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Policy Article

The Case for Healthcare Cost Transparency

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Abstract

Healthcare makes up nearly 18% of the US economy, with expenditures of $2.7T annually. Although the rate of growth of healthcare costs as a percent of GDP has moderated in recent years, it has risen from 13.8% of GDP in 2001. Slowing the growth of healthcare costs is indeed a critical national priority. In just the last few years, there has been a sea change occurring in the health insurance market, with consumers and patients being increasingly required to take on a larger share of their healthcare costs. These new insurance paradigms, such as reference pricing, coinsurance, and high deductible plans (e.g., "consumer-directed health plans") will require consumers to have access to tools to be able to make sound decisions, including what their out-of-pocket costs will be. Additionally, the rollout of the Affordable Care Act's health exchanges with the resultant increase in the number of newly insured, will have many consumers for the first time being made aware of the substantial out-of-pocket costs they will incur besides just insurance premiums. What is now badly needed is price transparency, something that has historically been lacking in the healthcare industry. The combination of greater cost sharing and transparent pricing will create a true healthcare marketplace and should result in lower costs, as consumers price shop and increasingly elect lower cost providers and treatment alternatives. In order to facilitate the movement towards meaningful healthcare cost transparency, five distinct policy initiatives are recommended.

Keywords: healthcare, transparency, insurance

Introduction

Recently, employers have increasingly begun to shift a greater percentage of healthcare costs to employees, commonly by offering coverage in some form of high deductible health plans (HDHPs) that in turn lowers premiums, typically on average by $1,000 to $2,000 per year (1). This effort comes after employers have shouldered the brunt of decades of escalating costs, and has gained momentum recently in the aftermath of the financial crisis and Great Recession. This trend is seen across all health insurance products, not just in formal consumer directed health plans (CDHPs), which are high deductible plans linked to some form of health savings account (2). For example, according to the Kaiser Family Foundation, the number of workers enrolled in a plan with an annual deductible of $1,000 or more reached 38% in 2013, an almost fourfold increase from pre-recession levels in 2006 (3). It seems inevitable that this trend will not only continue but likely accelerate (4).

Thompson Reuters reports that the average deductible in such plans is $1,750 with a 20% coinsurance (coinsurance is the patient's share of cost as calculated on a percent of the charges above the policy's deductible, as opposed to copay which is a fixed amount) (5). The Affordable Care Act (ACA) will also contribute to this trend towards HDHPs, as the lower premium options, like the Bronze Plans, have high deductibles, copays and coinsurance. Preliminary data (supplied by HealthPocket, Inc., and reported on in the *Wall Street Journal*) show that Bronze Plans may in fact have a significantly increased "out-of-pocket" cost over existing plans, with some preliminary estimates of typical deductible costs of approximately $5,000 (6). All this means that consumers

APR-DRG and severity	Minimum price	Median price	Average price	Maximum price	Difference between maximum and minimum price	Ratio of maximum to minimum price
Knee joint replacement (302)						
Severity 1	$5,202	$21,241	$21,040	$50,726	$45,524	9.8
Severity 2	$7,599	$21,887	$22,743	$66,901	$59,302	8.8
Severity 3	$16,069	$28,173	$30,376	$59,252	$43,183	3.7
Intervertebral disc excision and decompression (310)						
Severity 1	$2,832	$9,471	$9,276	$21,187	$18,355	7.5
Severity 2	$2,492	$11,184	$12,629	$47,465	$44,973	19.0
Severity 3	$16,807	$26,515	$28,946	$59,252	$42,446	3.5
Knee and lower leg procedures (313)						
Severity 1	$2,863	$11,790	$12,224	$26,179	$23,316	9.1
Severity 2	$6,311	$15,010	$15,644	$40,590	$34,280	6.4
Severity 3	$11,790	$31,908	$27,503	$42,892	$31,102	3.6
Hip joint replacement (301)						
Severity 1	$5,423	$23,383	$22,626	$44,867	$39,444	8.3
Severity 2	$9,612	$25,039	$25,235	$63,908	$54,296	6.6
Severity 3	$10,528	$32,581	$34,572	$59,252	$48,724	5.6

Source: Mathematica Policy Research analysis of private insured and self-insured fee-for-service claims for Massachusetts residents.

Note: Payments include patient cost-sharing in fee-for-service coverage. Payments made under managed care contracts are not included.

Figure 1. Observed Prices for Selected High-Volume DRGs Related to Musculoskeletal Procedures by Severity of Illness, 2009. Source: Massachusetts Health Care Cost Trends, MA Division of Health Care Finance and Policy, via the Center for Health Information and Analysis (7).

are becoming increasingly incentivized to factor the cost of care into their decisions, particularly with elective and non-emergent treatments.

Dramatic variability in healthcare costs

There exists huge variability in pricing of many healthcare services. The state of Massachusetts published a comprehensive review of healthcare pricing variability and concluded: "Prices paid for the same hospital inpatient services and for physician and professional services vary significantly for every service examined. There was at least a three-fold difference for every service and for most, a variation of six or seven-fold." (7).

The three diagrams on the following page illustrate that not only is the price variability great (in this case, for total knee replacement), it occurs within all geographic markets. Additionally, these data point to the facility fees being not only the largest component of cost, but also the one with the greatest price variability. This underscores the importance of having hospital price transparency in particular to allow for consumer price shopping for elective procedures (8).

Does higher cost equate to quality?

Importantly, this price differential cannot be explained by differences in quality, as shown in numerous studies (7). There is a challenge, however, as studies have also shown that there is a bias of many patients to associate higher price with higher quality (5). Unfortunately, there also remain very few specific quality measures for patients to factor into their decision making process (7). Educational initiatives to dispel this myth as well as efforts to provide more and better quality metrics are key.

Getting accurate pricing information prior to care

As pointed out by the U.S. Government Accountability Office (GAO) in a Report to Congressional Requesters, "meaningful price information is difficult for consumers to obtain prior to receiving

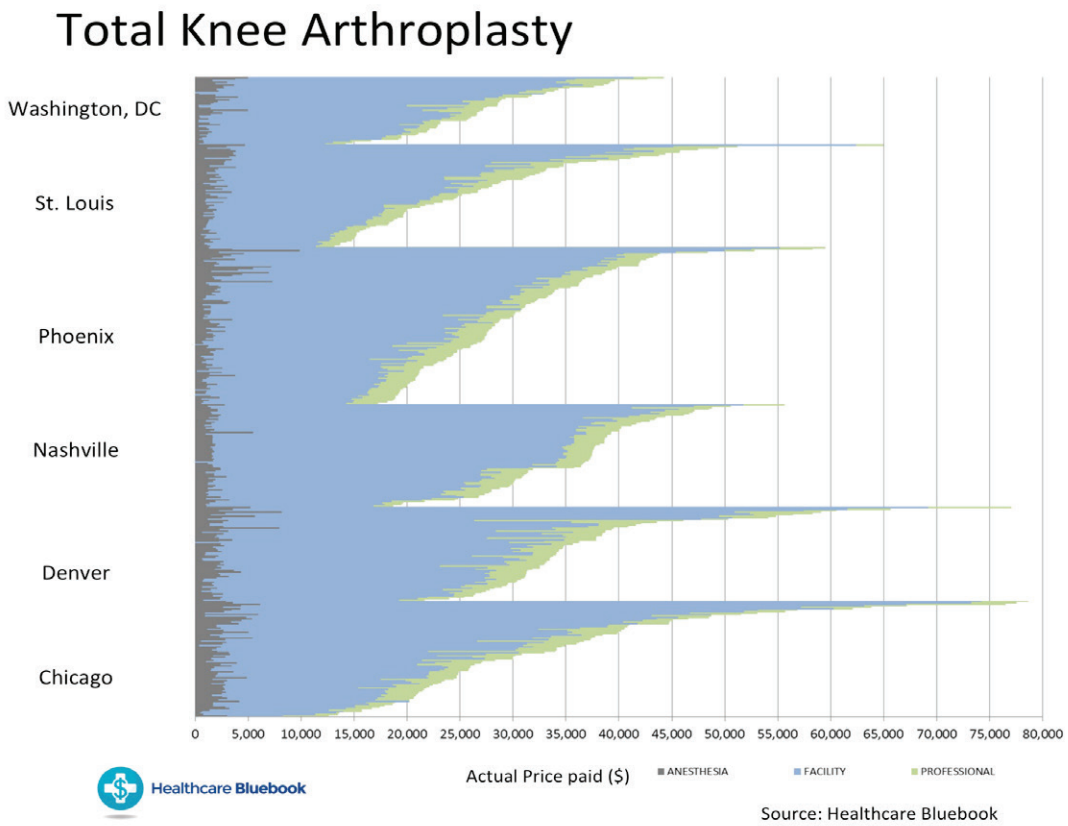

Figure 2. Variability of Actual Prices Paid for Total Knee Replacement in Diverse Geographic Markets. Source: Healthcare Bluebook, Consumer Pricing and Analytics Group. (8).

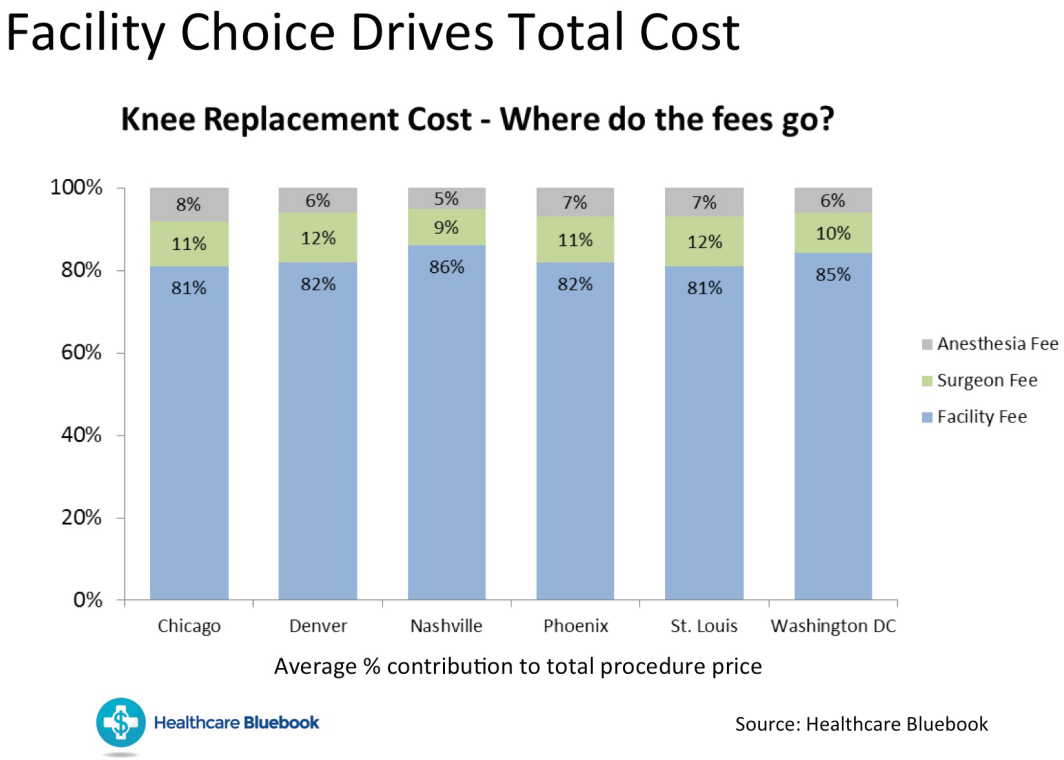

Figure 3. Facility Choice is Major Driver of Total Cost. Source: Healthcare Bluebook, Consumer Pricing and Analytics Group. (8).

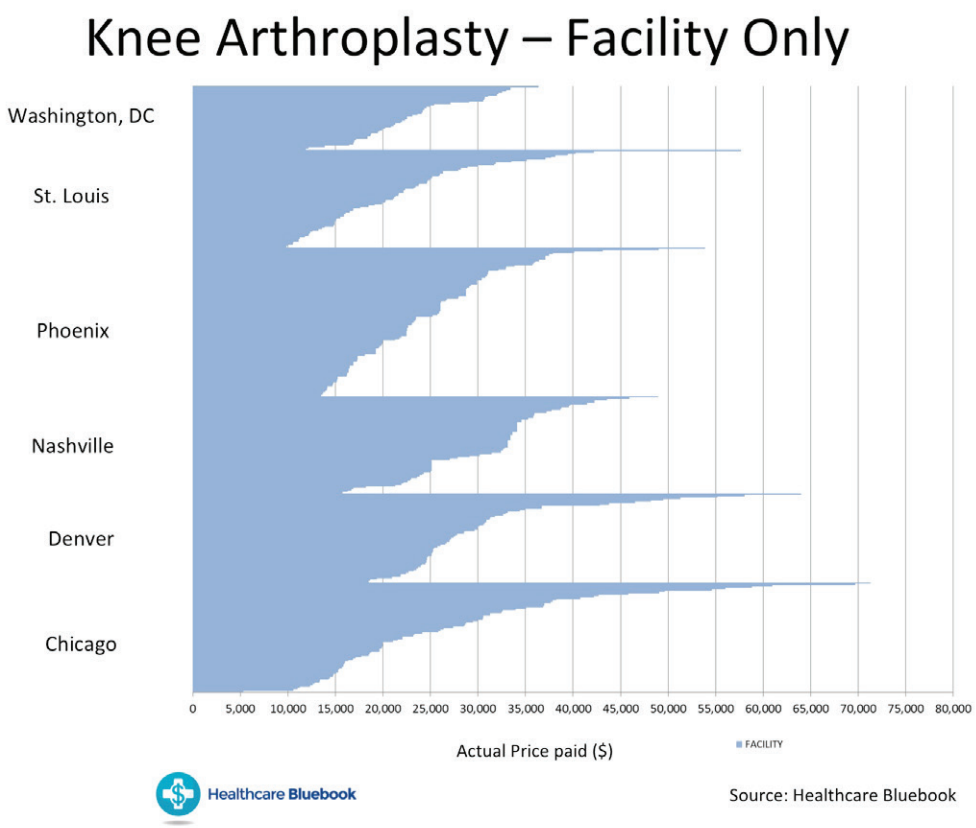

Figure 4. Variability of Facility Prices Paid for Total Knee Replacement. Source: Healthcare Bluebook, Consumer Pricing and Analytics Group. (8).

care" (9). They reviewed eight public and private price transparency initiatives (including one by the Department of Health and Human Services, or HHS) and concluded that only two of them offered a consumer's complete cost (and one wasn't the HHS effort). Likewise, in a recent study published in *JAMA*, the majority of hospitals were unable to provide comprehensive pricing data for hip replacement surgery (prior to treatment), and price quotes that were obtained ranged from about $11,000 to over $100,000 (10).

Hospitals might release some price data, but this has generally been their "billed charges", which are rates that are stated before any discounts or contractual arrangements are applied, and often referred to as the "charge master". These data are not a useful measure for true patient out-of-pocket costs (11). *Billed charges* can be thought of as the "sticker price", in contrast to *allowed charges*, which is the actual fee agreed on between a provider and the insurer or payer. Medicare pays a predetermined rate regardless of what is charged, and private insurance companies negotiate what they will pay, known as the "negotiated rate". The distinction is important, but the result is the same: huge price differentials exist for the same care.

Price transparency influences behavior

Putting market forces into healthcare purchasing decisions has been shown to be effective. The huge California Public Employees Retirement System (CalPERS), demonstrated that its members would use lower priced but comparable quality hospitals for knee and hip replacement surgery, if given financial incentive to do so. The Rand Corporation showed a decline in healthcare costs of 14% for people enrolled in a high deductible plans, creating "a strong financial incentive for the employee to manage health care costs carefully" (12).

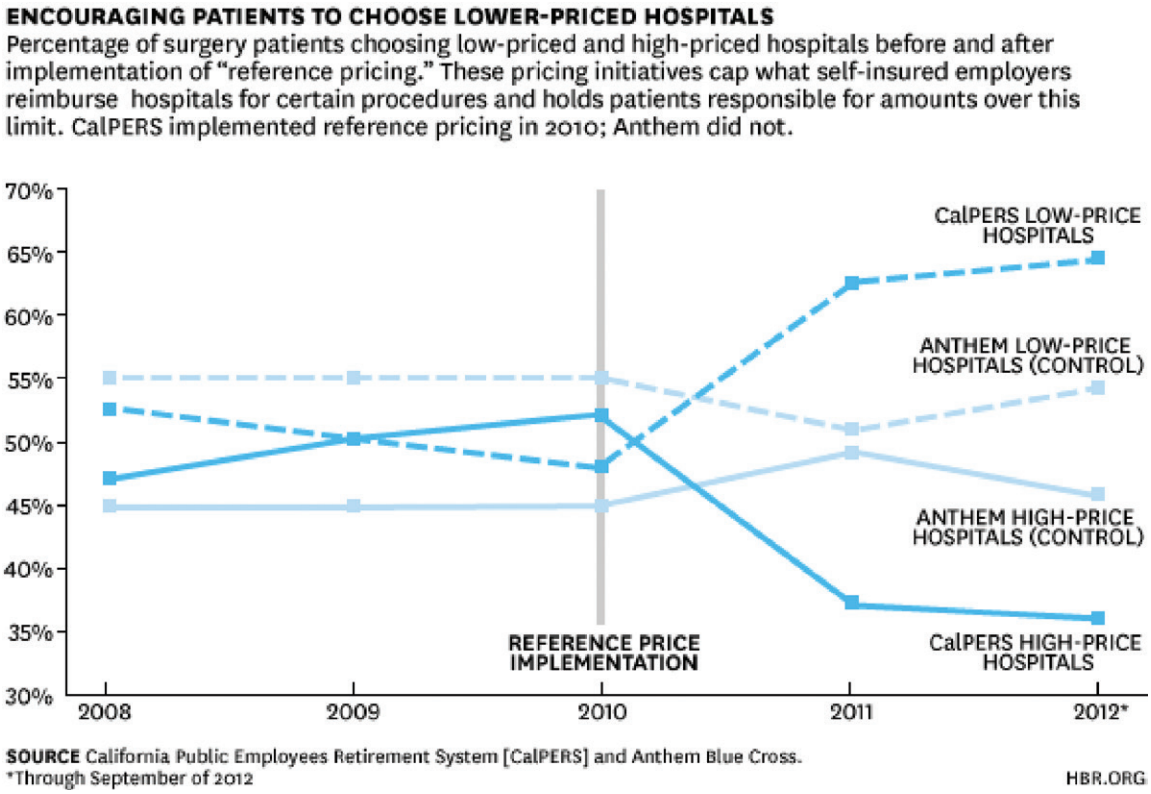

Figure 5. Patients Choose Less Costly Healthcare When Incentivized. Source: "Encouraging Patients to Choose Lower-Priced Hospitals". Reprinted by permission of Harvard Business Review. *From "How to Turn Employees Into Value Shoppers for Health Care" by J. Robinson, HBR Blog, 21 Oct 2013. Copyright 2013 by the Harvard Business School Publishing Corporation; all rights reserved.*

Efforts to facilitate transparency

Healthcare pricing transparency efforts are occurring at both the state and federal level, as well as in the private sector. Over 30 states have introduced price transparency legislation of some kind (13). Several bills have been introduced in the U.S. Congress as well (H.R. 4700 in 2010, and more recently H.R. 1326 and 2853 in 2013), but have failed to get out of committee. In May 2013, the Department Health and Human Services (HSS) released average inpatient charges for the 100 most frequently billed discharges for Medicare. This was a good start, but of limited value for several reasons, including that Medicare has a fixed daily co-pay and thus there is not a financial incentive for recipients to be price conscious.

The Affordable Care Act does mandate that hospitals publish a list of standard charges, but it's questionable to what degree that would represent true complete consumer cost as opposed to charge master data. The law also requires that beginning in 2014, participating health plans on the exchanges are to provide tools for their customers to help determine out of pocket costs, and some plans have already started (14). Additionally, several startup companies have introduced software and services designed to provide price transparency by analyzing medical insurance claims data, with $400M being invested in this space by venture capitalist since 2010 (15).

As the GAO study pointed out, access to claims data and/or negotiated rates was key to obtaining true consumer cost, and these firms are attempting to provide this information to consumers. However, another important finding from the GAO study was that pricing transparency can be hindered by agreements between insurers and providers that prohibit the public disclosure of those contracted negotiated rates (9).

Policy recommendations

Healthcare cost transparency offers a way to create marketplace forces in one of the largest sectors of the economy, and a chance for meaningful cost containment going forward. To promote this effort, legislative efforts should focus on the following:

- Support comprehensive price transparency efforts that supply consumers with a meaningful, true cost of care snapshot.
- Require hospitals to provide upfront binding prices for elective and non-emergent care.
- Prohibit contracts between insurers and providers that include nondisclosure clauses that stifle the public release of negotiated rates.
- Require insurers to provide full, anonymous, claims data to all employers who request it, in order to perform cost analysis, payment audits, and education of their employees.
- Promote consumer education as it relates to healthcare quality, specifically, that quality and cost are not related. Additionally, create incentives that will foster increased development and release of provider quality metrics so consumers can factor quality into their decisions as well as price.

Conclusions

As a result of years of escalating costs, employers are increasingly shifting healthcare insurance costs to their employees. This is primarily being accomplished by a movement towards high deductible policies, which lowers premiums, but increases patient deductibles substantially. The result of this shift will be to increasingly foster price sensitivity in consumers when choosing providers and treatments, something that has largely been lacking in the past. In order for the US healthcare system to function as an efficient marketplace, consumers must have access to accurate and transparent pricing data. This need is underscored even more by the demonstration of the marked price discrepancy that exists for the same care of similar quality. The evidence supports the assertion that consumers, when faced with increased out of pocket costs, will generally choose a lower cost option, and this should result in downward pressures on healthcare inflation.

Disclaimer

The author has no disclaimers.

Competing interests

The author declares he has no competing interests.

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About the author

For over twenty years Mark Ridinger has been a physician, entrepreneur, inventor and innovator, with broad expertise in clinical medicine, predictive analytics and informatics, population care management, and healthcare information technology. Dr. Ridinger's career experience has ranged from the practice of medicine to co-founding a successful healthcare IT startup, as well as strategic and management consulting. He also served as editor-at-large for a major peer reviewed medical journal. Mark has received several patents, has held board certification in both internal medicine and radiology and maintains a license to practice medicine. He is currently a Senior Fellow at the Center for Revolutionary Scientific Thought at the Potomac Institute for Policy Studies.