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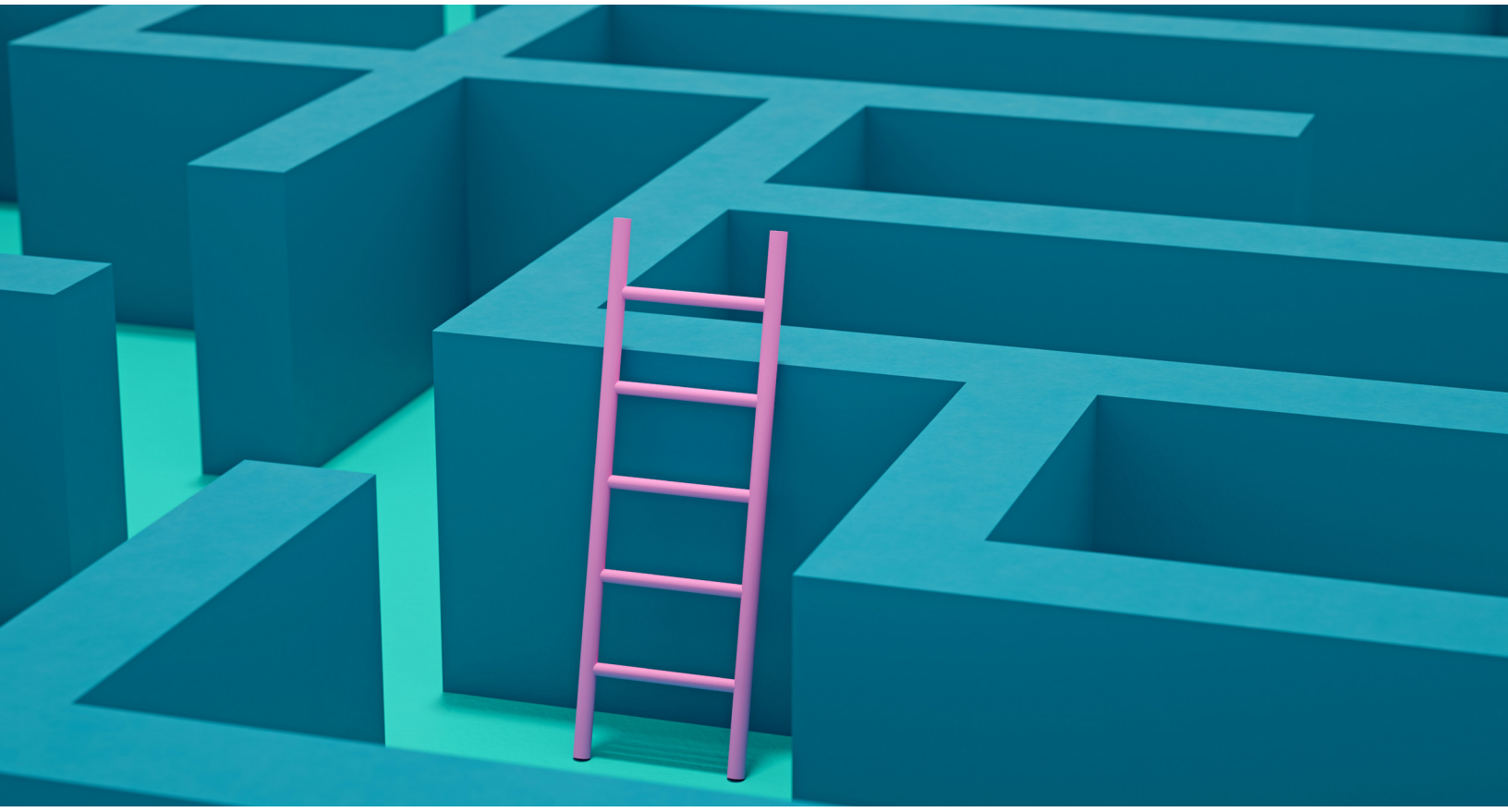
Healthcare Practice

How price transparency could affect US healthcare markets

Price transparency is one of several industry innovations that is increasing the potential for consumerism in US healthcare.

This article is a collaborative effort by Sarun Charumilind, Katherine Han, Jeff Ruff, Amit Shah, and Isaac Swaiman, representing views from McKinsey's Healthcare Practice.



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It has been more than a year and a half and three years, respectively, since federal price transparency rules went into effect for payers and hospitals. Together, the two rules require public disclosure of all commercial payer–provider negotiated rates, and they include other provisions aimed at improving price transparency.[1]

After a slow start,[2] payers and hospitals have made progress toward publishing negotiated rates.[3] In the meantime, regulators are continuing to take actions to further advance price transparency. For example, the Centers for Medicare & Medicaid Services (CMS) has shortened the time hospitals have to respond to notices of noncompliance and has imposed automatic fines for noncompliance.[4] The US House of Representatives recently advanced legislation that would impose more price transparency requirements on additional types of care delivery organizations.[5] Moreover, state and local governments in Massachusetts, Minnesota, New York City, and Virginia have enacted their own price transparency requirements.[6]

This article puts price transparency rules in context and explores their implications, including:

— the existence of price dispersion in US healthcare that is not explained by differences in quality of care

— how price transparency rules address some market inefficiencies driving this price dispersion but leave others unresolved

— that patients—if given proper incentives and information—would be interested in shopping for care that amounts to 20 to 25 percent of US healthcare claims spend, potentially unlocking gains in affordability for consumers

— the potential for price transparency rules, together with other innovations, such as advances in technology and analytics, to empower patients to shop for care more than ever, helping offset growth in healthcare costs

— implications for healthcare industry stakeholders, potential shifts in industry profit pools, and first-mover advantages for organizations that capitalize on this opportunity to improve healthcare for US consumers

Price transparency rules, and complementary industry innovations, could better align US healthcare cost and quality

Price transparency can help address two factors that limit the relationship between price and quality in US healthcare. First, price transparency helps resolve asymmetry in rate information by requiring payers and hospitals to publish rates and requiring payers to provide portals that patients can access to estimate out-of-pocket expenses.

Second, patients today have limited incentives to shop for healthcare because they bear only a partial share of cost-of-care differentials; the average

[1] In addition to requiring disclosure for commercial rates, the hospital transparency rule also requires the disclosure of negotiated rates with Medicare Advantage and Medicaid managed-care plans.
[2] Cynthia Cox et al., "Early results from federal price transparency rule show difficulty in estimating the cost of care," Peterson-KFF Health System Tracker, April 9, 2021.
[3] *Price transparency impact report: Q1 2023*, Turquoise Health, 2023.
[4] "Hospital price transparency enforcement updates," CMS, April 26, 2023.
[5] "H.R.5378 - Lower Costs, More Transparency Act," Congress.gov, December 11, 2023.
[6] "Pricing transparency provisions of an act promoting a resilient health care system that puts patients first ('Patients First')," Mass.gov, March 11, 2022; "62J.823 hospital pricing transparency," Office of the Revisor of Statutes, January 1, 2023; Emma G. Fitzsimmons, "Why New York hospitals will soon be more transparent about pricing," *New York Times*, June 7, 2023; Dan Helmer, "Virginia leads the way on medical price transparency," *Wall Street Journal*, July 14, 2023.

patient enrolled in an employer-sponsored plan pays 16 to 19 percent of the total cost of care via copays, coinsurance, and deductibles, with the rest being paid by the employer and payer.[7] Additionally, because the designs of health insurance benefits are complex, patients do not always share in the financial benefits when they make high-value, low-cost choices (for example, receiving eligible care in an alternative care setting, such as at home, rather than in traditional facility-based settings).

Although much of the discussion about federal price transparency rules has focused on disclosure of contracted rates between payers and care delivery organizations, several clauses specifically promote transparency for consumers. Examples include the following:

— Federal rules require that payers make out-of-pocket cost estimates available for consumers, originally for a select set of procedures and, as of January 2024, for all care.

— Federal rules encourage but do not require payers to launch member incentive programs that pass cost-savings benefits on to consumers who make high-value care decisions. For example, payers can make cash payments to members who choose high-value physicians and lower-cost, alternative care settings. Rules explicitly encourage payers to adopt this type of incentive program and offer payers the opportunity to count these member incentive payments in their medical-loss-ratio reporting.[8]

However, price transparency fails to address other factors, including the following:

— a lack of standardization of services for many episodes of care and limited consensus on how to measure care quality, which can make comparison shopping difficult for some categories of care

— information asymmetry, which exists because most patients have no clinical training and therefore must rely on care team recommendations[9]

— health insurance products that do not always match the true preferences of patients due to design by employers and payers

Achieving greater efficiency in US healthcare markets would require addressing these persistent factors in addition to striving for greater price transparency.

Price transparency could have a sizable impact on financials of individual payers and care delivery organizations

US healthcare prices vary widely; on average, prices for the same healthcare services differ by 30 to 40 percent within a given US metropolitan statistical area (Exhibit 1). This means substantial economic value is at stake in commercial rate negotiations between care delivery organizations and payers. Given that annual spending for commercial healthcare claims is roughly $1.1 trillion, every increase or decrease of 1 percent in commercial reimbursement rates leads to an increase or decrease of about $11 billion in national healthcare claims spend.[10]

[7] Paul Fronstin and Jake Spiegel, "Recent trends in patient out-of-pocket cost sharing," *Employee Benefit Research Institute Issue Brief*, July 28, 2022, Number 564.

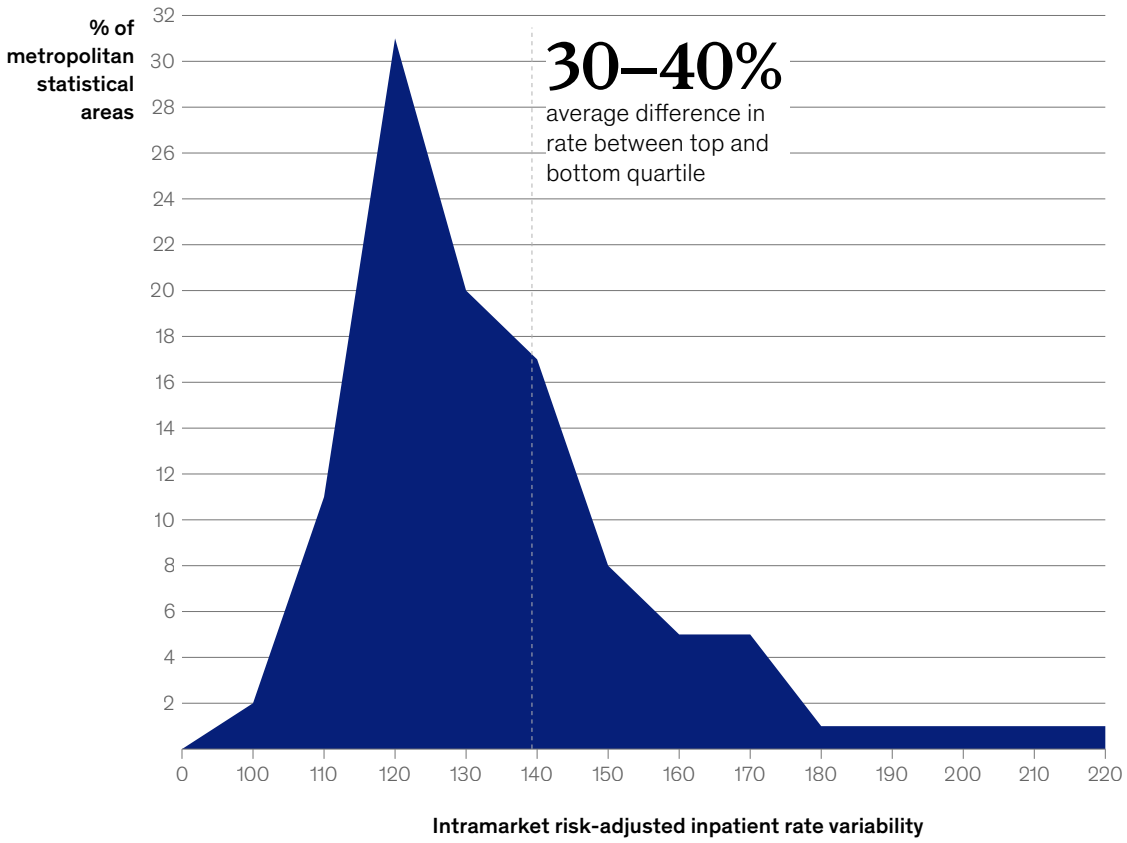
[8] "Transparency in coverage," Internal Revenue Service, the Employee Benefits Security Administration, and the Health and Human Services Department, November 12, 2020.

[9] This is less applicable for simple services such as labs and imaging but is particularly important for complex services such as surgery and chronic-care management. Additionally, referring clinicians do not always have transparent access into comparative costs to patients and payers of various care plans, which may limit the ability of both the physician and patient to factor in price when selecting care. Tuba Saygın Avşar et al., "Information asymmetry in hospitals: Evidence of the lack of cost awareness in clinicians," *Applied Health Economics and Health Policy*, May 24, 2022, Volume 20, Number 5.

[10] Based on 2022 national health expenditure (NHE) estimate of private healthcare expenditures totaling $1.3 billion and assuming that, on average, 85 percent of private healthcare expenditures are spent on healthcare claims. NHE reports are available at "NHE fact sheet," CMS, updated December 13, 2023.

Exhibit 1

Today, on average, the top quartile of payments is 30 to 40 percent higher than the bottom quartile for the same set of services.



Source: 2021 Truven Health Analytics commercial claims data

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Although price transparency may not be sufficient to transform the US healthcare market overall, individual care delivery organizations and payers could use the information in rate negotiations to bring rates more in line with each other's respective value.

Currently available price transparency data is incomplete and imperfect, but organizations could use it in several practical ways. For example, care delivery organizations that are charging premium rates for undifferentiated services may need to reevaluate or redefine their value propositions or prepare for margin compression. At the same time, high-performing care delivery organizations whose rates do not reflect their value and quality will be better equipped to engage payers with identifiable data substantiating that current rates are not competitive, helping to align rates with their true value. While price transparency data is incomplete and should not be used in isolation, the nature of price transparency data—published by payers

themselves and published on a payer–provider identifiable basis—makes price transparency data a unique and valuable complement to traditional claims-based benchmarking methods.

Employers can also use this newly available data to benefit their employees. For example, a Pennsylvania employer used price transparency data to find cases in which its negotiated rates were higher than those offered to other patients and used this information to reduce certain healthcare costs by as much as 43 percent.[11]

In addition to using price transparency data to optimize current contracts, organizations can also use it to increase the accuracy of performance assumptions, market analysis, and strategic value in evaluating potential organic and inorganic growth opportunities.

Price transparency rules are one of several innovations that could encourage consumer shopping in healthcare

Sixty-four percent of US patients have never shopped around for healthcare services by comparing prices,[12] but that may change. In 2022, out-of-pocket expenditures increased by more than 6 percent relative to 2021, averaging $1,425 per patient.[13] Inflation, clinical labor shortages, and other challenging macroeconomic conditions could propel further increases in healthcare costs over the next few years,[14] which could lead to higher out-of-pocket costs and premiums for patients.

In the meantime, technological advancements in recent years now make it possible for payers to offer members easy-to-use, personalized healthcare-shopping support similar to what they commonly experience with e-commerce, financial services, and airline travel. Our May 2023 survey of consumers revealed that patients trust cost estimates published by payers more than those published by other healthcare organizations, including care delivery organizations. Additionally, affordability is a top concern, with 89 percent expressing interest in shopping for at least one category of care if given the option and 33 to 52 percent of consumers willing to switch providers (for example, choosing a different physician or health system) in return for cash rebates of $25 to $100.[15] These results (as displayed in Exhibits 2, 3, and 4) indicate that members may respond well to payer-led efforts to increase access to this information.

Specifically, this consumer research implies that new price transparency rules, which encourage payers to offer information and cash rebates to members, could push patient-driven healthcare shopping over the tipping point. For example, payers could do the following to encourage shopping for at least some categories of care:

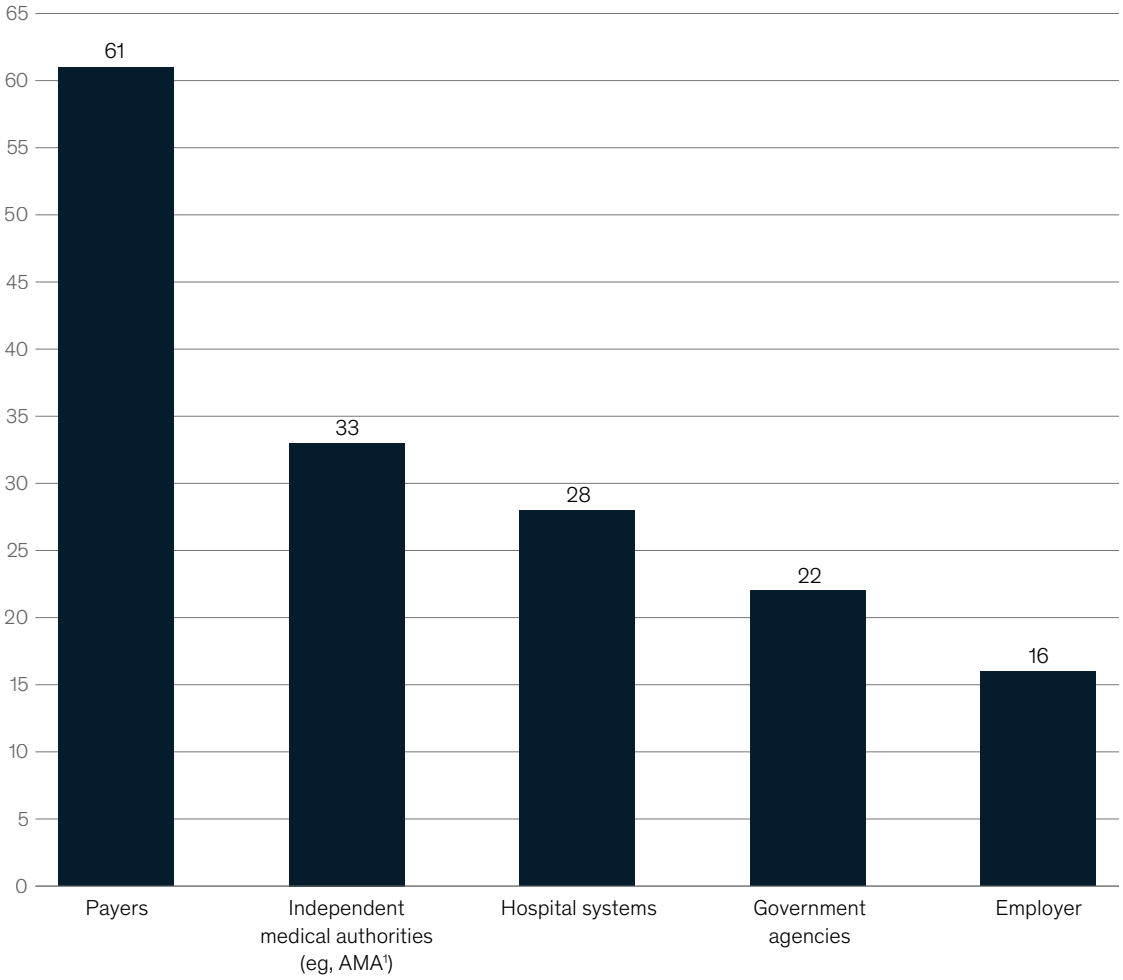
- launch digital shopping platforms that allow members to seamlessly compare costs, access, and quality of in-network physicians and other categories of providers
- make personalized provider recommendations that are tailored to a member's clinical history, geography, language, plan design, and other preferences
- offer personalized incentives for high-impact care choices (for example, choosing a high-performing primary care physician or scheduling surgery at a center of excellence)

[11] Based on public reporting of results from Lehigh County, a self-insured employer in Pennsylvania. The employer spends $30 million per year on healthcare benefits, initially realized $3 million in savings based on price transparency data, and has identified an additional $10 million in potential savings, including $4 million in medical spend and $6 million in drug spend. For more, see Sara Hansard, "One county combed hospital data to slash health plan costs 43%," Bloomberg Law, February 6, 2023.
[12] "Survey finds majority of healthcare consumers conditioned to not shop around for the best price," AKASA, October 4, 2022.
[13] "NHE fact sheet," updated December 13, 2023.
[14] Addie Fleron and Shubham Singhal, "The gathering storm in US healthcare: How leaders can respond and thrive," McKinsey, September 8, 2022.
[15] McKinsey consumer survey, May 2023.

Exhibit 2

Respondents said they trust payers more than anyone else to provide accurate cost information.

Consumers expressing trust in healthcare entities, %



Note: Question: Who would you trust to provide accurate information for your out-of-pocket costs for your appointments with healthcare providers?
[1]American Medical Association.
Source: McKinsey consumer survey, May 2023, n = 1,840

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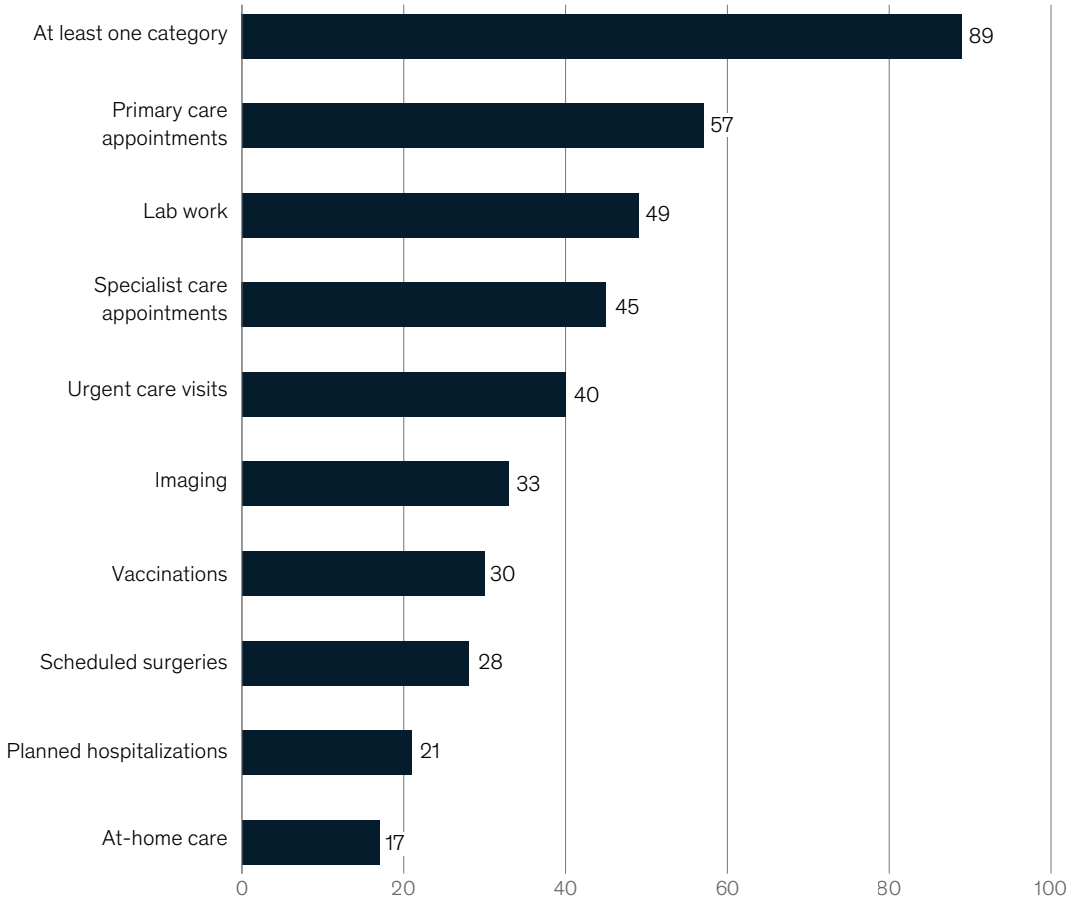
Exhibit 3

Consumers express a high willingness to shop for care if given the option.

Consumers willing to shop for care, by medical service, %



Note: Question: Assuming a provider search tool was available that made it easy for you to compare out-of-pocket costs for different healthcare providers, for what types of medical services would you use it?
Source: McKinsey consumer survey, May 2023, n = 1,930

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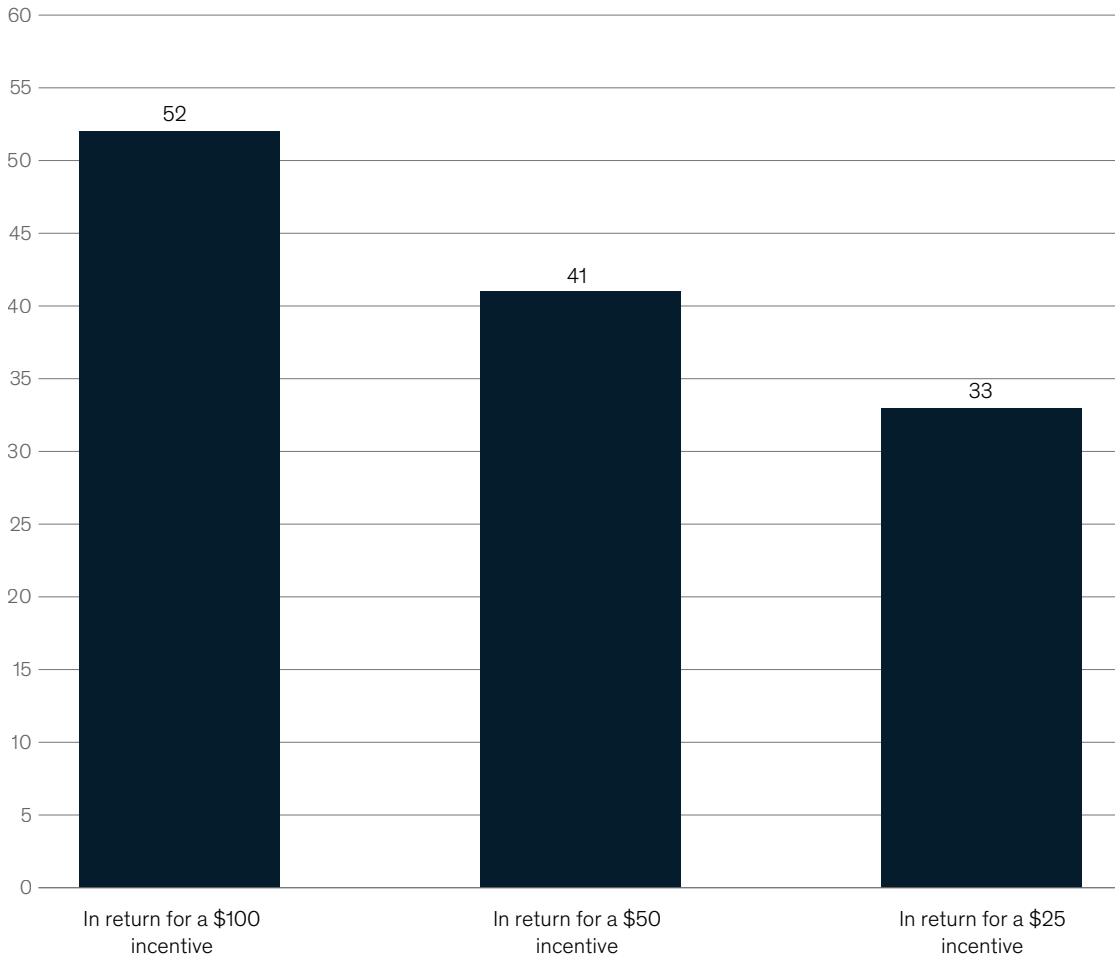
Exhibit 4

Surveyed consumers indicated that they are receptive to cash incentives as an enticement to see a different healthcare provider.

Likelihood of respondents to see a different healthcare provider in return for a cash incentive, %



Note: Question: Assuming care quality, location, appointment wait time were the same as your most recent appointment, how likely would you have been to see a different healthcare provider, if you received a rebate of each of these values?
Source: McKinsey consumer survey, May 2023, n = 1,668

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The timing of payers' offers of these recommendations and incentives is particularly important. As research on cascades of care has shown, making the right care decision at the beginning of a patient's care journey can help improve affordability of an overall care pathway or episode of care.[16] Critically, consumer survey results indicate that consumers are particularly willing to shop for care at the beginning of care journeys, such as when selecting a primary care physician or specialist. Because these decisions can have a substantial effect on downstream costs and quality of care, providing consumers with the incentives and information to shop for care at even a few key inflection points could generate meaningful benefits for patients.

Personalization of incentives and care recommendations will also likely be important. For example, our May 2023 consumer survey found that provider quality was the most important provider selection factor (15 percent of respondents). Other critical factors included the provider's location (10 percent) and days or times available for appointments (tied for importance with estimated out-of-pocket costs at 9 percent). As a result, incentives that address these types of consumer preferences may be more likely to encourage shopping behavior. Because federal price transparency rules do not specify the form incentives must take, payers could experiment with a variety of incentives to determine how best to promote consumer empowerment and satisfaction.

An increase in patient-driven healthcare with support from these types of personalized shopping experiences could substantially influence US healthcare profit pools. In total, we estimate roughly 73 percent of commercial claims spend occurs for care that is shoppable to some degree (Exhibit 5).[17]

[16] Carrie H. Colla et al., "Cascades of care after incidental findings in a US national survey of physicians," *JAMA Network Open*, October 16, 2019, Volume 2, Number 10.

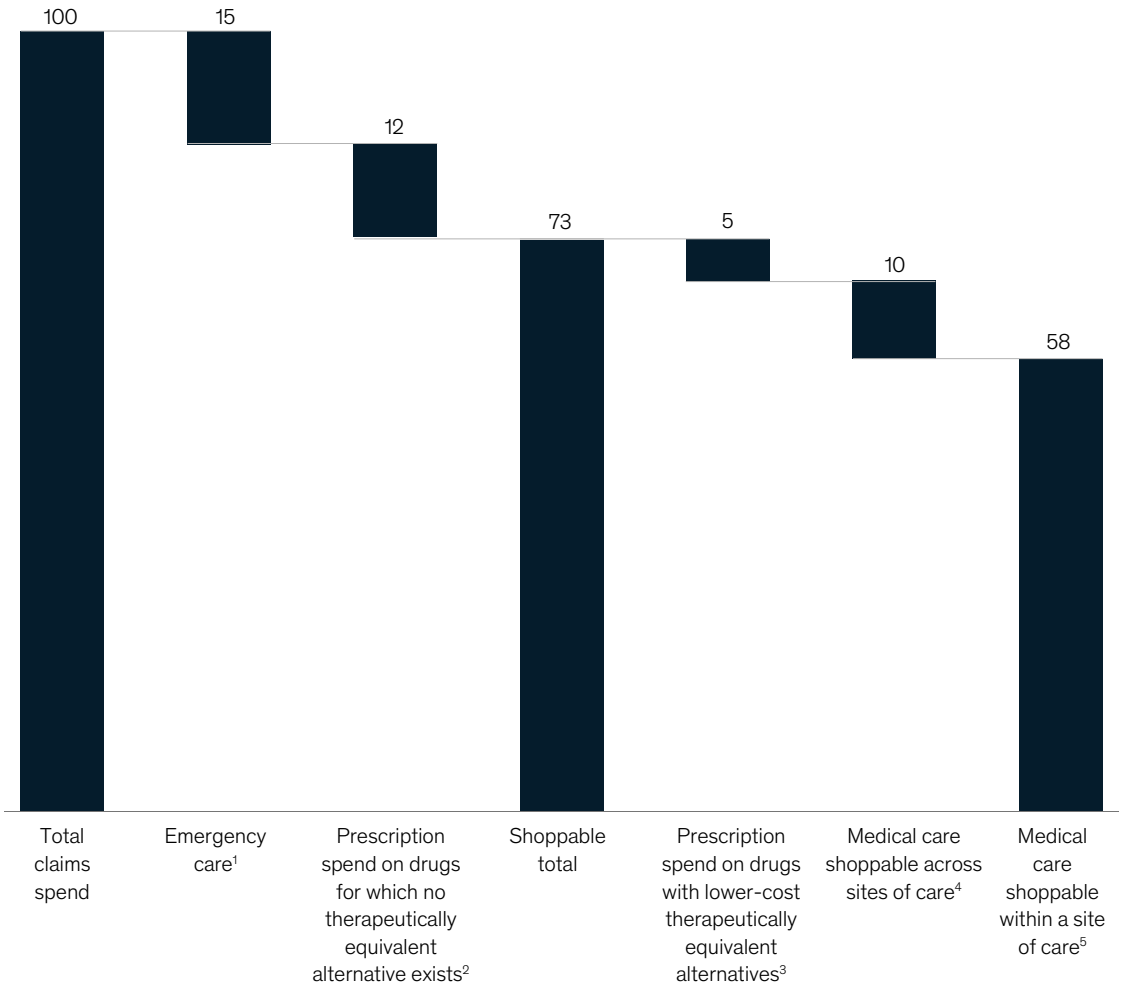
[17] Based on analysis of 2021 Truven Health Analytics Commercial claims data. For this analysis, we define "shoppable" care as nonemergency medical care for which a patient can make a choice of physician, health system, or care setting (such as facility-based or at-home care). We also consider retail pharmacy spend on drugs for which therapeutic equivalents are available.

In total, we estimate roughly 73 percent of commercial claims spend occurs for care that is shoppable to some degree.

Exhibit 5

In 2021, 73 percent of US commercial claims spend was shoppable.

Shoppable claims spend, %



[1]Includes all care billed alongside an ER claim, including ancillary expenses (eg, labs and imaging) associated with an ER visit and hospital admissions originating in the ER.
[2]Spend on drugs for which no therapeutically equivalent alternatives exist and, as a result, for which member-driven shopping is limited.
[3]Includes spend on drugs for which therapeutically equivalent, lower-cost drugs (eg, generics or biosimilars) are available.
[4]Includes care that members can choose to schedule across several sites of care (eg, facility-based or at-home infusion therapy).
[5]Includes spend on scheduled care for which members can shop within a given site of care (eg, physician office visits, labor and delivery).
Source: McKinsey analysis of 2021 Truven Health Analytics commercial claims data

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If roughly one in three commercial insurance members begin to shop for this care—something our surveys indicate is possible with the right information and incentives—then patients could reasonably shop for care for about 20 to 25 percent of all commercial claims spend. Because commercial claims account for the majority of care delivery organization profit pools in the United States, this level of shopping would have substantial implications for organizations across the care continuum.

Achieving this potential will not be easy. A new age of healthcare shopping would represent a paradigm shift for payers, care delivery organizations, pharmaceutical companies, and consumers. Uptake may be faster in certain care categories (such as physician appointments) than others (such as scheduled surgeries). And payers would need to make meaningful investments in consumer-facing analytics and digital experience to empower widespread adoption of shopping platforms.

However, our research makes two things clear: substantial consumer demand for healthcare shopping exists, and the reward for organizations that meet that demand could be dramatic. If price transparency rules help catalyze a new wave of innovation to meet this consumer demand, the impact of these rules could be profound—even if they are not a panacea for all the market inefficiencies in US healthcare.

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