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GAO

Report to Congressional Requesters

September 2011

HEALTH CARE PRICE TRANSPARENCY

Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care

GAO-11-791

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GAO Accountability * Integrity * Reliability

Highlights

Highlights of GAO-11-791, a report to congressional requesters

Why GAO Did This Study

In recent years, consumers have become responsible for a growing proportion of the costs of their health care. Health care price information that is transparent—available before consumers receive care—may help consumers anticipate these costs. Research identifies meaningful types of health care price information, such as estimates of what the complete cost will be to the consumer for a service. GAO defines an estimate of a consumer's complete health care cost as price information on a service that identifies a consumer's out-of-pocket cost, including any negotiated discounts, and all costs associated with a service or services. GAO examined (1) how various factors affect the availability of health care price information for consumers and (2) the information selected public and private health care price transparency initiatives make available to consumers. To do this work, GAO reviewed price transparency literature; interviewed experts; and examined a total of eight selected federal, state, and private insurance company health care price transparency initiatives. In addition, GAO anonymously contacted providers and requested the price of selected services to gain a consumer's perspective.

What GAO Recommends

GAO recommends that the Department of Health and Human Services (HHS) determine the feasibility of making estimates of complete costs of health care services available to consumers, and, as appropriate, identify next steps. HHS reviewed a draft of this report and provided technical comments, which GAO incorporated as appropriate.

View GAO-11-791. For more information, contact Linda T. Kohn at (202) 512-7114 or kohnl@gao.gov.

What GAO Found

Several health care and legal factors may make it difficult for consumers to obtain price information for the health care services they receive, particularly estimates of what their complete costs will be. The health care factors include the difficulty of predicting health care services in advance, billing from multiple providers, and the variety of insurance benefit structures. For example, when GAO contacted physicians' offices to obtain information on the price of a diabetes screening, several representatives said the patient needs to be seen by a physician before the physician could determine which screening tests the patient would need. According to provider association officials, consumers may have difficulty obtaining complete cost estimates from providers because providers have to know the status of insured consumers' cost sharing under health benefit plans, such as how much consumers have spent towards their deductible at any given time. In addition to the health care factors, researchers and officials identified several legal factors that may prevent the disclosure of negotiated rates between insurers and providers, which may be used to estimate consumers' complete costs. For example, several insurance company officials GAO interviewed said that contractual obligations with providers may prohibit the sharing of negotiated rates with the insurer's members on their price transparency initiatives' websites. Similarly, some officials and researchers told GAO that providers and insurers may be concerned with sharing negotiated rates due to the proprietary nature of the information and because of antitrust law concerns.

The eight public and private price transparency initiatives GAO examined, selected in part because they provide price information on a specific health care service by provider, vary in the price information they make available to consumers. These initiatives include one administered by HHS, which is also expected to expand its price transparency efforts in the future. The price information made available by the selected initiatives ranges from hospitals' billed charges, which are the amounts hospitals bill for services before any discounts are applied, to prices based on insurance companies' contractually negotiated rates with providers, to prices based on claims data that report payments made to a provider for that service. The price information varies, in large part, due to limits reported by the initiatives in their access or authority to collect certain price data. In addition to price information, most of the selected initiatives also provide a variety of nonprice information, such as quality data on providers, for consumers to consider along with price when making decisions about a provider. Lastly, GAO found that two of the selected initiatives—one publicly available with information only for a particular state and one available to members of a health insurance plan—are able to provide an estimate of a consumer's complete cost. The two initiatives are able to provide this information in part because of the type of data to which they have access—claims data and negotiated rates, respectively. For the remaining initiatives, they either do not use more meaningful price data or are constrained by other factors, including concerns about disclosing what providers may consider proprietary information. As HHS continues and expands its price transparency efforts, it has opportunities to promote more complete cost estimates for consumers.

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Abbreviations

AHRQ	Agency for Healthcare Research and Quality
APCD	All Payer Claims Database
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DOJ	Department of Justice
FEHB	Federal Employee Health Benefits
FTC	Federal Trade Commission
HHS	Department of Health and Human Services
OPM	Office of Personnel Management
PPACA	Patient Protection and Affordable Care Act
WHA	Wisconsin Hospital Association

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United States Government Accountability Office
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Congressional Requesters

Health care spending increased in recent years by an average of nearly 7 percent per year, from $1.4 trillion in 2000 to $2.5 trillion in 2009.[1] Consumers are becoming responsible for a growing proportion of this spending, such as in the case of those with insurance who face increased use of high-deductible health plans and other forms of cost sharing.[2] For example, from 2006 to 2010, the percentage of covered workers enrolled in high-deductible health plans increased from 4 percent to 13 percent, and the percentage of covered workers with a deductible of $1,000 or more for single coverage almost tripled, from 10 percent to 27 percent.[3] Depending upon the insurance plan, insured consumers are generally responsible for the cost of health care services until their deductible has been met. Even after reaching their deductibles, consumers may face significant out-of-pocket costs, such as fees associated with care received from a physician, laboratory, or hospital that are outside of an insurance network and may also bill for their services separately. Consumers without health insurance are also responsible for the cost of their care, and without a third party to negotiate on their behalf these consumers are generally responsible for paying what the provider charges, minus any agreed-to discounts, rather than discounted rates negotiated between the insurer and provider.

[1]Office of the Actuary, Centers for Medicare and Medicaid Services, *National Health Expenditures Tables*, table 1, accessed November 23, 2010, https://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf.

[2]Many health plans require enrollees to pay a portion of their health care costs up to a certain threshold, known as the deductible. A high deductible health plan is defined by the Internal Revenue Service (IRS) as a health plan with a higher annual deductible than typical health plans and has a maximum limit on the annual deductible and out-of-pocket medical expenses (including copayments but not premiums) that a consumer would pay. For 2011, the IRS set the minimum annual deductible for single coverage in a high deductible health plan at $1,200 and the maximum annual deductible and other out-of-pocket expense at $5,950. IRS Pub. 969, (2011), p. 3.

[3]The Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits 2010 Annual Survey* (2010).

Consumers generally learn of their health care costs after receiving care, such as when they receive a bill from their provider or an explanation of benefits from their insurer. In contrast, information on health care prices is considered transparent when this information is available to consumers before they receive health care services.[4] Transparent health care price information may help consumers anticipate their health care costs and reduce the possibility of unexpected expenses. When accompanied by information on the quality of care, transparent price information may also help consumers make more informed choices about their care. Specifically, research suggests that health care price transparency is most relevant for consumers who are having services that can be planned for in advance.[5] Researchers have identified characteristics of the most meaningful types of transparent price information, such as information that includes estimates of what the complete cost will be to a consumer for a service or services.[6] Based on this research, we define an estimate of a consumer's complete health care cost as price information on a health care service or services that (1) reflects any negotiated discounts; (2) is inclusive of all costs to the consumer associated with a service or services, including hospital, physician, and lab fees; and (3) identifies a consumer's out-of-pocket cost.

In recent years various federal, state, and private sector efforts have been initiated to make health care price information available to consumers. Federal efforts include various price transparency initiatives administered by the Department of Health and Human Services (HHS) and Centers for Medicare and Medicaid Services (CMS) that provide price information on health care services, prescription drugs, and health insurance plans. For

[4]In this report, we generally refer to "price" as information that is made available to the public by, for example, an insurer or state price transparency initiative. We generally refer to "cost" as a type of price information that is reflective of what a consumer may be expected to pay for a health care service.

[5]For example, to assist decision making, research suggests that health care price transparency is most relevant for consumers who are having services that are nonurgent, such as a knee replacement, or not complex, such as a colonoscopy. See, for example, Paul Ginsburg. "Shopping for Price in Medical Care," *Health Affairs*, vol. 26, no. 2 (2007).

[6]In addition to identifying consumers' out-of-pocket costs, research suggests that price information should also be actionable, easy to understand, easily available, timely, credible, and be paired with quality information. See, for example, Quality Alliance Steering Committee, *Recommendations for Reporting Cost and Price Information to Consumers*, accessed August 18, 2010, www.healthqualityalliance.org/.../Cost-Price%20Recommendations_Final.pdf.

example, HHS provides price information on insurance plans, such as the amount of cost-sharing and premium rates for specific plans, through its healthcare.gov website. In addition, CMS's Medicare Plan Finder provides information on prescription drug prices, and CMS's Health Care Consumer Initiatives provide information on the price Medicare pays for common health care services by various geographic areas.[7] At the state level, the National Conference of State Legislatures reports that at least 30 states have proposed or enacted some form of price transparency legislation,[8] and a report by America's Health Insurance Plans, an industry group, states that at least 25 states have price transparency initiatives that provide publicly accessible websites with health care price information.[9] Additionally, with the enactment of the Patient Protection and Affordable Care Act (PPACA) in 2010, hospitals operating in the United States are required annually to make public and update a list of their hospital's standard charges for items and services provided by the hospital.[10]

In addition to existing price transparency initiatives, more efforts are planned that may increase the amount of health care price information available to consumers. For example, under PPACA, Health Insurance Exchanges for each state must be developed by January 1, 2014, to facilitate the purchase of qualified health plans and assist small

[7]Specifically, CMS's online Medicare Plan Finder tool enables consumers to compare both the prices of prescription drugs and Medicare Part D prescription drug coverage plans. Another CMS initiative, entitled Health Care Consumer Initiatives, provides price information based on what Medicare pays for common health care services at the county or other geographic areas, state, and national levels. Additionally, in June 2011, CMS proposed rules to allow organizations that meet certain qualifications to access Medicare claims data in an effort to help consumers and employers select high-quality, low-price health care providers. 76 Fed. Reg. 33567 (June 8, 2011).

[8]National Conference of State Legislatures, *State Legislation Relating to Transparency and Disclosure of Health and Hospital Charges* (Updated December 2010), accessed June 9, 2011, http://www.ncsl.org/default.aspx?tabid=14512. GAO did not independently verify the laws reviewed in this study. State price transparency legislation makes price information available to consumers through various forms, such as requiring hospitals to make information available upon request or requiring hospitals to submit price information to a state agency that makes the information publicly available.

[9]America's Health Insurance Plans, *Health Care Provider Financial Information: State Reporting Requirements* (January 2011).

[10]PPACA, § 1001, 124 Stat. 119, 130-8, amended by § 10101(f), 124 Stat. 119, 885-7 (codified at 42 U.S.C. § 300gg-18).

employers in facilitating enrollment of their employees in these health plans.[11] The Exchanges must require participating health plans to permit individuals to learn through a website or other means the amount of cost sharing, such as deductibles and copayments, for which they would be responsible when receiving specific health care services if covered under each company's insurance plan.[12]

In light of consumers' increased responsibility for paying the costs of their health care and efforts aimed at making price information transparent, you asked us to study the extent to which health care price information actually is available to consumers and other interested parties. This report describes (1) how various factors affect the availability of health care price information for consumers and (2) the information selected public and private health care price transparency initiatives make available to consumers and other interested parties.

To describe how various factors affect the availability of health care price information for consumers, we reviewed relevant literature, such as reports from the Congressional Budget Office and the Center for Studying Health System Change.[13] In addition to reviewing relevant literature, we interviewed researchers who have expertise in health care price

[11]PPACA, § 1311, 124 Stat. 119, 173-181, amended by § 10104(f), 124 Stat. 119, 900-01 (codified at 42 U.S.C. § 18031(e)(3)(C)). States have flexibility in designing their Exchanges to meet local needs, as long as the health insurance plans offered meet minimum certification standards established by the federal government. The federal government is exploring ways to partner on an Exchange with states that will not be certified by January 1, 2014.

[12]PPACA, § 10104(f), 124 Stat. 119, 900-01 (codified at 42 U.S.C. § 18031(e)(3)(C)). To implement these Exchanges, HHS has issued guidance and has begun the rulemaking process. For example, in July 2011, CMS issued proposed rules that include requirements that states must meet if they elect to establish and operate an Exchange and requirements that health insurance plans must meet to participate in the Exchanges, among other things. For more information, see 76 Fed. Reg. 41,866 (July 15, 2011) and 76 Fed. Reg. 41930 (July 15, 2011). Additionally, according to CMS officials, healthcare.gov also provides cost sharing information such as deductible and out-of-pocket costs for consumers.

[13]We identified relevant literature by searching on an Internet search engine using the term "health care price transparency" in conjunction with the following terms: "legal barriers," "regulatory barriers," "factors," "antitrust laws," "violation of privacy," "proprietary," and "barriers to." Additionally, we searched the Congressional Budget Office's and Congressional Research Service's websites, as well as previous work conducted by GAO.

transparency;[14] a selection of hospital, physician, and insurer associations; officials from two of the largest insurance companies by enrollment; and officials from the selected public and private price transparency initiatives in our review (see below for information on how we selected these initiatives). In our review of relevant literature and interviews with officials, we focused on identifying factors that affect the availability of health care price information, including estimates of complete costs to consumers. To provide illustrative examples of how the factors we identified may affect the availability of health care price information, including estimates of consumers' complete costs, and to gain the perspective of consumers on this issue, we anonymously contacted representatives from 39 providers—19 hospitals and 20 primary care physician offices. From these providers we requested price information on two selected health care services: full knee replacement surgery and diabetes screening. We randomly selected these hospitals and physicians from a health care market in Colorado, which requires certain providers to make price information on selected services available to consumers upon request.[15] We did not assess the accuracy of the price information provided by these selected providers, nor did we evaluate the effectiveness of Colorado's law. (See app. I for more information about our methodology for selecting and contacting hospitals and physicians and the information we obtained.)

To describe the information selected public and private price transparency initiatives make available to consumers and other interested parties, we judgmentally selected a total of eight price transparency initiatives that met our definition of a price transparency initiative—initiatives that make provider-specific price information on a specific health care service available to consumers and other interested parties.[16]

[14]To identify researchers with subject-matter expertise we reviewed relevant literature and selected researchers who testified before Congress in matters related to price transparency or who authored relevant literature.

[15]Specifically, Colorado requires each licensed hospital to disclose, upon request, the average facility charge to a person seeking care or treatment for a frequently performed inpatient procedure prior to admission for such a procedure. Colo. Rev. Stat. § 6-20-101 (2011). We selected Colorado in part because its law does not specify the manner in which consumers may request price information from hospitals, thus making the state more suitable for requests by telephone.

[16]For the purposes of this study, we are excluding initiatives that are focused solely on providing the prices of prescription drugs or insurance plans.

Specifically, our eight selected initiatives include: one federal price transparency initiative, which was the only federal price transparency initiative we identified that met our definition;[17] five state initiatives,[18] which we selected based on input from researchers with subject-matter expertise and on the initiatives' geographic variation; and two private initiatives, which we selected from among those provided by the top 10 insurance companies by enrollment in 2009 and based upon input from researchers with subject-matter expertise.[19] See table 1 for a summary of the eight public and private initiatives that we selected.

[17]We also reviewed the Office of Personnel Management's (OPM) Federal Employee Health Benefits (FEHB) program. OPM administers this program by setting price transparency expectations, such as a minimum number of health care services to include, for insurance companies that participate in FEHB. Due to the third party relationship of OPM in providing price information to consumers, we do not discuss OPM's price transparency initiative along with the other selected price transparency initiatives. In addition, the federal government has other price transparency initiatives that do not meet our definition of a price transparency initiative, such as HHS's Medicare Plan Finder and healthcare.gov.

[18]In some cases, a statewide initiative is administered by a private third party entity, such as a state hospital association, but the state has a role in its initiation, regulation, or ongoing development of the price transparency initiative. In these cases, we have classified these as "public (state) initiatives" for the purpose of our review.

[19]In our review we identified several types of private sector price transparency initiatives, such as websites that aggregate price information from public sources and companies that contract with employers to provide health care price information for the company's employees.

Table 1: Selected Public and Private Sector Price Transparency Initiatives

Type of initiative	Administrating entity and name of price transparency initiative
Public (federal)	Centers for Medicare and Medicaid Services Hospital Compare
Public (state)	California Common Surgeries and Charges Comparison
	Florida Health Finder
	Massachusetts MyHealthCareOptions
	New Hampshire HealthCost
	Wisconsin Hospital Association PricePoint[a]
Private	Aetna Member Payment Estimator
	Anthem Care Comparison

Source: GAO.

[a]In some cases, a statewide initiative is administered by a private third party entity, such as a state hospital association, but the state has a role in its initiation, regulation, or ongoing development of the price transparency initiative. In these cases, we have classified these as "public (state) initiatives" for the purpose of our review.

For each of the eight initiatives we selected, we interviewed officials and reviewed documentation to identify the types of health care price and other information these initiatives make available—including the extent to which the initiatives make available price information that includes estimates of consumers' complete costs for health care services. As part of this documentation review, we also reviewed the information available to consumers on the selected initiatives' websites.

We conducted this performance audit from November 2010 to September 2011, in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Research indicates that making price and other contextual information available is important for consumers to be able to anticipate the costs of their care and also to make informed health care decisions. In recent years, many public and private price transparency initiatives have been initiated to provide consumers with information about the price of their health care services.

Health Care Pricing

Determining the price of a health care service often involves coordination between providers, insurers, and consumers. Providers, such as hospitals or physicians, charge consumers fees for the services they receive, which are known as billed charges. Payers, such as insurance companies, often have contractual agreements with providers under which the payers negotiate lower payment rates for a service on behalf of their members or beneficiaries. These rates are known as negotiated rates. In the case of Medicare specifically, CMS sets the program's payment rates for providers based on a formula that includes several factors, such as geographic location.

For consumers with health insurance, their out-of-pocket costs for a health care service is determined by the amount of cost sharing specified in the benefits of their health insurance plan for services covered by the insurer. For consumers who lack health insurance, they are often billed for the full amount charged by the provider, such as a billed charge from a hospital. The estimated out-of-pocket cost for an uninsured consumer will typically be the billed charge for a health care service minus any charity care or discounts that may be applied by the provider.[20]

Health Care Services and Episodes of Care

Providers and payers often price health care services using the various codes used by health care professionals. For example, physicians may bill for their services based on Current Procedural Terminology (CPT) codes developed by the American Medical Association. Individual health care services, such as those referred to by individual CPT codes, can be grouped or bundled together into an episode of care, which refers to a group of health care services associated with a patient's condition over a defined period of time. An episode of care for a knee replacement, for example, includes multiple services such as those provided during the actual surgery, as well as preoperation and postoperation consultations.

[20]Some research indicates that uninsured patients rarely pay the full billed charge, and amounts charged may be heavily discounted based on charity care or other reduced payment programs. For example, one source estimates that most hospitals in the United States collect only 5 percent or less of billed charges from uninsured patients. See, for example, William O. Cleverly, Paula H. Song, and James O. Cleverly, *Essentials of Health Care Finance*, 7th ed. (Sudbury, MA: Jones & Bartlett Learning, 2011). For more information also see, Uwe E. Reinhardt, "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy," *Health Affairs*, 25, no. 1 (2006); and Mark Merlis, "Health Care Price Transparency and Price Competition," National Health Policy Forum (Mar. 28, 2007).

The episode of care would also include services provided by various providers who typically bill separately, such as a hospital, surgeon, and anesthesiologist. PPACA requires HHS to develop a national pilot program, which may include bundled payments for episodes of care surrounding certain hospitalizations, in order to improve the coordination, quality, and efficiency of health care services.[21]

Importance of Quality and Other Contextual Information

According to researchers, it is important for consumers to have access to quality of care and other information to provide context to the price information and help consumers in their decision making. For example, according to the Agency for Healthcare Research and Quality (AHRQ),[22] appropriate quality of care information for consumers may include the mortality rates for a specific procedure, the percentage of patients with surgical complications or postoperative infections, or the average length of stay, among other measures.[23] By combining quality and price information, some researchers argue that consumers can then use this information to choose providers with the highest quality and the lowest price—thereby obtaining the greatest value when purchasing care.[24] Furthermore, some research suggests that information on volume (the number of services performed) may be used as an indication of quality for

[21]PPACA, § 3023, 124 Stat. 119, 399 (codified at 42 U.S.C. § 1395cc-4).

[22]AHRQ is an agency within HHS, whose mission is to improve the quality, safety, efficiency, and effectiveness of health care by using evidence to improve health care, improving health care outcomes through research, and transforming research into practice. AHRQ also sponsors the Healthcare Cost and Utilization Project which is a family of health care databases and related software tools developed through a federal-state-industry partnership to build a multistate health data system for health care research and decision making. These databases include clinical and nonclinical information, such as charges for all patients regardless of payer by various regions and areas in the United States. We did not include this project in our study because it did not meet our definition of a price transparency initiative.

[23]Specifically, these measures are part of AHRQ's Talking Quality program which provides guidance for sponsors of consumer reports on health care quality. The specific measures cited above relate to the Institute of Medicine's six domains of health care quality, which includes patient safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity measures.

[24]For more information on our work on value in health care, see GAO, *Value in Health Care: Key Information for Policymakers to Assess Efforts to Improve Quality While Reducing Costs*, GAO-11-445 (Washington, D.C.: July 26, 2011).

certain procedures.[25] This assumes a positive association between the number of times a provider administers a service and the quality of the service provided. Information about previous patients' satisfaction with a provider's service can also help consumers make decisions about their health care.

Development and Use of Public and Private Price Transparency Initiatives

Public price transparency initiatives often began in response to laws or orders requiring an agency or organization to make price information available to consumers, while private sector initiatives started primarily through voluntary efforts. For example, in response to a 2006 federal executive order to promote quality and efficiency in federal health care programs, federal agencies that administer or sponsor a health care program were directed, among other things, to make available to enrollees the prices paid for health care services.[26] In response, agencies including HHS (including its component agencies such as CMS and AHRQ) and OPM began to make health care price information available. Similarly, over 30 states have proposed or enacted some type of price transparency legislation, though what is actually required varies greatly across the states.[27] For example, some states, such as Colorado and South Dakota, require hospitals to disclose, upon request, the expected or average price for the treatment requested.[28] In contrast, some states, such as Maine and Minnesota, require that certain health care price information be made publicly available through an Internet website.[29] While many public price transparency initiatives began as a result of legislation, private sector price transparency initiatives, such as insurance company initiatives, were established voluntarily for various reasons. For

[25]See, for example, E.A. Halm, C. Lee, and M.R. Chassin, "Is Volume Related to Outcome in Health Care? A Systematic Review and Methodologic Critique of the Literature" *Annals of Internal Medicine*, vol. 137, no. 6 (2002).

[26]Exec. Order No. 13,410, 71 Fed. Reg. 51,089 (Aug. 28, 2006). The executive order also directed agencies to improve usage of health information technology, implement programs to measure quality of services, and identify and develop approaches that facilitate high-quality and efficient health care.

[27]National Conference of State Legislatures, *State Legislation Relating to Transparency and Disclosure of Health and Hospital Charges* (Updated December 2010), accessed June 9, 2011, http://www.ncsl.org/default.aspx?tabid=14512.

[28]Colo. Rev. Stat. § 6-20-101 (2011), S.D. Codified Laws § 34-12E-8 (Michie 2010).

[29]Me. Rev. Stat. Ann. title 22 § 8712(2) (West 2011), Minn. Stat. § 62J.82 (2011).

example, insurance officials that we spoke with said their price transparency initiatives started for reasons such as increased interest from employers to curb costs, to gain a competitive edge over other insurance companies without price transparency initiatives, and to help their members become better health care consumers. Other private price transparency initiatives, such as Health Care Blue Book and PriceDoc, were started to help consumers find and negotiate fair prices for health care services.[30]

Though both public and private price transparency initiatives have become more widespread in the last 5 years, some research suggests that even if consumers have access to price information, such as price information made available by these initiatives, they may not use such information in their decision making.[31] For example, insured consumers may be less sensitive to prices, since the financial costs of selecting one provider over another may be borne by the insurer, not the consumer. Despite these concerns, some research indicates that consumers want access to price information before they receive health care services and have tried to use price information to some degree to inform their decision making.[32] Furthermore, research states that incentives may be helpful to further consumers' use of transparent price information. Specifically, financial incentives may include insurers providing lower out-of-pocket costs for their members if they select low-price, high-quality providers.[33]

[30]See http://healthcarebluebook.com/ and http://www.pricedoc.com/ for more information.

[31]See, for example, Congressional Research Service, *Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Health Sector*, RL34101 (Apr. 29, 2008); and Paul Ginsburg, "Shopping for Price in Medical Care," *Health Affairs*, vol. 26, no. 2 (2007).

[32]See, for example, The Commonwealth Fund Commission on a High Performance Health System, *Data Brief – Health Care Opinion Leaders' Views on the Transparency of Health Care Quality and Price Information in the United States* (New York: The Commonwealth Fund, November 2007).

[33]See for example, Paul Ginsburg, "Shopping for Price in Medical Care," *Health Affairs*, vol. 26, no. 2 (2007).

Various Health Care and Legal Factors Make Estimates of Consumers' Complete Costs Difficult to Obtain

Several health care and legal factors can make it difficult for consumers to obtain price information—in particular, estimates of their complete costs—for health care services before the services are provided. The health care factors include the difficulty of predicting in advance all the services that will be provided for an episode of care and billing services from multiple providers separately. In addition, according to researchers and officials we interviewed, legal factors, such as contractual obligations, may prevent insurers and providers from making available their negotiated rates, which can be used to estimate consumers' complete costs.

Various Factors, Such as the Difficulty of Predicting Health Care Services in Advance, Billing from Multiple Providers, and the Variety of Insurance Benefit Structures, Can Make Estimates of Consumers' Complete Costs Difficult to Obtain

One factor that may make it difficult for consumers to obtain estimates of their complete costs for a health care service is that it may be difficult for providers to predict which services a patient will need in advance. Specifically, physicians often do not decide what services their patients will need until after examining them. Researchers and officials we spoke with commented that health care services are not standardized across all patients because of each patient's unique circumstances, which influence the specific services a physician would recommend. For example, when we anonymously contacted 20 physicians' offices to obtain information on the price of a diabetes screening, several representatives said the patient needs to be seen by a physician before the physician would know what tests the patient would need.[34]

In addition, even after identifying what health care service or services a patient may need, additional aspects associated with the delivery of a service may be difficult to predict in advance, such as the length of time a patient stays in a hospital. This factor can make it challenging for providers to estimate consumers' complete costs in advance. For example, when we anonymously contacted 19 hospitals to obtain information on the price of a full knee replacement surgery, several hospital representatives quoted a range of prices, from about $33,000 to about $101,000. The representatives explained that the price for the procedure could vary based on a variety of factors, such as the time the patient will be in the operating room and the type of anesthetic the patient

[34]See appendix I for the information we obtained when contacting selected providers about the price of selected health care services.

may receive, and some noted that they would need to know this information if they were to provide a more specific price estimate.

Several hospital and physician office representatives we spoke with recommended that insured consumers contact their insurer for complete cost information; however, the inability to predict which health care services will be needed in advance also makes it challenging for insurers to provide complete cost estimates. Officials from an insurer association commented that, if asked by their members for cost estimates, insurance company representatives may require more information—such as the CPT codes for the services a patient will receive—before the insurers can provide a cost estimate. However, in the instances when providers cannot predict in advance the codes for which they will bill, consumers will be unable to provide the respective codes to insurers and obtain complete cost estimates from them.

Another factor is that many services included in one episode of care may be provided by multiple providers, such as a hospital and surgeon, who bill for their services separately. This makes obtaining complete cost information challenging because, in these cases, consumers may have to contact multiple providers to obtain estimates of their complete costs. Many providers can only give price estimates in advance for the services that they provide, and are often unaware of the prices for services performed by other providers. For example, when we contacted hospitals anonymously for the price of a full knee replacement, none were able to provide information on the complete cost to consumers for this service. The hospital representatives we contacted who could provide price information were only able to provide us with the hospital's estimated charges or a Medicare deductible amount for the service and could not provide us with the charges associated with the other providers involved in the service, such as a surgeon or anesthesiologist. Charges from these providers are typically billed separately from the hospital's charges, even though some of these services are provided in the hospital. Similarly, when we called physicians' offices to obtain information on the price of a diabetes screening, most representatives could not tell us how much the associated lab fees would cost and some noted that this was because the lab fees are billed separately. Several hospital and physician office representatives we spoke with suggested we contact the other providers, such as a surgeon or lab, separately in order to obtain information on the price of these services. However, officials from a provider association questioned how consumers would even know which providers to contact to get price information if the consumers do not know all of the different providers who are involved in an episode of care in advance.

Lastly, consumers may have difficulty obtaining complete cost estimates from providers because providers are often unaware of these costs due to the variety of insured consumers' health benefit structures. For example, according to officials from a provider association, physicians may have difficulty accessing insured consumers' health benefit plan information, and thus may not be able to provide estimates of consumers' out-of-pocket costs under their specific benefit plans. For example, officials stated that for physicians to inform a patient about the price of a health care service in advance they have to know the status of consumers' cost sharing under their specific health benefit plan, such as how much consumers have spent in out-of-pocket costs or towards their deductible at any given time. Without this information, physicians may have difficulty providing accurate out-of-pocket estimates for insured consumers. In addition, different consumers may have out-of-pocket costs that vary within the same benefit plan, which adds to the variety of potential costs a patient could have, and creates complexity for providers in providing complete cost estimates to consumers.

Officials from provider associations commented that insurers should be responsible for providing complete cost information to their insured customers because insurers can provide price information specific to insured consumers' situations. However, insurers may also have difficulty estimating consumers' complete costs. Specifically, according to a 2007 report by the Healthcare Financial Management Association, many insurers do not have data systems that are capable of calculating real-time estimates of complete costs for their members prior to receiving a service.[35] As a result, insurers may have difficulty maintaining real-time data on how much their members have paid towards their deductibles, which could affect an estimate of the complete cost.

Additionally, according to officials from an insurance company, it is difficult for insurers to estimate complete costs when insured customers receive services from providers that are outside of the insurer's network. These estimates may be difficult to provide because insurers have not negotiated a rate with providers out of the insurer's network, and thus may be unaware of these providers' billed charges before a service is

[35]For more information, see "The Opportunity of Price Transparency," *Healthcare Financial Management Association* (2007): 4. The Healthcare Financial Management Association is an organization that seeks to provide education, analysis, and guidance, among other things, to health care finance professionals.

given. Officials from an insurance company explained that this concern is especially a problem for their members who go to an in-network hospital and are seen by a nonparticipating physician within that hospital during their visit. The officials explained that this can occur without the patient's knowledge because patients often do not choose certain providers, such as radiologists or anesthesiologists, and consumers may be faced with significant out-of-pocket costs.

Researchers and Officials Identify Legal Factors That May Prevent the Disclosure of Negotiated Rates, Which Can Be Used to Estimate Consumers' Complete Costs

Researchers and officials we interviewed identified several legal factors that may prevent providers and insurers from sharing negotiated rates, which can be used to estimate consumers' complete costs. First, some officials stated that some contractual obligations between insurers and providers prohibit the disclosure of negotiated rates with anyone outside of the contracting entities, such as an insurer's members.[36] Specifically, most officials representing insurance companies have reported that some hospitals have included contractual obligations in their agreements with insurers that restrict insurers from disclosing negotiated rates to their members. For example, some insurance company officials we interviewed told us that these contractual obligations prohibited the sharing of specific information on negotiated rates between providers and insurers on their price transparency initiatives' websites. Officials from one insurance company said that they generally accept these contractual obligations, particularly in the case of hospitals that have significant market leverage, because they do not want to exclude these hospitals from their networks.[37]

Second, some of the officials and researchers we spoke with reported that providers and insurers may be concerned with sharing their negotiated rates, considered proprietary information, which may be protected by law from unauthorized disclosure. Some officials and

[36]For example, officials from one insurance company said one of the contractual obligations with a provider states that the insurer is prohibited from disclosing specific negotiated contract rates to its members, unless such information is provided in an explanation of benefits or through calls placed individually to the insurer's member services department.

[37]Although the insurance officials said that some providers impose contractual obligations that restrict the disclosure of negotiated rates, officials from one insurance company told us that they were able to negotiate their contracts with providers without such contractual obligations by explaining the methodology used to develop and present price information to consumers.

researchers we spoke with suggest that without these rates, it could be more difficult for consumers to obtain complete cost estimates. According to officials from an insurer association, proprietary information such as negotiated rates may be prohibited from being shared under the Uniform Trade Secrets Act, which many states have adopted to protect the competitive advantage of the entities involved.[38] These laws are designed to protect against the wrongful disclosure or wrongful appropriation of trade secrets, which may include negotiated rates. For example, if a hospital was aware that another hospital negotiated a higher rate with the same insurance company, then the lower-priced hospital could seek out higher negotiated rates which may eliminate the first hospital's competitive advantage. Conversely, if officials from an insurance company were aware that another insurer paid the same hospital a lower rate for a given service, the higher-paying insurer may try to negotiate lower payment rates with that hospital.

Lastly, some researchers and officials noted that antitrust law concerns may discourage providers and insurers from making negotiated rates public.[39] For example, some insurance company officials we spoke with expressed concerns that sharing negotiated rates publicly would give multiple competing providers access to each other's rates, and therefore could lead to collusion in price negotiations between providers and insurers.[40] According to the Federal Trade Commission (FTC) and the Department of Justice (DOJ)—the principal federal agencies enforcing the antitrust laws—antitrust laws aim to protect and promote competition by preventing businesses from acting together in ways that can limit competition. Joint guidance from FTC and DOJ indicates that without appropriate safeguards, exchanges of price information—which insurance

[38]Many states have adopted the Uniform Trade Secrets Act, proposed by the Uniform Law Commissioners, which protects proprietary information. Uniform Law Commission, Trade Secrets Act, accessed July 14, 2011, http://www.nccusl.org/Act.aspx?title=Trade%20Secrets%20Act. States that have not adopted the Uniform Trade Secrets Act may have similar laws that protect proprietary information from being misappropriated.

[39]According to the Department of Justice, the three major federal antitrust laws are the Sherman Antitrust Act, the Clayton Act, and the Federal Trade Commission Act. In addition, many states also have antitrust laws.

[40]However, these insurance officials agreed that antitrust restrictions do not prevent the sharing of negotiated rates and other components of complete cost estimates with their members.

company officials told us could include negotiated rates—among competing providers may present the risk that competing providers communicate with each other regarding a mutually acceptable level of prices for health care services or compensation for employees.[41]

Although some officials and researchers noted that antitrust laws may discourage making negotiated rates public, the FTC and DOJ guidance also identifies circumstances in which exchanges of health care price information—that could include negotiated rates—are unlikely to raise significant antitrust concerns. These circumstances require the collecting of price information by a third-party entity and ensuring that any information disseminated is aggregated such that it would not allow recipients to identify the prices charged by an individual provider.[42] Under these circumstances, consumers may not be hindered in their ability to have information that will allow them to make informed decisions about their health care.

Selected Initiatives Vary in the Information They Make Available, and Few Initiatives Provide Estimates of Consumers' Complete Costs

The price information made available to consumers by the eight selected price transparency initiatives varies, in large part due to differences in the price data available to each initiative. Additionally, we found that few of the selected initiatives are able to provide estimates of consumers' complete costs, primarily due to limitations of the price data that they use and other obstacles.

[41]See U.S. Department of Justice and the Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care* (1996). According to FTC and DOJ guidance, providers may act individually to provide price information to a purchaser without concern; however under certain circumstances, if they act collectively it may raise antitrust concerns because it may lead to collusion.

[42]While careful adherence to the guidelines will usually not generate FTC or DOJ enforcement action, both agencies have made clear that each case or business practice requires an analysis of the particular facts and circumstances involved. To the extent that any uncertainty exists, a provider or other entity may take advantage of DOJ's expedited business review procedure or FTC's advisory opinion procedure for guidance in order to alleviate antitrust concerns.

Selected Initiatives Vary In the Information They Make Available to Consumers and Other Interested Parties

The eight public and private price transparency initiatives that we examined vary in the price information they make available to consumers. (See table 2.) Three public initiatives in California, Florida, and Wisconsin make information available on hospitals' billed charges, which are typically the amounts hospitals bill payers and patients for services before any negotiated or reduced payment discounts are applied. In general, hospitals' billed charges do not reflect the amount most payers and patients ultimately pay for the service. Two private initiatives administered by Aetna and Anthem provide their members with price information based on their contracts with providers, and this information reflects the insurer's negotiated discounts. Similarly, the federal initiative provides price information based on Medicare payment rates. Initiatives in Massachusetts and New Hampshire provide price information, based on payments made to providers, using claims data, and these prices reflect any negotiated discounts or other reductions off the billed charges.[43] Despite differences in the types of price information they provide, the selected initiatives are generally similar in the types of services for which they provided price information,[44] with most providing price information only for a limited set of hospital or surgical services that are common, comparable, or planned in advance, such as a knee replacement or a diagnostic test.[45]

[43]New Hampshire's and Massachusetts' claims data include all payments for that service contributed by private health insurance plans and their members, as well as payments from self-insured plans for state government employees and their members.

[44]The selected price transparency initiatives use different terms to refer to what we describe as the health care "services" for which consumers can look up price information.

[45]In some cases, the state law specified the number or types of services made available by the price transparency initiative. See, e.g., Cal. Health & Safety Code § 1339.56(a) (2008), Fla. Stat. Ann. § 408.05(3)(k)(4) (West 2011).

Table 2: Types of Health Care Services and Price Information Made Available by Selected Price Transparency Initiatives, 2011

Selected price transparency initiatives	Health care services for which price information is made available[a]	Type of price information made available
Centers for Medicare and Medicaid Services (CMS) Hospital Compare	43 common inpatient hospital services	Median Medicare payment rates[b]
California Common Surgeries and Charges Comparison	37 inpatient surgical services	Median billed charges from hospitals[c]
Florida Health Finder	Over 150 inpatient, outpatient, and ambulatory surgery center services	Range (25^{th} to 75^{th} percentile) of billed charges from hospitals[c]
Massachusetts MyHealthCareOptions	37 inpatient and outpatient hospital services	Median and range (15^{th} to 85^{th} percentile) of insurers' aggregated payments made to that provider based on claims data[d]
New Hampshire HealthCost	42 preventative health, emergency visits, radiology, surgical procedures, and maternity services	Median payment made by that specific insurance plan to that specific provider based on claims data[d]
Wisconsin Hospital Association PricePoint	316 inpatient hospital services, 75 outpatient surgical services, and 27 emergency department and urgent care services	Average and median billed charges from hospitals and median and range (20^{th} to 80^{th} percentile) of billed charges from ambulatory care centers[c]
Aetna Member Payment Estimator	40 hospital service bundles and 460 physician service bundles (comprised of 3 categories of physician office visits, surgical procedures, and diagnostic tests and procedures)	Aetna's negotiated rates[e]
Anthem Care Comparison	59 service bundles including hospital inpatient and outpatient services, physician office visits, and diagnostic and imaging services	Range of Anthem's negotiated rates[e]

Source: GAO analysis of selected price transparency initiatives and interviews with administering officials.

[a]The selected price transparency initiatives use different terms to refer to what we describe as the health care "services" for which consumers can look up price information.

[b]Medicare payment rates are the prices CMS recently paid providers for services provided to Medicare beneficiaries. These payment rates are set by CMS and based on various factors such as geographic location.

[c]Billed charges are the amount hospitals and other providers bill payers and patients for a service, before any negotiated or reduced payment discounts are applied, and thus generally do not reflect the amount most payers and patients ultimately pay for the service.

[d]Claims data reflect the amount, based on the record of payments made by consumers and payers, a provider was previously reimbursed for the service and incorporates any insurer's negotiated discounts or any reduced discounts given. Initiatives used claims data to identify and report price information in different ways. New Hampshire's price transparency website uses its claims data to report a single point estimate of the estimated cost of the service, based on the median of all payments paid by that specific insurance plan to that provider for that service. Massachusetts's price transparency website combines the claims of all the applicable insurers and reports a price reflecting the aggregated price per provider for that service, as paid by these insurers.

[e]Negotiated rates are the prices an insurance company has negotiated with a provider to provide a health care service. These prices reflect prices under contract and any discounts that have been agreed to.

Various factors help explain the differences in the types of price information made available by the selected initiatives. In some cases, the initiatives provide certain types of price information because of the price data available to them, generally through state law. For example, the Wisconsin initiative provides price information based on hospitals' billed charges because the state contracted with the Wisconsin Hospital Association (WHA) to collect and disseminate hospital information, including hospitals' billed charges, when the state privatized hospital data collection. WHA saw this as an opportunity to develop a price transparency initiative that reported billed charges for consumers.[46] In both California and Florida, initiative officials said that state laws enabled the state to collect and make hospitals' billed charges public and this gave the states the authority to make this information available to consumers.[47] In Massachusetts, officials said that 2006 state health reform legislation provided the state with the necessary authority to collect claims data for the price transparency initiative.[48]

In other cases, the price information the initiatives provide reflects choices made by initiative officials regarding the types of information that they considered would be most helpful to consumers. For example, in developing Hospital Compare, CMS officials chose to provide price information based on Medicare payment rates to hospitals because, according to officials, this information would be more helpful than hospitals' retrospective billed charges for Medicare patients. The officials explained that hospitals' billed charges are too divergent from what Medicare and insurance companies actually pay for the same service, and CMS officials reasoned that Medicare rates could give consumers, particularly those without insurance, a point of comparison from which

[46]Wisconsin's price transparency website, called PricePoint, has served as a model for other states. Since its launch, WHA has been hired by at least 16 states to develop PricePoint websites for their initiatives.

[47]See Cal. Health & Safety Code §§ 1339.56(c) (2008), Fla. Stat. Ann § 408.05 (3)(k)(4) (West 2011). Florida's initiative provides a disclaimer that patients rarely are required to pay billed charges without any discounts and this type of price information may not be the most meaningful indicator of what the consumer can be expected to pay. Similarly, California's initiative acknowledges that the charges do not reflect how much the hospital is typically paid for a service because the discounts have not been applied.

[48]Health care claims data must be submitted to a state agency and such information was then added to the state's price transparency initiative. See Mass Regs. Code tit. 129 § 2.05(3) (2009).

they may be able to negotiate lower prices with providers.[49] In New Hampshire, officials said they successfully sought legislation to get access to claims data from all payers in the state to establish an All Payer Claims Database (APCD) for their initiative.[50] Based on an earlier experience with posting billed charges and feedback from consumers, New Hampshire officials were convinced that billed charges were not useful for insured consumers.

Additionally, some factors that may limit access to certain price data also limit how the price information is presented to consumers. For example, some of the selected initiatives, such as Florida and Anthem, present price information as a range, which avoids providing a specific price that providers may consider proprietary.[51] Anthem officials further noted that the primary reason the initiative provides price information as a range is so that the price information can better reflect for consumers the billing variation and differences in treatment decisions that occur when health care services are delivered to different patients. In Massachusetts, the initiative combines the claims, or prices paid, by commercial insurers for that specific hospital service and reports a provider's median price as well as a range of prices paid for that service. Officials explained that they present aggregated price information across all health plans to avoid disclosing prices that may raise proprietary concerns among providers and insurers. In another approach, the two initiatives by New Hampshire and Aetna bundle multiple services typically performed at the same time into the price presented, such as bundling all associated costs for a hip replacement surgery. By doing so, New Hampshire officials said that they are able to mask the specific rates paid for individual items, and avoid proprietary concerns, while providing an easily understandable estimate for the total health care service. Lastly, officials from the Aetna and

[49]At the same time, CMS officials described reliance on Medicare payment data as a weakness of their initiative because consumers do not know how to understand and use that price data.

[50]See N.H. Rev. Stat. Ann. §§ 420-G:11, 420-G:11-a (2011). APCD is a database of payment reimbursement records to providers that may include claims from private insurance company payers and their members and public payers (Medicare and Medicaid). According to the APCD Council, as of November 2010, 13 states, including Massachusetts, are using or in the process of developing APCDs.

[51]Although presenting prices as ranges, rather than single point estimates, may be useful for avoiding proprietary concerns, ranges may also be so broad that they lose the utility for meeting consumers' needs to compare prices and anticipate health care costs.

Anthem initiatives cited provider resistance as limiting the extent to which they can make price information available to their members for all providers in the insurers' networks—with provider-imposed contractual obligations requiring the Aetna and Anthem initiatives to omit price information for certain providers in the initiatives' websites' search results.

In addition to providing the price of a service, most selected initiatives also provide a wide range of nonprice information, such as information on quality of care measures or patient volume. Five of the eight selected initiatives provide quality information for consumers to consider along with price when making decisions about a provider. (See table 3.) In addition to providing quality and volume measures, initiatives also shared information, such as resources for understanding and using price information, including explanations of the source and limitations of the price data, glossaries, and medical encyclopedias. Initiatives also provided a range of supplementary financial information to give context to the price information provided. For example, Massachusetts' initiative presents symbols ($, $$, $$$) to indicate how the provider's price compares to the state median for that service in an effort to provide what officials described as more easily understood price information for consumers who are familiar with graphical ratings systems. Additionally, Wisconsin's initiative provides pie charts representing the percentage different payer types—such as private insurers, Medicare, and Medicaid—paid to a specific hospital in relation to the total billed charges, which indicates at an aggregate level the extent of discounts given by payer category.

Table 3: Quality and Volume Information Provided by Selected Price Transparency Initiatives

Selected price transparency initiative	Quality data	Volume data	Examples of quality and volume data[a]
Centers for Medicare and Medicaid Services (CMS) Hospital Compare	✓	✓	Process of care measures, how many Medicare patients were treated for a service at a given facility
California Common Surgeries and Charges Comparison		✓	The number of discharges for a service in a given year
Florida Health Finder	✓	✓	Patient safety indicators, total number of hospitalizations by service at a facility
Massachusetts MyHealthCareOptions	✓	✓	Information on patient safety practices, number of patients treated
New Hampshire HealthCost			None
Wisconsin Hospital Association PricePoint		✓	The number of discharges for a service in a given year
Aetna Member Payment Estimator	✓		Designation of quality and efficiency for hospitals and selected specialists
Anthem Care Comparison	✓	✓	Mortality rates, number of patients who received that treatment

Source: GAO analysis of selected price transparency initiatives and interviews with administering officials.

[a]Quality data and other nonprice information provided by the initiatives' websites came from a variety of national sources, including WebMD, CMS, Leapfrog Group, and AHRQ. Many state initiatives also relied on information reported to state agencies, such as the California Office of Statewide Health Planning and Development, the Florida Center for Health Information and Policy Analysis, and the Massachusetts Division of Health Care Finance and Policy.

Some officials expressed reservations about how consumers may use price and quality information together.[52] Insurance company officials we spoke with see linking price to quality information as a means for consumers to identify high-value providers and for the company to create more cost-efficient provider networks. In Hospital Compare, however, quality data and price data are not linked. CMS officials said that while quality data are featured prominently on Hospital Compare, price information is featured less prominently. CMS officials explained that promoting price information to consumers, in the absence of greater consumer education about how to understand price information in relation to quality, could lead consumers to select high-priced providers due to an assumption that price is indicative of quality. Due to similar concerns that consumers may assume that a higher price is a sign of higher quality,

[52]These nonprice data, such as the frequency or quality of a provider in performing a procedure, is often gathered from national sources, such as WebMD, CMS, and AHRQ, or directly from providers' data submissions, such as data submitted to state agencies, which may vary based on the states' reporting requirements.

Aetna's initiative provides information to educate consumers that high quality and low price are not mutually exclusive.

Lastly, in addition to the variety of price and other information made available by the selected initiatives, the initiatives also vary in terms of who has access to the initiatives' websites and in terms of their expected audiences. For example, the price information provided by the federal initiative we selected is available to all consumers through a publicly available website. CMS officials said the expected audience of this initiative includes insured and uninsured consumers, researchers, Medicare beneficiaries, and providers. Like the federal initiative, all of the selected state initiatives' websites are publicly available, although they include price information only for their particular state. In contrast, the price information provided by the two selected insurance company initiatives' websites are accessible to their members, but not to the general public.

Few Selected Initiatives Provide Estimates of Complete Costs to Consumers

Few of the selected initiatives provide estimates of consumers' complete costs, which is price information that incorporates any negotiated discounts; is inclusive of all costs associated with a particular health care service, such as hospital, physician, and lab fees; and identifies consumers' out-of-pocket costs. (See table 4.) Specifically, of our eight selected initiatives, only the Aetna and New Hampshire initiatives provide estimates of a consumer's complete cost. The two initiatives are able to provide this information in part because they have access to and use price data—negotiated rates and claims data, respectively—that allow them to provide consumers with a price for the service by each provider that is inclusive of any negotiated discounts or reduced payments made to the billed charge. Specifically, Aetna bases its price data on its contractual rates with providers, which include negotiated discounts. New Hampshire provides price information based on its records of closed claims of particular providers for particular services under a consumer's specific health insurance plan.[53] Both initiatives use claims data to identify all of the hospital, physician, and lab fees associated with the services for which they provide price information. For calculating estimated out-of-pocket costs, Aetna links member data to its price transparency website,

[53]Since New Hampshire uses claims data over a year old, officials adjust the claims' prices across the board with a 5 percent increase for every year to account for an estimated annual rate of inflation in medical costs.

which automatically updates and calculates the member's estimated out-of-pocket costs in real-time based on the provider and service reported, and the member's partially exhausted deductibles. In contrast, to calculate out-of-pocket costs, insured users of New Hampshire's initiative's website enter their insurance plan, their deductible amount, and their percentage rate of co-insurance. New Hampshire's Health Cost website then uses that information to calculate an out-of-pocket cost, along with a total cost for the service by provider. Both initiatives demonstrate that while providing complete cost information presents challenges, it can be done—either as undertaken by Aetna for its members or as carried out by New Hampshire, which makes complete cost information available through publicly accessible means.

Table 4: Extent to Which Selected Price Transparency Initiatives Provide Price Information That Reflects Estimates of Consumers' Complete Costs

Selected price transparency initiative	Components of complete cost estimates provided by initiative			Complete cost estimate provided by initiative
	Price reflects negotiated discounts	Price inclusive of all associated costs, including hospital, physician, and lab fees	Identifies out-of-pocket costs	
Centers for Medicare and Medicaid Services Hospital Compare	✓			
California Common Surgeries and Charges Comparison			[a]	
Florida Health Finder			[a]	
Massachusetts MyHealthCareOptions	✓[b]			
New Hampshire HealthCost	✓	✓	✓[c]	✓
Wisconsin Hospital Association PricePoint			[a]	
Aetna Member Payment Estimator	✓	✓	✓[d]	✓
Anthem Care Comparison	✓	✓		

Source: GAO analysis of selected price transparency initiatives' documentation and interviews with administering officials.

[a]Selected initiatives in Florida, Wisconsin, and California report price information as billed charges, that is, the price billed to consumers with no negotiated discounts from insurers or providers included. An uninsured patient may expect to be billed the full amount charged by the provider; however, some research indicates that uninsured patients rarely pay the full billed charge. In practice, what an uninsured consumer may be expected to pay out-of-pocket is often arranged on a case-by-case basis with the provider, and may depend on various factors, such as the consumer's ability to pay, the availability of charity care or sliding scale deductions, and state restrictions on what hospitals can collect from uninsured patients.

[b]Massachusetts's initiative uses the claims data of applicable insurers that reflect payments made after negotiated discounts have been applied. The price presented is an aggregate of all the prices paid by these insurers to that provider for that service.

[c]For insured consumers, New Hampshire's initiative identifies an estimated out-of-pocket cost, by health plan, for that provider and that service. For uninsured consumers, the New Hampshire initiative reports price information based on billed charges minus a 15 percent discount for uninsured consumers, which it states is a typical uninsured discount.

[d]Aetna's initiative provides out-of-pocket costs only to its intended audience, Aetna members.

As table 4 shows, six of the eight initiatives that we reviewed do not provide estimates of consumers' complete costs. The reasons for this vary by initiative, but are primarily due to the limitations of the price data that each initiative uses. For example, initiatives in California, Florida, and Wisconsin provide price information based on billed charges from hospitals, which do not reflect discounts negotiated by payers and providers, all associated costs (such as physician fees), and out-of-pocket costs. An official representing Wisconsin's initiative said that WHA commonly receives requests from consumers to include physician fees in the price estimate, but the initiative does not have access to these price

data, as they are part of a separate billing process and the hospitals do not have these data to submit. California officials said that collecting claims data from insurers would require additional legal authority, raise proprietary concerns, and pose resource challenges. Florida officials acknowledged that providing a billed charge is not as meaningful for consumers as other types of price data, such as claims data. However, while Florida officials have the authority to collect claims data,[54] they said that at this time they are limited from pursuing such information due to the expected financial costs of collecting and storing the data and the challenges of overcoming the proprietary concerns of providers and insurers. Florida officials characterized their initiative's inability to report out-of-pocket costs as a major limitation. The federal initiative provides price information that reflects what Medicare pays to hospitals for a given service but does not reflect what consumers, including Medicare beneficiaries, would pay out-of-pocket. CMS officials said that providing out-of-pocket costs was too complicated to calculate in advance due to consumers' medical variation and technological limitations.

In contrast, other initiatives have access to data that may enable the initiatives to provide more complete cost estimates to consumers, but certain factors limit the extent to which this type of information is made available. For example, the Massachusetts initiative has access to claims data that could be used to provide more complete cost estimates to consumers, such as negotiated discounts for commercial insurers.[55] However, it presents price information that aggregates the prices paid by commercial insurers for particular services, in part due to insurers' and providers' concerns about the initiative disclosing price information by insurer. As a result, consumers are unable to see an estimate for a particular provider that is specific to their insurance company or to calculate their out-of pocket costs based on their specific plan. The officials noted that providers' and insurers' resistance to publicly reporting payments made by insurers may also be a challenge for states seeking access to more meaningful price information for their initiatives, such as claims data. Lastly, Anthem's initiative does provide a price inclusive of all

[54]Fla. Stat. Ann § 408.061(c) (West 2011).

[55]Furthermore, although Massachusetts has access to claims data that in some cases provide all associated costs, such as physician fees, for a specific health care service, officials there said that they currently lack the technical capability to identify from the claims data which hospital and physician fees should be linked. They noted that insurance plans are not consistent in how they report physician fees in the claims data.

associated fees and negotiated discounts, but currently does not use the specific details of consumers' insurance plan benefits, such as their deductible, copayment, or coinsurance, to estimate consumers' out-of-pocket costs.[56]

Conclusions

Transparent health care price information—especially estimates of consumers' complete costs—can be difficult for consumers to obtain prior to receiving care. For example, when we contacted hospitals and physicians to obtain price information for two common services, we generally received only incomplete estimates, which are insufficient for helping consumers to anticipate all of the costs associated with these services or to make more informed decisions about their health care. Our review identified various health care and legal factors that can make it difficult for consumers to obtain meaningful health care price information, such as estimates of consumers' complete costs, in advance of receiving services. This lack of health care price transparency presents a serious challenge for consumers who are increasingly being asked to pay a greater share of their health care costs.

Despite the complexities of doing so, two of the eight price transparency initiatives we examined were able to make complete cost estimates available to consumers. Making meaningful health care price information available to consumers is important, and the fact that two initiatives have been able to do it suggests that this is an attainable goal. To promote health care price transparency, HHS is currently supporting various efforts to make price information available to consumers—including the CMS initiative in our review—and the agency is expected to do more in this area in the future. We note in our review, for example, that HHS provides price information on insurance plans through its healthcare.gov website. Similarly, CMS's web-based Medicare Part D Plan Finder also provides information on prescription drug prices and CMS's Health Care Consumer Initiatives provide information on the price Medicare pays for common health care services at the county and state levels. In the near future, HHS's price transparency efforts are expected to expand. For example, PPACA requires HHS to provide oversight and guidance for the Exchanges that are expected to provide certain price information for

[56]Anthem officials said that they are exploring the possibility of developing an out-of-pocket cost calculator for their consumer initiative.

consumers through participating insurers. PPACA also directs HHS to develop a pilot program which may include bundled payments, providing another possible opportunity for price transparency. In total, HHS has several opportunities to promote greater health care price transparency for consumers.

Recommendations for Executive Action

As HHS implements its current and forthcoming efforts to make transparent price information available to consumers, we recommend that HHS take the following two actions:

- Determine the feasibility of making estimates of complete costs of health care services available to consumers through any of these efforts.
- Determine, as appropriate, the next steps for making estimates of complete costs of health care services available to consumers.

Agency Comments

HHS reviewed a draft of this report and provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the Secretary of Health and Human Services and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or kohnl@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.

Linda T. Kohn
Director, Health Care

List of Congressional Requesters

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
House of Representatives

The Honorable Cliff Stearns
Chairman
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
House of Representatives

The Honorable Joe Barton
House of Representatives

The Honorable Michael Burgess
House of Representatives

The Honorable Gene Green
House of Representatives

Appendix I: Methodology and Results of Contacting Selected Providers for Price Information

To obtain illustrative examples of factors that influence the availability of health care price information for consumers, we anonymously contacted hospitals and primary care physicians with zip codes located in the Denver, Colorado, health care market.[1] We requested the price of a full knee replacement from hospitals and the price of a diabetes screening from primary care physicians. We requested these prices for patients without insurance and for patients with Medicare (without supplemental health insurance). Specifically, we called 19 hospitals and 20 primary care physicians between February 28 and March 10, 2011, and contacted each provider up to three times in an attempt to get a response.[2] We determined that we obtained a response from representatives if they answered the phone or they transferred us to a price quote voice mail message that requested specific information from us about the requested service so representatives could call back with cost estimates. In cases where we were asked to provide more information, such as in the case of receiving a price quote voice mail, we did not provide such information in order to help maintain our anonymity. We considered hospitals and physicians nonresponsive if no one answered the phone, or if we received a voice mail message that did not indicate what we needed to provide in order to receive price information, in all three attempts.

[1]We selected a health care market in Colorado because this state requires certain providers to respond to consumers' requests for price information, but does not restrict how consumers may request such information. For more information, see Colo. Rev. Stat. § 6-20-101 (2011). We did not evaluate the effectiveness of the law. We specifically selected the Denver health care market, as defined by a hospital referral region, because it was the health care market in Colorado with the most hospitals with zip codes in Colorado. A hospital referral region, as defined by the Dartmouth Atlas of Health Care, represents a regional health care market. Furthermore, we determined that the Denver health care market did not have any characteristics that would make it particularly unique compared to other health care markets in the United States.

[2]For purposes of this study, we contacted selected providers using contact information from the Centers for Medicare and Medicaid Services' (CMS) Hospital Compare database (for hospitals) and the National Provider Identifier Registry (for primary care physicians). We excluded hospitals and physicians with addresses located outside of Denver, Colorado, for the purposes of this study. We contacted 19 hospitals because there were only 19 hospitals in the Denver, Colorado, hospital referral region that provided knee replacement surgery, according to CMS's Hospital Compare database. For primary care physicians, we randomly selected a nonrepresentative group of 20 physicians with a specialty such as internal medicine, family medicine, and general practice to be a comparable sample size to that of the hospitals.

Results from Contacting Hospital Representatives

We received a response from representatives at 17 of the 19 hospitals we contacted. Of the 17 hospital representatives that responded, 10 did not provide any type of price information. None of the hospital representatives could provide a complete cost estimate for a full knee replacement, meaning the price given was not reflective of any negotiated discounts, was not inclusive of all associated costs, and did not identify consumers' out-of-pocket costs. Almost all of the hospital representatives that responded (14 of 17) required more information from us to provide a complete cost estimate, such as current procedural terminology (CPT)[3] codes, the length of time in the operating room, the model of knee used, or what kind of anesthetic would be provided, which we did not provide. Of the 7 hospital representatives that were able to provide some price information, 5 provided billed charges in either a range, such as between $32,974.73 and $100,676.50 or an average charge, such as $82,390, which is typically reflective of what an uninsured consumer would pay.[4] (See table 5 for more information.)

[3]According to the American Medical Association, CPT is a medical nomenclature used to report medical procedures and services under public and private insurance programs.

[4]According to Hospital Compare, CMS's quality and price transparency initiative, the median Medicare payment to hospitals within 25 miles of Denver, Colorado, for a major joint replacement or reattachment of a lower extremity without major complications or comorbidities ranges from $446 to $18,668. According to CMS officials, there may be a wide range of median Medicare payments to hospitals for this health care service because the data provided in Hospital Compare include cases in which Medicare was only responsible for a portion of the payment. Because these cases do not reflect the full amount paid for a service, CMS officials stated that they plan to remove these cases from the data in October 2011.

Table 5: Results of Contacting Hospitals for the Price of a Full Knee Replacement on Behalf of a Patient with Medicare and without Health Insurance from Those Who Responded

Hospital number and insurance status	Type of price provided	Actual price provided	Price reflective of consumers' complete cost estimates (Y/N)?	Examples of responses from representatives[a]
1. Medicare	Deductible	$1,132 (inpatient services) and $162 (outpatient services) and 20% of Medicare approved amount	N – Does not include associated fees	Representative did not know what the surgeon would charge.
2. Medicare	Average and range of billed charges, Medicare-allowable amount	$82,390 or $65,000 - $95,000; with Medicare: $13,360 to 16,650.	N – Does not include associated fees or identify out-of-pocket costs	The charges vary depending upon length of stay (2-4 days), length of time in operating room, and model of knee used.
3. Medicare	None	N/A	N/A	It would take a week to get an estimate after speaking with a nurse.
4. Medicare	None	N/A	N/A	Asked to leave message with name, date of procedure, physician's name, procedure, and phone number and they will call back with an estimate.
5. Medicare	None	N/A	N/A	Asked to leave message with name, phone number, CPT codes, physician's name, insurance company name, subscriber's identification number, and date of birth.
6. Medicare	None	N/A	N/A	Requested us to ask the physician for CPT codes, and provide physician's name. The estimate would only include the hospital facility fees, and unsure what the other charges would be.
7. Medicare	Deductible	$1,132	N – Does not reflect negotiated rates or include associated fees	Could not provide a charge for the procedure. The deductible does not include physician, rehabilitation, or anesthesiology fees.
8. Medicare	None	N/A	N/A	Requested CPT codes, how long the length of stay would be in the hospital, how long the patient would be in the operating room, and under what kind of anesthetic (local or general).
9. Medicare	Range of billed charges, co-payment, and deductible	$32,974.73 to $100,676.50; with Medicare: $2,662 to $2,566 and $1,100 deductible	N – Does not include associated fees	Hospital charges vary based on how many days patient is in the hospital and variation in cases. Representative provided a disclaimer that the price is just an estimate and the hospital is not liable for any differences.

Hospital number and insurance status	Type of price provided	Actual price provided	Price reflective of consumers' complete cost estimates (Y/N)?	Examples of responses from representatives[a]
10. Medicare	Average billed charge and deductible	$50,000 and $1,132	N – Does not reflect negotiated rates and does not include associated fees	Did not provide.
11. Uninsured	None	N/A	N/A	Asked to leave message with name, phone number, procedure, CPT and International Statistical Classification of Diseases (ICD)-9 codes, and date of service. The representative said no one else could provide this information because it is complicated and they would need to check information with the patient's insurer.
12. Uninsured	None	N/A	N/A	Needed the procedure and diagnostic codes, the name of the hospital, name, phone number, and insurance information.
13. Uninsured	None	N/A	N/A	Asked to leave message with first and last name, phone number, CPT code (can get from physician), physician's name, insurance company name, subscriber's identification number, and date of birth.
14. Uninsured	Range of billed charges	$65,000 to $95,000	N – Does not include associated fees[b]	Range of billed charges is dependent on the model of implant used, number of days in hospital, and how long the operating room time is.
15. Uninsured	Average billed charge	$58,581.59 (including a discount for self-payers) or $50,023.42 if paid within 4 days of receiving the bill	N – Does not include associated fees	Did not provide.
16. Uninsured	None	N/A	N/A	Asked to leave message with phone number, patient name, procedure, CPT code, ICD-9 code, and date of service (if scheduled).
17. Uninsured	None	N/A	N/A	Recommended we contact an orthopedic surgeon or physician for price information.

Source: GAO analysis of anonymous phone calls to hospitals.

[a]When we called several hospitals we received a price quote voice mail message which asked us to list information, such as diagnosis codes for the service we inquired about and personal information, and a representative would call back with a cost estimate. We considered this receiving a response since this method was the way these hospitals responded to such requests. In cases where we were asked to provide additional information by a voice mail or representative, we did not provide such information in order to help maintain our anonymity.

[b]According to the hospital representative we spoke with, the range of billed charges provided were considered an out-of-pocket cost for an uninsured consumer.

Results from Contacting Physician Office Representatives

We received a response from 18 of the 20 representatives we contacted. Of the physician representatives that responded, most could provide some type of price information (14 of 18), but only 4 out of 18 representatives who responded could provide a complete cost estimate for a diabetes screening. Most representatives who responded (13 of 18) required more information from us to provide a complete cost estimate, such as a diagnosis from a physician and the amount the laboratory would charge, which we did not provide. Additionally, almost half (8 of 18) of representatives who responded said the patient needs to be seen by a physician before determining a complete cost estimate. All 14 physician representatives who were able to provide some type of price information provided price information based on billed charges.[5] (See table 6 for more information.)

[5]According to Medicare.gov, Medicare patients may receive two free diabetes screening tests per year and they generally have to pay 20 percent of the Medicare-approved amount for the doctor's visit.

Table 6: Results of Contacting Physicians for the Price of a Diabetes Screening on Behalf of a Patient with Medicare and without Health Insurance from Those Who Responded

Primary care physician number and insurance status	Type of price provided	Actual price provided	Price reflective of consumers' complete cost estimates (Y/N)?[a]	Examples of responses from representatives[b]
1. Medicare	Billed charge	$75 for an office visit for a person without insurance	N – Does not reflect negotiated rates, include associated fees, or identify out-of-pocket costs	Price is different for everyone. Patient would need to come in for office visit and then the physician would decide on a test.
2. Medicare	Billed charge, Medicare deductible and co-payment	$125 for an office visit, $250 to $500 quarterly, and 20% of the office visit (about $25)	N – Does not include associated fees	Not sure what the lab would charge.
3. Medicare	Range of billed charges	$100 to $200 for office visit for a person without insurance	N – Does not reflect negotiated rates, include associated fees, or identify out-of-pocket costs	There would be other tests that would need to happen depending upon a visit with the physician.
4. Medicare	Billed charges	Physician fee is $85, blood draw is $25	N – Does not reflect negotiated rates or identify out-of-pocket costs	Unsure of what Medicare would cover.
5. Medicare	None	N/A	N/A	Did not know what Medicare covers or the charge amount. The lab services are also an additional charge and are billed separately.
6. Medicare	None	N/A	N/A	The price varies based on the office visit and the diagnosis and whatever Medicare would pay. Lab work would also cost extra.
7. Medicare	Billed charge	$90 to see a physician	N – Does not reflect negotiated rates, include associated fees, or identify out-of-pocket costs	Requested the name of the specific test as it would be ordered from the physician. They needed to know what services the physician would order to determine the price.
8. Medicare	Billed charge	$33 for nurse's visit, $8 for glucose test	N – Does not reflect negotiated rates or identify out-of-pocket costs	Unsure of the price Medicare would charge.
9. Medicare	None	N/A	N/A	Respondent had no idea how much it would cost and said they are not taking new Medicare patients anyway.
10. Uninsured	Billed charges	$159 to see a physician	N – Does not include associated fees[c]	Have to be seen by a physician before determining costs. For lab tests, the price depends because some tests are done by the lab and some are given in the office.

Primary care physician number and insurance status	Type of price provided	Actual price provided	Price reflective of consumers' complete cost estimates (Y/N)?[a]	Examples of responses from representatives[b]
11. Uninsured	Billed charges	$120 to see a physician, $37.40 for a comprehensive metabolic panel, $66 for a 1 hour screen	Y[c]	Have to be seen by a doctor first to determine what services are needed.
12. Uninsured	Billed charges	$241 to see physician, $14 for the glucose test, and $32 for a blood draw	N – Does not include associated fees[c]	Unsure of the lab cost because it is a separate charge. It can range based on what services the patient receives.
13. Uninsured	Range of billed charges	$89 - $150 to see a physician, 30% discount for self-paying patients	N – Does not include associated fees[c]	Need to be seen by a physician here to determine what lab work would need to be done. A range is provided because it depends on the complexity of the visit.
14. Uninsured	Billed charges	$250 for a new patient exam and the test is $125 including blood work	Y[c]	Did not provide.
15. Uninsured	Billed charges	$57 for the test and about $120 for office visit. There is a 30% discount for the office visit for paying day of.	Y	The price depends on the length of the visit.
16. Uninsured	Range of co-payment if qualifies for Colorado Indigent Care Program (CICP)[d]	$5 - 35	Y	Without being in the CICP program, they could not provide price information.
17. Uninsured	None	N/A	N/A	Person needs to be an established patient and have a physical every year. Also the physician does not take uninsured patients.
18. Uninsured	Range of billed charges and billed charge	$120 for physician's visit and test could range from $100 to $500	N – Does not include associated fees[c]	Blood tests are billed separately. The tests done will depend upon what services the physician orders.

Source: GAO analysis of anonymous phone calls to primary care physicians' offices.

[a]In cases where a representative did not mention a negotiated discount for an uninsured patient, we assumed that a negotiated discount was not applicable.

[b]When asked for additional information by a physician representative, we did not provide it in order to help maintain our anonymity.

[c]According to the physician representative we spoke with, the billed charges provided were considered an out-of-pocket cost for an uninsured consumer.

[d]CICP provides funding to clinics and hospitals for Colorado residents or migrant farm workers who are United States citizens or legal immigrants, who have income and resources combined at or below 250 percent of the Federal Poverty Level, and are not eligible for the Medicaid Program or Child Health Plan *Plus*.

Appendix II: GAO Contact and Staff Acknowledgments

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Staff Acknowledgments

In addition to the individual named above, Will Simerl, Assistant Director; Rebecca Hendrickson; Giselle Hicks; Krister Friday; Martha Kelly; Julian Klazkin; Monica Perez-Nelson; Rebecca Rust; and Amy Shefrin made key contributions to this report.

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