

Health Care Price Transparency

Opportunities to Improve Affordability and Data Effectiveness

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Health Care Price Transparency: Opportunities to Improve Affordability and Data Effectiveness

Testimony of Christopher M. Whaley¹
The RAND Corporation²

Before the Committee on Ways and Means
United States House of Representatives

May 16, 2023

Chairman Smith, Ranking Member Neal, and members of the committee, thank you for the opportunity to testify today. My name is Christopher Whaley. I am a health economist at the nonprofit, nonpartisan RAND Corporation, where I focus on health care price transparency and the evolving structure of health care markets and the impacts of those changes on the quality of care and health care spending. The information I share today draws on a variety of studies conducted by my RAND colleagues and me over the past several years.

My remarks today focus on variation in prices paid for common health care services and health care price transparency. The United States leads the world in health care spending, in large part due to high and variable prices paid to providers.³ Rising health care spending erodes worker wages and other benefits, particularly for lower-income Americans, and strains government finances.⁴

¹ The opinions and conclusions expressed in this testimony are the author's alone and should not be interpreted as representing those of the RAND Corporation or any of the sponsors of its research.

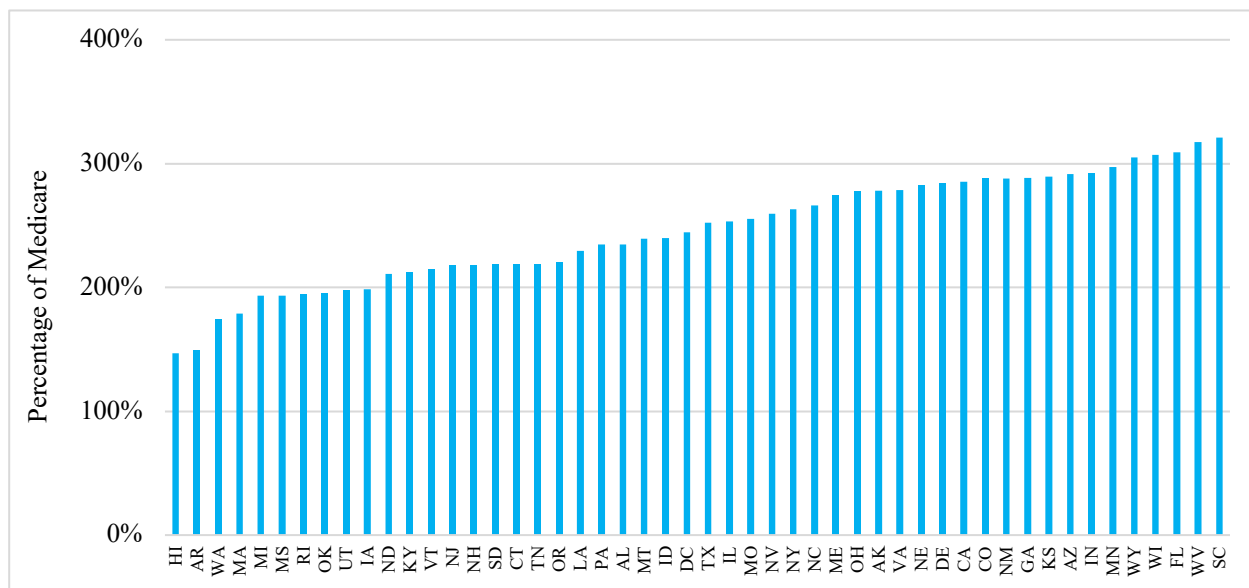
² The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest. RAND's mission is enabled through its core values of quality and objectivity and its commitment to integrity and ethical behavior. RAND subjects its research publications to a robust and exacting quality-assurance process; avoids financial and other conflicts of interest through staff training, project screening, and a policy of mandatory disclosure; and pursues transparency through the open publication of research findings and recommendations, disclosure of the source of funding of published research, and policies to ensure intellectual independence. This testimony is not a research publication, but witnesses affiliated with RAND routinely draw on relevant research conducted in the organization.

³ Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan, "It's the Prices, Stupid: Why the United States Is So Different from Other Countries," *Health Affairs*, Vol. 22, No. 3, 2003; GF Anderson, P Hussey, and V. Petrosyan. "It's Still The Prices, Stupid: Why the US Spends So Much on Health Care, and a Tribute to Uwe Reinhardt," *Health Affairs*, Vol. 38, No. 1, 2019.

⁴ Daniel Arnold and Christopher M. Whaley, "Who Pays for Health Care Costs?: The Effects of Health Care Prices on Wages," RAND Corporation, WR-A621-2, 2020, https://www.rand.org/pubs/working_papers/WRA621-2.html.

Health care price variation occurs in both commercial insurance and in Medicare. RAND research highlights that hospital prices paid by commercial insurers vary significantly, ranging from 1.5 times the prices paid by Medicare in Hawaii to 3.2 times the prices paid by Medicare in South Carolina (Figure 1).⁵ In the Medicare program, while Traditional Medicare sets prices administratively, prices vary based on the site of care in which care is delivered for the same type of service. For example, Medicare pays \$1,059 for a colonoscopy performed in a hospital outpatient department, compared with \$591 for the same service delivered in an ambulatory surgical center.⁶

Figure 1. Inpatient and Outpatient Hospital Prices Paid by Private Insurers Relative to Medicare Rates, by State



SOURCE: Whaley et al., 2022.

With both Medicare and commercial payers, price variation and site-of-care payment differentials create an “arbitrage opportunity” that drives provider consolidation. My research shows that, once previously independent physicians consolidate into hospitals or health systems, physicians refer patients to higher-priced sites of care, substantially increasing revenues to the provider organization and increasing health care spending.⁷ Despite the increase in revenues to

⁵ Christopher M. Whaley, Brian Briscoe, Rose Kerber, Brenna O’Neill, and Aaron Kofner, *Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative*, RAND Corporation, RR-A1144-1, 2022, https://www.rand.org/pubs/research_reports/RR1144-1.html.

⁶ Christopher M. Whaley, Xiaoxi Zhao, Michael Richards, and Cheryl L. Damberg, “Higher Medicare Spending on Imaging and Lab Services After Primary Care Physician Group Vertical Integration,” *Health Affairs*, Vol. 40, No. 5, 2021.

⁷ Whaley et al., 2021; Michael R. Richards, Jonathan A. Seward, and Christopher M. Whaley, “Treatment Consolidation After Vertical Integration: Evidence from Outpatient Procedure Markets,” *Journal of Health Economics*, Vol. 81, 2022; David M. Cutler, Leemore Dafny, David C. Grabowski, Steven Lee, and Christopher

hospitals and health systems, research that I've conducted finds that physicians themselves do not appear to benefit financially from consolidation.⁸ Importantly, studies have found that higher private insurance prices are not driven by underpayments from public payers or uninsured patients (e.g., “cost-shifting”) or differences in provider quality and that consolidation does not improve provider quality.⁹

Policymakers have undertaken efforts to increase price transparency as one means to address these underlying drivers of increased health care spending. In this testimony, I will first share how price transparency has helped address price variation and health care spending; second, describe recent actions taken to make prices more transparent; and, third, identify potential solutions to improve the use of price transparency data, and in particular, recent Transparency in Coverage data from insurers.

How Price Transparency Can Help Health Care Innovation

Developing policies to address the wide variation in prices requires information on provider prices. Historically, health care prices have been notoriously opaque to those that pay the bills—employers, consumers, and both state and federal governments. Many commercial payers consider price information to be a trade secret, and gag clauses commonly prohibit disclosure of the prices paid to providers. Although it is ethical to provide patients with price information, research shows that consumers do not often effectively use price transparency to shop for care,¹⁰ the lack of transparent, usable price information hinders the ability of researchers to understand

Ody, “Vertical Integration of Healthcare Providers Increases Self-Referrals and Can Reduce Downstream Competition: The Case of Hospital-Owned Skilled Nursing Facilities,” National Bureau of Economic Research, Working Paper 28305, 2020.

⁸ Christopher M. Whaley, Daniel R. Arnold, Nate Gross, and Anupam B. Jena, “Physician Compensation in Physician-Owned and Hospital-Owned Practices,” *Health Affairs*, Vol. 40, No. 12, 2021.

⁹ Austin B. Frakt, “How Much Do Hospitals Cost Shift? A Review of the Evidence,” *Milbank Quarterly*, Vol. 89, No. 1, 2011; Austin B. Frakt, “The End of Hospital Cost Shifting and the Quest for Hospital Productivity,” *Health Services Research*, Vol. 49, No. 1, 2014; Chapin White, “Contrary to Cost-Shift Theory, Lower Medicare Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates,” *Health Affairs*, Vol. 32, No. 5, 2013; Peter S. Hussey, Samuel Wertheimer, and Ateev Mehrotra, “The Association Between Health Care Quality and Cost: A Systematic Review,” *Annals of Internal Medicine*, Vol. 158, No. 1, 2013; Zack Cooper, Joseph J. Doyle, Jr., John A. Graves, and Jonathan Gruber, “Do Higher-Priced Hospitals Deliver Higher-Quality Care?” National Bureau of Economic Research, Working Paper 29809, February 2022, revised January 2023; Daniel J. Crespino and Christopher Whaley, “The Effect of Hospital Discharge Price Increases on Publicly Reported Measures of Quality,” *Health Services Research*, Vol. 58, No. 1, 2023; Nancy D. Beaulieu, Leemore S. Dafny, Bruce E. Landon, Jesse B. Dalton, Ifedayo Kuye, and J. Michael McWilliams, “Changes in Quality of Care After Hospital Mergers and Acquisitions,” *New England Journal of Medicine*, Vol. 382, No.1, 2020.

¹⁰ Christopher Whaley, Jennifer Schneider Chafen, Sophie Pinkard, Gabriella Kellerman, Dena Bravata, Robert Kocher, and Neeraj Sood, “Association Between Availability of Health Service Prices and Payments for These Services,” *JAMA*, Vol. 312, No. 16, 2014; Sunita Desai, Laura A. Hatfield, Andrew L. Hicks, Michael E. Chernew, and Ateev Mehrotra, “Association Between Availability of a Price Transparency Tool and Outpatient Spending,” *JAMA*, Vol. 315, No. 17, 2016; Sunita Desai, Laura A. Hatfield, Andrew L. Hicks, Anna D. Sinaiko, Michael E. Chernew, David Cowling, Santosh Gautam, Sze-jung Wu, and Ateev Mehrotra, “Offering a Price Transparency Tool Did Not Reduce Overall Spending Among California Public Employees and Retirees,” *Health Affairs*, Vol. 36, No. 8, 2017; Christopher Whaley and Austin Frakt, “If Patients Don’t Use Available Health Service Pricing Information, Is Transparency Still Important?” *AMA Journal of Ethics*, Vol. 24, No. 11, 2022.

competition dynamics and the impacts on cost and quality, of entrepreneurs from developing new benefit design innovations to help control spending, and of policymakers from overseeing market conduct and competition. The lack of transparent pricing also creates barriers to understanding the drivers of health care solutions and designing solutions. Rather than placing the responsibility of putting downward pressure on health care spending by trying to navigate the complex payment system,¹¹ price transparency can be an effective tool to enable policymakers to design impactful programs and policies.

I will illustrate how this can be done. Following the Great Recession in 2009, the California Public Employees' Retirement System (CalPERS), which is the second largest public purchaser of private health insurance in the country, faced budgetary consequences caused by rising health care costs. CalPERS recognized the same variation in provider prices, driven in part by site-of-care price differentials. In collaboration with its workforce, CalPERS used price transparency data to design and implement a reference-based pricing model in which patients are given financial incentives to receive care from lower-priced and high-quality providers, including non-hospital facilities, such as ambulatory surgery centers. For common outpatient services, CalPERS patients who receive care from an ambulatory surgical center are exempt from additional cost sharing. Patients who receive care from a higher-priced hospital are financially responsible for the difference in provider prices.

Across several procedures, using price transparency data to create patient financial incentives to receive care from lower-priced providers led to sizable financial savings for CalPERS and its employees. As shown in Figure 2, by the second year of the program, 90 percent of eligible CalPERS patients received care from lower-priced providers.¹² While not a direct price transparency program, this benefit design innovation would not have been possible without CalPERS' access to transparent information on provider prices. Other employers and innovators have used price transparency information to implement similar benefit design innovations, create bundled pricing payment programs, and audit the prices negotiated on their behalf.¹³ The state of

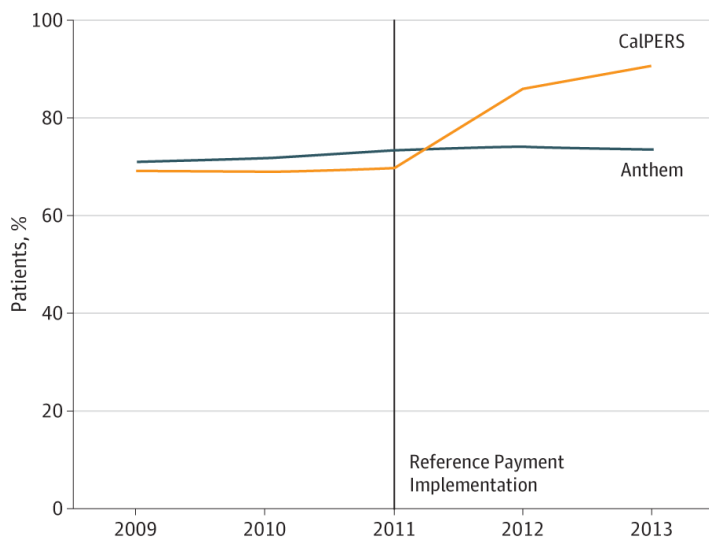
¹¹ Michael Chernen, Zack Cooper, Eugene Larsen Hallock, and Fiona Scott Morton, "Physician Agency, Consumerism, and the Consumption of Lower-Limb MRI Scans," *Journal of Health Economics*, Vol. 76, 2021.

¹² James C. Robinson, Timothy T. Brown, Christopher Whaley, and Emily Finlayson, "Association of Reference Payment for Colonoscopy with Consumer Choices, Insurer Spending, and Procedural Complications," *JAMA Internal Medicine*, Vol. 175, No. 11, 2015.

¹³ Christopher Whaley, Timothy Brown, and James Robinson, "Consumer Responses to Price Transparency Alone Versus Price Transparency Combined with Reference Pricing," *American Journal of Health Economics*, Vol. 5, No. 2, 2019; Jonathan Gruber and Robin McKnight, "Controlling Health Care Costs Through Limited Network Insurance Plans: Evidence from Massachusetts State Employees," *American Economic Journal: Economic Policy*, Vol. 8, No. 2, 2016; Anna D. Sinaiko and Meredith B. Rosenthal, "The Impact of Tiered Physician Networks on Patient Choices," *Health Services Research*, Vol. 49, No. 4, 2014; Christopher M. Whaley, Christoph Dankert, Michael Richards, and Dena Bravata, "An Employer-Provider Direct Payment Program Is Associated with Lower Episode Costs," *Health Affairs*, Vol. 40, No. 3, 2021; Lisa Esquivel Long, "Anthem-Parkview Reach Agreement," *Fort Wayne Business Weekly*, July 30, 2020.

Indiana has used price transparency data to limit hospital facility fees and implement hospital price benchmarks.¹⁴

Figure 2. Percentage of Patients Choosing Ambulatory Surgery Centers Over Hospital Outpatient Departments Before and After Implementation of Reference-Based Benefits



SOURCE: Robinson et al., 2015.

As recently highlighted by the Congressional Budget Office,¹⁵ price transparency information enables innovators and entrepreneurs to develop programs such as reference pricing that improve care efficiency. Gaining access to price data is challenging, which limits the ability to understand market dynamics and develop tools that direct patients toward lower-priced providers, stifling competition and innovation of new insurance products and payment models. Obtaining health care price data, whether for designing insurance benefit design innovations, regulating markets, or conducting research, has traditionally required obtaining medical claims data from national health insurers. These data can be expensive and often come with limitations—such as restrictions on identifying prices for specific providers. In RAND’s price transparency work, to disclose provider-specific prices, we have obtained medical claims data from self-funded employers across the country and 11 state all-payer claims data.¹⁶ While important for informing policy, this process is not replicable for other important uses of health care price transparency data.

¹⁴ Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare and Medicaid Services, Department of Health and Human Services, “Transparency in Coverage,” *Federal Register*, Vol. 85, November 12, 2020.

¹⁵ Michael Cohen, Daria Pelech, and Karen Stockley, *Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals’ and Physicians’ Services*, Congressional Budget Office, September 2022.

¹⁶ Whaley et al., 2022.

Recent Initiatives to Increase Price Transparency

I will now speak to recent federal policies that have expanded the scope of available price information, with two requirements—hospital-posted rates for common services in machine readable files and insurer-posted rates for all services through Transparency in Coverage (TiC) requirements.¹⁷ As of February 2023, only one-quarter of hospitals are estimated to be fully compliant with the requirements, including posting prices for 300 services.¹⁸ The *Wall Street Journal* found hospitals purposefully hiding price information from online search queries.¹⁹ The Centers for Medicare & Medicaid Services (CMS) has been reluctant to penalize non-compliant hospitals and has only issued four fines for non-compliance since the rule took effect on January 1, 2021. CMS has recently announced efforts to increase enforcement and fines of hospitals that are noncompliant with the price transparency rules.²⁰ Stronger penalties and enhanced federal enforcement are likely to improve the usability of these data. As with other mandatory data reporting, such as Hospital Cost Reports, compliance with price transparency requirements could be a requirement for Medicare participation. At the state level, Colorado recently passed legislation that prohibits hospitals that do not post price transparency information from sending medical debt to collections.²¹ These actions are likely to increase compliance and could serve as a national model for ensuring compliance with federal regulations.

Potential Policy Options to Improve Transparency in Coverage Data

While the hospital-posted data currently have limitations in availability and standardization that limit use, the more recent insurer-posted TiC data, which became public starting July 2022, offer more promise to drive entrepreneurial, policy, and research activity around understanding health care prices and developing policies to restrain spending growth. Insurers have largely complied with the TiC requirements, and the data are widely available. Because all in-network prices are posted, rather than the selected services in the hospital requirement, these data are comprehensive. They are also updated on a regular basis, allowing for monitoring of price changes over time and in response to market activity.

However, the TiC data have suffered from the opposite problem of too much data, which makes the data unusable. Although promising, these data have not been widely used due to

¹⁷ Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare and Medicaid Services, Department of Health and Human Services, 2020.

¹⁸ Cynthia A. Fisher, Ilaria Santangelo, Marie B. LaRobardier, Olivia Dann, and Linda Bent, *Fourth Semi-Annual Hospital Price Transparency Report*, PatientRightsAdvocate.org, February 2023.

¹⁹ Tom McGinty, Anna Wilde Mathews, and Melanie Evans, “Hospitals Hide Pricing Data from Search Results,” *Wall Street Journal*, March 22, 2021.

²⁰ Centers for Medicare and Medicaid Services, “CMS OPPS/ASC Final Rule Increases Price Transparency, Patient Safety and Access to Quality Care,” press release, November 2, 2021.

²¹ Meg Wingerter, “Hospitals Can’t Send Patients’ Medical Debt to Collections or Sue Them Unless They Have Prices Posted Under New Law,” *Denver Post*, June 20, 2022.

challenges with how the data are constructed and reported by insurers.²² Many TiC data files are terabytes in size, rendering them difficult to open without advanced computational resources.

One problem with using the existing TiC data is that insurers frequently report prices for every possible combination of procedure and provider. For example, prices for cardiology services will be listed for dermatologists, who rarely provide such services. This construction creates two main problems. First, it greatly expands the size and scope of the data. The inflation of file size due to overpopulation of data fields is a large reason why the data are currently inaccessible. Second, it can create misleading findings from the data. If dermatologists are not providing cardiology services (but are included in the data), then using TiC data to measure prices for cardiac care will create misleading interpretations of prices.

I will conclude my remarks today with a couple of recommendations for how to improve the submission of data that will facilitate broad use of these data as a tool in improving health care affordability.

First, it is critical that TiC data only include prices for providers and facilities that actually perform those procedures. CMS could require insurers to post prices only for providers who have submitted bills for a given procedure within the past year. An alternative would be to require hospitals to include the number of billed services within a given reporting period, allowing users to measure provider volume. This restriction would make the TiC data informative and more usable to employers, regulators, and researchers.

Secondly, CMS could implement other possible changes to collect price information and make those data transparent for use in policymaking. For example, rather than insurers individually reporting prices, the Department of Health and Human Services could require insurers to report data to CMS or another third party, which could audit data submissions and make data available in a user-friendly format. Rather than large insurer-hosted JavaScript Object Notation (JSON) files, modern relational database technologies enable users to query this central data source and create accessible data extracts, similar to other data hosted by CMS.

Conclusion

Significant progress has been made to increase the transparency of health care prices at the federal and state levels, but much more needs to be done to leverage these data as a powerful tool in controlling growth in health care spending. Largely due to data collection and reporting limitations, data use is minimal nearly one year after the data started being reported. Actions are required to improve the data reporting and useability to empower policymakers, employers, and consumers to make informed purchasing decisions. Enabling broader use of these data can help address the large variation in health care prices and improve health care affordability.

²² Yang Wang, Jianhui (Frank) Xu, Mark Meiselbach, Yuchen Wang, Gerard F. Anderson, and Ge Bai, “Insurer Price Transparency Rule: What Has Been Disclosed?” *Health Affairs Forefront*, February 2, 2023.