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Price Transparency in United States' Health Care: A Narrative Policy Review of the Current State and Way Forward

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Abstract

Health care price transparency is gaining momentum as a tangible policy intervention that can unleash market principles to increase competition, help begin to decrease U.S. health care expenditures, and provide Americans with access to affordable, high-quality health care. Indeed, pricing reform is required to facilitate patient shopping in health care. In this narrative policy review, we offer a brief history of health care price transparency efforts and an overview of the health care price transparency literature. Further, we highlight the current rules and legislative initiatives aimed at achieving the full potential of health care price transparency. Lastly, we offer key takeaways and highlight suggestions for future policy directions, including the need to ensure hospital and insurance compliance through more appropriate penalties and incentives, importance of reducing regulation to promote financial upside that can be obtained by both patients and providers who actively promote shopping for lower cost, higher quality health care goods and services, and the need for transparent and easily found quality metrics, including outcomes most important to patients, driven by physicians "on the ground" with patient input.

Keywords

price transparency, health care prices, health care transformation, health policy, health care economics

What do we already know about this topic?

Better aligning incentives and using market forces could make a positive difference in American health care by decreasing expenditures and improving quality through competition. This would benefit patients. Health care price transparency at the state and federal levels has gained substantial interest as one way to influence market behavior. The initial outcomes of such policies are promising but much more remains to allow health care price transparency to reach its full positive potential.

How does your research contribute to the field?

This narrative policy review article highlights the history of health care price transparency, including policy initiatives and key scientific articles on the topic. Lastly, we offer tangible "next steps" and areas for consideration by stakeholders, including policymakers, moving forward.

What are your research implications toward theory, practice, or policy?

Our work condenses the history (including policies) and broad literature on health care price transparency in one place, allowing stakeholders (including policymakers) to read a single article to get a comprehensive overview on this important topic. Further, our recommendations and "next steps" can guide future policy endeavors that can help patients/health care consumers.

Introduction

In 2022, health care expenditures in the United States (U.S.) continued to grow to 17.3% of Gross Domestic Product (GDP), reaching $4.5 trillion or $13,493 per person.[1] The percentage of spending on health care is notably higher in the U.S. than other wealthy nations.[2] High U.S. health care prices have been recognized as a key driver of the high spending in the U.S. compared to other countries since the beginning of the 21th century.[3,4] These facts—in and of themselves—are not necessarily a negative if the U.S. gets "more" (ie, improved quality, better clinical outcomes, and/or groundbreaking innovation) for the dollars spent.[5] At present, however, the evidence on quality and clinical outcomes is inconsistent compared to peer countries,[6] while the U.S. is clearly the global leader in driving medical innovation that benefits patients worldwide.[7] But this is only part of the current American health care story.

Despite the passage and implementation of the Affordable Care Act (ACA), nearly 1 in 10 U.S. adults (or 23 million people) have medical debt, with millions of patients carrying $10,000 or more in medical debt.[8] Further, two-thirds of personal bankruptcies in the U.S. are attributed to medical issues, including medical debt, which equates to about 530,000 Americans.[9] This likely reflects ways in which incentives are currently aligned in the U.S. health system. For instance, the Federal Trade Commission (FTC) has expressed concern about the impact of pharmacy benefit manager (PBM) business practices, specifically suggesting that PBM practices may result in restricted access to lower cost pharmaceuticals and higher out-of-pocket costs for consumers.[10] Indeed, PBMs are part of the apparatus to occlude clear prices for patients. Additionally, Hernandez and colleagues acknowledge that misaligned incentives around discounts, such as copay cards, likely play a key role in pharmaceutical utilization in the context of the increase in list and net prices from 2007 to 2018, but many patients who lack insurance or who are on high deductible insurance plans remain financially vulnerable to high list prices.[11] Hence, while the FTC raised these issues surrounding PBMs in the context of exercising its regulatory authority to curtail these issues, this research speaks to a deeper issue that incentives exist within the U.S. health system that drive high prices and medical debt. The current reality does not encourage competition based on price and quality, and addressing these misaligned incentives is likely critical for achieving lower consumer prices.

Thus, the current reality for American health care consumers is that they pay high prices and incur significant personal debt. It logically follows that many American patients routinely risk not being able to afford the clinical care and groundbreaking innovation that the US health care system produces. This is unacceptable.

Across the American health care delivery system, incentives are misaligned, a significant bureaucratic paperwork exists, the true cost of care delivery is unknown, and prices from a patient point of view are shrouded in mystery. This exacerbates the pitfalls outlined above.

While a simple fix is an unrealistic expectation, it is not only possible but critical that stakeholders begin to address the flaws in America's health care delivery system by promoting competition that drives down costs and improve care quality, including outcomes most important to patients. One such policy that has garnered widespread support and can begin the necessary path forward in "fixing" health care delivery is health care price transparency.

In this current manuscript, we will briefly examine the history of health care price transparency in the U.S., including rules and policies implemented to support its progress. Further, via a narrative policy review approach, we will consider academic literature and mainstream media coverage on U.S. health care price transparency, focusing on recent and proposed policy changes. We will then acknowledge and discuss the possibilities and limitations of price transparency within the U.S. health care delivery system and suggest future areas for policy innovation and scholarly inquiry.

Background: Historical Perspectives in Academic Literature

The lack of price transparency in the U.S. health care delivery system creates a challenge to establishing a competitive market and empowering patients to the full extent possible, as such information is needed to facilitate shopping in health care. Without insight into prices (and what those prices purchase as specifically as possible) before care is delivered, consumers (ie, patients) are left vulnerable to high price setting common in monopoly-type settings.[12] While this concern was initially raised by Nobel Prize winning economist

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Kenneth J. Arrow in 1963 to describe physician price-setting, the growth of public and private third-party payors and the increasing role of hospitals to deliver medical goods and services shifted the power of price setting to negotiations between health care professionals and these third-party payors, not patients.[13] Cooper and colleagues found that hospital prices for inpatient and outpatient care grew significantly faster than physician prices from 2007 to 2014.[14] While this suggests that hospitals in the current era may be more responsible for setting and driving high prices than physicians, it remains the case that consumers have lacked historically both the power and necessary information to make informed choices with respect to their health care.

The Congressional Research Service (CRS) published a 2007 study of price transparency in other markets to see what lessons could be applied to healthcare.[15] The report compared efforts where price transparency lowered consumer prices, such as NASDAQ trading, to where price transparency increased consumer prices, such as Danish Competition Authority action on all ready mixed concrete contracts in 1993.[15] The report notes how differences in information about the process of setting prices (as seen in the NASDAQ example) tends to result in greater public pressure for price reduction, whereas greater information of prices on intermediary goods (as seen in the mixed concrete example) does not necessarily lead to lower overall prices. This is relevant to hospital prices because hospital prices are often negotiated with third party payors. The increase in prices can occur because of increased ease of "collusion" among sellers, as they simply now know competitors' prices and can all raise their prices to be at the "high end," and changes in seller incentives to avoid offering better prices to better informed buyers for fear of lowering the overall average sale price.[16] This research provides early evidence that simply making prices available does not automatically lower prices. The report also acknowledges the role of non-market forces, including seller reaction to media coverage and possible regulator action. The important takeaway, in other words, is likely that the seller response to price transparency is a critical component of actually achieving lower prices, and information should be made available to buyers when goods or services differ on quality.

At the federal level, addressing this issue was not a primary health care policy lever used efforts until the Trump administration.[17] However, the focus on health care price transparency has taken on greater significance more recently. We believe one key reason is related to the continued high cost of US health care, which was mentioned earlier. Since the beginning of the 21st century, high prices have been recognized as a key driver of the differences in health care spending between the U.S. and other countries,[3,4] yet quality has remained largely unclear and inconsistent.[18] To date, this is only worsening, not improving. Second, policymakers and society as a whole have continued to shift towards a health care delivery system that is more consumer-directed, incentivizing patients to take more control of their health and care decisions.[19] This includes financial decisions related to how they spend their health care dollars. Some health insurance coverage options have shifted to include health savings accounts (HSAs), and there are many more high deductible plans available in which patients now bear a greater portion of financial risk.[19,20] This increased financial risk for consumers is intended make health care consumers more cautious about their health care decisions and to use that caution to help control health care spending by incentivizing them to choose lower cost care.

Price transparency is a logical part of that approach because it allows consumers to compare prices and opt for lower cost care,[21] always keeping in mind the quality of care being provided. There is some research that suggests health care consumers respond to these initiatives in specific clinical situations, especially when health care providers list prices as a means to compete for health care consumer dollars. For example, Mehta et al found that ambulatory surgery centers (ASCs) that listed their prices online saw significant increases in patient volume, revenue, third-party administrator contracts, and patient satisfaction.[22] This suggests that providers seeking to meet a specific clinical need can benefit by participating in price transparency; in other words, price transparency can be good for business. Interestingly, discouragement from a peer medical practice, hospital, or insurance company was reported as the most important barrier to price transparency.[22] Thus, peer attitudes and social pressure may be key factors in whether health care providers participate in price transparency initiatives. This likewise suggests that social pressure historically existed to protect price setting behavior and likely still exists, as this paper will discuss further. This is an important point that should not be overlooked.

While federal price transparency initiatives were limited until more recently, at the state level, a number of health care price transparency work had been undertaken (eg, health care price transparency websites),[23,24] including in New Hampshire, Maryland, Massachusetts, California, Tennessee, and Florida, among others, though with mixed results. New Hampshire established the website "NH Health Cost"[25] in 2007, which—at the time—provided price insights on 42 commonly used health care services.[26] While the website has expanded and been refined over the years, it was only used by 1% of residents within the first 3 years of being launched, and while online advertising increased awareness, it did not—in initial analyses—lead to increased usage of lower priced health care professionals.[27] The California Public Employees' Retirement System (CalPERS), which administers health care benefits for state employees, their dependents, and retirees, offered a commercial price transparency website and mobile application called "Castlight" starting in 2014 to beneficiaries enrolled in an Anthem Blue Cross preferred provider organization (PPO) plan.[28] The tool listed prices for laboratory testing, imaging, and office visits. In the

14 months that followed the tool's creation, offering beneficiaries the price transparency tool alone was not associated with high usage or with lower spending for beneficiaries that used the price transparency tool.

These results, however, may not tell the full story. A large study by Whaley and colleagues of 18 self-insured employers offering a variety of insurance plans, including high deductible and PPO plans, found that use of the "Castlight" price transparency tool was associated with lower medical claims for advanced imaging, laboratory testing, and—to a lower extent—for clinician office visits from 2010 to 2013.[29] In addition, Robinson and Brown studied the impact of reference pricing by comparing members of CalPERS to Anthem Blue Cross beneficiaries from 2008 to 2012.[30] Reference pricing puts limits on the amount that employers will pay for some procedures that are covered by employer-provided insurance and leaves employees responsible for the difference in cost, thereby incentivizing employees to choose lower cost care. Surgical volumes for CalPERS members increased by 21.2% at low-price facilities and decreased by 34.3% at high-prices facilities, while prices charged to CalPERS members declined at low-price facilities and high-price facilities.[30] This suggests that price shopping can be achieved when combined with other approaches that incentivize consumers to choose lower-cost care.

Similar results have been reported elsewhere. Whaley et al found in a separate study analyzing data from 2017 to 2018 that prices decreased for beneficiaries in employer-sponsored plans that received a financial payment to choose care from lower-cost providers and that the effects were most concentrated among imaging studies, specifically magnetic resonance imaging (MRI) studies.[31] This again suggests that consumers can respond to price transparency initiatives when they are incentivized. However, consumers may not be the only market actors to respond to prices becoming publicly available. For example, Christensen et al reported that hospitals decreased their prices in the context of charge price transparency regulation and hypothesized this occurred in part because hospitals did not want to develop a reputation for overcharging patients.[32] In other words, hospitals as market actors may be sensitive to the public's perception of their behavior and lower their prices once prices become public.

Given several of the price transparency successes reported in the literature, the mixed results of state level health care price transparency initiatives are not indicative that improving market conditions is inappropriate. The inconsistency is more likely related to the barriers in place that prevent true health care "shopping."[21] These include patient lack of awareness, inability to compare "apples to apples" and fully understand health care professional recommendations, patients' relationships with their providers, and poor incentive structure within health plans.[21] A deficiency of actionable quality information, including outcomes most important to patients (eg, quality of life), may also play a role in state level efforts falling short of expectations. Patients also must consider the opportunity cost associated with finding lower cost providers. More importantly, patients most also consider the opportunity cost and technical challenges with transmitting information obtained from the lower cost provider back to the ordering provider. The health care price transparency progress made by states and the lessons learned through their efforts, however, offer a beneficial roadmap to greater success with federal initiatives through the U.S. Centers for Medicare and Medicaid Services (CMS). This is especially true as a number of more recent issues and societal changes have altered the viewpoint on health care price transparency at the federal level, leading to a desire for action that can build and improve upon the initial steps undertaken at the state level.

It is not just "common sense" in the setting of growing health care delivery issues and societal changes that create the perfect backdrop for health care price transparency progress. Americans across the ideological spectrum desire it as well. Nearly 9 out of every 10 Americans are in favor of health care price transparency.[33] In addition to being an area of active policymaking and a subject of academic study, price transparency remains an area of interest in the popular press[34-38] and for "think tanks" across the ideological spectrum.[24,39,40] Health care price transparency has also been called "an ethical and policy imperative for American health care."[41] Ultimately, when taken altogether, the current atmosphere is optimal for health care price transparency changes that will likely have a broad positive impact for patients through increased competition leading to better care quality and improve efficiency.

Federal Health Care Price Transparency Rules and Policy Initiatives

With the passage of the ACA, the Secretary of U.S. Health and Human Services (HHS) was provided the power to issue regulations that hospitals would be required to abide by, including efforts to force hospitals to post prices for goods and services.[24,42] While initial steps were taken to improve price transparency at the federal level over the ensuing years, tangible progress did not occur for nearly a decade.

In June 2019, President Donald J. Trump issued an executive order focused on improving health care price and quality transparency.[43] Shortly thereafter, in November 2019, the U.S. CMS finalized a rule that required hospitals to post prices related to 300 of the most "shoppable" procedures, goods, and services beginning January 1, 2021.[44] Those goods and services considered "shoppable" included many common laboratory tests, such as a basic metabolic panel, and common radiology services, including lumbar spine X-rays.[44] However, it also included common surgical procedures, including primary lower extremity (ie, hip or knee) joint arthroplasty (ie, replacement).[44] The American Hospital

Association (AHA) sued the Trump Administration to try to block the measure but was unsuccessful.[45]

In October 2020, the Trump Administration took another step to further health care price transparency, with CMS finalizing its health insurance price transparency rule.[46] While initially delayed with the transition to the Biden Administration, the rule took effect in July 2022.[47] Indeed, health care price transparency was one of the rare policy areas that made substantial progress under President Trump and was continued by President Biden.[48]

While the rules outlined by CMS provide progress in "fixing" American health care, they are not nearly as strong as if legislation was to be passed by Congress. Codifying and building upon the health care price transparency rules demonstrates to all stakeholders the importance and "staying power" of health care price transparency. In December 2023, the U.S. House of Representatives passed "The Lower Costs, More Transparency Act" in a strongly bipartisan manner by a vote of 320 to 71.[49] While not law until passed by the U.S. Senate and signed by the President, the passage of health care price transparency legislation in the U.S. House of Representatives demonstrates a desire—even in a strongly divided legislative branch—to address health care issues negatively impacting the American people. While the exact policies are likely to change as the bill moves to the Senate,[50] progress is clearly being made.

This also applies to regulation. In November 2023, CMS provided a key update on hospital price transparency, including the results of a recent audit that listed hospitals across the country that have been issued civil monetary penalties for non-compliance.[51] This suggests a significant regulatory commitment to enacting price transparency. Price transparency is a rare policy issue for which there is strong bipartisan support across multiple branches (ie, executive and legislative branches) of the U.S. federal government. This bipartisan support underscores the importance of understanding the impact of price transparency policy changes and of refining current approaches to price transparency policy reform to help it realize its full potential.

Assessment of Health Care Price Transparency Literature

Given the novelty and scope of the price transparency rule change, a full analysis of the outcomes of the price transparency rule change will require years of data.[52] Other issues confound the goal of a robust, unbiased academic study. In addition to lawsuits, low initial compliance with the rule change and the lack of national data before the rule change are 2 additional obstacles.[53] Despite this, there is a growing body of literature studying the newly disclosed prices with the goal of better understanding the impact of the rule change in the short term.

Parente used an upper bound analysis to estimate the impact of the price transparency rule for the commercial population by 2025 for income level, region, and state.[52] Using the 40% reduction in expenditures for "shoppable" services by shifting from negotiated commercial prices to cash prices suggested by the analysis from Lawrence Van Horn et al[54]—the same estimate used by the White House and HHS in 2019—Parente estimated the overall impact of price transparency for the commercial population in 2025 to be as high as $80.1 billion.[52] The analysis notably projected greater percent savings for low income beneficiaries at or below 137% of the Federal Poverty Line and variation across regions and states. It also projected that the growing use of high deductible health plans may reinforce potential savings from price transparency, because recent research has shown that price information leads to a shift to lower cost providers, in particular for those beneficiaries subject to high deductibles.[55] It should be noted that the growth in high deductible plans reinforce the broader, consumer-oriented changes in U.S. health care that we have been discussing.

The study from Gul et al also found low compliance with the new price transparency rule. In their study, only 29% of hospitals were found to be compliant with the rule despite the $300 per day fine for non-compliance.[56] Compliant hospitals were more likely to disclose lower cost procedures. Low compliance was also found in a larger study by Jiang et al that examined 3,558 Medicare certified general acute care hospitals 6 months after the price transparency rule went into effect.[57] They found that 55% of hospitals had not posted a readable file listing their commercial negotiated prices.[57] In their study, peer behavior of hospitals in the same market played a key role in whether hospitals were compliant with the price transparency rule. This suggests that in the same way Mehta and colleagues reported that peer behavior was the barrier to price disclosure for ASCs before the new federal rule,[22] hospitals likely took cues from competitors within their market when deciding to disclose their prices after the new price transparency rule. This may afford policymakers an opportunity for intervention.

Researchers are also using the new price disclosures to better understand the overall landscape of U.S. health care prices. Price variation is the dominant emerging theme of this research. In a cross-sectional study of 153 academic medical centers more than 1 year after the new price transparency rule went into effect, Gul et al found wide variation in negotiated prices for urologic procedures among hospitals.[56] The authors also reported wide variation in price according to insurance type, with cash prices being lower than the price for Medicare, Medicaid, or commercial insurance at 16% of hospitals in the study.[56] Wang et al similarly found that cash prices were lower than median commercial prices in 47% of the instances they studied across 2379 hospitals and were more likely to be lower in specific instances, such as non-metropolitan location or hospitals with stronger market power.[58] This suggests that consumers in many cases may pay lower prices by forgoing insurance, which seems to defeat the purpose of using insurance to protect beneficiaries

from financial risk. It is important to note that this may not always be the case, as the size of the deductible would also contribute to determining whether the cash price would, in fact, be cheaper overall. However, given the variability across individual insurance plans, consumers are left on their own to calculate their personal out-of-pocket costs. This adds an additional layer of opacity to an already complex and cumbersome patient experience.

Price variation among insurance types has been reported in other studies. Meiselbach and colleagues examined negotiated prices for insurers offering both commercial insurance plans and Medicare Advantage. They found that the same insurer's median negotiated prices for commercial plans were 2 to 3 times higher than those for Medicare Advantage plans and that larger differences were associated with system-affiliated, non-profit, teaching hospitals, and large national insurers.[59] While these differences likely reflect differing incentives within the commercial and Medicare Advantage markets, respectively, the variation does underscore the oddity that the same service in the same hospital could vary so widely even when the insurer is the same. These findings are similar to a study from RAND on the prices paid by employers and private insurers for inpatient and outpatient services, which found that employers and private insurers paid 224% of what Medicare would have paid for the same service at the same facility.[39] This may suggest a need for policymakers to look more closely at incentives within the markets rather than the prices alone.

While price variation exists within a hospital or health system, there is growing evidence that care setting impacts price, too. RAND found that for 5 procedures commonly performed at ASCs and hospital outpatient departments, the average hospital outpatient department price was $6,169 compared to $2404 at ASCs.[39] This price variation by setting seems to apply within the commercial market. A national study by Wang et al of commercial prices for colonoscopies at 3582 hospitals and 3899 ASCs found that fees for colonoscopies paid to hospitals were approximately 55% higher than those paid to ASCs in the same county and with the same insurer.[60]

The fact that the price difference applies to sites of care within the same geographic data has been observed elsewhere. For example, Chernew et al observed that patients, on average, bypassed 6 lower-priced providers on their way to their eventual MRI treatment location.[61] This study underscored the importance of physician referral patterns in explaining why patients bypassed lower-priced providers. In addition, MRI scans ordered by a physician practicing in a vertically integrated practice owned by a hospital were 36.3% more expensive and 27% more likely to receive a hospital based scan.[61] Together, these findings underscore that the doctor-patient relationship may give physicians a unique role in making referrals for services at difference price points and that the employment status of that physician is an important factor in the costs associated with their referral. They also suggest that vertically integrated care—as currently set up—may not deliver lower-priced care even in the context of price transparency.

Finally, researchers are discovering more about features that impact negotiated prices. Wang and colleagues found that greater insurer market power was associated with lower negotiated prices for "shoppable" procedures, an expected free market outcome. For "shoppable" services at 1506 hospitals in metropolitan areas, the largest insurer negotiated prices that were 23% lower, while cash prices were 17% higher.[62] The effect generally diminished with insurers with less market power for "shoppable" procedures. On the other hand, in markets where hospitals had stronger market power relative to insurers, hospitals were more likely to offer cash prices below their median negotiated rates for "shoppable" services.[58] This may suggest that the variability within a market depends - in part - on which market actor holds the most power.

Key Takeaways and Suggestions for Future Directions

Consumers' lack of clarity on health care prices has long been recognized as a problem in U.S. health care because they have been vulnerable to price-setting behavior characteristic of monopolies, not free markets. In addition, high prices in U.S. health care have been recognized as a key driver of U.S. health care spending, and current research suggests that hospital prices are growing at a faster rate than physician prices. The modern era has seen a growing interest in empowering U.S. health care consumers to play a greater role in their health care spending. Price transparency is an important component of that shift, and recent federal and state policy changes are designed to bring more price transparency to U.S. health care, with the belief that it can ultimately lower prices and spending. As the Congressional Budget Office (CBO) writes, "If more consumers started using price information to choose lower-priced providers, then, over time, those changes in price sensitivity might pressure providers to accept negotiated prices that were much lower than they would be under current law."[63]

Several lessons stand out from our assessment of health care price transparency. First, it will be challenging to realize the full benefits of price transparency if compliance remains low. The consistently low reported compliance rates with the new price transparency rule will impede progress that can be made from price transparency policy changes. This represents a challenge for policymakers, who could consider 2 specific approaches. First, if policymakers are serious about making price transparency a reality for patients rather than a rule or law that hospitals disregard, they must consider stiffer penalties that hospitals cannot afford to ignore. Second, our work suggests that peer hospital behavior is a key factor in hospitals' decision-making about price disclosure. Policymakers can leverage this by offering incentives, such as a certain offering a portion of shared savings to early

adopters in similar ways to CMS's Medicare Shared Savings Program[64] and by targeting specific hospital markets rather than using a top-down, "one size fits all" approach.

Employers, likewise, will need to wrestle through some of the incongruencies that price transparency has uncovered. The large differences in prices paid by commercial plans and Medicare should give employers pause. This may create an opportunity for employers to work with policymakers to address these large differences, especially where those differences reflect misaligned incentives in the current policy framework. With 54.5% of the U.S. population covered by employment-based health insurance,[65] employers have substantial power to demand changes that benefit their employees' health and—by proxy—their business endeavors. Employers may also recognize that lower-priced care for "shoppable" services is available in different settings and look for ways to incentivize their employees to choose those lower-priced settings.

For patients to benefit from price transparency tools, several conditions must be met, including price differences for health services that are meaningful, accessible, and convenient for them as consumers, including allowing for clear "apples to apples" comparisons.[66,67] This may provide insight into why the simple creation of a price transparency tool, such as a website listing prices, does not assure this occurs and suggests a need for a broader set of reforms for price transparency to realize its full potential. Indeed, price transparency seems to be more effective when it is combined with approaches that incentivize consumers to choose lower cost care, such as reference pricing or "reimbursing" (either with cash or a portion of shared savings into an HSA, for example) consumers for choosing lower-priced providers. This suggests a role for health plans. Insurance plans can create incentives within their plan to reward consumers for choosing lower-priced care. Given the emerging data around price differences based on setting, this may mean incentivizing consumers to receive "shoppable" services in lower cost settings, such as ASCs as opposed to hospitals. To facilitate this, policymakers could consider payment reform whereby products that have the same unit and code definition for common services no longer differ by care setting. A colonoscopy performed in a hospital outpatient department and an outpatient physician office, for example, could be coded the same way to better allow for direct comparison in price by setting.

It also should underscore the importance that the information generated in a lower cost setting must be easily shared with the patient and ordering provider—even if that provider is part of a different health system. This is a notable departure from the traditionally siloed approach to health care data. However, policymakers should realize that consumers may opt to forgo lower-priced care if transmitting that information back to their ordering provider becomes too cumbersome, which it often is at present. In economic terms, the opportunity cost associated with information sharing must be low for price transparency to realize its full potential.

This further suggests a need to reshape the debate around price transparency around consumers. The goal of price transparency is to empower consumers to opt for lower-priced, higher quality care. While listing master charge, commercial, and cash prices is helpful, what would be more helpful to consumers is if they better understood what their out-of-pocket costs will be for a service given their particular form of insurance. This represents an administrative departure from the traditional health care business model, but this is how other sectors of the economy work—the consumer is the point of focus for competition based on reasonable out-of-pocket costs for a high-quality product. While the hospital and insurance health care price transparency rules, which include elements that are in the midst of potentially becoming law through Congress, begin to make this necessary change, checking and comparing prices for "shoppable" goods and services must become a greater part of patient and physician routine based—as noted above—on the specific insurance type and setting, among other factors. This cannot impede care flow, or other elements or physicians will not make this a priority. Any legal or contractual barrier for physicians to refer to less costly providers or settings must also be removed. Further, there must be an incentive for such effort, including sharing in savings. HSAs offer this opportunity in a manner that that is beneficial from a tax standpoint as well; thus, HSAs should be expanded to all patients across different coverage types, which has been a focus of some in the popular press as well.[68]

Research suggests that physician referral patterns likely play an important role in consumers forgoing lower priced care. This suggests an opportunity for intervention. Health plans can create incentives for physicians and other providers to refer patients to lower priced "shoppable" services. As noted above, these could include shared savings programs. In addition, if price transparency were re-designed around helping consumers understand their specific out-of-pocket costs, then physicians and their staffs could work with their patients to help them identify lower cost care settings because all parties could benefit financially. This could become part of the health care consumer experience. It should be noted that this may involve physicians needing to refer patients outside of their vertically integrated hospital system. Policymakers should consider ways to protect physicians and other providers from negative consequences that could arise from this action designed to help U.S. health care consumers pay lower prices, including revisiting any Stark Law issues that may come about if the lower priced care is, in fact, within their own system or network.

Given the popular support for price transparency and the growing interest among policymakers and those interested in health policy, it is also important to acknowledge price transparency's limitations. First, given the unique nature of the patient-doctor relationship, some patients may choose to pay for higher-priced care, especially if paying a higher price protects their access to a provider's desired expertise.

Second, price shopping is limited in specific clinical situations, especially for goods and services that are not "shoppable." These may include medical emergencies like acute stroke or care settings that require high resources, such as specialty critical care. In fact, international research on the relationship between price and quality suggests that there are conditions like myocardial infarction, stroke, and congestive heart failure where higher prices may suggest better quality.[69] In these instances, price shopping may not be feasible or desirable. Lastly, without transparent and accurate quality data, including outcomes most important to patients, the full benefit of price transparency is not likely to be appreciated. In fact, without such insight, prices and rates with health care price transparency may actually increase, as hospitals and insurers realize they are charging well below the most expensive option and increase their prices and rates to almost match it. However, if quality is known, this will not occur, as patients will better know what health care they are receiving for their dollars. Physicians, consumers, and other stakeholders must demand transparent quality, including outcomes most important to patients; importantly, however, the government should remove barriers for this to occur by those "on the ground".

One area for future research that will be important is the relationship between price transparency and hospital consolidation. One of the fundamental assumptions of price transparency is the idea that consumers can choose a lower priced service of equal or greater quality. This requires that consumers have a choice in care settings. In the era of hospital consolidation and vertical integration, this may not always be the case, and further research should be undertaken to better elucidate the relationship between price transparency and hospital consolidation. For policymakers, it may suggest a need to increase hospital competition; allowing physician-owned hospitals to compete for patients on price and quality may offer 1 solution. Furthermore, the need for price transparency in our modern era should underscore the failure of vertical integration to deliver lower prices in many cases and to control health care costs despite the promises of prior generations of health policy analysts.

Conclusion

Price transparency can facilitate a transition to increased patient shopping in health care. In order to realize the full potential of price transparency, policymakers must ensure compliance with the new federal rules, work to codify them through Congress, and create more and improved incentives for hospitals, insurers, health care professionals, and consumers to allow patients to benefit from lower priced, higher quality health care.

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