Physician-Based Approaches to Price Transparency: A Solution in Search of a Problem?

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Abstract: Physician-based transparency approaches have been advanced as a strategy for informing patients of the likely financial consequences of using services. The structure of health care pricing and insurance coverage, and the low uptake of existing tools, suggest these approaches are likely to be unwieldy and unsuccessful. They may also generate new ethical challenges.

Most patients have little notion of what the likely out-of-pocket cost of a given health care service is likely to be; their doctors are likely to be equally uninformed. It's startling to realize that that has been the norm in the US health services market for decades. The opacity of health care prices has only been recognized as a problem since about 2010, when a private company, Castlight Health, began to make price information available.[1] The federal government has since implemented rules requiring hospitals and insurers to make price information transparent to prospective patients.[2]

Recently, legal scholars have offered new approaches to addressing this transparency problem, approaches that also have the effect of informing the physician about their patient's likely out-of-pocket cost. Alicia Hall argues that providing information about the likely out-of-pocket cost of a service should be part of a physician's obligations under rules governing informed consent.[3] In an article in this issue of the *Journal of Law, Medicine & Ethics*, Christopher A. Bobier argues, instead, that the CMS should require that physicians give patients an estimate of their likely out-of-pocket costs for non-urgent procedures before the patient undergoes treatment.[4] But physician-based transparency approaches are unlikely to be useful to patients and may conflict with physicians' ethical responsibilities.

One fly in the transparency ointment is that consumers today rarely use price transparency tools, even when these are available.[5] Part of the reason is the nature of medical care. Consider a knee replacement surgery (a standard shoppable service). An orthopedic surgeon will perform the surgery. But the procedure is also likely to involve an anesthesiologist, perhaps a second surgeon, likely some diagnostic scans and bloodwork, the use of an operating room, and probably follow-on physical therapy. If something goes wrong, many other services and providers will be called for. Often, each step along this chain will involve a distinct out-of-pocket payment. Information about a single component is of limited use to a patient making a choice about surgery.[6]

Even when procedures are narrowly-defined, it is very hard to compute expected out-of-pocket costs for a specific patient. The out-of-pocket expense will vary by provider, because negotiated reimbursement rates and co-insurance vary across providers. It will vary by how much that patient has spent already in the calendar year (whether or not the patient has exceeded the deductible or out-of-pocket maximum) — the very same procedure performed by the very same provider likely has a different out-of-pocket cost in February

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and in November.[7] It will vary according to how much other care the patient expects to need later in the year (whether the patient anticipates reaching the out-of-pocket maximum) and according to how much money remains if a patient has a tax-favored savings account.

Providing a patient with a useful estimate of out-of-pocket expense is challenging — and it begs the question of how the patient might use that information. One argument is that revealing information might make patients better shoppers. But shopping entails comparisons of prices across providers and the approaches that both Hall and Bobier propose, which rely on physicians informing individual patients, would be unwieldy for shopping purposes, when patients need to collect estimates from multiple providers.

Physician-based approaches to transparency are therefore impractical. They are also costly — in terms of physician office costs and already-constrained visit time. Under these approaches, providers would become aware of the pocketbook implications of their patient-specific treatment recommendations. Is that ethically desirable? Out-of-pocket spending accounts for only a very small fraction (10.6%) of total health spending — insurance pays most costs.[8] The ethical position of a doctor in the three-way transaction among the doctor, patient, and payer/insurer seems quite different from that of the car salesman posited by Bobier. Should an ethical physician consider all the costs of a procedure, including the cost to the public or private insurer, or only the immediate out-of-pocket cost to this patient? Would an ethical physician offer a different treatment recommendation for a given patient in January, when she faces her full deductible, as in December, when she has reached her out-of-pocket maximum and faces no further cost-sharing? As an agent of the patient, an ethical physician ought to provide the best assessment of the clinical consequences of a medical recommendation, not make an out-of-pocket cost vs benefit tradeoff.

High medical prices are serious concern — and collecting information about prices is critical to informing health policy.[9] But consumers do not demonstrate much interest in out-of-pocket price information. Castlight Health was ultimately a financial failure.[10] We should be cautious about recommending costly and burdensome solutions to problems that are largely theoretical. Putting individual physicians in a position where they must weigh — or might be perceived as weighing — social and individual costs against individual benefits is a risky solution in search of a problem.

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Note

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