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506781	0.00	0.
92001	0.00	0.
95001	0.00	0.
94011	0.00	0.
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Health System Improvement

Price Transparency in Health Care: An Introduction

The price for the same medical service can vary dramatically depending on the provider.

But more expensive providers do not necessarily deliver higher-quality care. And unlike shopping for almost every other service, it can be nearly impossible for consumers to get accurate estimates of how much they will have to pay for care before they get the bill.

This variation in prices and lack of price transparency have serious consequences for consumers and for our health care system: We frequently pay too much for care that is not always high-quality.

Policymakers and other stakeholders need more information about the prices that providers are paid to better understand the extent of price variation and to take steps to address unnecessarily high health care prices. Consumers also need more accurate information about the price and quality of providers to inform their health care decisions.

This brief explains why we need greater transparency in health care pricing, in particular, what price information consumers need. It also discusses several efforts that states and the federal government have made to improve consumers' access to information on health care prices.

Price Variation and Lack of Price Transparency Drive Higher Health Care Spending

There is growing evidence that high health care prices are one of the main contributors to rising health care spending, and that some providers are paid significantly more than other providers in the same area for the same exact medical care.¹ Why do health care prices vary so much? One reason is that insurers negotiate prices directly with individual providers, and providers who have greater market power or brand recognition can often negotiate significantly higher prices. This method of setting health care prices means that there is little connection between the price of care and the quality of that care.²

In addition, consumers and others who pay for health care (such as employers) often cannot get adequate information about these negotiated prices. Sometimes, consumers can gain access to providers' retail prices—also called “chargemaster” prices (see page 3). While these prices may be useful to uninsured consumers, they are not accurate estimates of the prices paid by health plans or of what insured consumers pay for care out of pocket. In the end, consumers and payers often pay too much for care that may not be higher-quality.

Prices for the same health care service can vary drastically across providers, and it is difficult for consumers to get information to compare providers based on both price and quality.

Making information on health care prices and quality accessible will help consumers compare costs, choose high-value providers, and anticipate their expenses. It will also help policymakers and others hold health care providers accountable for setting fair prices.

What are “chargemaster” prices?

Every provider sets its own list prices for health care services, which are compiled in a schedule that is often called a “chargemaster.” These prices can vary considerably across providers and can be difficult to obtain.

Chargemaster prices often have little to do with the actual amounts that health plans, insured consumers, and public programs pay for care. For example, chargemaster prices are typically higher than the negotiated prices that private insurers set with providers and higher than Medicare and Medicaid payments to providers.

However, chargemaster prices may be useful to uninsured consumers, who are often responsible for paying the full chargemaster price for care. In many instances, these consumers can negotiate discounts directly with providers to lower their bill. So, having other providers’ chargemaster prices could help uninsured consumers as they try to compare providers or negotiate their final bill.

Greater Price Transparency Can Help Combat Unnecessary Price Variation

To address price variation, policymakers, payers, and consumers all need better information about the price of care. Policymakers and payers need this information to develop effective methods of addressing unnecessarily high health care prices. The public needs better information on the scope of price variation in our health

care system to generate demand for policies that hold the health care industry more accountable for setting fair prices.

To address price variation, some insurers and employers are beginning to give consumers incentives to shop for care based on price and quality. For example, some employers are redesigning their plan benefits to help consumers compare providers based on both price and quality and to reward consumers for choosing high-value providers (those that deliver the best care at the best price). Some of these benefit redesign strategies could even pressure overly expensive providers to lower their prices. These strategies include reference pricing and value-based provider networks.³ (For more information on reference pricing, see Families USA’s *How to Make Reference Pricing Work for Consumers*.)

To implement these benefit designs effectively, however, employers need better price information. And in order for these benefit designs to drive consumers toward higher-value providers, consumers need better information about price and quality that allows them to compare providers.

Consumers Need Better Price Information to Help Them Make Informed Decisions

Increasingly, insurers and employers are asking consumers to take greater financial responsibility for their care.

- » For example, high-deductible health plans are becoming more popular with employers. The number of employers that include deductibles in their health plans and the average size of these deductibles have been growing in recent years.⁴
- » Consumers who buy coverage on their own through the health insurance marketplaces can also face significant deductibles and other cost-sharing, like co-insurance.⁵

For consumers with higher cost-sharing, the total price of care that a provider sets with their health plan can have a significant effect on their own out-of-pocket medical expenses.

Consumers will never be in a strong position to compare providers when they need urgent or emergency care. And while consumers have more of an opportunity to shop for care for other medical services, like scheduled and elective procedures, getting the information they need to anticipate their out-of-pocket medical expenses or to compare providers is very difficult. When consumers do have the opportunity to compare providers, consumers should have the right to accurate and easily understandable information to help them select the best care at the best price and to help control their out-of-pocket costs.

What kind of price information do consumers need?

There are a growing number of initiatives designed to improve access to price information. But not all initiatives provide the level of information that consumers need to anticipate their out-of-pocket costs and to compare providers based on price and quality.

In order for consumers to use price information to help inform their health care decisions, they need accurate estimates about the price of care from different providers that are tailored to their individual circumstances. Price estimates for *insured consumers* should contain the following information:

- » **Negotiated or discounted prices:** Any negotiated, discounted prices that have been set with their insurer.
- » **Total price for care:** The total (combined) price for all of the separately billed services that are included in the delivery of the health care procedure they need. For example, if a consumer needs a CT scan, the price estimate should include imaging fees and physician fees for interpreting the scan results.
- » **Consumer share of the bill:** The portion of the bill that the consumer is responsible for paying through cost-sharing, including deductibles, co-insurance, and copayments.
- » **Guaranteed, binding estimates:** A consumer's health plan cannot charge more than the estimated out-of-pocket costs unless the consumer requires additional unexpected services during the course of treatment that have separate cost-sharing. Providing this type of individualized, binding estimate will ensure that consumers have reliable information that they can trust when comparing providers.

Uninsured consumers need similar binding estimates directly from providers. It may be more difficult to obtain an estimate that includes all services that are part of a single procedure if different services are billed separately by different providers. However, providers should work with consumers to help them identify the other health care professionals who will be involved in their care and to help direct consumers to where they can get information on the price of these additional health care services. (See “Challenges to Providing Consumers with Better Price Information” on page 6.) For uninsured consumers, having information on the prices health plans pay for care could also help them negotiate lower prices for their own care.

Consumers Also Need Information on Quality

In addition to meaningful price information, consumers should have access to easily understandable information on the quality of providers. Consumers rightly prioritize the quality of their care over the cost of that care.⁶

Unfortunately, there is a common misperception that more expensive care is inherently better care. Giving consumers price information without understandable information on quality can actually lead them to choose lower-value, more expensive care because they assume it is higher-quality. However, research has found that when consumers have easy-to-understand information about both the cost and quality of different providers,

Giving Providers Price Information

Consumers are not the only ones who have been left in dark about the price of care. Doctors also often do not have information about the different prices of comparable medical devices or the prices charged by other providers, like imaging facilities, hospitals, and other physicians.

Given that providers’ treatment and referral decisions drive a significant portion of health care spending, providers are critical partners in promoting high-value care. There are several payment models that ask providers to take greater responsibility for the cost of care, like shared-savings programs and global payments. These models require providers to more carefully consider the prices of the medical professionals and facilities they refer patients to and the prices of health care services.¹ In order for these models to work effectively, providers need better information about price and quality to inform their referrals and their choice of treatments and medical devices.

There are some unique challenges to making price information more available to providers. Hospitals are often contractually prohibited from sharing information with doctors about the prices they have negotiated with medical device manufacturers. There are also concerns that giving providers information about the payments that health plans agreed upon with other providers could actually raise prices (see “Ensuring that Transparency Does Not Raise Prices” on page 7). While not the primary focus of this brief, efforts to improve providers’ access to price and quality information are also needed.

they are more likely to choose care from providers that deliver the best care at the best price.⁷

It is also important that information on quality and price be presented in easy-to-understand formats. For example, consumers might have an easier time understanding simple labels, like “average” or “better,” rather than having to interpret actual quality measurements, like the percentage of a provider’s patients that receive evidence-based screenings.

Quality information also needs to be presented so that consumers can easily understand what aspect of their care the quality information is describing.⁸

Challenges to Providing Consumers with Better Price Information

Several significant challenges make it difficult to give consumers the information they need to accurately estimate the cost of their care.

- » **Legal barriers:** There are often restrictions on making information available on the prices health plans negotiate with providers. For example, contracts between health plans and health care providers can include “gag clauses” that prohibit health plans from sharing this type of information, even with consumers in their plan.
- » **Developing accurate cost-sharing estimates:** When health plans *are* able to share information on negotiated prices, a simple estimate of the full price doesn’t tell a consumer how much he or she would pay have to pay out of pocket for that care. It is important that insured consumers have access to individualized price estimates that include the amount they would have to pay through cost-sharing, including any portion of their deductible they owe, copayments, and/or co-insurance.
- » **Medical procedures that include multiple billed services:** There is the additional challenge

that a single medical procedure can often include multiple, separately billed services. For example, the total price for a hip replacement surgery could include separate bills from the surgeon performing the operation, the anesthesiologist, and the hospital where the surgery was performed. Providing consumers with an estimate of only one of those bills does not give them an accurate idea of what the cost of their care will be, and consumers are not in a strong position to piece together the individually billed services they need for a given procedure.

These challenges are not insurmountable. Some states have passed laws that ban “gag clauses” in contracts between health plans and providers, opening the door for more health plans to make price information available to consumers. And health plans *do* have the claims data and enrollee information that are necessary to develop better price information tools. These tools can give consumers tailored price estimates that include cost-sharing and the costs of all billed services that are part of a given procedure.

For uninsured consumers, it may be even more difficult to obtain provider-specific price estimates for multiple billed services that are part of a medical procedure. Providers should be prepared to help these consumers identify which other separately billed services could be involved in their care and help direct consumers to resources that have information on the price of these additional health care services.

Consumers are not in a strong position to piece together the individually billed services they need for a given procedure.

Ensuring that Transparency Does Not Raise Prices

Initiatives designed to gather and share price information need to consider the valid concern that making all prices that providers and health plans have negotiated publicly available could inadvertently raise health care prices.

For example, if lower-priced providers have access to information about the higher prices other providers are able to negotiate, lower-priced providers may push for higher prices during negotiations with plans. In addition, providers may be less inclined to give discounts to health plans once price information is public and they know that other providers could match their price. In areas where providers have significant market power to negotiate higher rates, these could be real concerns.

There are many ways to provide better price information that can safeguard against these concerns: Initiatives could allow only health plan members to see the prices their plans have negotiated with individual providers. And publicly accessible information could be limited to aggregated information, such as the average or median reimbursement a provider receives for procedures across all health plans.

Creating a More Transparent Health Care System

Federal Efforts to Improve Price Transparency

There are a number of efforts underway at the federal level to improve price transparency in our health care system. The Centers for Medicare and Medicaid Services (CMS) has started to make Medicare claims data publicly available for common services that are provided by inpatient and outpatient hospitals, as well as for physician services. These data include Medicare payments to Medicare providers, along with the providers' "chargemaster" prices for select services.

Making these data publicly available is an important step toward improving price transparency. It has many potential uses for policymakers, payers, and researchers who are trying to identify high-value providers and evaluate variations in price and quality. But these data are not very useful for consumers who are trying to estimate what their care might cost them.

The Affordable Care Act also included important funding opportunities for states that could be used to improve price transparency. The law allocated \$250 million in state grants through 2015 to fund improvements in states' processes for reviewing proposed increases in health plans' premium rates (a process known as "rate review"). States can also use these grants to fund data centers that are designed to provide the public with better information about the price of care from different providers. To date, 18 states have used rate review grant funds to establish or improve state-based efforts to collect and publicly report health care price information.⁹

State Efforts to Improve Price Transparency

States can play an invaluable role in improving consumers' access to health care price information. However, state laws and regulations aimed at improving price transparency vary considerably, and in many states, these laws do not mandate the level of price transparency that consumers need.

For example, many states have mandates that require health care providers to publicly disclose their chargemaster prices for common procedures.¹⁰ This type of requirement has many limitations. While chargemaster price information could be useful to uninsured consumers, these mandates often apply only to hospital facilities and not physician services. This means that these prices do not always provide enough information to estimate the full price for procedures. They also are typically not available in user-friendly formats. Nor are these prices useful to insured consumers, whose financial responsibility is based on the prices negotiated by their insurance company.

State disclosure laws

A handful of states are taking more aggressive steps to improve price transparency. For example, **Massachusetts** passed a law in 2012 that requires health plans to give consumers provider-specific, binding estimates of the cost of care upon request. (See “Massachusetts Takes Steps to Provide Consumer-Friendly Price Estimates” on page 9.)

All-payer claims databases

Another promising state strategy is the establishment of “all-payer claims databases” (APCDs). APCDs collect data on medical, dental, and pharmaceutical claims from all public and private payers across the state. This includes data from Medicaid, private health plans, state employee health plans, and, ideally, self-insured employee health plans and Medicare.

If done well, APCDs have the potential to gather price information that could be immensely useful to consumers. For example, because APCDs collect claims data, they have information about the negotiated prices actually paid by insurers for services, not just providers' list prices. They also have the information needed to estimate the full price for an episode care.

Most states have established their APCDs through legislation, although a few have developed an APCD through payers voluntarily agreeing to participate. Eleven states currently operate APCDs, six additional states are working toward implementing one, and three states have voluntary efforts to establish APCDs.¹¹

While APCDs can be a powerful tool to collect data, states need to have strategies for translating that data into understandable and easily accessible price information for consumers. For example, states can develop websites with provider comparison tools that allow consumers to compare providers based on price and quality. Ideally, such websites would allow insured consumers to see specific estimates of

Massachusetts Takes Steps to Provide Consumer-Friendly Price Estimates



In 2012, Massachusetts passed Chapter 224 of the Acts of 2012, “An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency, and Innovation.” This major piece of legislation was designed to tackle rising health care spending, and it included significant provisions to improve health care transparency for consumers. Among these provisions was a requirement that health plans have a toll-free number and website where consumers can get estimates of prices and their total out-of-pocket costs (through cost-sharing) for specific procedures. These estimates must be binding and must include the combined costs of multiple services that are provided within a given procedure.ⁱⁱ

This requirement took effect on October 1, 2013, and the state is phasing it in over time. Health plans are now required to provide this estimate within two days of gathering adequate information from providers and consumers to estimate the scope of services included in the procedure.

To help ensure that this process is not overly burdensome for consumers, the state has specified that health plans cannot require consumers to provide them with diagnostic codes for services in order to get estimates. If the plan needs that level of information, it is required to obtain it from the provider with the permission of the consumer. This requirement is a strong first step toward ensuring that consumers can easily take advantage of these estimates.ⁱⁱⁱ

Starting on October 1, 2014, plans will be required to have a website that provides price estimates in real time.^{iv}

the negotiated price for care under their health plan and any cost-sharing they would be responsible for paying.

New Hampshire’s Insurance Department created a website called NH Health Cost to translate price data from its APCD into price estimates for consumers. It provided median, provider-specific prices for common procedures. For insured consumers, this website provided health plan-specific, median prices that reflected negotiated discounts. Unfortunately, the website is currently not operating due to problems with the data reporting process.¹²

Even in states with operating APCDs, there is still significant work to be done to ensure that price information is presented in formats that are easy for consumers to understand. A recent review of all states’ price transparency laws, regulations, and state-mandated websites found that many state-mandated websites are not designed in consumer-friendly ways or are poorly operated.¹³

Moving forward, states that want to improve consumer access to price information will need to focus not just on gathering information for consumers, but also on providing that information in useful formats.

Conclusion

To tackle the widespread variation in health care prices, policymakers, payers, and consumers all need more transparent information about the price and quality of care.

In particular, consumers need better information on health care prices and quality. They need accurate information to help them anticipate their out-of-pocket medical expenses. And benefit designs that encourage consumers to select high-value providers can succeed only if consumers have information that empowers them to compare providers based on both price and quality.

States can play a pivotal role in improving price transparency. Moving forward, states should consider taking steps to improve consumer access to meaningful price and quality information.

Consumers have a right to accessible, easy-to-understand information on health care prices and quality so they can compare providers and anticipate their medical expenses. Policymakers need this information to address unnecessary variations in what providers are paid for care. States can take concrete steps to make information on health care prices and quality more widely available.

Endnotes

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Sidebar notes

i Shared-savings and global payment models are designed to reward providers for delivering higher-quality care at lower cost. In a shared-savings program, a group of providers agrees to work together to improve their shared patients' health outcomes while lowering the total cost of care for that population. If the providers end up meeting quality goals and lowering costs, they receive a portion of the savings. In global payment models, a group of providers is paid a capitated monthly amount for each patient whose care they are primarily responsible for managing (often based on a patient's primary care physician), which is expected to cover the total cost of all care. This can give providers an incentive to provide higher-value care, so long as there are strong requirements that providers meet quality goals.

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A selected list of relevant publications to date:

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