Healthcare Price Transparency: Research Findings and Implications for Policy and Practice

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Healthcare expenditures account for approximately 20% of the US gross domestic product (GDP). High prices, especially those paid by commercial payers, are a key driver. Unlike most other markets, commercial healthcare prices are opaque, leaving patients and employers uninformed and disadvantaged when purchasing healthcare services. To address this issue, the Centers for Medicare and Medicaid Services (CMS) implemented the *Hospital Price Transparency Final Rule* in January 2021 and the *Transparency in Coverage (TIC) Final Rule* in July 2022, requiring hospitals and commercial insurers to publicly disclose their prices, including insurer, plan, provider, and procedure information. The aim is to enable patients and employers to compare prices, stimulate price competition, and contain healthcare expenditures. The scope of the mandated pricing information disclosure at the individual hospital and insurer level is comprehensive and unprecedented compared to existing pricing sources such as commercial claims databases.

While continued efforts are needed to enhance compliance and improve the quality of price transparency data, a growing body of empirical literature has documented wide pricing variations and described pricing dynamics. The findings of this literature have the potential to provide implications for healthcare policy and practices aiming at containing healthcare spending, improving affordability for patients, and reducing the financial burden for employers.[1–6] In this Viewpoint article, we summarize some findings and their implications. This article is not intended to provide a comprehensive literature review of the large number of studies using price transparency data. Rather, it discusses some representative research to illustrate the general implications for policy and practice shared by this literature.

First, consistent with prior research on hospital pricing, hospitals with for-profit ownership, system affiliation, or located in areas with highly concentrated hospital markets are found to negotiate higher prices.[1] Additionally, physician-owned hospitals are associated with 18% lower negotiated prices for eight common outpatient procedures compared to non-physician-owned private hospitals in the same market.[2] These results can inform healthcare purchasers when forming networks of affordable providers. For example, self-insured employers could encourage patients to access affordable providers for standard and shoppable services through benefit designs (e.g., reference pricing). These findings also support evidence-based policymaking related to the restrictions on establishing or expanding physician-owned hospitals.

Second, commercial facility fees for colonoscopy services delivered at ambulatory surgical centers are approximately 36% lower than those in hospitals located in the same county.[3] These findings provide rigorous evidence for site-neutral payment reforms. In fact, the current site-dependent payment policy in government programs and private plans alike pays more for the same services when they are delivered in a hospital versus alternative facilities, such as physician offices or ambulatory surgical centers. This issue has generated substantial policy and media interest because the site-based price differentials are challenging to justify from the perspective of patients and plan sponsors. Moreover, they incentivize hospitals to consolidate physician practices to receive inflated facility fees for the same service provided. Hospital-physician vertical integration further reduces market competitiveness, expands hospital market power, and raises prices for commercial patients and payers.

Third, wide variation in commercial prices exists across insurers for the same shoppable procedure delivered in the same hospital. Typically, insurers with the largest local market share negotiate the lowest rates—a 31%, 24%, 12%, 9%, and 5% lower prices for laboratory tests, radiology procedures, evaluation and management services, medical and surgical care, and emergency room visits, respectively, relative to smaller insurers.[4] For patients and fully insured employers, opting for plans offered by the largest insurers in the local market represents potential cost-saving opportunities. Additionally, for self-insured employers negotiating prices directly with hospitals or through purchasing coalitions, prices negotiated by the largest local insurer can potentially serve as a benchmark.

Fourth, many commercial insurers also participate in Medicare Advantage (MA) and Medicaid managed care (MMC) programs, negotiating different prices across

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market segments for the same procedure and hospital. MA prices are less than half of the commercial prices negotiated by the same insurer for the same hospital.[5] Compared to MMC insurers with little presence in the commercial market, MMC insurers with substantial commercial market enrollment share negotiate 4%, 4%, and 7% lower prices for outpatient surgery and medicine procedures, radiology services, and emergency room visits, respectively.[6] These findings are unique in that they documented within-insurer and between-market segment price differentials. As more Medicare and Medicaid beneficiaries are enrolled in managed care programs, understanding how to improve both fiscal accountability and patient access in these programs is becoming increasingly relevant and important. Further empirical research and policy discussions are warranted.

Finally, discounted cash prices, typically paid by uninsured patients, are often more affordable than commercial negotiated prices for shoppable hospital services. Specifically, for the 70 CMS-designated shoppable services, discounted cash prices are lower than or equal to the median commercial-negotiated prices 47% of the time for the same service provided at the same hospital.[1] This trend is particularly evident in hospitals with nonprofit or government ownership, located in communities outside metro areas, characterized by higher uninsured rates, lower household income, or located in communities with higher hospital market concentration but lower insurer market concentration.[1]

These findings are relevant not just for uninsured patients, but also for insured patients who pay out-of-pocket before reaching their deductibles. Insurance, while mitigating financial risk exposure for enrollees, often reduces patients' price sensitivity, inadvertently encouraging service overutilization and contributing to high prices.[7] In response, insurance plans implement various measures—such as cost sharing, prior authorization, utilization review, and network restrictions—resulting in administrative costs and complexities for both providers and patients. The discrepancies between discounted cash prices and insurer-negotiated prices underscore the burden of these administrative complexities, particularly for routine shoppable services that expose patients to limited financial risks. For such services, self-insured plans may consider leveraging affordable discounted cash prices as a reference benchmark during price negotiations or steer patients to providers offering competitive discounted cash prices, facilitating direct payment arrangements or reimbursement to patients. Recent legislative actions in Tennessee and Texas, allowing cash payments to count towards insurance deductibles, exemplify steps towards incentivizing patients' utilization of and competition among providers for discounted cash prices. For the same purpose, Congress may consider adopting similar measures and relaxing restrictions on health savings accounts (HSAs), thereby generating savings for patients and employers.[7]

In conclusion, data disclosed in compliance with price transparency regulations has enabled researchers to uncover insights into pricing dynamics and suggest approaches to contain commercial healthcare expenditures, particularly for shoppable services. Beyond these dimensions, future research using the price transparency data should investigate other factors influencing commercial prices, such as self-insured status, plan design features, and the effects of private equity acquisition and vertical integration between insurers and providers. Furthermore, research on prescription drug prices (disclosure pending CMS rule-making) is warranted. Meanwhile, it is important to highlight the absence of utilization, quality, patient characteristics, and other non-pricing information in the price transparency data and the need for continuous improvement in compliance, data quality, and usability. Nevertheless, the disclosed pricing information has the potential to empower patients and employers in price comparison and negotiation processes, facilitate empirical research, and support evidence-based policy approaches. As more longitudinal data becomes available, research examining whether price transparency requirements can effectively contain healthcare spending will be invaluable for patients, employers, and taxpayers.

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