Price Transparency in Health Care: MYTHS v. FACTS

MYTH 1: Price transparency won't lower prices – it might even cause patients to choose the highest priced service thinking that it's the best.

FACT: All the published data show the opposite. Transparency almost always leads to at *least* modest savings. The amount of savings are directly associated with the presence and extent of incentives that are given to patients to use the information. When employers or plans offer zero/low cost-sharing for high-value care, or share savings with patients, uptake in usage of the tools increases significantly.
New Hampshire launched a crude public price transparency tool in 2007 (displaying just average prices), and on one category of services alone (imaging), patients saved almost $8 million and other payers (employers and taxpayers) saved $36 million over a five-year period. By year 5, out-of-pocket costs for consumers had dropped by 11%, and for people with deductibles, they saw almost double that in savings.[1] Those are good results among the general public. But the state took it a step further for its own state employees by creating an incentive program that provided financial rewards to employees who used the transparency tool to choose higher-value care. Within three years, the program has saved $12 million and paid out $1 million to employees. 90% of enrollees have used the tool, and 2/3 of them repeat shop and save each year, saving on average over $600 each time they use the program. In 2015 alone, the program produced a 13:1 return on investment.[2] Kentucky started paying state employees shared savings incentives to use a price-shopping tool in 2013 and the state's taxpayers saved more than $13 million, and the enrollees themselves received almost $2 million in incentive payments.[3]

Some studies found that price transparency reduces prices by 10-17%[4], up to 14%[5]. Other results are more modest when financial incentives are not provided to patients to shop, but they are never zero.[6] With health care consuming a fifth of the economy, even the most modest results could make a huge difference. Employers who use "steering," that is, incentivizing enrollees through zero cost sharing for using the lower-cost, high-quality providers, save on average double digits in the first year, and up to 60% several years in.[7]

MYTH 2: Patients don't need prices because health care is different – the third party system means that patients don't really shop when they need care.

FACT: Every time tools are made available to patients that align price transparency with incentives for choosing higher value care, patients do in fact shop and they choose higher value care, often saving millions for themselves and their employer.

Again, New Hampshire launched a crude public price transparency tool in 2007 (displaying just average prices), and on one category of services alone (imaging), patients saved almost $8 million and other payers (employers and taxpayers) saved $36 million over a five-year period. By year 5, out-of-pocket costs for consumers had dropped by 11%, and for people with deductibles, they saw almost double that in savings.[8] Those are good results among the general public. But the state took it a step further for its own state employees by creating an incentive program that provided financial rewards to employees who used the transparency tool to choose higher-value care. Within three years, the program has saved $12 million and paid out $1 million to employees. 90% of enrollees have used the tool, and 2/3 of them repeat shop and save each year, saving on average over $600 each time they use the program. In 2015 alone, the program produced a 13:1 return on investment.[9] Kentucky started paying state employees shared savings incentives

[1] https://revcycleintelligence.com/news/healthcare-price-transparency-in-nh-reduced-out-of-pocket-costs
[2] https://comm.ncsl.org/productfiles/83101945/Costs5_FGA-Forbes-Shop-LS16.pdf
[3] https://thefga.org/research/kentucky-health-care-savings-vitals-smartshopper/
[4] https://pubs.aeaweb.org/doi/pdfplus/10.1257/pol.20150124
[5] https://jamanetwork.com/journals/jama/articlepdf/1917438/joi140130.pdf
[6] https://www.sciencedirect.com/science/article/pii/S0167629618310476
[7] Chase, Dave (2017). **CEO's Guide to Restoring the American Dream.** Seattle, WA. Health Rosetta Media, p. 81.
[8] https://revcycleintelligence.com/news/healthcare-price-transparency-in-nh-reduced-out-of-pocket-costs
[9] https://comm.ncsl.org/productfiles/83101945/Costs5_FGA-Forbes-Shop-LS16.pdf

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to use a price-shopping tool in 2013 and the state's taxpayers saved more than $13 million, and the enrollees themselves received almost $2 million in incentive payments.[10]

The retiree health program for California public employees (CalPERS) started using price transparency to develop reference prices in their benefit design. Providers quickly responded by lowering prices to compete for enrollees.[11] The system saw a 9-14 point increase in enrollees using the more competitively-priced providers[12], and an overall reduction in prices by 17-21%.[13]

Each of these examples, and dozens more from both public sector and private employer experiences with transparency initiatives within an insurance plan, proves that the third party system does not have to be a barrier to consumerism. When purchasers of care have incentives, through benefit design and cost-sharing structure that reward higher-value care, enough people respond to those incentives to deliver meaningful price reductions.

This trend will expand, particularly led by millennials, the largest generational cohort in the U.S., 51% of whom surveyed by United Healthcare shopped for care online.[14]

MYTH 3: Patients only need to see their own out-of-pocket costs, not the full contracted rate for all payers made public.

FACT: First, patients are increasingly bearing the entire cost of care out-of-pocket, due to the increase in deductibles over time. On exchange plans, deductibles can be as high as $10,000. Employer-sponsored deductibles have tripled in the past 10 years.[15]

Second, employee share of premiums is very often the highest or second-highest out-of-pocket cost for patients. Also, out-of-pocket costs, and high priced care is what has driven and is continuing to drive premiums for Americans through the roof. What's more, every bit of employer contribution to an employee's health benefit is *that worker's* compensation package, meaning it is money that might otherwise have been spent on wage increases, retirement contributions or other comp – but instead, it has been snatched away into spiraling and wasteful health care cost increases.

At the time of service, depending on the patient's deductible status, an over-priced claim may not be entirely paid by the patient, but if not, it's paid by the self-insured employer or the issuer for fully-insured plans. That claims history is what's used to determine premium rates the next year. So high prices on the total health service, regardless of the patient's immediate out-of-pocket share of that price, affects that patient's out-of-pocket exposure through premium hikes the following year.

We see this phenomenon with painful clarity in the fact that exchange premiums doubled in the first five years of ACA implementation, such that almost everyone who isn't eligible for federal subsidies has fled this unaffordable marketplace. Employer-sponsored plans are also unaffordable - premiums have increased 55% in the past decade.[16] The number one driver of premium hikes each year are increasing prices –

[10] https://thefga.org/research/kentucky-health-care-savings-vitals-smartshopper/
[11] Robinson CR, Brown TT, Whaley C. Reference pricing changes "choice architecture" of healthcare for consumers. Health Aff. 2017;3:524-530. doi: 10.1377/hlthaff.2016.1256.
[12] Ibid.
[13]Reforming America's Healthcare System Through Choice and Competition, U.S. Department of Health & Human Services, U.S. Department of the Treasury, U.S. Department of Labor, Dec. 3, 2018. https://www.hhs.gov/about/news/2018/12/03/reforming-americas-healthcare-system-through-choice-and-competition.html
[14] https://newsroom.uhc.com/consumer-sentiment-survey-2018.html
[15] https://www.kff.org/report-section/kaiser-family-foundation-la-times-survey-of-adults-with-employer-sponsored-insurance-executive-summary/
[16] https://www.kff.org/report-section/kaiser-family-foundation-la-times-survey-of-adults-with-employer-sponsored-insurance-executive-summary/

hospital prices increased 42% between 2007-2014[17], and drug prices have increased more than the rate of inflation for each of the last 10 years.[18] It's these increasing prices driving up the premiums, not alternative explanations such as increased utilization (which has stayed largely flat or decreased[19]) or underlying costs of care (refuted by the fact that self-paying cash prices for most services have stayed relatively stable[20]).

MYTH 4: Public transparency isn't necessary, as long as patients have access to the prices on their own plans.

FACT: Without the ability to compare the prices offered under their own plan versus other plans, patients and their employers have no way to know whether their plan is giving them the best deal, nor do they have any way to see whether a provider is generally more reasonably-priced across *all payers,* which speaks to the overall morality and trustworthiness of a provider. What's more, there are a number of situations where the cash price of certain health care services is less expensive than the patient's share of the insurance-contracted rate.[21]

MYTH 5: Health care prices are trade secrets, proprietary between providers and insurers.

FACT: In every other business, the final price that a consumer pays is not considered a trade secret – our economy would collapse if this maxim were applied to other services and products. Insurers and providers often argue that their contracted rates are proprietary information. But patients are provided that information, millions of times a day, *after* the patient is already on the hook financially, in the form of an Explanation of Benefits. Patients are under no obligation to protect that information, indeed, it's considered by HIPAA to be part of their own health information to which they have an absolute right. They certainly could post it on Facebook or publish it on a web site with legal impunity if they so chose. Policies promoting price transparency merely demand that patients have access to this exact same information *before* they're on the hook for it.

MYTH 6: If patients see prices, they'll be scared to get care they really need.

FACT: Patients shouldn't have to choose between avoiding financial ruin and health care. But the solution to this Sophie's choice isn't to trick patients into getting care they can't afford by hiding upfront prices. A key reason why prices are so financially ruinous in the first place is precisely because they *can* be – because of this deceptive, after-the-fact surprise attack billing strategy. What's more, patients who experience a ruinous bill after the fact for a routine procedure might just learn that they should avoid care in the future, even when that care is not routine but lifesaving. Further, this argument conveniently protects providers, sworn to do no harm, from having to admit the financial harm they're inflicting on patients and competing openly and honestly for their business on the basis of price and quality. Practice standards require providers to tell patients up front about the clinical risks of procedures they're about to undergo, sometimes even requiring that patients signing off in writing that they have been so advised. Why should the financial risks of the procedures be exempted from this disclosure? Providers worried about the good of their patients should make sure that their prices are fair and affordable in the first place rather than ambushing patients with catastrophic costs after it's too late or a patient to object, negotiate or shop elsewhere.

[17] https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05424
[18] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05147
[19] https://www.healthcostinstitute.org/images/easyblog_articles/276/HCCI-2017-Health-Care-Cost-and-Utilization-Report-02.12.19.pdf
[20] https://clearhealthcosts.com/blog/2017/03/cash-prices-stay-level-overall-costs-continue-rise/
[21] https://www.latimes.com/business/healthcare/la-fi-medical-prices-20120527-story.html

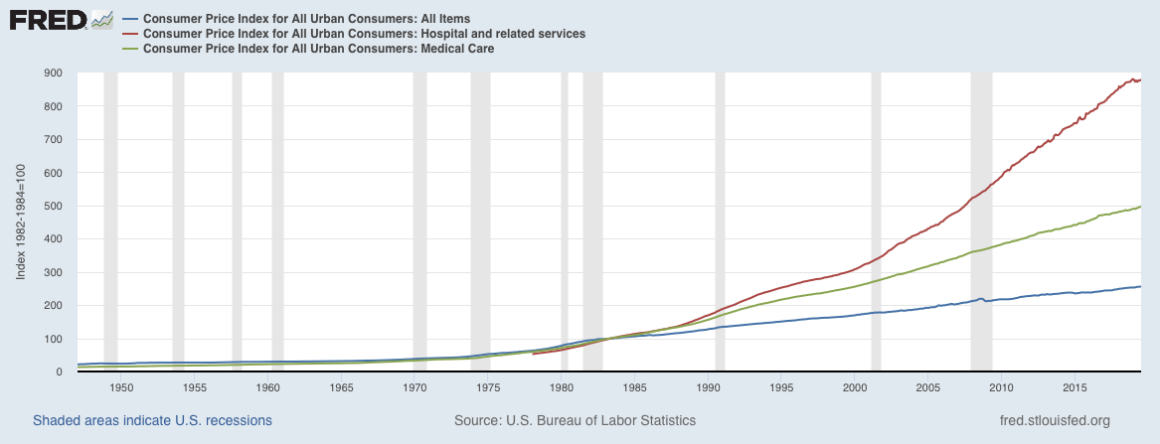
Price Transparency in Health Care: MYTHS v. FACTS

MYTH 7: Transparency will lead to higher prices because not every provider can afford to give their lowest price to all payers, and so they'll raise prices for some payers (usually the ones with the most volume, that is, the most patients).

FACT: Americans understand volume discounts, and if the bigger "discounts" off the bloated sticker prices received by some insurance companies are due to high volume, providers should have nothing to fear from openly disclosing that fact. On the other hand, certain insurance companies are getting price "concessions" from providers due to less justifiable reasons, such as anti-competitive gag clauses, anti-steering clauses, best-price guarantees, and other reasons that run counter to the interests of patients, their employers, and other purchasers of care. Price transparency exposes that the "discount" is really just an anti-competitive pay-off for steering patients to those high-priced provider systems rather than lower-cost alternatives. Independent of anti-competitive practices, it is true that a law of economics is that price competition will lead to convergence around a competitive price for services of similar quality. In other words, the staggering and irrational variability in prices for health care that leads to massive gouging of patients and other payers, will end. Sellers of care will then start to compete not only on price, but also on quality, convenience and other factors to differentiate themselves in the marketplace - just like in every other business.

MYTH 8: Transparency will lead to higher prices because providers have been offering lower prices out of fear that their competitors were undercutting them. Once they see that their competitors charge more than they do, they'll raise their prices to match.

FACT: If this were true, we would expect to see a race to the bottom in health care prices, as hospitals scramble to undercut each other, not knowing if the other guy down the street is offering a lower price. Instead, growth in prices for health care has outpaced inflation every year in recent memory, especially for hospitals. See graph below comparing the annual price increases for all goods/services compared to medical care, including hospitals.



MYTH 9: Transparency will lead to higher prices because providers will engage in anti-competitive collusion to fix prices at a higher rate than they're offering now.

FACT: Sure, some providers, upon seeing the prices of their competitors, could call up those competitors and plot to all offer the same price. Of course, that would be illegal collusion under our current antitrust law. This argument is like saying that glass storefronts facilitate looting by tempting looters with a better view of what they might steal. The solution is to enforce laws against stealing and looting, not painting every window black. Under this logic, we should end the public display of prices at grocery stores, movie

theaters, real estate listings and every other industry, because it might just facilitate illegal price-fixing among the sellers of these products. By the way, health care providers and health insurers are incredibly sophisticated market actors – there is no reason to think they don't already know what their competitors charge.

MYTH 10: Health care prices are too complex for patients to understand and respond to rationally.

FACT: Americans engage in complex commerce all the time, including comparing and choosing cell phone plans, trading stocks, buying and selling houses, comparing cable TV bundles to streaming options, selecting car insurance and then figuring out when and when not to use their insurance for repairs, and more. While all Americans might not use transparent price information, enough of them will that price will be something that hospitals will have to compete on price. However, patients are only one audience for price information. Employers, brokers, and others who purchase care or have influence over patients' health care decisions will be able to use the information to design benefits, including cost-sharing, reference pricing, and formularies around that information. In this way, they could help patients make high-value decisions without having to independently analyze all the information themselves.

An example would be a self-insured union retiree health plan that uses price transparency to analyze the prices of imaging centers. Some are contracted with the union plan, some aren't. But even the out-of-network centers would have price variation around them. The union plan could then offer zero cost-sharing for lower cost MRIs at freestanding imaging centers, compared to a $100 copay for the pricey hospital-based center, regardless of network status. Patients wouldn't have to analyze the prices of each center, they would just respond to the simpler decision between copay or no copay. Price transparency would still have worked to create price competition between MRI facilities, even if the patients never looked up the net price.

By the way, this strategy would mean that network status wouldn't matter nearly as much, just the price and quality of the provider. Over time, the union would rely on the insurance company's network negotiations less and less, and instead steer patients on the basis of transparent price and quality rather than network status of providers. This would increase the union's ability to cut the middleman insurance plan out altogether and save enrollees even more.

MYTH 11: Most health care is essential and emergency. Patients can't shop when they're in pain or unconscious.

FACT: The vast majority of health care services are routine or elective (meaning, they're scheduled in advance and not emergencies). Fewer than half of all hospitalizations originate from an ER visit.[22] More than 70% of emergency room visits could be treated in a different setting, such as an urgent care or outpatient clinic. ER spending accounts for only 6% of all health care spending. [23] Given these numbers, it would seem that most care is not the sort where a patient is utterly incapable of making judgments about where to receive care. Given how few ER visits are actual emergencies, it's even likely that many patients who visit the ER are aware that their condition isn't a life-threatening emergency, and are choosing the ER for other reasons, such as delayed billing (you don't have to pay before being treated), or convenience (24-7 access).

When health plans or their plan sponsors design benefits to give patients an incentive to use non-ER settings when appropriate, such as round-the-clock, zero-cost nurse lines or telemedicine, low-cost urgent care, walk-in or same-day primary care appointments, nurse midwives or chronic disease health coaches, ER visits have been shown to decrease and health outcomes improve. Even in cases of urgent conditions

[22] Morganti KG, et al. The Evolving Role of Emergency Departments in the U.S. 2013. RAND., p.4.
[23] Lee MH, Schuur JD, Zink BK. Owning the cost of emergency medicine: beyond 2%. Ann Emerg Med. 2013;62(5):498-505.

that do require an ER visit, most patients are conscious and able to make choices about which ER they prefer. In cities where there is more than one option and the situation is emergent but not life-threatening, such as broken bones or unmanaged pain in cancer patients, there is evidence that patients often choose to visit the hospital where their specialists have privileges or which are closer to their home, even if that is not the closest ER from where they're starting.

MYTH 12: Most patients just go where their doctor refers them.

FACT: Sure, because patients have very little other information with which to make judgments other than a doctor's referral. Before Yelp, Amazon reviews, Consumer Reports or Kelley Bluebook, customers for many other types of goods and services also only relied on word-of-mouth from trusted friends and authorities, such as their mechanic (for car purchases) or a foodie friend (for restaurant recommendations). With the introduction of online shopping to obtain price information and crowd-sourcing tools such as Yelp and Kelley Bluebook to compile quality information, consumers are less likely to just take one friend's word for it. This is especially true for homogenous commodity-like services such as lab tests.[24] Relying solely on word-of-mouth persists only in markets where reliable price and quality information is not otherwise available.

It is true that, even as other tools become available, a doctor's referral is still one of the most powerful steering tools for patients, because of the trust relationship between doctor and patient. That is why, when price and quality information is baked into the referral work-flow, doctor referrals are one of the best ways to help patients find their way to high-value care. Innovative employers have found ways to harness the steering power of physicians by using on-site or near-site clinics, direct contracts and Centers of Excellence for specialist and complex care, with payment structures for providers that align physician referrals with the patient and employer goals of lower cost and high quality care. These models have shown double digit savings, with better health outcomes.

MYTH 13: Employers already have price information and they're the main consumers anyway – patients don't need it.

FACT: Although self-insured employers pay all the claims for their workers, they do so through a third-party administrator (TPA), usually one of the major health insurance companies, who serves as the claims processor and help to administer the plan, manage open enrollment, and so forth. These TPAs have every incentive to keep employers in the dark about the prices they pay, because revealing prices in a timely fashion would enable employers to evaluate whether their administrator is a giving them a good deal and to solicit better offers. TPAs often throw out the canard that HIPAA prevents the employer from seeing their own claims (categorically false). What's more, almost all insurance brokers, who market themselves as the buyer's agent, are actually paid by insurance companies to renew the employers' plan, and they receive large end-of-year bonuses, usually undisclosed to their clients, if they deliver a certain size book of business to a particular insurance company. In other words, they market themselves as a buyer's agent, but they are actually merely the marketing department and sales force for insurance companies. As such, the majority of these employers have trouble overcoming the barriers and bureaucracy erected by these middlemen to prevent them from analyzing their own costs effectively, comparing prices between plans, between providers, understanding the types of care that drive premiums up each year, and so forth.

For all these reasons, most self-insured employers are not actively managing their costs, or even aware of the facts and patterns driving their skyrocketing claims each year. They often do not know about the staggering price and quality variability between different hospitals and other providers in their area and the amount of savings and better clinical outcomes that could be achieved by steering workers to the highest-

[24] https://www.sciencedirect.com/science/article/pii/S0167629618310476

value care. Those employers that do want to make these changes must fight to overcome the obstacles erected by the middlemen who benefit from keeping their clients in the dark, and then they must have the HR bandwidth to be able to analyze and make actionable intentionally complex and technical data.

Transparent price information for all providers and all payers would allow easier analysis by an employer's HR department. What's more, it would allow apps and other tech innovators to scrape up all the complex data, analyze it for employers (and patients) and present it in clearer and more actionable ways so that employers don't need to be actuarial scientists in order to identify the best deal for their workers. Self-insured plans are regulated by ERISA, which requires that plan trustees – the employers themselves – manage the plan assets, that is, the premium revenue and expenditures, prudently and solely in the interest of the beneficiaries. Courts have suggested that this fiduciary duty is of the highest possible standard of prudent stewardship. Employers not only have the right to pricing data, they have the absolute legal obligation to know it and use it to benefit their workers.

MYTH 14: Showing all prices for all payers is a massive regulatory burden on providers.

FACT: Providers already have price information, as parties to the pricing contracts with insurers, and they transmit it electronically as part of the claims process millions of times a day. For self-paying patients, they know the cash price that they charge patients, because they manage to find a way to bill those patients later.

Providers use fee schedules negotiated with insurers for all billing codes. They know the billing codes a patient is requesting, and they can combine the price for each code into an itemized list or a bundled price.

MYTH 15: Price transparency is impossible when you don't know which services a patient will need in advance.

FACT: Saying that hospitals can't tell patients prices upfront because they don't know the specific combination of services a patient might receive is tantamount to a restaurant refusing to show customers a menu because they don't yet know what the customer will order or what coupons they'll bring with them. Customers face this type of business transaction all the time in other industries and it creates no impediment in those industries to providing upfront price lists, even in the face of uncertainty about the exact combination of services that will be provided. Industries like this include law, body shops (who also have separate prices for different insurance companies), consultants, graphic designers, plumbers, general contractors, and others who combine hourly labor rates with add-ons for certain projects and parts/equipment. Health care is not unique in this way and its practitioners deserve no special exemption from disclosing to consumers their prices.

MYTH 16: Rural hospitals will have to shut their doors, because they won't be able to offer competitive prices in a transparent world.

FACT:
From a fairness standpoint, patients receiving care in a rural hospital are just as deserving as all other patients to know how much services costs ahead of time, especially if they are expected to pay a portion of those prices in the form of cost-sharing. Those with chronic conditions need to stay engaged in seeking value, regardless of the location where they receive care, otherwise they may forgo medically necessary care.

Some may argue that real price transparency may reveal that certain "vulnerable" institutions are not price competitive. While that may be true for some services, extensive experience at the state level shows that many community, safety-net or rural facilities are excellent values and price competitive. In fact, real price

transparency is an opportunity for these facilities to attract additional higher reimbursing privately insured patients seeking high-value care whose plans will pay more than the publicly-funded Medicaid and Medicare programs that many of these facilities so heavily rely on now. What's more, with the movement among employers toward incentivizing enrollees to select higher-value providers, such as with lower cost-sharing or even incentive payments, reasonably-priced rural hospitals that could benefit from price transparency, attracting new business from employers who discover their competitiveness and steer patients toward them with financial incentives.

MYTH 17: Price transparency turns insurers and providers into fee-for-service commodity traders – they should be able to compete for business by designing unique products instead.

FACT: Price transparency actually helps businesses compete on quality and convenience, because it exposes exactly what patients get for a price. If an insurer or a hospital wants to make the case that it's offering the best value for patients because of the uniqueness of its product offering, price transparency will only validate that for consumers when they compare prices of competitors who are not offering those bells and whistles.

Medicare Advantage and Medicaid Managed Care offer a useful illustration of this principle. Actual allowed costs for health care services or coverage are set by formula by the government for all providers. The only differentiator is the additional package of offerings the plans create to serve patients. They manage to do this successfully – so much so that most American seniors can choose among several dozen Medicare Advantage plans being offered in their community. Price transparency allows for an even more vibrant and competitive marketplace – by allowing for *different* prices for the same services AND a diversity of offerings. Plans and providers will have to actually design products that appeal to consumers on the price, in combinations of offerings that meet their needs.

MYTH 18: Price is not the most important, quality is.

FACT: *Value* is the most important. Value is the unique combination of price and quality that meets a consumer's needs. To allow for consumers in a market to assess value, they must have both. And by the way, we don't have quality transparency either, so this isn't an either-or, we need both!

MYTH 19: Hospitals need higher reimbursement rates than independent facilities to run 24-hr emergency rooms, research and training, and to treat uninsured patients.

FACT: Hospitals have a number of federal funding streams designed precisely to compensate them for those costs, including the CMS uncompensated care payment, 340B program (for safety net hospitals), DSH (for hospitals who treat a disproportionate share of low-income people), GME (for training medical students and residents), NIH (for research), CAH (critical access hospitals), and many, many more. What's more, hospitals' emergency departments generate more than 40% of their inpatient admissions, meaning the ER is actually a loss-leader for hospitals, generating revenue rather than net costs.[25]

There is little relationship between prices charged by hospitals and the amount of uncompensated care or community benefit they provide. Recall the arguments for the ACA – covering the uninsured through subsidized exchange plans or Medicaid expansion would offset the cost of uncompensated care for hospitals and they would be able to lower their prices for commercial patients. Indeed, the amount of

[25] Morganti KG, et al. The Evolving Role of Emergency Departments in the U.S. 2013. RAND., p.4.

uncompensated care delivered by hospitals has dropped significantly since passage of the ACA.[26] But prices in the commercial market have only gone up even more dramatically. Enough crying wolf – no amount of public funding to hospitals for any purpose has managed to shield commercially insured patients from ever-increasing hospital prices.

The cost of training, research and uncompensated care is low compared to hospitals' operating margins, which are over 8% on average, a figure that outpaces the profit of insurers, pharmacies and PBMs.[27]

Finally, this argument is not an argument against price transparency per se, it's a preemptive defense against the embarrassment that price transparency will create when hospital gouging is exposed. If hospitals want to concede that they are gouging, but justify that gouging because they deserve more public funding to support the extra activities they perform, price transparency should actually help them make their case more effectively with policy makers and public opinion. Their resistance suggests that they know that exposing the truth about revenue, expenses, and prices would actually sway public opinion in the opposite direction.

MYTH 20: Don't some hospitals have such high quality that higher prices are justified?

FACT: We don't know. Do you? Does anyone? Without price and quality transparency, these are just unsubstantiated assertions. The only way to verify if prices are justified by quality is to be transparent about both and compete on that basis.

MYTH 21: You can't have transparency in an ACO/MCO world.

FACT: Actually, ACOs (accountable care organizations) are based on transparency to the purchaser of care (though not the public). They don't bill on a fee-for-service basis, but their prices are still agreed to in advance by the purchasers (though not necessarily the patients). It is similar to the difference between paying for a cell phone plan on a subscription basis or on a pre-paid phone card basis. Most of us choose a bundle that includes a monthly price for a certain amount of data, texting and talk minutes, the cost of the phone, and so forth. This is like an ACO that includes total case management of a patient or population for a per member per month fee, or for a bundled price for a certain procedure and all its sequelae. Others prefer to purchase a phone and then buy minutes later with a pre-paid phone card (similar to the fee-for-service model in health care). Both models are fully transparent to at least the non-patient purchaser such as an employer, or government program. However, ACOs are not necessarily transparent to patients about the total cost of care, or their own cost-sharing, so transparency is still essential and possible in an ACO world.

Just like cellular companies post their prices if you choose a monthly subscription model or if you choose a pre-paid card on top of the cost of a phone, so providers who participate in both FFS and in ACO models can publish their different price structure for the different types of care, episode or bundle, or for patients who are part of an ACO. Indeed, price transparency policies would facilitate the development of ACOs by forcing hospitals and purchasers to understand the cost of the underlying care and services that make up bundles or capitated rates. This greater insight into unit costs would help prevent the failure of ACOs that we've seen due to ill-informed business models.

[26] https://www.kff.org/uninsured/issue-brief/declines-in-uncompensated-care-costs-for-the-uninsured-under-the-aca-and-implications-of-recent-growth-in-the-uninsured-rate/
[27] https://www.americanprogress.org/issues/healthcare/reports/2019/06/26/471464/high-price-hospital-care/

MYTH 22: Price transparency doesn't work in a consolidated market where there's one dominant health care provider system.

FACT: Consolidated health systems often are formed by acquiring one hospital, facility or physician practice at a time, sometimes preserving unique pricing structures between that facility and insurance carriers. This means that prices can still vary between different entities within a single health system.

Price transparency actually creates a national or regional market and helps overcome local monopolies. The way this works is that patients can see lower-priced providers in the next town over, or even further away, and choose to travel, since most care is not an emergency. Alternatively, they can obtain the lower prices of a more distant provider and ask their local system to match that price in order to keep their business. An example of the game-changing competitive effect of price transparency on distant markets is described in this video about the price-transparent Surgery Center of Oklahoma.

Disruptive startups like Carrum Health, Redirect Health, SurgiPrice, and SANO Surgery, Zero Card, and non-profit alliances of employers such as the Employer Centers of Excellence Network and The Alliance are all developing networks of direct contracts with price-transparent providers across the country. They offer those discounts to their customers or members, usually employers and other plan sponsors, who will often achieve major savings, even with covering travel and lodging for patients and their companion to visit these remote providers. Broad-based price transparency will facilitate even more of this disruptive competition in the face of local monopolies without requiring a mediating startup or organization to facilitate that competition.

This compilation has been brought to you by AllBetter Health, an insurgent benefits advisory firm saving employers 20-40% in Year 1, while increasing plan generosity for patients at the same time. We know that the secret super-power of health care is that world-class care - built on love, honesty and connection – is dramatically less expensive than the sick-care status quo. If you're ready to join the Revolution, or if you have myths and facts you'd like to see added to this list, email us at *admin@allbetter.health*.