Inclusion of prices in EHRs could prompt a new wave of cost-effectiveness research, an imperative in a country where health care expenditures comprise 17.9% of the gross domestic product, or $3.5 trillion annually. As with any intervention, better training and educational programming around pricing will be necessary for physicians and patients and is not a reason alone the intervention should fail. Further research in clinical communication may help structure undergraduate, graduate, and continuing medical education on cost-effectiveness, with a potential role for medical specialty societies akin to the American Board of Internal Medicine’s Choosing Wisely campaign. Many organizations are already working to modernize medical education, including the American Medical Association’s Accelerating Change in Medical Education program, a $29 million effort to help transform existing medical education frameworks.

Both Cho and colleagues and Dr Mummadi and colleagues note challenges with EHR design, highlighting the need to redesign order sets, modify defaults, and promote user-centered design. We agree with the need for these changes and hope that the health information technology industry will learn how to ameliorate harms from information overload from the best practices of user-centered design in other “safety-critical” industries such as commercial aviation and nuclear power. Regardless, poor design does not excuse the need for core functions such as medication–medication interactions, logging and displaying vital signs, or computer physician order entry, and one would suggest as much. In an era of unaffordability, we are suggesting that the inclusion of price is a core feature just as medication dosage or the body part to be imaged are critical for ordering drugs and radiology studies. To ignore the need to include cost information is to burden future generations by refusing to confront a challenging problem and engage in a sustained effort to find a solution.

In a systematic review, Mummadi and colleagues note a heterogeneity of effects resulting from implementation of price transparency in EHRs. Included studies varyingly targeted imaging, procedures, or diagnostic laboratory tests and occurred in a variety of geographies and care settings, including outpatient community practices and academic tertiary care hospitals. Rather than suggesting that price transparency is ineffective, this collation of studies demonstrates a natural scientific experiment in the evolution of the intervention of price transparency: researchers in different environments are using a variety of methods to implement transparency, providing evidence of both more and less effective interventions. Other noted signals of increased utilization in specific subspecialty environments may in fact reflect appropriate use.

More than $9.5 billion is spent in the United States daily on medical products and services. Implementing price transparency properly is challenging. This does not mean that it should not be tried.

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Disclaimer: This article represents the opinions of the authors and does not reflect the views of CMS, the FTC, or any of its commissioners.

CORRECTION

Incorrect Value in Results: In the Original Investigation entitled “Effect of Bempedoic Acid vs Placebo Added to Maximally Tolerated Statins on Low-Density Lipoprotein Cholesterol in Patients at High Risk for Cardiovascular Disease: The CLEAR Wisdom Randomized Clinical Trial” published in the November 12, 2019, issue of JAMA, a value was incorrect in the text. In the last sentence of the Results section, the value reported as 0.5 for mean creatinine concentration should have been reported as 0.05. This article has been corrected online.


Incorrect Data in Table and Discussion Section: In the Research Letter entitled “Prevalence of Oral HPV Infection in Unvaccinated Men and Women in the United States, 2009-2016” published in the September 10, 2019, issue of JAMA, data were incorrect in the Table and the Discussion section of the text. In the Table, in the “2015-2016” column of the “Women, %” section, the values reported for black, non-Hispanic women and Hispanic women were transposed, the value for black, non-Hispanic women should have been reported as 13.4 and the value for Hispanic women as 17.8. In the first sentence of the Discussion section, the value reported as 37% should have been 38%. This article has been corrected online.