American Academy of Actuaries

Issue Brief

Implications of Hospital Price Transparency on Hospital Prices and Price Variation

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Key Points

- Price transparency may be a necessary but not sufficient mechanism to lower hospital prices and health care spending.
- Whether price transparency leads to increased competition, lower hospital prices, and lower variation in prices depends on whether:
  - (1) data are submitted in a form that is uniform, accurate, complete, and easily usable to make comparable observations;
  - (2) payers use the data to develop hospital networks and negotiate hospital prices that focus on creating high-quality and cost-effective networks; and
  - (3) consumers use the information to seek care at lower-cost and high-quality providers.
- Consumers might not have an incentive to seek lower-priced care unless their out-of-pocket costs are tied to prices and referring providers also have an incentive to refer patients to lower-priced providers.
- It is yet to be understood how price transparency will impact health care expenditures overall and consumer affordability.

The United States spends significantly more on health care than other developed nations do, with higher health care prices explaining much of the difference.[1] Hospital services—the largest component of health care spending—make up nearly one-third of all spending.[2] Not only are hospital prices the subject of much attention, so is the variation in prices by facility and by payer. Price differences among hospitals can be dramatic and aren't necessarily tied to differences in quality.[3] Price differences by payer represent negotiations unique to each facility-payer. The opacity of hospital pricing makes it difficult for consumers to compare prices for services and for researchers and policymakers to understand the drivers of hospital spending.

As the Congressional Budget Office discussed in a recent analysis,[4] there are significant differences in the way that reimbursements for care are developed for commercial plans as compared to Medicare fee-for-service (FFS). Medicare FFS uses a regulatory setting method, while commercial plans negotiate prices or purchase access to negotiated prices with provider systems or even individual providers. The consistency and predictability of Medicare payments allow Medicare payments to be a comparator to commercial prices—but even with this comparison, relative commercial prices for a given hospital service are hard to make sense of for payers and payees, much less for a consumer.

1 "It's Still the Prices, Stupid: Why the US Spends So Much on Health Care, and a Tribute to Uwe Reinhardt"; *Health Affairs*; January 2019.
2 "National Health Spending Growth in 2019: Steady Growth for the Fourth Consecutive Year"; *Health Affairs*; January 2021.
3 "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured"; *The Quarterly Journal of Economics*; February 2019. "Do Higher-Priced Hospitals Deliver Higher-Quality Care?" National Bureau of Economic Research, Working Paper 29809; February 2022.
4 *The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services*; Congressional Budget Office; January 2022.

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The Centers for Medicare and Medicaid Services (CMS) issued regulations aimed at promoting transparency in health care pricing.[5] Beginning in January 2021, transparency in pricing regulations require hospitals to provide a list of prices, in both a comprehensive, machine-readable format and a consumer-friendly, "shoppable" format. Unless there are regulatory delays, beginning in July 2022, health plans will be required to disclose commercial contract terms with each provider for each service. In 2023, health plans will be required to provide cost estimation tools to consumers. The stated aims of these and other transparency measures are to empower consumers with information, support competition on the basis of price and quality, and provide unprecedented transparency to employers, providers and patients to drive down health care costs.

This issue brief offers perspectives on factors contributing to hospital pricing and price variation, discusses potential stakeholder uses and impacts of emerging transparency data, and offers an actuarial perspective on emerging transparency requirements. However, it is worth noting that all health care is local, and each market has a different combination of providers, payers, and population, as well as differences in regulation, economy, and care delivery mores.

Background: What Are the Drivers of Hospital Prices and Price Variation?

Hospital prices sometimes seem arbitrary. Frequently, it is difficult for a consumer to know the negotiated price of a service until after a bill arrives, and often it can sometimes seem like there is no connection between billed amount and quality or effectiveness of the treatment received. Further, facilities are not generally incentivized to be transparent to each patient or hold costs for an individual down, because their customer—the patient—does not often bear the weight of the full price if they are insured.

For the uninsured or those who must pay for a significant amount of their care out-of-pocket (OOP), the prices may seem excessive. Hospital price variation is a problem, not only because of price differences, but because it adds to the confusing and complicated

5 *Hospital Price Transparency*, Centers for Medicare & Medicaid.

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nature of the U.S. health care system, and it obfuscates the true cost of care being provided. Payers hold their prices close, fearing competitive disadvantage. Hospitals negotiate with payers to set prices and are incentivized to maximize their price list going into negotiations. Further, consumers have no gauge on the appropriate price for hospital services. For consumers seeking value for shoppable services, it can be difficult because quality metrics, such as CMS Hospital Compare,[6] are not combined with negotiated pricing, and they have no way to make comparisons of value and quality based on the current pricing methods.

Policymakers have enacted laws requiring price transparency to help address these problems. Removing the secrecy of price negotiations might equalize prices across payers. It may bring down the prices of some "outlier" services and on the other hand, it may provoke increases in unit costs for providers who have previously been lower cost. It may provide more information for patients shopping for care. When coupled with quality data, it may establish the baseline for efficiency comparisons.

To provide a fuller context for price variations in hospitals, this issue brief provides information on the components of hospital prices and drivers of price variations.

Components of Hospital Prices

First, there is a distinction to be made between prices and hospital expenses or input costs.

Hospital Expenses or **Input Costs**—how much it costs for a hospital to provide a service.

Hospital Chargemaster—the initial "list" price, established by the hospital before negotiations with payers. For uninsured patients, this is the "cash price."

Hospital Price—the allowed amount charged for a service. For commercial insurance products, the allowed price is often the chargemaster amount modified for a negotiated discount, but there are several other methods also used such as bundled payments or Diagnosis Related Groups (DRG)-based payments. The negotiated price is sometimes expressed as a multiple of the Medicare price. CMS establishes Medicare FFS prices each year.

Payer Price—the portion of the hospital price covered by a third-party payer after patient cost-sharing requirements. This may be paid by a private insurance company, Medicare, Medicaid, etc.

6 CMS Hospital Compare; Centers for Medicare & Medicaid Services.

Patient Price or **Out-of-Pocket Costs**—the portion of the hospital price covered by patient cost-sharing (i.e., deductibles, coinsurance, copays).

Variation in Hospital Input Costs

In theory, hospital prices should be a function of hospital input costs for a given service. In practice for commercially insured contracts, however, the chargemaster prices may bear little relation to the costs of performing the service. Insurers negotiate discounts from these chargemaster prices. The correlation between hospital input costs for a service and the hospital price (i.e., allowed charge) for that service is unknown. Nevertheless, hospital input costs drive hospital revenue and profit targets. Therefore, it is helpful to examine the drivers of hospital input costs within the hospital setting.

Cost variation in medical facilities is driven by numerous components, which can be attributed to either hospital decisions, patient characteristics, or market influences. Below is a list of factors that may impact hospital cost of care:

Hospital Decisions

Service Mix. The average cost of care may vary depending on the mix and intensity of services offered. Whereas some hospitals may offer basic services for certain conditions, others may offer a greater intensity of care, or a higher expertise of care for similar conditions or procedures. Some hospitals may opt for the latest technology and most expensive equipment. The breadth of services is also a factor. A 2019 study indicated that hospitals that specialize in specific services can provide better cost efficiency than hospitals that provide a broad range of services.[7]

Cost Structure. All hospitals must make decisions about budget. This includes an evaluation of services that are making and losing money, and how to subsidize essential services that may not be profitable. In addition, facility fees, physician fees, supplies, room costs, etc., are all considered and either bundled into the cost of services, or billed separately. Finally, depending on risk-sharing arrangements, hospitals consider gains or losses from these variable arrangements. These decisions about how to charge for costs and subsidize care led to variations in pricing between hospitals. A study examining hospital costs for over 3,000 facilities in the U.S. found that nearly half of hospital expenses are considered overhead and are not connected with a specific service. The other half is almost evenly split between labor costs and non-labor costs of services.[8]

7 "Service mix, market competition, and cost efficiency: A longitudinal study of U.S. hospitals"; *Journal of Operations Management*; July 2019.
8 "Hospital Cost Structure and the Implications on Cost Management During COVID-19"; *Journal of General Internal Medicine;* September 2020.

Patient Characteristics

Patient Risk Mix. Some hospitals may treat patients with more complex conditions, comorbidities, or additional determinants of health that may require additional care. All else being equal, treating high-risk patients could lead to greater input costs than the same services for a lower-risk patient.[9] Compounding this, the underlying conditions of the patient population, and even the community determinants of health that impact the hospital itself, have a large impact on costs to treat the patients.

Payer Mix. Insurance coverage of the patient population has an impact on hospital revenues and subsequent prices. In hospitals where most patients are covered under Medicare or Medicaid, hospital revenues are limited by what those programs will reimburse for services. In hospitals where patients are primarily covered by private insurance, the facilities have more leverage in price-setting. Hospitals often attempt to balance these multiple revenue streams. Hospitals also have incentive to attract privately insured patients, who bring higher revenue, through increased marketing and specialty care centers. Although there is significant research into the relationship between payer mix and hospital unit costs, the correlation remains unclear.

Uncompensated Care. The percentage of patients who leave some or all of their hospital bill unpaid varies by hospital and by the portion of the care that is not covered by a third-party payer. Public funds reimburse providers for a substantial portion of uncompensated care.[10] Each facility writes off the remaining uncompensated care but will typically adjust prices to cover the shortfall. The Kaiser Family Foundation estimates that public dollars cover nearly 80% of this amount, leaving a small portion that must be covered by private sources. Of this, some is covered by philanthropic organizations or provider charity, and the remainder may get shifted in the form of higher prices. Whether this shifting occurs is an unresolved question.[11]

Market Influences

Payer Contracting Market Dynamics. In markets where one large hospital system attracts the majority of its residents, that hospital system has greater leverage with insurers and other payers when negotiating contracted rates. The opposite is generally true in markets with one or two insurance options and many hospital choices (although a caveat is "must-have" hospitals in saturated markets that can also negotiate higher prices). To gain volume, hospitals have an interest in remaining "in-network" for a large insurance carrier and will typically accept lower compensation. These negotiations are different with each insurance carrier. The Health Care Cost Institute (HCCI) performed

9 "The extra cost of comorbidity: multiple illnesses and the economic burden of non-communicable diseases"; *BMC Medicine;* December 2017.
10 "Sources of Payment for Uncompensated Care for the Uninsured"; Kaiser Family Foundation; April 6, 2021.
11 "The extra cost of comorbidity: multiple illnesses and the economic burden of non-communicable diseases." Op. cit.

a study looking at market concentrations of hospital networks and concluded that most markets were becoming increasingly monopolistic from 2015 to 2019. Further, more concentrated markets are correlated with higher hospital prices.[12]

Cost of Equipment and Labor. The cost of paying physicians, purchasing medical equipment, and even the basics of keeping the lights on will vary by location and market. Cost of labor is a function of cost of living, cost of education for physicians and other medical professionals, and the availability of medical professionals to staff the facility. This includes primary contracting partners, who may either be employed by hospitals, or remain independent. Regarding equipment costs, it is incumbent upon each hospital to determine what equipment is necessary, and how frequently it should be replaced or updated. Plentiful, or even redundant equipment may increase utilization, which FFS-based institutions may welcome. Further, new and innovative equipment may entice high-profile specialists to a facility but add to the costs that must be covered. In addition, frequent innovations and changes in medical device costs add to the bill and are typically outside of hospital control.

All of the above factors may lead to significantly different input costs for the same medical service at different hospitals. Higher-priced hospitals could have higher input prices. Nevertheless, even after controlling for patient mix, market power contributes to hospital price variation.[13]

Beyond understanding the differences, it is important to connect hospital prices back to the reality of input costs. A 2016 study at the University of Utah Health measured the marginal input cost of care for labor, facilities, and supplies, and the variability in input cost for the same procedure and different patients. The result led to greater transparency in input cost among the medical staff, and an understanding of care efficiency that led to better outcomes.[14] In implementing transparency initiatives, it is important to examine both prices and the underlying input costs for a more accurate consumer measuring stick.

By identifying the components of hospital prices and listing the potential sources of variance in price between hospitals, it is clear how complex the issue of hospital prices has become. The next section explores the implications of transparency.

12 *Hospital Market Concentration*; Health Care Cost Institute.
13 "The Price Ain't Right?" Op. cit.
14 "Implementation of a Value-Driven Outcomes Program to Identify High Variability in Clinical Costs and Outcomes and Association With Reduced Cost and Improved Quality"; *Journal of the American Medical Association*; September 13, 2016.

Implications of Increased Price Transparency for Hospitals, Payers, Consumers, and Others

The implementation of the "Hospital Price Transparency"[15] rules could greatly expand stakeholder visibility into unit prices. In theory, pricing agreements will be visible for each facility and each contracted payer at the service category level. This section explores potential implications of hospital pricing transparency for various stakeholders.

Implications for Hospitals

Hospital systems may not welcome increased scrutiny of cash and negotiated pricing, fearing that high-cost outliers are more likely to receive scrutiny than market-leading prices. There may be concerns that templates into which pricing is collapsed provide an incomplete or biased picture. The effort required to develop and maintain pricing files is not insignificant, nor does it inherently improve patient care. Because the requirement is to report negotiated prices rather than input costs, the exercise of reporting is not likely to surface opportunities to control care delivery or administrative *costs*—which, at a macro level, are a key driver of hospital pricing. On the other hand, this requirement may encourage hospitals to examine their input costs more closely to control subsequent pricing.

Increased price transparency can impact hospitals in many ways. In contemplating potential reactions, it is important to note that hospitals require both cash flow and operating margin to remain solvent and fund investments. Pricing is an important lever available to impact operating margin. As noted earlier, each hospital has a unique combination of competitive environment, cost structure, service mix, patient mix, payer contracts, uncompensated care, and reputation. While not formulaic, these factors almost certainly affect pricing.

With this backdrop, increased scrutiny of high outlier prices could lead to meaningful price reductions for those services. Cash price reductions might occur voluntarily, while contracted price changes will more likely result from negotiation. To preserve revenue, hospitals may seek to increase prices for services that are low relative to market. Hospitals may also look to increase prices in cases where payers are seen to be more generous with competitor hospitals.

15 Hospital Price Transparency; Centers for Medicare & Medicaid Services. Transparency in Coverage; Centers for Medicare & Medicaid Services.

Implications for Payers

As is true of hospital systems, developing and maintaining the required databases will be labor-intensive. Health plans are unlikely to learn much about their own cost structure or contracts from the compilation effort, though intelligence on contracts between providers and other health plans may be of use in negotiations.

Price transparency data are likely to be a meaningful factor in payer-provider negotiations, at least in competitive markets. Payers will look to improve pricing on high-cost outliers, or where competitors appear to have achieved lower overall unit prices. As noted above, payers with favorable contracts might also experience upward pressure on future contracted rates.

It is unclear whether or how much transparency will shift the balance of power in negotiations. Payers with significant market share generally have more leverage, while hospitals with highly valued capabilities or with few competitors may not be motivated to negotiate. Payors might also expect scrutiny of contracting from large plan sponsor customers. Reference pricing for payers and plan sponsors may be adopted more frequently.[16]

Overall, it seems likely that scrutiny over price variation will lead to less price variation in the future. Facilities with high-cost outlier prices are likely to come down, while lowest-in-market prices may tend to rise. The overall impact on price or cost is less clear.

Implications for Consumers

Absent other incentives, increasing availability of data on hospital prices is unlikely to affect consumer behavior to a meaningful degree.[17] This information is not widely publicized, unwieldy in size, and difficult for most consumers to navigate—although post-disclosure, some companies may seek to build tools for consumers. Even with the more robust cost estimation tools that will be available in 2023, consumers may not use price information to seek lower-priced care.

The potential for transparency tools to change consumer behavior seems greatest for non-emergent care often performed in an outpatient setting or for care that could be widely viewed as a commodity. Consumers may be less open to shopping for high severity or life-threatening procedures.

16 Under reference pricing, the employer or insurer establishes its maximum contribution toward payment for a service, product, or episode of care, typically selecting some midpoint in the distribution of prices in each local market. Employees retain the ability to select their own physician and facility and, if they use one charging less than the reference payment limit, receive full coverage after satisfying their customary copayment provisions. If they select a facility charging above the reference level, however, they pay the difference between that level and the price charged. Reference pricing has been applied to procedures (for example, joint replacement and colonoscopy) and to components of care (such as laboratory and imaging tests). It derives from initiatives in Europe, where some public payers limit reimbursement for each drug to the lowest price charged for any drug within its therapeutic class.

17 "Americans Support Price Shopping for Health Care, But Few Actually Seek Out Price Information"; *Health Affairs*; August 2017.

Inpatient stays are increasingly reserved for high-intensity events. Whether expecting a newborn or treating cancer, patient concern is often focused on ensuring the best outcome. The recommendation of the doctor, perceived quality of the facility, proximity, prior use of a facility, and inclusion as an in-network option (where insurance coverage exists) might matter more to a consumer than the overall price. As well, the hospital price is a meaningful but not complete part of the total cost of care dilemma. Costs for pre- and post- care not to mention surgeons, anesthesiologist, lab work, etc., confound efforts to understand overall consumer costs.

Consumers are less likely than policymakers to care deeply about prices of all health care services. Instead, interest in "cost" increases when they need medical treatment, and that interest tends to be focused on the specific care they need.

More fundamentally, a consumer is more likely to be focused on understanding their exposure to OOP costs, not the total medical bill. This interest will be better met by the OOP tool expected to be available by 2023. Using this tool, consumers will gain access to negotiated prices and OOP costs for the 500 most shoppable services, as specified by regulation. But there are likely to be challenges.

For other than simple care, it is difficult to predict in advance the precise set of services that will actually be performed. Even when the course of treatment is known, there may be little or no variation in OOP costs when comparing multiple facilities if the benefit plan has costs expressed as fixed dollar amounts, or the OOP limit is expected to be met under each alternative.

Interest in pricing and use of new tools to shop for care are likely to vary based on a consumer's specific circumstances. Consumers without any coverage will generally be the most price-sensitive, although care is essentially unaffordable for many Americans absent coverage. Consumers with a high-deductible health plans (HDHPs), which have a significant upfront deductible that applies to almost all services, are very price-sensitive and may be avid users of new transparency tools. Conversely, consumers with chronic conditions may not be particularly price-sensitive, fully expecting to reach OOP limits regardless of provider choice.

Other Implications

Variation in pricing might be viewed as a symptom of other key issues like the unaffordability of health care for many Americans, the tendency for costs to increase more rapidly than inflation or increases in anti-competitive markets. The greater availability of price data facilitates the evaluation of these larger issues by researchers, including actuaries, and can lead to action by policymakers and regulators. Increased transparency promotes closer monitoring of price changes and variation along with correlation to the overall health care spend. Researchers can also further study the relationship of price and price changes to market competition. Ultimately, policymakers and regulators will need to consider whether transparency is leading to a sufficient increase in competitive behavior or whether more assertive interventions are needed to achieve stated goals.

Many transparency data sets are unwieldy and are likely to require scrubbing to be truly approachable. Firms with expertise in managing and rationalizing large data sets are already emerging to help make sense of this new data. It remains to be seen whether the additional cost introduced by this effort will be offset through future savings.

Actuarial Implications: How Will Actuaries Be Thinking About Price Transparency?

The emergence of large, comprehensive data sets is likely to be of interest to many researchers and may bolster existing policy proposals or give rise to new ones. Even when presented with the issues of the emerging data, stakeholders will be reviewing this information to make sense of it. Actuaries, depending on their line of work and stakeholder alignment, should expect to be involved with understanding the impacts on their business, the market in which they operate, and the health system at large. Ultimately, the challenge actuaries will face will be to understand and apply the expected impact of transparency on their estimates of cost of care, on policyholder behavior, and on the potential for disruption in provider contracting.

Hospital Contracting Analysis

Actuaries will work with their hospital contracting and finance counterparts within their organizations to understand how any changes in pricing structure will change the financial outcome for the organization of interest (e.g., provider, payer, employer). This analysis will also necessarily consider the lens of shifts in market power and address which party will have more leverage in their negotiations. Will there be downward pressure on high-cost outliers, will low-cost providers be able to negotiate higher prices, or does lack of market power (leverage) override a convergence on prices? Actuaries

would consider how hospital price transparency could impact network design including eligibility criteria for in-network status for broad versus narrow networks, and placement within a tiered network. Further, convergence on prices (in total and for shoppable services) does not indicate the potential impact to the consumer's OOP expense or their behavior. For example, consumers who are frequent utilizers of health care services and consistently reach their OOP maximum for their policy year may be indifferent to the hospital price for an upcoming service because their expected net financial impact is minimized. Actuaries are likely to be involved with the analytics and explanation of how hospital price transparency is impacting each stakeholder's financial impact.

Premium Pricing and Hospital Contract Changes

Premium pricing reflects the entire basket of health care goods and services covered by a health plan as well as how those goods and services are used by the plan enrollees. When developing premiums for a future period, actuaries are likely to reflect known and estimable contractual changes when calculating rates. The resulting impact on premiums from a change in unit price needs to considers 1) the utilization of the specific service by patients at the specific hospital within the payer's network portfolio, 2) the insurance design and how much the patient will be liable for in OOP expenses when utilizing the specific service, and 3) the offsetting costs and utilization driven by shifts in care stemming from transparency in pricing. As an example, a material unit price change for a given service may not be meaningful to the premium charged if it is low-utilized service, at a low-utilized provider, or in a plan with high member OOP cost-sharing requirements. Based on HCCI's 2019 Health Care Cost and Utilization Report,[18] inpatient and outpatient spend represents approximately 47% of all allowed commercial medical and drug spend. For each 1% reduction in inpatient and outpatient costs, allowed commercial medical and drug spend will decline by 0.47%. Other cost factors included in premiums (and cumulatively likely dilute these savings) include prescription drug rebates, administrative costs including those toward quality improvement expenses, taxes, and profits.

Premium Pricing and Consumer Behavior Changes

The consumer behavior outcomes from the initial implementation of the transparency rule are yet to be understood. Actuaries developing premiums are less likely to assume that greater price transparency will result in quantifiable consumer behavior changes, especially if transparency tools are not tied to other financial incentives. As stated previously, consumers are financially interested in their own OOP costs, but transparency alone may not affect those costs. In addition, financial factors are not the only factors when deciding to use a particular health care provider for a particular service. The OOP

18 *2019 Health Care Cost and Utilization Report*; Health Care Cost Institute; October 2021.

estimator tools that may have a direct link to the patient's financial liability may be more impactful. Nevertheless, even when armed with the OOP cost estimator tools, consumers may consider other variables like relying on their health care providers for advice on which treatment path is the optimal one for them, personal preference for a given hospital system, influence of their insurer's network design, the distance from the hospital to home or other post-acute recovery location, and assurance of continuity of care. Actuaries involved in product design may consider how price transparency is factored into the product design like through narrowed networks or reference-based pricing, where both design elements can drive consumer behavior change to lower-cost settings.

Self-Funded Market Analysis

The availability of hospital price data will allow self-funded employers to see the variation in contracted prices for specific services at hospitals that their covered population utilizes. Actuaries who are involved with helping self-funded employers estimate the financial value of their provider network may need to provide context to what this emerging information means while also supporting the employer's ability to push for change. For example, a smaller self-insured employer might not have the ability to design its own network but rather can push on its third-party administrator (TPA) to explain how the TPA will address the variation in its contracted hospital prices when compared to peers and, possibly, in-network inclusion status or other design levers to make meaningful change for the TPA's self-insured accounts.

Regulators

Actuaries at the state and federal level are involved with balancing the needs of patients, health care providers, and payers. In early analysis of data available from the federal price transparency rule,[19] issues with the available data sets include lack of standardized use of the required file format and data definitions, both of which make comparing hospital prices difficult given the data limitations.

CMS enforces the federal rule pertaining to price transparency. While CMS has published guidance to hospitals on how to create the machine-readable files, CMS may need to consider further standardization of this information so that it can become useful in the way policymakers had originally intended. Actuaries involved with rate review would consider the assumptions made in the rate development that are specifically impacted by price transparency and document their assumptions in any required rate filing documents or actuarial memorandum. Rate reviewers may need additional analysis or

19 "Early results from federal price transparency rule show difficulty in estimating the cost of care"; Peterson-KFF—Health System Tracker; April 9, 2021.

detail to support the assumptions that impact the filed premium rates. Regulators are also involved with reviewing network adequacy and will carefully review the development of new narrow networks that are byproducts of the transparency rule.

Actuaries involved with state level health care cost growth targets (either total cost or hospital costs) might find value in the more robust set of price data that could become available with the rollout from the "Transparency in Coverage" rule whereby beginning in July 1, 2022, health plans would be required to provide machine readable files with "rates for all covered items and services between the plan or issuer and in-network providers" and "allowed amounts for, and billed charges from, out-of-network providers."[20] Once widely available, CMS expects "researchers could better assess the cost-effectiveness of various treatments; state regulators could better review issuers' proposed rate increases; patient advocates could better help guide patients through care plans; employers could adopt incentives for consumers to choose more cost-effective care; and entrepreneurs could develop tools that help doctors better engage with patients."[21]

Summary

Price transparency may be a necessary but not sufficient mechanism to lower hospital prices and health care spending. Prior research has already established that prices charged within commercial lines of business can vary dramatically across hospitals for particular services without being explained by differences in quality. The variations reflect many factors, including hospital cost allocation strategy with consideration for the mix of services provided, patient characteristics, and contracted payers. Even after controlling for these factors, hospitals with market power have higher prices. Policymakers are pursuing price transparency to increase competition, lower overall hospital prices, and lower the variation in prices. Whether those goals are achieved depends on whether (1) data are submitted in a form that is uniform, accurate, complete, and easily usable to make comparable observations; (2) payers use the data to develop hospital networks and negotiate hospital prices that focus on creating high-quality and cost-effective networks; and (3) consumers use the information to seek care at lower-cost and high-quality providers (with this last one also requiring consumer-friendly quality metrics). Even still, consumers might not have an incentive to seek lower-priced care unless their OOP costs are tied to prices (e.g., via coinsurance or reference pricing) and referring

20 "Health Plan Price Transparency Plans and Issuers"; Centers for Medicare & Medicaid.
21 "Health Plan Price Transparency Third Party Use"; Centers for Medicare & Medicaid.

providers also have an incentive to refer patients to lower-priced providers. Last, it is yet to be understood how price transparency will impact health care expenditures overall and, also importantly, consumer affordability. Affordability can pose barriers to access into the health care system, which can then beget inequities in receipt of care and patient outcomes. If price transparency can bring down health care system costs and make health care more affordable, then price transparency would be seen as a success. If price transparency coupled with plan design does not bring down health care system costs, then policymakers may need to consider other alternatives to addressing the cost and affordability issues of the existing health care system.