VIEWPOINT

The Disruptive Innovation of Price Transparency in Health Care

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Until very recently, health care in the United States was delivered behind the secure walls of a fortress that kept information on the prices charged for health care and the quality of that care opaque from public view.

Over time, enormous and ever-increasing amounts of money have disappeared behind the fortress walls. Much good undoubtedly was done for patients entering the castle in search of succor. But it has been nearly impossible for prospective patients thinking of entering the health care system to know what they or someone else will have to give up in return for whatever care they will receive from the inhabitants of the fortress.

In recent years, the US public has been made aware through decades of cross-national research and by the media that US health spending per capita is roughly twice as high as it is in most other developed nations, in comparable international purchasing-power parity dollars, even though the American population on average is much younger than those of, for example, most European nations.

The bulk of that spending differential cannot be explained by the relatively higher use of health care per capita in the United States. In terms of real health care resources consumed per capita, many other countries with lower health spending rank above the United States.[1] Research has shown that, instead, the largest part of the spending differential can be explained by the much higher prices Americans pay for health care products and services.[2]

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There are at least 2 major reasons for these higher prices.

First, the private health insurance sector in the United States is so fragmented in any local market as to limit the market power of individual insurers to resist high prices in most market areas—certainly vis-à-vis the ever more consolidated hospital sector.[3] The prices private insurers pay for health care are the benchmark for all health care prices in the United States. Medicare always has had to adapt to private-sector prices to ensure elderly people access to health care services. As the Medicaid program has shown, if government programs set prices too much below private-sector prices, their insured beneficiaries lose access to providers of care.

A second factor facilitating high US prices for health care has been the shroud of secrecy draped over the health care prices negotiated in the private sector. Those prices were kept as trade secrets. Rare are the physicians, hospitals, imaging centers, or other clinicians or health care centers who post on their websites the prices for frequently performed procedures. Furthermore, few health care practitioners or centers are willing to quote prices over the phone for even standard procedures, such as a normal vaginal delivery.

As a consequence, the often advanced idea that American patients should have "more skin in the game" through higher cost sharing, inducing them to shop around for cost-effective health care, so far has been about as sensible as blindfolding shoppers entering a department store in the hope that inside they can and will then shop smartly for the merchandise they seek. So far the application of this idea in practice has been as silly as it has been cruel.

But the hitherto tranquil life within the walled-off health care fortress, protected from the rigors of open price competition, may soon come to an end. Life inside the fortress will increasingly be disrupted by what is now celebrated elsewhere as "disruptive innovations"[4] trained on the fortress by energetic insurgents, some of them equipped with a potent new weapon: modern electronic information technology. These insurgents' banner reads Transparency.

Independent entities, many of them entrepreneurial start-ups, have taken up its cause. An interesting website not linked to any insurer, for example, is the Healthcare Blue Book.[5] It provides what it calls "fair prices" by zip code for hospital and physician services, as well as laboratory tests and imaging services. Fair prices are defined to be the average amount that most clinicians, hospitals, and health care centers in an area will accept from major insurance carriers and can be used by self-insured patients to bargain over fees.

Another high-tech West Coast start-up has developed software allowing employees of firms with group insurance to find the prices charged by individual clinicians and health care organizations in distinct market areas for particular procedures, as well as information on the quality of these procedures. That firm is now working with employers and their agents (private health insurers) to facilitate the introduction of reference pricing.[6]

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Reference pricing was first introduced in Germany during the early 1990s, and subsequently in other countries, to control market prices for pharmaceuticals. But it can be broadened to any reasonably well-defined medical procedure. Under that method, the insurer within a market area contributes only a set amount for a particular medical procedure, pegged on the lower price range for the procedure. The insured, fully apprised of the prices for the procedure charged by competing health care service providers within the area, must then pay the full difference between that reference price and whatever higher price a hospital, physician, laboratory or imaging service chosen by the insured may charge. That form of cost sharing is much more blunt and more powerful than mere coinsurance.

To illustrate, using reference pricing for hip and knee replacement for members of the California Public Employees' Retirement System from 2008 to 2012, the large insurance company WellPoint has succeeded in lowering the prices charged by high-priced hospitals for these procedures by as much as 34.3%, and even in low-price hospitals by 5.6%.[7] By enlisting raw price competition as it does, reference pricing may well turn out to be the sleeper in cost-containment efforts in US health care.

The power of reference pricing to control prices could even be enhanced if all hospitals were mandated to use Medicare's diagnosis related group system for all patients, with every hospital using the same relative value scale implicit in the system and competing solely on setting the monetary conversation factor that translates relative value scales into monetary fee schedules (and analogously for physicians with Medicare's resource-based relative value scale). Broad price competition in US health care could then occur on the basis of only one single number: the monetary conversation factor, which could easily be made public.

For close to half a century this country has debated the relative virtues of government vs market. Government is understood to be government regulation or government-run insurance systems such as Medicare or Medicaid, or at least a so-called all-payer system under which all providers of health care (clinicians, hospitals, nursing homes, pharmacies, and others) are paid on a common fee schedule set by the government or negotiated between associations of insurers and associations of providers. In their almost united opposition to government, US physicians and health care organizations have always paid lip service to the virtue of market, possibly without fully understanding what market actually means outside a safe fortress that keeps prices and quality of services opaque from potential buyers. Reference pricing for health care coupled with full transparency of those prices is one manifestation of raw market forces at work.

It is easy to understand why those who provide health care in the United States may not be charmed by this and other disruptive innovations coming their way. Even raw market forces cannot work properly when society expects providers of health care to serve the uninsured and Medicaid patients at revenues below production costs.

But the health insurance system was never designed to be fair. It is beside the point. The point is that in developing their next strategic 5-year plans, prudent planners among the providers of health care now must include the contingency of vastly disruptive innovations, such as those that promote price and cost transparency into their plans.

ARTICLE INFORMATION

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