

Price Transparency in Health Care

Report from the HFMA Price Transparency Task Force



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healthcare financial management association

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EXECUTIVE SUMMARY

As patients face increased exposure to healthcare costs, they have an urgent need for meaningful and transparent price information. To bring this about, all stakeholders should be committed to providing or using price, quality, safety, and other information that patients and other care purchasers need to make informed healthcare decisions. This report focuses on the issue of price transparency, while affirming the need for that information to be presented in the context of other relevant information. The definitions shown in the sidebar below are used in this report to distinguish among charge, cost, and price, and among different stakeholders and stakeholder interests.

GUIDING PRINCIPLES AND POLICY CONSIDERATIONS

To be effective, price transparency must offer clear information that is readily accessible to patients and enables them to make meaningful comparisons among providers. It will also require a collaborative effort among providers, care purchasers, and payers to identify and develop the information and tools that

will be most useful to patients. The following statements represent the task force's consensus on basic principles that should guide efforts to achieve these goals. These guiding principles informed the task force's recommendations.

- Price transparency should empower patients and other care purchasers to make meaningful price comparisons prior to receiving care.
- Any form of price transparency should be easy to use and easy to communicate to stakeholders.
- Price transparency information should be paired with other information that defines the value of services for the care purchaser.
- Price transparency should ultimately provide patients with the information they need to understand the total price of their care and what is included in that price.
- Price transparency will require the commitment and active participation of all stakeholders.

Common Definitions

Charge, Cost, and Price

Charge. The dollar amount a provider sets for services rendered before negotiating any discounts. The charge can be different from the amount paid.

Cost. The definition of cost varies by the party incurring the expense:

- To the patient, cost is the amount payable out of pocket for healthcare services.
- To the provider, cost is the expense (direct and indirect) incurred to deliver healthcare services to patients.
- To the insurer, cost is the amount payable to the provider (or reimbursable to the patient) for services rendered.
- To the employer, cost is the expense related to providing health benefits (premiums or claims paid).

Price. The total amount a provider expects to be paid by payers and patients for healthcare services.

Stakeholders

Care purchaser. Individual or entity that contributes to the purchase of healthcare services.

Payer. An organization that negotiates or sets rates for provider services, collects revenue through premium payments or tax dollars, processes provider claims for service, and pays provider claims using collected premium or tax revenues.

Provider. An entity, organization, or individual that furnishes a healthcare service.

Other Definitions

Out-of-pocket payment. The portion of total payment for medical services and treatment for which the patient is responsible, including copayments, coinsurance, and deductibles.

Price transparency. In health care, readily available information on the price of healthcare services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value.

Value. The quality of a healthcare service in relation to the total price paid for the service by care purchasers.

The task force also recognizes that price transparency may have unintended consequences that may need to be addressed as greater transparency takes hold. These include the impacts of transparency on price negotiations within the business-to-business marketplace between health plans and providers and on providers' ability to provide societal benefits.

RECOMMENDATIONS FOR PRICE TRANSPARENCY FRAMEWORKS

Because care purchasers' information needs and sources vary, the task force recommends different price transparency frameworks for different care purchaser groups.

Insured patients. Health plans should serve as the principal source of price information for their members. Along with other suppliers of price information, health plans should innovate with different frameworks for communicating price information to insured patients.

Transparency tools for insured patients should include some essential elements of price information, including:

- The total estimated price of the service
- A clear indication of whether a particular provider is in the health plan's network and information on where the patient can try to locate a network provider
- A clear statement of the patient's estimated out-of-pocket payment responsibility
- Other relevant information related to the provider or the specific service sought (e.g., clinical outcomes, patient safety, or patient satisfaction scores)

Patients should be alerted to the need to seek price information from out-of-network providers. To ensure valid comparisons of provider price information, health plans and other suppliers of such information should make transparent the specific services that are included in the price estimate. The task force also recommends that government agencies should develop similar transparency frameworks for beneficiaries of public programs such as Medicare and Medicaid.

Uninsured and out-of-network patients. The provider should be the principal source of price information for uninsured patients and patients who are seeking care from the provider on an out-of-network basis.

Price transparency frameworks for uninsured and out-of-network patients should reflect the following basic considerations.

- Providers should offer an estimated price for a standard procedure without complications and make clear to the patient how complications or other unforeseen circumstances may increase the price.
- Providers should clearly communicate preservice estimates of prices to uninsured patients and patients seeking care on an out-of-network basis.
- Providers should clearly communicate to patients what services are—and are not— included in a price estimate. If any services that would have significant price implications for the patient are not included in the price estimate, the provider should try to provide information on where the patient could obtain this information.
- Providers should give patients other relevant information (e.g., clinical outcomes, patient safety, or patient satisfaction scores), where available.

Employers. Fully insured employers should continue to use and expand transparency tools that assist their employees in identifying higher-value providers.

Self-funded employers and third-party administrators should work to identify data that will help them shape benefit design, understand their healthcare spending, and provide transparency tools to employees.

Referring clinicians. Referring clinicians should help a patient make informed decisions about treatment plans that best fit the patient's individual situation. They should also recognize the needs of price-sensitive patients, seeking to identify providers that offer the best price at the patient's desired level of quality.

CONCLUSION

Patients are assuming greater financial responsibility for their healthcare needs and in turn need information that will allow them to make informed healthcare decisions. Price is not the only information needed to make these decisions, but it is an essential component. Based on the recommendations in this report, the task force calls upon all stakeholders to join in a concerted effort to provide the price information that patients and other care purchasers require.

INTRODUCTION

The movement toward transparency in the U.S. healthcare system has been slow and not entirely steady, posing challenges to patients and other care purchasers, providers, and health plans alike. It is time to build on the successes of early adopters and promote transparency throughout the healthcare system.

To bring this about, all stakeholders should be committed to providing or using price, quality, safety, and other information that patients and other care purchasers need to make informed healthcare decisions. This report focuses on the issue of price transparency, while affirming the need for that information to be presented in the context of other relevant information.

Why transparency matters now. Long an issue for uninsured patients, the lack of price information is becoming a significant issue for insured patients as well. Among those covered by employer-sponsored insurance, employee-cost sharing has been growing quickly.¹

At the time of this report, newly insured patients gaining coverage through the state and federal marketplaces mandated by the Affordable Care Act are also expected to take on high deductibles with what are expected to be the most popular bronze and silver plan options.² As patients face increased exposure to healthcare costs, they have an urgent need for meaningful and transparent price information. Patients are being asked to act as consumers in a marketplace in which price—a fundamental driver of consumer behavior—is often unknown until after the service they purchase has been performed.

As patients' financial responsibility for healthcare costs has grown, so too has media and government scrutiny of the healthcare marketplace. When the spotlight turns to prices, providers are often unable to respond to requests for price information or can provide only estimates within a wide price range.³ Accurate price information may not be available, but charge information is. Providers thus find themselves defending or trying to explain why charge information often bears little relationship to the price that most patients are actually asked to pay.⁴

The U.S. healthcare marketplace is complex. Prices vary by payer; government programs such as Medicare and Medicaid set payment rates, which may be below the cost of providing care.⁵ Providers typically have contractually negotiated rates with numerous health plans. But when patients seek price information and it is not available, the lack of transparency becomes the subject of public criticism and possible legislative action.

Although this report focuses on the price transparency needs of patients, price transparency will also benefit other stakeholders. Employers currently lack the information they need to identify higher-value providers and adopt benefit plans that will encourage their employees to use these providers. Emerging payment models ask healthcare providers to take on risk for managing the total cost of care for a patient population; these providers need reliable price information from other providers when making referral decisions to manage the total cost of care effectively.

Achieving a more transparent system is a multi-stakeholder issue and requires consensus among hospitals, physicians, and other care providers; the pharmaceutical and medical device industries; commercial and governmental payers; employers; patients and consumer advocates; and regulatory agencies to develop a workable, meaningful solution. A task force representing most of these stakeholders came together to produce this report (see a list of task force members on the inside front cover).

Audiences for this report. The primary audience for this report is industry stakeholders in provider, payer, and purchaser settings that this report calls upon to take specific actions to increase the transparency of healthcare prices. This report is also intended for use by other audiences—including federal and state legislators and policy makers, members of the media, and patients—that can benefit from an understanding of the issues and definitions of key terms related to price transparency in their efforts to shape public policy, influence public opinion, provide information on the healthcare system, or seek informed access to healthcare services.

COMMON DEFINITIONS

The following definitions represent the task force’s consensus on distinctions among charge, cost, and price, and among different stakeholders and stakeholder interests. In most instances, comments that offer background information on the defined term or a discussion of the rationale follow each definition.

CHARGE, COST, AND PRICE

Charge. The dollar amount a provider sets for services rendered before negotiating any discounts. The charge can be different from the amount paid.

Medicare or Medicaid beneficiaries, privately insured patients, and uninsured patients who qualify for financial assistance rarely pay full charges. Uninsured patients who do not qualify for financial assistance may be asked to pay full charges, but often ultimately pay a lower price.⁶ In the absence of accessible, more accurate information on prices, however, charges continue to be used in academic studies, policy reports, and the media as a proxy for price. Indeed, Section 2718 of the Affordable Care Act requires that “[e]ach hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital’s standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.”

While there has been an historical relationship between charges and prices for healthcare services, that relationship has become less relevant as new payment models have emerged.

For hospitals, several factors have contributed to the widening gap between charges and the prices paid by most patients. The relationship of Medicare outlier payments to charges has put significant upward pressure on charges; as noted in a recent report from the Center for Medicare & Medicaid Services’ Office of Inspector General: “Although hospital charges do not affect the Medicare payment amount on most ... claims, hospital charges directly affect whether a hospital receives an outlier payment and, if so, the amount of payment.”⁷ Upward pressure on charges also resulted from Medicare’s shift to fixed price, diagnosis-related group payments, as providers turned to

payment from charge-based indemnity plans to help offset losses on Medicare. As commercial insurers also began to move away from charge-based contracting, even more pressure was put on charges for the remaining payers who still made charge-based payments (in FY12, for example, just under 20 percent of not-for-profit hospitals’ net patient revenues came from percent-of-charges contracts).⁸

There are significant differences between charges and prices, both with respect to hospital services and with respect to services delivered by other providers. Physicians who treat Medicare beneficiaries are paid according to the Medicare physician fee schedule, for example, and negotiate payment rates with health plans for privately insured patients. But billed charges (often described as “standard rates”) for uninsured or out-of-network patients are often significantly higher than the price paid by Medicare or health plans for the same service. In some instances, patients do not even know they have received care from an out-of-network physician until after the fact, as scheduling a procedure at an in-network hospital does not guarantee that physician services received as part of that procedure (which are billed separately) will be in-network.

Cost. The definition of cost varies by the party incurring the expense—patient, provider, insurer, or employer.

- *To the patient*, cost is the amount payable out of pocket for healthcare services, which may include deductibles, copayments, coinsurance, amounts payable by the patient for services that are not included in the patient’s benefit design, and amounts “balance billed” by out-of-network providers. Health insurance premiums constitute a separate category of healthcare costs for patients, independent of healthcare service utilization.
- *To the provider*, cost is the expense (direct and indirect) incurred to deliver healthcare services to patients.
- *To the insurer*, cost is the amount payable to the provider (or reimbursable to the patient) for services rendered.
- *To the employer*, cost is the expense related to providing health benefits (premiums or claims paid).

Because the definition of cost varies according to the party in question, this report will minimize the use of the term “cost.” When the term must be used—to describe, for example, the

direct and indirect costs a provider incurs to deliver healthcare services—the party to whom the cost applies will be specified. When referring to the costs incurred by a patient or other care purchaser for healthcare services, this report will use the terms “payment” or “price.”

Price. The total amount a provider expects to be paid by payers and patients for healthcare services.

The price of healthcare services often differs depending on whether the patient has insurance coverage or is eligible for financial assistance.

For an insured patient, the price for healthcare services is the rate negotiated for services between the payer and the provider, including any copayments, coinsurance, or deductible due from the insured patient.

For an uninsured patient, price is first determined by eligibility for financial assistance. If the patient qualifies for financial assistance, the price is reduced according to the terms of the provider’s financial assistance policy, provided that the patient works with the provider to supply the documentation necessary to establish financial need.⁹

If an uninsured patient has the financial means to pay for the services rendered, the price could be as much as the provider’s full charge for the services, although the patient and the provider may negotiate a discount from the charge.

About Balance Billing

Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or any amounts that may remain on the patient’s annual deductible) that exceed the health plan’s payment for a covered service. In-network providers are contractually prohibited from balance billing health plan members, but balance billing by out-of-network providers is common.

STAKEHOLDERS

Care Purchaser. Individuals and entities that contribute to the purchase of healthcare services.

In general, the patient is the principal care purchaser. Other important care purchasers include private employers and public-sector healthcare purchasers such as state employee and retiree agencies that contribute to employees’ purchase of health insurance and the cost of actual healthcare claims, including through self-funded health plans.

Payer. An organization that negotiates or sets rates for provider services, collects revenue through premium payments or tax dollars, processes provider claims for service, and pays provider claims using collected premium or tax revenues.

Examples include commercial health plans (also known as insurers), third-party health plan administrators, and government programs such as Medicare and Medicaid.

Provider. An entity, organization, or individual that furnishes a healthcare service.

Examples of providers include (but are not limited to) hospitals, health systems, physicians and other clinicians, pharmacies, ambulance services, ambulatory surgical centers, rehabilitation centers, and skilled nursing facilities.

Under the healthcare payment system in place at the time of this report, each provider typically prepares its own bill for the patient and the patient’s insurance carrier (if applicable) for the services the provider renders. An inpatient hospital procedure, for example, typically results in a bill from the hospital for the services it provides and a bill from multiple physicians on the hospital’s medical staff (e.g., anesthesiologist, radiologist, surgeon, etc.). If rehabilitation or skilled nursing services are delivered by another provider or providers following the inpatient stay, the provider(s) also bills separately for services rendered. Patients, in other words, may receive different services from different providers, and are typically asked to pay separately for each provider’s services. Also, as not all providers are under contract with insurers, varying payment arrangements are common. New payment methods such as bundled payment and

population-based payment are encouraging providers to move toward more “all-inclusive” pricing models that combine the services of multiple providers into a single price.

OTHER DEFINITIONS

Out-of-pocket payment. The portion of total payment for medical services and treatment for which the patient is responsible, including copayments, coinsurance, and deductibles. Out-of-pocket payment also includes amounts for services that are not included in the patient’s benefit design and amounts for services balance billed by out-of-network providers.

For insured patients, out-of-pocket payment can be affected by a number of variables beyond the copayments, coinsurance, or deductibles specified in the patient’s health plan’s summary of benefits and coverage. The use of an out-of-network provider, for example, can significantly increase the amount of an out-of-pocket payment. Out-of-pocket payment for insured patients thus depends on the specifics of each patient’s benefit design and on the contracting status of the relevant providers.

For uninsured patients, out-of-pocket payment can rise to the full charge for a service, although as noted earlier, patients rarely pay full charges today.

Price transparency. In health care, readily available information on the price of healthcare services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value.

The intended outcome of price transparency is to provide patients and other care purchasers with the information they need to make an informed choice of provider. Price transparency is just one component of the information that care purchasers need to make this choice; the quality and safety of services a provider delivers, for example, are other important components of the information a care purchaser needs.

Value. The quality of a healthcare service in relation to the total price paid for the service by care purchasers.

Although the basic definition of value seems straightforward, it is complicated by the fact that value is ultimately the determination of the individual stakeholder. Quality, for example, can comprise elements of access and convenience, patient safety, patient satisfaction, patient experience, adherence to clinical guidelines and evidence-based medicine, and clinical outcomes. Patients will likely weigh these elements differently—one patient may put the highest priority on convenient access, for example, while another may put the highest priority on the provider’s safety record. The price a patient is willing to pay will vary in relationship to the patient’s preferences.

Given that value is the determination of the individual stakeholder, a goal of transparency should be to provide the right information on key elements of price, quality, and other relevant information to enable patients and other care purchasers to choose a provider that best fits their definition of value.

GUIDING PRINCIPLES FOR PRICE TRANSPARENCY

To be effective, price transparency must offer clear information that is readily accessible to patients and enables them to make meaningful comparisons among providers. It will also require a collaborative effort among providers, care purchasers, and payers to identify and develop the information and tools that will be most useful to patients. The following statements represent the task force's consensus on basic principles that should guide efforts to achieve these goals.

Principle 1. Price transparency should empower patients to make meaningful price comparisons prior to receiving care. It should also enable other care purchasers and referring clinicians to identify providers that offer the level of value sought by the care purchaser or the clinician and his or her patient.

Relevance. Price transparency is most immediately relevant for healthcare services that can be scheduled in advance, enabling the patient, other care purchaser, or referring clinician to identify providers, therapies, or treatments that offer the desired combination of price and quality. But price transparency is ultimately relevant for all healthcare services. Employers with self-funded health plans, for example, need price information across a provider's services, as well as prices for pharmaceutical, medical device, and other treatment options, to make informed decisions on benefit design for their employees.

Differences in information needs. Patients, other care purchasers (e.g., employers), and referring clinicians are different audiences with different information needs. A patient may be seeking a particular service within a particular budget (with parameters, for example, such as a deductible or copayment or individual financial resources). An employer may be trying to identify providers that can consistently deliver a desired level of value to an insured population. And a referring clinician may be focused primarily on identifying a provider that can best meet the particular clinical needs of the patient within the parameters of the patient's insurance coverage or ability to pay.

Principle 2. Any form of price transparency should be easy to use and easy to communicate to stakeholders.

Ease of use and access. Ease of use is most important with respect to individual patients, who in most instances will not have the same in-depth understanding of the healthcare system that other care purchasers do. But all stakeholders should have easy access to the information that will enable them to make informed decisions on provider choice.

Communication methods. The manner in which price information is communicated to stakeholders can have a significant impact on how that information is used. Individual patients, for example, may equate low price with low quality. In one study of 1,400 adult employees, price information that was presented through the number of dollar signs (with "\$" representing low price and "\$\$\$" representing high price) led a significant number of employees to use low price as a proxy for low quality. But when a star ranking system was used to rate providers as "being careful with my healthcare dollars," employees in the study were significantly more likely to choose a lower-price provider.¹⁰ Any system of price transparency will likely need to experiment with the most effective means of communicating price information to various audiences.

Principle 3. Price transparency information should be paired with other information that defines the value of services for the care purchaser.

Quality as a component of value. Price alone is not sufficient to enable patients and other care purchasers to make an informed choice of providers. As noted in this report's definition of value, information on quality—comprising a range of factors from patient satisfaction and experience to adherence to clinical standards and evidence-based medicine to patient safety and clinical outcomes—is needed to ensure that a provider offers the desired level of value.

Quality models and metrics. This report's focus is on price transparency, but the task force urges organizations involved in defining the quality of healthcare services to seek consensus

on models and appropriate quality metrics that will provide patients and other care purchasers with ready access to relevant information in addition to price when making their healthcare decisions.

Principle 4. Price transparency should ultimately provide patients with the information they need to understand the total price of their care and what is included in that price.

Effects of fragmentation. At the time of this report, a dominant fee-for-service payment system has led to fragmentation of healthcare delivery, and a unit of care is typically provider-specific. Patients may need to purchase units of care from multiple providers to treat a condition or have a procedure done. They may also need to pay separately for pharmaceuticals or medical devices. As a result, it can be difficult for patients to obtain price estimates for everything that will be needed as part of the treatment or procedure. A hospital, for example, may be able to provide a price for the services it will render as part of an inpatient procedure, but not for the services of physicians who will be involved in the procedure, for the pharmaceuticals that are prescribed post-discharge, or for a post-acute care facility that provides rehabilitation services.

Benefits of new payment and care delivery models. New payment and care delivery methods are beginning to reshape how a unit of care is defined. As an example, the Center for Medicare and Medicaid Innovation, which was created by the Affordable Care Act, has launched a Bundled Payments for Care Improvement initiative that asks providers—including, depending on the model, hospitals, physicians, and post-acute care facilities—to define a single price for a set of services that make up an episode of care. Other initiatives, such as the Pioneer Accountable Care Organization (Pioneer ACO) model, are moving toward population-based payment, which will pay providers in the ACO a certain amount per assigned Medicare beneficiary to manage the care of the ACO's assigned beneficiary population. Commercial health plans are developing similar models for bundled and population-based payment. If successful, these models should provide patients and other care purchasers with significantly greater clarity on both the services included within a unit of care and the total price for those services.

Information sources for insured patients. Health plans have the most comprehensive understanding of price in today's health-care marketplace, and are best situated to provide price information to their members. Many health plans already offer tools that provide price and quality information to their members. There are also a growing number of independent vendors that use data from health plans and/or employers in web-based tools and telephonic products to inform employees about price.¹¹ To provide the most helpful price information, these tools should be tied to the specifics of an individual's benefit design and include information on applicable copayment, coinsurance, or deductible requirements. They should also assist members in identifying in-network providers and identify any impact that selection of an out-of-network provider is expected to have on the patient's responsibility for payment.

Information sources for uninsured patients. Uninsured patients will likely face a greater challenge obtaining information on the total price of care in today's marketplace. Many states have enacted legislation that encourages or mandates greater transparency although, to the extent these efforts rely on charge data, they may be of limited usefulness for patients seeking price information.¹² As noted earlier, today's fragmented healthcare system also makes it difficult for any single provider to furnish prices for all providers, treatments, and therapies that may be involved in caring for a patient, although these capabilities are expected to develop as new payment methods take hold. In the meantime, providers should strive to offer patients assistance in identifying additional providers from whom the patient should seek price information.

Parameters of price estimates. Price information will likely take the form of an estimate or price range, given that unexpected complications may increase the price of care. Providers should make clear that they are providing estimated prices for a standard procedure or service, describe what is included in the estimate, and indicate who will pay for any services related to unexpected complications. Some providers have begun to distinguish between avoidable complications, such as a hospital-acquired condition, and unavoidable complications, such as a complication arising from a comorbidity that was not evident prior to a procedure, covering the price of care related to treatment of an avoidable complication.^{13,14}

As providers grow more sophisticated in their pricing capabilities, they should ideally be able to identify common complications associated with a procedure or service, the likelihood of such complications, estimates of the price for treating any such complications, and information on the process by which any significant deviations from the price estimate will be reconciled. In some emerging payment models, such as bundled payment or population-based payment, the risks and associated costs of complications will already be built into the price of care.

Importance of comparable data. All care purchasers have a strong interest in better understanding total price of care. Comparable data on price, quality (including readmission and complication rates), and utilization can help identify high-quality, cost-effective providers to help inform patient choice, benefit design decisions, and clinical referrals. Again, in today's marketplace, health plans are the best source of this data for their enrollees.

Principle 5. Price transparency will require the commitment and active participation of all stakeholders.

The healthcare payment system is complex. There are many different sources of price and quality information, many different benefit designs for patients that are insured, and an increasing variety of payment models and quality indicators. Given these complexities, providers, payers, patients, and other care purchasers should work together to define and provide the price and quality information that care purchasers need to make informed provider choices. Transparency efforts should also remain flexible to adapt to changing healthcare payment and delivery models.

POLICY CONSIDERATIONS

While the task force supports greater price transparency, it also recognizes the potential for unintended consequences that may need to be addressed as greater transparency takes hold. This section addresses two significant issues that will require monitoring and, potentially, policy solutions: the impact of transparency on prices in different markets and payment environments and the impact of transparency on the provision of societal benefits.

POTENTIAL IMPACT OF TRANSPARENCY ON PRICES

As this report has indicated, price transparency can take a variety of forms depending on such factors as for whom the price information is intended and the information needs of that intended audience. Moreover, a variety of submarkets exist within the broader healthcare marketplace. Most prices for commercially insured patients, for example, are the product of private negotiations between health plans and providers in a business-to-business marketplace. Certain areas of health care are becoming, or already are, more like a retail marketplace, including the market for elective procedures such as Lasik eye surgery or cosmetic surgery. Recent trends in consumer-driven and value-based insurance design are moving “commodity services” such as lab work, imaging, and screening tests, as well as some procedures, more toward a retail model. And new payment models are potentially reshaping how care will be delivered and priced. Price information needs—and the impact of price transparency—might vary significantly among different markets and payment environments.

TRANSPARENCY IN THE BUSINESS-TO-BUSINESS MARKETPLACE

Among the unique features of the U.S. healthcare marketplace is the existence of a business-to-business marketplace between providers and private health plans. For a typical hospital, this marketplace determines payments that make up approximately one-third of the hospital’s total revenue.

Risk of price inflation. From a consumer perspective, as a general rule, the more transparency the better. But within a business-to-business marketplace, some healthcare economists and the federal antitrust enforcement agencies have noted that public transparency of negotiated rates could actually inflate prices by discouraging private negotiations that can result in lower prices for some buyers.¹⁵ Providers, for example, may have less

incentive to offer lower prices to certain payers if they know other payers in the market will demand similar rates. They may also have less incentive to offer lower prices if they think this will set off a price war with other providers in the market. Within the privately insured market, these considerations suggest that an approach to transparency that emphasizes out-of-pocket payments for insured patients instead of full transparency of negotiated rates may be preferable.¹⁶

Evidence for price reduction. In other contexts, evidence suggests that price transparency may help lower prices. This effect has been noted in pilot programs involving reference pricing, one of several payment models that have emerged in recent years as alternatives to fee-for-service payment. Reference pricing sets a limit on the amount that, for example, a large employer with a self-funded plan will pay for healthcare services purchased by its employees. (This price limit establishes the reference price.) The employer communicates to employees a list of the providers who have agreed to accept the reference price (or less) for their services. If an employee chooses a provider who has not accepted the reference price, the employee is responsible for the amount the provider charges above the reference price.

The Safeway chain of grocery stores launched a reference pricing pilot in 2009 to address market variations in price for screening colonoscopies that, in one regional market, varied from \$848 to \$5,984 for the same procedure. Safeway set a reference price of \$1,500 for the facility and provided employees with a list of physicians who used the facilities that charged less than the \$1,500 limit. (The physicians were paid according to a uniform fee schedule that had little variation across facilities.) The success of the pilot led to nationwide expansion of the program in 2010, with the reference price reduced to \$1,250.¹⁷

If a provider cannot lower its costs for providing a reference-priced service, it may raise its prices on other services to help mitigate the impact of meeting the reference price. Employers and other care purchasers should be sensitive to the potential for cost shifting when focusing on price reductions for a particular service.

Need for impact monitoring. The above examples suggest that price transparency may have varying impacts on prices

depending on such factors as the context in which price transparency is introduced, the means by which price information is communicated to stakeholders, and the nature of the information that is communicated. As the healthcare industry develops frameworks for price transparency, it should remain sensitive to these factors and carefully monitor the impacts on prices of any price transparency frameworks that are introduced into the marketplace.

PROVISION OF SOCIETAL BENEFITS

One goal of price transparency is to make the healthcare system more efficient, encouraging providers to focus on maximizing the efficiency of their operations and reducing their internal cost structure so they can better compete on price. In some instances, however, providers offer services (e.g., a Level I trauma center) or programs (e.g., a strong teaching and

research mission) or serve low-income, indigent, or rural populations to address community or societal needs but may not produce a profit or positive margin, regardless of improved efficiencies.^{18,19}

As noted in one analysis of this problem, “until the political system is willing to level the playing field by explicitly paying for under- and unfunded services, market changes such as price transparency and specialization, although beneficial in their own right, could have severe negative consequences.”²⁰ This is not an argument against price transparency, but a reminder that any system of price transparency should be implemented with full awareness of these potential consequences, which may require policy solutions to ensure the continued provision of services such as those described above.

RECOMMENDATIONS FOR PRICE TRANSPARENCY FRAMEWORKS

While all care purchasers share a common need for greater price transparency, the framework for different care purchasers varies according to such factors as the most important information needed and the source of that information. This section outlines the task force's recommendations for price transparency frameworks for different groups of care purchasers.

PRICE TRANSPARENCY FOR PATIENTS

Recommendation 1. Because health plans will, in most instances, have the most accurate data on prices for their members, they should serve as the principal source of price information for their members.

As noted earlier in this report, many health plans have already developed or are in the process of developing web-based or telephonic transparency tools for their members. These tools have the potential to benefit both patients and health plans, providing patients with needed information while strengthening the health plan's value to its members. Employers with self-funded health plans have the option of working with health plans (which often serve as third-party administrators for self-funded plans) or other vendors in developing transparency tools for insured employees and their dependents.

Recommendation 2. Health plans and other suppliers of price information should innovate with different frameworks for communicating price information to insured patients.

Health plans and other transparency tool vendors should be encouraged to continue to innovate with different transparency frameworks to see which are the most effective in communicating with patients.

Recommendation 3. Transparency tools for insured patients should include some essential elements of price information.

Building on the features of existing price transparency tools, essential elements of price information for insured patients include the total estimated price of the service, the provider's network status, and the patient's estimated out-of-pocket responsibility, along with other available provider- and service-specific information.

Total estimated price of the service. This is the amount for which the patient is responsible plus the amount that will be paid by the health plan or, for self-funded plans, the employer. The amount will necessarily be an estimate for several reasons. The patient, for example, may use additional services not included in the estimate or the physician may code and bill for a service different from the service for which the patient sought an estimate.

The price estimate for in-network services is a communication between the health plan and the insured patient and should follow the form of an explanation of benefits, representing the total estimated price (i.e., the plan's negotiated rate for the service) as a dollar amount, not as a percent discount from charges, to avoid confusing the patient. For services received from out-of-network providers, because the provider's pricing information is not available to the health plan, the health plan can only provide information about the benefit structure for that type of out-of-network care (e.g., a 20 percent co-insurance obligation).

Network status. The tool should provide a clear indication of whether a particular provider is in network and information on where the patient can try to locate an in-network provider, such as a list of in-network providers that offer the service.²¹

Out-of-pocket responsibility. Another essential element is a clear statement of the patient's estimated resulting out-of-pocket payment responsibility, tied to the specifics of the patient's health plan benefit design, including coinsurance and the amount of deductible remaining to be met (as close to real time as possible).

Other relevant information. Information related to the provider or the specific service sought (e.g., clinical outcomes, patient safety, or satisfaction scores) should be included where it is available and applicable. This information should clearly communicate what has been measured and to whom the measurement pertains (e.g., to the facility, the physician, etc.).

Recommendation 4. Insured patients should be alerted to the need to seek price information from out-of-network providers.

The price of healthcare services for an insured patient can vary significantly depending on whether the services are provided by an in-network or an out-of-network provider. If a provider is out-of-network, the patient may face a higher coinsurance payment or be responsible for the out-of-network provider's entire bill, depending on the patient's benefit design. This issue can arise in a variety of situations, as described below.

Intentional. If a patient seeks care from an out-of-network provider (based, for example, on that provider's reputation) and contacts the health plan for assistance, the health plan should continue to clearly explain what percentage (if any) of out-of-network provider charges the plan will cover, and describe any other significant out-of-network benefit plan issues (e.g., a "reasonable and customary rate of reimbursement" limit on what the health plan will pay). The health plan should also inform the patient that—if the patient intentionally seeks care from an out-of-network provider—it is the patient's responsibility to independently obtain price information from that provider.

Inadvertent. In another situation, a patient may schedule a procedure at an in-network provider but receive services as part of that procedure from an out-of-network provider. A typical example is a patient who chooses an in-network hospital or ambulatory surgical center for the procedure but receives services from an out-of-network provider (such as a pathologist, radiologist, or anesthesiologist). In this case, the in-network provider should, to the extent possible, inform the patient of the need to also check the network status of physicians who will be involved in the procedure.

For example, if the in-network provider furnishes a pre-service estimate to the patient, the estimate should note that individual physician services will be billed separately and that the patient should confirm the network status of the physicians. The in-network provider may not know which individual physicians will be providing services to the patient during the procedure, but will typically know which medical groups have been engaged to provide these services. The patient should be provided with the

names of these medical groups so the patient can confirm the groups' network status with his or her health plan and understand the possible financial implications in advance of the procedure.

Emergency. In a third situation, a patient needs emergency medical care and is taken to the nearest emergency department. The patient will have no advance opportunity to identify the network status of any providers involved in his or her emergency care. This is a situation that may well need a policy solution to balance the interests of patients, health plans, and providers.²²

Recommendation 5. To ensure valid comparisons of provider price information, health plans and other suppliers of such information should make transparent the specific services that are included in the price estimate.

Suppliers of price information should make sure that price estimates are accompanied by explanations of what services are included in such estimates, as well as the impact of differences in network status on such estimates, to help patients make valid comparisons among providers. For example, when comparing prices associated with receiving an imaging service, the patient should be informed if the estimate includes the facility costs associated with taking the image and the radiologist's fee for the professional reading.

Recommendation 6. The provider should be the principal source of price information for uninsured patients and patients who are seeking care from the provider on an out-of-network basis.

Price transparency for the uninsured is subject to a substantial and expanding number of laws at both the federal and state levels and it is the first responsibility of providers to ensure that policies and practices adhere to these legal requirements. Regardless of legal requirements, however, it is in a provider's best interest to be proactive in its approach to price transparency. A growing number of patients face significant financial responsibility for healthcare services and are becoming increasingly price sensitive. As consumer price sensitivity has intensified, so too has media attention to healthcare prices. Providers that can speak accurately and confidently about their prices will be

better positioned to succeed in this environment than providers that can only refer back to their charge schedule.

Recommendation 7. Providers should develop price transparency frameworks for uninsured patients and patients receiving care out of network that reflect several basic considerations.

There are several basic considerations that providers should take into account when developing price transparency frameworks.

Clarify the limitations of the estimate. Prices in most instances will take the form of an estimate; that is, provide a price for a standard procedure without complications and make clear to the patient the services included in the price and how complications or other unforeseen circumstances may increase the price.²³ New payment models such as bundled payment, described earlier in this report, may enable providers to set firm prices for certain procedures. As noted, some providers are covering the price of care related to avoidable complications within the provider's control so that the estimated price to the patient does not increase in these situations.

Serve as the primary price information resource for these groups.

Providers should clearly communicate preservice estimates of prices to uninsured patients and patients seeking care on an out-of-network basis. Federal and state laws define basic requirements for communicating prices to patients who are eligible for financial assistance. Beyond that, the provider should, at a minimum, offer clear information on how a patient can obtain price estimates and ensure that the patient can easily reach someone who can address such requests.

Providers should consider which approaches are most useful in providing information to uninsured patients in their markets, including the possible use of web and mobile technologies to respond to queries from an uninsured patient or provide information about the price of a particular service. A national steering committee of experts including patients, hospitals, physicians, payers, and others have developed a set of patient financial communication best practices (available at hfma.org/communications) that providers should refer to when developing or reviewing their patient communication practices.

Identify inclusions and exclusions. Providers should clearly communicate to patients what services are and are not included in a price estimate. If any services that would have significant price implications for the patient are not included in the price estimate, the provider should try to provide information on where the patient could obtain this information.

Offer other relevant information. Providers should give patients other relevant information, where available. The task force notes that some states have begun to make both price and quality data available on public websites and encourages all states to furnish such information on providers. A number of public and private organizations also offer public access to data on patient outcomes, safety, and patient satisfaction or credentialing information on providers who have met certain quality benchmarks. The price estimate that a provider gives to patients can reference and provide links to various reliable websites where the provider knows relevant information is available.

Recommendation 8. Transparency tools for beneficiaries in Medicare health plans or Medicaid managed care programs should follow this task force's recommendations for patients with private or employer-sponsored insurance coverage.

Beneficiaries of federal and state healthcare programs, including Medicare and Medicaid, will have different sources for price information depending, for example, on the Medicare option they have chosen (e.g., traditional Medicare or Medicare Advantage) or the structure of Medicaid within their state (e.g., whether the state has a Medicaid managed care plan).

For Medicare beneficiaries enrolled in Medicare Advantage or another Medicare health plan, and for Medicaid beneficiaries in a Medicaid managed care program, the health plan or company administering the program will be the best source of price information. Medicare health plans and companies administering Medicaid managed care programs should provide beneficiaries with transparency information and tools similar to those described for patients with private or employer-sponsored insurance coverage on page 13.

Recommendation 9. The Centers for Medicare & Medicaid Services and state administrators of Medicaid programs should develop user-friendly price transparency tools for traditional Medicare and Medicaid beneficiaries.

Traditional Medicare beneficiaries pay a percentage of Medicare-approved amounts for many healthcare services and also are responsible for certain deductibles (e.g., the Part B deductible) and payments for certain prescription drugs and medical devices and supplies. The Centers for Medicare & Medicaid Services (CMS) has taken steps toward greater quality transparency through its Hospital Compare website (www.medicare.gov/hospitalcompare).

The task force urges CMS to add user-friendly price transparency functions to the website, similar to those that are being developed by health plans, to assist traditional Medicare beneficiaries in better understanding their out-of-pocket responsibilities and to assist them in locating high-value providers. Although information on Medicare-approved payments is publicly available, the task force notes that this information in its current format can be difficult for Medicare beneficiaries to locate and understand.

State administrators of Medicaid programs should also work to develop web-based or telephonic price transparency tools for their beneficiaries.

Recommendation 10. To supplement information provided by CMS and state administrators of Medicaid programs, providers should offer information on out-of-pocket payment responsibilities to traditional Medicare and Medicaid beneficiaries upon a beneficiary's request.

While CMS is developing price information and tools, traditional Medicare beneficiaries should contact providers for information on their out-of-pocket payment responsibilities for scheduled services. Medicaid beneficiaries who are not in a Medicaid managed care program should also contact providers for information on their out-of-pocket payment responsibilities.

PRICE TRANSPARENCY FOR EMPLOYERS

Employers' transparency needs include helping employees understand, first, what their out-of-pocket payments will be under an employer-sponsored health plan and, second, how much the employer is paying for employees' care.

State-Supported Transparency Website Recommendations

Public, state-supported websites that provide information on the price and quality of care for providers within a state can provide a valuable resource, especially for uninsured patients who do not have access to transparency tools offered by health plans or other transparency vendors, and for patients who are seeking care at an out-of-network provider.

Consistent with the task force's overall guidance and recommendations, the task force recommends that state-supported transparency websites should:

- Enable patients to make meaningful price comparisons among providers prior to receiving care
- Be easy for patients to access and use
- Experiment with the most effective means of communicating price information to patients
- Pair price information with other information comprising a range of factors (e.g., patient satisfaction and experience,

provider compliance with clinical standards and evidence-based medicine, patient safety, and clinical outcomes) to help patients identify providers that offer the desired level of value

- Emphasize, to the extent data are available, the average amount paid for services instead of the average amount charged
- Conform with the U.S. Department of Justice and Federal Trade Commission's *Statements of Antitrust Enforcement Policy in Health Care*

In particular, if the price information offered on a state-supported transparency website is based in whole or in part on prices negotiated between health plans and providers, that information must be sufficiently aggregated so that recipients of the information cannot identify specific negotiated prices.

Recommendation 11. Fully insured employers should continue to use and expand transparency tools that assist their employees in identifying higher-value providers.

The task force agrees that the framework for employer price transparency will vary depending on whether the employer offers its employees a fully-insured or a self-insured plan. When an employer purchases health insurance for its employees from a health plan (fully insured), it does not need to know the rates negotiated between the health plan and providers. Employers in this instance should, however, expect that the health plan will provide its employees with transparency tools that enable employees to understand their out-of-pocket payment responsibilities and provide price, quality, and other relevant information that help employees identify higher-value providers.

Recommendation 12. Self-funded employers and third-party administrators (TPAs) should work to identify data that will help them shape benefit design, understand their healthcare spending, and provide transparency tools to employees.

Employers that offer their employees self-funded plans directly pay the claims for their employees' care. A self-funded employer may use a health plan or other third-party administrator to administer the plan, but the employer bears the risk. In this instance, employers and TPAs should identify information that can help the employer make informed decisions on benefit design for its employees, understand how its funds are being spent, and provide transparency tools for its employees.

PRICE TRANSPARENCY FOR REFERRING CLINICIANS

Clinicians who refer patients for diagnostic testing, specialist or acute care, or other healthcare services can play a significant role in communicating price information to patients. There are indications that clinicians are increasingly willing to take on this role. The results of a Bain & Company survey from 2011 indicated that more than 80 percent of physicians "agree" or "strongly agree" that bringing healthcare costs under control is part of their responsibility.²⁴ Other studies suggest that presenting physicians with price information leads them toward more careful consideration of the need for tests, although, as appropriate, information on the quality of patient care is the main driver of clinician decisions.²⁵⁻²⁶ As discussed

below, changes in payment and care delivery have begun and should continue to encourage clinicians to make use of this information.

Recommendation 13. Referring clinicians should help patients make informed decisions about treatment plans that best fit the patient's individual situation. They should also recognize the needs of price-sensitive patients, seeking to identify providers that offer the best price at the patient's desired level of quality.

Most clinicians will encounter more price-sensitive patients as exposure to higher deductibles and other forms of patient cost-sharing increases. At the time of this report, resources such as the Choosing Wisely campaign (www.choosingwisely.org), a collaborative effort of more than 50 specialty societies, are helping clinicians and their patients make informed decisions about appropriate treatment plans to meet the patient's individual situation.

When a treatment plan has been decided upon, clinicians will need price information to help their patients find providers that best meet the patient's clinical and financial needs. For insured patients, the clinician will typically want to refer the patient to his or her health plan as the best source of information. To address the needs of uninsured patients, clinicians should request that providers to whom they refer patients make price information available to help in referral decisions. In non-emergent situations, the clinician should provide the patient with a list of providers so that the patient can obtain and compare price information from them before the referral decision is made.

Clinicians who assume some degree of financial risk for managing a patient's total cost of care under new payment models (including shared savings models and global or capitated payment models) may need some information on the cost of care provided by others treating that patient. The specific information required will depend on the type of financial risk assumed by the clinician, the ways in which attribution is handled, and the clinician's relationship with other providers delivering care (e.g., whether they are part of the same ACO). The relevant stakeholders should determine the best way to ensure that clinicians have the information necessary for making such decisions.

CONCLUSION

The lack of price transparency in health care threatens to erode public trust in our healthcare system, but this erosion can be stopped. Patients are assuming greater financial responsibility for their healthcare needs and in turn need the information that will allow them to make informed healthcare decisions. Price is not the only information needed to make these decisions; as this report has noted, price must be presented in the context of other relevant information on the quality of care. But it is an essential component. The time for price transparency in health care is now.

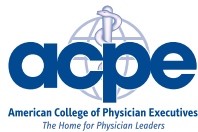
The work of this task force is highly encouraging. Stakeholders representing the distinct and at times disparate perspectives of patients, providers, payers, and employers have engaged in frank and constructive discussions of stakeholder needs and capabilities and have reached consensus on specific recommendations to achieve a more transparent healthcare pricing system. But this report is only a starting point: It is now incumbent upon all industry stakeholders to act on these recommendations in a concerted effort to provide the price information that will give patients the ability to make informed care decisions and, in the process, continue to earn their trust.

1. The percentage of workers enrolled in an employer-sponsored plan with an annual deductible of \$1,000 for individual coverage grew from 10 percent to 38 percent from 2006 to 2013 for firms of all sizes. At smaller firms (employing 3 to 199 workers), the growth was even more dramatic, going from 16 percent to 58 percent within the same time period. See Kaiser Family Foundation, *2013 Employer Health Benefits Survey*, Aug. 20, 2013. Available at kff.org/report-section/2013-summary-of-findings.
2. As of Feb. 1, 2014, the Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE) indicated that 62 percent of enrollees on the marketplaces selected silver plans, 19 percent selected bronze plans, 12 percent selected gold plans, and 7 percent selected platinum plans. An additional 1 percent selected catastrophic coverage. See ASPE Issue Brief, *Health Insurance Marketplace: February Enrollment Report*, Feb. 12, 2014. An analysis of plans offered on the marketplace in six states indicated that, for a non-subsidized silver plan, the average deductible is \$2,550 (reflecting a range of \$1,500 to \$5,000 in the plans studied). See Avalere Health, *Despite Lower Than Expected Premiums, Exchange Consumers Will Face High Cost-Sharing Before the Out-of-Pocket Cap*, Oct. 1, 2013.
3. For example, the U.S. Government Accountability Office (GAO) sought price information on selected procedures from 39 providers (19 hospitals and 20 primary care physician offices) as part of a 2011 report on healthcare price transparency. Of those providers that were willing to provide a price estimate for a full knee replacement surgery, the estimate ranged from about \$33,000 to about \$101,000. See GAO, *Health Care Price Transparency: Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care*, Sept. 2011.
4. As explained in the "Common Definitions" section of this report, there is a critical distinction between charges (the dollar amount a provider sets for services rendered before negotiating any discounts) and prices (the total amount a provider expects to be paid). See pages 5 and 6 of this report.
5. At the Dec. 12, 2013, public meeting of the Medicare Payment Advisory Commission (MedPAC), MedPAC staff noted that overall Medicare margins for hospital inpatient and outpatient services from 2011 to 2012 remained steady at minus 5.4 percent. MedPAC staff also noted that, if current law remains in effect, they expect that even more efficient providers will have negative margins on Medicare payments by 2015. See pp. 67-71 of the meeting transcript at www.medpac.gov/meeting_search.cfm?SelectedDate=2013-12-12%2000:00:00.0
6. For example, a study of actual prices paid by uninsured patients in California hospitals from 2001 to 2005 showed that they paid prices similar to those of Medicare patients. See Melnick, G. A., and Fonkyeh, K., "Hospital Pricing and the Uninsured: Do the Uninsured Pay Higher Prices?" *Health Affairs*, March-April 2008, pp. w116 – w122.
7. Department of Health and Human Services, Office of Inspector General, *Medicare Hospital Outlier Payments Warrant Increased Scrutiny*, Nov. 2013.
8. Moody's Investors Service, *U.S. Not-for-Profit Hospitals' 2012 Medians Show Balance Sheet Stability Despite Weaker Performance*, Aug. 2013.
9. Note that section 501(r) of the Internal Revenue Code, which was added by the Affordable Care Act, limits the price that not-for-profit hospital organizations can request for emergency or other medically necessary care provided to an uninsured patient who qualifies for financial assistance to no more than amounts generally billed to insured patients for these services.
10. Hibbard, J. H., Greene, J., Sofaer, S., et al., "An Experiment Shows that a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care," *Health Affairs*, March 2012, pp. 560-568.
11. For an overview of transparency tools available on the market at the time of this report, see Catalyst for Payment Reform, *The State of the Art of Price Transparency Tools and Solutions*, Nov. 2013. Available at www.catalyzepaymentreform.org/images/documents/stateofheart.pdf.
12. The National Conference of State Legislatures, for example, has identified 31 states that have enacted legislation regarding transparency and disclosure of health costs. See www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx.
13. Since 2008, the Centers for Medicare & Medicaid Services has identified categories of hospital-acquired conditions for which extra payment is denied if the condition is acquired during hospitalization.
14. Geisinger's ProvenCare™ model, for example, covers the price of any follow-up care if a patient eligible for a ProvenCare procedure experiences an avoidable complication within 90 days of the procedure.
15. For a summary of the federal antitrust agencies' concerns regarding provider exchanges of price information, see the U.S. Department of Justice and Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care*, Statement 6, Aug. 1996.
16. For an overview of the potential adverse effects of transparency in business-to-business healthcare marketplaces, see Cutler, D., and Dafny, L., "Designing Transparency Systems for Medical Care Prices," *New England Journal of Medicine*, March 10, 2011, pp. 894-895.

17. For a description of the Safeway program, see Robinson, J. C., and MacPherson, K., “Payers Test Reference Pricing and Centers of Excellence to Steer Patients to Low-Price and High-Quality Providers,” *Health Affairs*, Sept. 2012, pp. 2028–2036.
18. For an overview of challenges facing rural hospitals, see American Hospital Association, *Trendwatch: The Opportunities and Challenges for Rural Hospitals in an Era of Health Reform*, April 2011. Available at www.aha.org/research/reports/tw/11apr-tw-rural.pdf.
19. For an analysis of the costs to academic medical centers and teaching hospitals of maintaining their teaching and research missions, as well as providing standby capacity for medically complex patients, see L. Koenig, A. Dobson, S. Ho, et al., “Estimating the Mission-Related Costs of Teaching Hospitals,” *Health Affairs*, Nov. 2003, pp. 112–122.
20. Altman, S. H., Shactman, D., and Eilat, E., “Could U.S. Hospitals Go the Way of U.S. Airlines?” *Health Affairs*, Jan.–Feb. 2006, pp. 11–21.
21. A provider has a similar and important responsibility to alert patients or potential patients if the provider knows it is not in the patient’s network.
22. A number of states have attempted policy solutions for this issue. For an overview of the different approaches and their strengths and weaknesses, see Hoadley, J., Lucia, K., and Schwartz, S., *Unexpected Charges: What States Are Doing About Balance Billing*, California HealthCare Foundation, April 2009.
23. Price estimates for home remodeling provide a useful comparison, in that they can involve a significant financial commitment and are subject to any unknown complications unique to the home (e.g., presence of asbestos or defective plumbing) that may arise after remodeling begins.
24. Farkas, C., and van Biesen, T., *The New Cost-Conscious Doctor: Changing America’s Healthcare Landscape*. Bain & Co., 2011.
25. In a controlled study at The Johns Hopkins Hospital, clinicians (physicians and nonphysicians) who ordered lab tests through a computerized physician order entry system (CPOE) showed a decrease in the number of tests per patient day ordered when fee data for the test was presented in the CPOE. See Feldman, L.S., Shihab, H.M., Thiemann, D., et al., “Impact of Providing Fee Data on Laboratory Test Ordering: A Controlled Clinical Trial,” *JAMA Internal Medicine*, May 27, 2013, pp. 903–908.
26. A study of California physicians participating in capitated health plans indicated that while physicians are willing to refer patients to more distant hospitals for a lower price with similar quality, they are not willing to accept lower quality for a lower price. See Ho, K., and Pakes, A., *Hospital Choices, Hospital Prices and Financial Incentives to Physicians*, National Bureau of Economic Research Working Paper No. 19333, Aug. 2013.

PARTICIPATING ORGANIZATIONS

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