Congressional Research Service
Informing the legislative debate since 1914

IN FOCUS

August 19, 2015

Price Transparency in the Private Health Insurance Market

Do Consumers Know How Much Health Care Services Cost?

Unlike virtually all other services, consumers typically receive health care without knowing its price. Providers often do not disclose how much they charge, and consumers often receive pricing information only after the bill arrives. Even if a consumer seeks out information to make price comparisons, geographic variations and differences in quality of service make comparisons challenging. Prices may even vary based on who is paying the bill (health plans or consumers). Given the uncertainty around health care prices, there has been a push toward filling the price information gap through price transparency.

What Is Price Transparency?

Price transparency is the practice of making information on the price of health care services readily available. That information should be clear, relevant, and accessible to help consumers make informed decisions.

Why Is There Uncertainty Around Health Care Prices?

The mystery surrounding health care prices stems partly from the multiple payers in the health care system (provider, health plan, and consumer). Each party has its own *costs* associated with health care services, and thus it is difficult to determine the dollar amount for health care services. Additionally, the price or costs (particularly to the consumer) of health care services may vary depending on who is paying as well as the consumer's insurance status (see **Table 1**).

When a consumer obtains a health care service, the provider charges a certain dollar amount for services rendered. The applicable *charges* are then recorded on the claim that is submitted to the health insurance plan or the consumer. The charge is like the sticker price on a car; an amount that serves as a starting point for negotiation. Charges do not reflect the actual amount paid for health care services and are irrelevant for many consumers.

The amount providers generally receive in payment is discounted from the charge. Health insurance plans contract with a wide range of providers. These providers accept the plan's *negotiated payment* in full for services to the plan's consumers; this group of providers is *in-network*. For insured consumers, the price is then divided into a portion paid by the health plan and a portion paid by the consumer.

Insured consumers are often required to pay an amount for the health care services (i.e., *cost sharing*) via *coinsurance* or a *co-payment*. Because this is the amount insured consumers are required to pay out of pocket for health care services, it could be considered the most relevant dollar amount to the insured consumer.

The amount insured individuals pay for health care services differs from what uninsured individuals pay (see **Table 1**). It is often assumed that uninsured individuals would pay full charges because they would not receive the discount that is negotiated by health plans. This may not always be the case. The charge may be adjusted for an uninsured individual's income and financial status, resulting in a lower cost for the consumer. For example, the individual may qualify for financial assistance or charity care. Additionally, consumers themselves may negotiate a discount from the charge and thus lower their costs.

Key Terms

Cost: The term's meaning can vary depending on the party incurring the expense—the consumer, provider, or health plan. For the consumer, cost is the amount payable out of pocket for health care services (i.e., cost sharing). For the provider, cost is the expense incurred to deliver services to consumers. For the health plan, cost is the amount payable to the provider for services rendered.

Charge: The dollar amount a provider sets for services rendered before negotiating any discounts.

Negotiated Payment: The maximum amount on which payment is based for covered health care services. The payment may be negotiated by the health plan or the consumer.

In-Network: The facilities, providers, and suppliers a health plan has contracted with to provide health care services.

Out-of-Network: The facilities, providers, and suppliers a health plan has not contracted with to provide healthcare services.

Cost Sharing: Also referred to as out-of-pocket costs for the consumer. The amount an insured consumer pays for health care services according to the terms indicated in the health plan. A plan's cost-sharing requirements may include deductibles, coinsurance, and co-payments.

Deductible: The amount an insured individual pays before his or her health insurance plan begins to pay for services.

Coinsurance: The share of costs, figured in percentage form, an insured consumer pays for a health service.

Co-payment: A fixed amount an insured consumer pays for a health service.

Table 1. Illustrative Example of a Health Care Bill for an Insured and Uninsured Consumer

	Insured (In-network service with 25% coinsurance)	Uninsured
Provider Charge	$1,000	$1,000
Plan's Negotiated Payment	$600	N/A
Consumer's Negotiated Payment	N/A	$1,000
Plan Pays	$450 *(75% of plan's negotiated payment)*	N/A
Consumer Pays	$150 *(25% of plan's negotiated payment)*	$1,000

Source: CRS illustrative example.

What Are the Limitations of Price Transparency?

A number of health care and legal factors make price transparency difficult. For example, it may be difficult for a provider to predict which services a consumer may need in advance and thus to give an accurate price estimate. Also, while price transparency information may allow consumers to be more knowledgeable in making medical decisions, price information may not necessarily be the primary or only issue a consumer considers. A consumer may rely heavily on the recommendations of a physician whose medical advice may not align with the consumer's price preferences. Legal factors affecting price transparency include contractual obligations between health plans and providers that prohibit the disclosure of a plan's negotiated payment. Plans may also consider their negotiated payment to be proprietary information.

In addition to price transparency, quality is a significant component of making meaningful health care decisions. The relationship between price and quality of care is nuanced, and thus price alone does not provide the full picture. Accordingly, there is a push to provide both price and quality information side by side to assist consumers in making an informed decision.

Who Has Jurisdiction over Price Transparency?

Private health insurance and providers are regulated primarily at the state level. Individual states have established standards and regulations overseeing the business of insurance and providers. Despite the states' role as the primary regulators, federal requirements may overlap. However, federal laws often establish federal minimum requirements while generally giving states the authority to enforce and expand those requirements.

What Are Some State Approaches to Price Transparency?

State laws and regulations that address price transparency vary considerably. The variation ranges from states with no laws and regulations that address price transparency to states with laws and regulations that address multiple components of price transparency.

For example, states may require health care providers to provide consumers with a price estimate of the treatment and the costs that must be paid by the consumer. Some states may require providers to give average or median prices for the most common procedures. Yet, the applicability of such a mandate may vary by state—that is, it may apply to certain types of providers (e.g., hospitals, ambulatory surgical centers, or physicians) or to certain procedures (e.g., inpatient or outpatient).

States may also mandate the creation of an all-payer claims database (APCD), which is a large-scale database that collects health care claims from a variety of providers and payers. An APCD has information about negotiated payments for health care services. However, not all states have strategies on how to translate this data. In addition, the data may not be in a format easily understandable to consumers.

How Does Federal Law Address Price Transparency?

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) requires providers (particularly hospitals) and insurers to provide certain information related to price transparency to consumers. Hospitals are required to establish and update a set of standard charges for health care items and services provided by the hospital and to make the information public. Guidelines from the Department of Health and Human Services state that hospitals "either make public a list of their standard charges ... or their policies for allowing the public to view a list of those charges in response to an inquiry."

The ACA requires tax-exempt hospitals to (1) regularly perform a "community health needs assessment"; (2) create and publicize a "financial assistance policy" (FAP); (3) limit charges for FAP-eligible individuals; and (4) adopt certain policies related to bill-collection efforts. Although price transparency relates to all of these ACA requirements, it is most closely related to the second requirement, which makes price information available to consumers: the tax-exempt hospital must widely publicize the FAP to the community it serves.

Health plans are mandated to provide a summary of benefits and coverage (SBC) to individuals at the time of application, prior to the time of enrollment or reenrollment, and when the health insurance plan is issued. The SBC provides information related to cost sharing; exceptions, reductions, and limitations on coverage; and other coverage features. The ACA also requires health plans seeking certification to participate in exchanges (marketplaces where individuals can shop for coverage) to disclose information on *out-of-network* costs, among other health plan features, to consumers. Moreover, selected cost-sharing information for exchange plans is available through public websites designed for consumers (HealthCare.gov) and researchers (Data.HealthCare.gov).

Bernadette Fernandez, Specialist in Health Care Financing

IF10282

Disclaimer