reflects the insurers' negotiated discounts with providers. These insurers hope that publishing this information will encourage patients to seek out higher value providers.[64]

New businesses are also entering this space. For example, Castlight Health of San Francisco uses claims and other data to create pricing information for their employer-customers, including customized information about the employers' benefits, provider network, and cost-sharing requirements.[65] Employees can then log on to the website to find personalized information about their costs.[66] Other companies offer consumers more general cost information such as average prices for insured patients for different procedures, tests, and medications in a particular area.[67]

Businesses are also tackling secrecy in other parts of the health care system. One example is MedPassage, which allows hospitals to shop for medical devices without allowing the device companies access to their competitors' information.[68] The company estimates that hospitals have saved between 30 percent to 60 percent by comparing prices.[69]

Recommendations to improve price transparency

These public and private efforts should serve as a starting point for additional reforms. For patient-level transparency, the focus must be on making price information more accessible and understandable for patients. The three keys to patient-level price transparency are:

- Providing full-episode costs with patient-specific, out-of-pocket costs
- Offering a guarantee of the price so the estimate is meaningful
- Including quality data

Policymakers must also develop ways to educate patients about how to use this information and to combat patient assumptions that higher costs necessarily mean higher quality. Combining quality and price data to inform patients of overall value should help these efforts. Unless public perception changes, price information will not necessarily drive consumers toward lower-cost, higher-value providers.

Setting standards for making sure that patients can easily shop for and compare insurance plans and providers based on value is critical, but it is not sufficient to lower costs. Transparency at other points in the health care system is also necessary.

Administrative actions to increase transparency

As a starting point, there are reforms the Department of Health and Human Services can adopt without any changes to existing law.

First, HHS must focus greater resources on implementing the Affordable Care Act requirement that insurers provide cost-sharing information, including the amount that the individual would pay for a specific item and service by in-network providers. HHS should do the following:

- Require information be presented in such a way that patients can view their out-of-pocket costs for an entire episode of care.
- Require standardized definitions for an episode of care and other terms necessary for consumers to understand their out-of-pocket costs for easier comparisons.
- Require easy access to information about provider networks and covered medications to make cost-sharing information meaningful.

Second, HHS should encourage the development of statewide, all-payer claims databases. Analyses of the information included in these systems can inform states' provider network decisions and payment rates, and hopefully will result in policies that drive consumers towards higher-value providers. State regulators can also use this data to assist in rate review to keep premiums lower.

The Center for Medicare & Medicaid Innovation should offer states grants to help build databases that include Medicare data. This funding should be contingent upon states agreeing to use this information in their efforts to reform their payment and delivery systems and to improve price transparency, and to test whether these efforts can help lower Medicare and Medicaid costs and improve quality. States using these funds should also collect data in a consistent and timely manner to help lower administrative costs for those using these systems.

Legislative actions to increase transparency

Parallel to these administrative actions, federal and state legislators should establish the following minimum requirements for price transparency:

- The Affordable Care Act's cost-sharing disclosure requirements should be modified so that the plan's quoted costs for episodes of care are guaranteed, unless the patient receives additional, unanticipated services.
- Insurers' provider directories should include rankings of higher-value providers to encourage patients to seek out their services.
- Hospitals and other institutional health care providers should provide uninsured and out-of-network patients with episode-based costs, which would also be guaranteed. Providers should also give consumers instructions on how to access relevant quality information.

Federal law should also authorize greater dissemination of Medicare claims information. The price transparency sections of the SGR Repeal and Medicare Provider Payment Modernization Act legislation are a promising start.

Including price and utilization information on Medicare's Compare websites in a consumer-friendly, searchable format is an important change. Once this information is included in all of the Compare websites, the websites' star rating systems should include an overall "value" score for each health care provider, calculated using both quality and price data.

The Medicare Data Sharing for Performance Measurement Program's qualified entity program should also be dramatically expanded to allow more researchers, policymakers, providers, insurers, and self-insured employers access to the detailed, granular levels of data—such as provider-level procedure codes and diagnosis codes—that would not be helpful to include in Medicare's Compare websites or other consumer-focused websites. Restrictions on how researchers may analyze this data, including the requirement that Medicare claims data be aggregated with other claims data, should be lifted to allow for greater research flexibility.[70]

Lastly, federal law should also increase price transparency in the device industry. As MedPassage and similar models show, it is possible to design a system that allows for comparison shopping between products without revealing prices to competitors. Device manufacturers should submit their average prices for implantable devices—in addition to other devices selected by the secretary of health and human services—to the Centers for Medicare & Medicaid Services or a third-party contractor. Hospitals and physicians could then view this information through a restricted website. Website users would agree to keep this information confidential and not disclose prices to outside parties.

Past legislation would have required similar disclosures, but the Centers for Medicare & Medicaid Services would have then publicly posted the information. Keeping the information confidential would address the industry's claims about possible collusion. Federal law should also prohibit device manufacturers from restricting how hospitals may share device prices with physicians who practice in their facilities.

Conclusion

The past year has brought increased focus on the role that excessive prices play in keeping our nation's health care costs so high. The Obama administration should respond by taking specific, meaningful steps to increase price transparency, starting with more vigorous implementation of the Affordable Care Act's transparency provisions. Moreover, growing bipartisan interest in increasing price transparency presents an uncommon opportunity to adopt additional consumer-friendly reforms that will lower health care prices. The proposals in this report outline specific steps that both the Obama administration and lawmakers can take that will advance price transparency and increase value throughout the health care system.

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