Price Transparency in Health Care Has Been Disappointing, but It Doesn’t Have to Be

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Price transparency has been touted as a way to reduce health care spending, but there’s one big problem: it has rarely worked. That may have more to do with how it has been implemented in the past rather than a fundamental problem with the concept itself.

The idea behind price transparency is that informed consumers can price shop for medical services that have widely varying prices, like elective surgeries or magnetic resonance imaging (MRI). The concept is very popular, both in the United States and abroad. Most recently, President Trump signed an executive order aimed at requiring hospitals to disclose what patients will “actually pay” for care. But evidence shows that transparency does little by itself. Some argue health care prices may actually go up in some cases. Giving consumers information alone does not mean they will actively use it to shop around for lower costs.

Consumers Rarely Use Health Care Price Tools

A study published in the American Journal of Managed Care surveyed more than 140 million health plan members across 31 different commercial plans who had access to price transparency tools. Only 2% used them. Many members did not know the tools existed at all.

Sunita Desai, PhD, and colleagues at Harvard Medical School in Boston set out to measure the association between employer-provided price information and outpatient spending. In a 2016 article in JAMA, they reported that they found that employees rarely used the information, nor was it associated with lower spending. Aetna offers a website with real-time, personalized price estimates that is used by only 3.5% of its members. Perhaps these tools can be effective in reducing health care spending, but evidence shows that low overall use is a significant bottleneck to achieving that goal.

The lack of use may have to do with the fact that health care is different from other consumer goods and services. Researchers from the Harvard T.H. Chan School of Public Health in Boston illuminated some reasons consumers may not seek or use price information for health care the way they do for other products.

More Cost Sharing Doesn’t Seem to Work

Proposals to promote utilization of price tools and subsequent spending reductions have largely centered on increasing cost sharing. For example, price transparency has been paired with high-deductible health plans. The hope is that sharing some of the cost with members would incentivize use of price information to lower out-of-pocket costs in the deductible range of their plans.

It hasn’t seemed to work. In a subgroup analysis in their 2016 article in JAMA, Desai and colleagues found no decrease in health spending related to transparency tool usage among members with high deductibles. Another study found that consumers did not price shop for cheaper care when switched into a high-deductible plan. One study, by researchers at the University of Southern California, Los Angeles, and other institutions did find modest savings from high-deductible health plans as a result of

Joël Coste, MD, PhD, an epidemiologist at the Hôpital Cochin in Paris and the study’s senior author, emphasized that the findings don’t prove that stopping statins caused the heart attacks or strokes. Although his team controlled for factors including discontinuation of other heart drugs, previous hospital admissions, comorbidities, and frailty indicators, data on other factors, like smoking, obesity, baseline cholesterol levels, and the precise reasons for statin discontinuation, were not available.

A large, randomized clinical trial looking at statin outcomes among people aged 70 years or older is under way in Australia, but the results aren’t expected for a few years. Until then, the new study suggests “potential cardiovascular risk reduction associated with continuing statin therapy after the age of 75 years in persons already taking these drugs for primary prevention,” Coste said.

Note: Source references are available through embedded hyperlinks in the article text online.
using lower-cost physicians and receiving cheaper laboratory tests.

Although high-deductible health plans provide a financial incentive, it may be too weak to promote the desired shopping effect. Many people ultimately spend through their deductibles, so they have little incentive to save on specific services.

**Other Approaches Seem More Promising**

Deductibles aren’t the only source of financial incentives. Other types of incentives seem to work better.

For example, a recent article in the *American Journal of Health Economics* by Christopher Whaley, PhD, and colleagues at the University of California, Berkeley, examined **pairing price transparency with reference pricing** for Safeway employees. Here’s how it works: payers set a maximum reimbursement threshold for shoppable health care services, which is the reference price. Patients who use providers with prices above the reference price pay the difference out of pocket. Under properly designed programs, members are given price transparency tools that help them find lower-priced care.

The study watched for employee health care behavior changes over 2 years, looking at laboratory and imaging test prices. After the first year, during which only price transparency tools were offered, the authors confirmed the findings of previous studies: health plan members rarely shopped.

But when the reference pricing information was added in the second year things changed. Shopping picked up and prices decreased. Specifically, laboratory test prices dropped 27% and imaging test prices decreased 13%. The authors concluded that price tools will capture the attention of consumers only if the consumers have strong financial incentives to shop in the first place.

Another option is pairing price transparency with rewards programs. Like reference pricing, rewards programs set maximum reimbursement thresholds. Then, members who use services at prices below their thresholds receive rebates. Another recent study by Whaley and colleagues in *Health Affairs* evaluated a 2017 rewards program with more than 250,000 eligible shoppers. Shoppers who sought lower-cost care using price transparency tools were given checks ranging from $25 to $500, depending on how much of the cost of services fell below the threshold.

This incentive drove more people to use the pricing tool. For all services, 8.2% of the intervention group used the price shopping tool compared with 1.4% in the comparison group. However, usage of the tool varied from service to service. For example, 18.9% of people in the intervention group used the price shopping tool for MRIs compared with 2.6% in the comparison group, whereas 3.3% of those in the intervention group vs 0.9% in the comparison group used it for ultrasound examinations. The authors found a modest 2.1% reduction overall in prices paid for shoppable services in the intervention group relative to the comparison group, with the greatest effect seen in imaging procedures like endoscopies.

Both reference pricing and rewards programs increase engagement with price transparency tools. But reference pricing seems much more effective in lowering prices. This makes some sense. **Evidence from behavioral economics shows** that financial losses are more salient than gains. Thus, a reward for using lower-priced services is less motivating than having to spend more up front.

Evidence has been building against price transparency. But the idea may be effective in pushing health care prices downward if paired with the right incentives. ■

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**Bench to Bedside**

**Autophagy Genes Linked to Sepsis Survival in Mice**

Tracy Hampton, PhD

More than 30 million people worldwide and 17 million adults in the United States develop sepsis each year. With limited treatments beyond antibiotics and fluids, nearly 270,000 people die annually from sepsis in the United States. Researchers have now identified a set of **autophagy** genes that may help cells survive robust, and potentially fatal, systemic inflammatory responses to sepsis.

The study, conducted in the laboratory of Herbert Virgin IV at the Washington University School of Medicine in St Louis, focused on the effects of interferon γ (IFN-γ)—a cytokine that mobilizes macrophages during infection but can also trigger cell death. Interferon-γ is part of the “cytokine storm” that results when the body mounts an immune response to septic infection, which leaves patients feverish or chilled, disoriented, and in pain. Published in the *Proceedings of the National Academy of Sciences*, the findings show that macrophages require a variety of autophagy genes to survive exposure to this cytokine.

To arrive at their results, the researchers systematically inactivated individual genes in mouse macrophage cells using CRISPR-Cas9 editing techniques and then treated the cells with IFN-γ. Cells deficient...