



OVERVIEW

The Institute of Medicine estimates that \$105 billion of annual waste in health care spending can be attributed to lack of competition and excessive price variation.¹ A lack of public information on the price of health care services contributes to this excessive spending by denying employers, other purchasers, and consumers the information they need to make high-value choices. This brief explains what can be done to make prices more more transparent, with the goals of: 1) arming consumers and purchasers with information they need to make and encourage smart decisions and 2) containing health care costs. Price transparency, however, is not sufficient by itself to drive improved affordability; purchasers and health plans need to implement complementary incentives for consumers and providers.

I. Why Price Transparency is Needed

Making information available on the price of services allows for smarter choices about where to seek care and highlights opportunities to bring down overall costs.

Health care is like no other major sector of the U.S. economy. The lack of information about price and quality prevents purchasers and consumers from being able to answer the most basic questions when they purchase services: Who does a good job? What does it cost?

This information is critical for employers and other purchasers facing rising health care costs that are desperate to make care more affordable to stay competitive. They seek out price information to design benefits that reward consumers who make high-value choices. Health plans can also use price information to identify and reward high-performing providers—those who deliver high-quality services at a competitive price.

Consumers are a growing audience for price information, as health plans and purchasers respond to the alarming growth in health care spending by having consumers take on a greater share of their costs through arrangements such as high deductible health insurance plans. To navigate an environment where they are no longer shielded from the costs of their care, consumers need reliable information on both the relative price and quality of health care services to choose the best value. There is significant price variation for the same service within and across U.S. regions.² However, meaningful information on prices is almost never made available to consumers prior to receiving care.³

Price transparency also plays a role in containing costs system-wide. Health care costs are a function of both care utilization (the number of times a service is used) and the pricing of that care. By revealing trends in service prices across communities, public and private sector actors can identify price outliers and intervene where rates are inappropriately high.⁴ Paired with health plan efforts to reward consumers who choose lower-cost, high-quality providers, the rate of health care spending would begin to slow.

The Robert Wood Johnson Foundation (RWJF) is committed to addressing the problem of high and rising health care costs and overall spending on health care. This policy series is one of several projects RWJF is supporting as part of this commitment to increase the focus on value in the health care system.

Ultimately, having real prices in the public domain should lead to better, safer care. Purchasers and health plans will encourage consumers to be active shoppers, demanding additional information about their care, such as quality and consumer experience, so they can make good choices. Differentiating providers on price and quality will also bring to light unnecessary or risky services and reveal low performers. Health plans will form innovative provider networks and benefit structures not based on reputation but on high performance.

There is an important role for government to play. Working with the private sector, government can take specific steps to make price information available. These steps are summarized below and explained in more detail in [Section V](#). However, the solution is not the same for all health care markets. More concentrated markets require different strategies than highly competitive markets to ensure that transparency has the intended outcome of making care more affordable.

SUMMARY OF POLICY LEVERS TO ACHIEVE PRICE TRANSPARENCY GOALS

State-Level Policies	Prohibit gag clauses and other anti-competitive practices
	Create All-Payer Claims Databases (APCD) or require plans in state and federally-facilitated insurance marketplaces to submit paid claims to a formally organized private sector database
	Require plans in state and federally-facilitated insurance marketplaces to provide useful cost calculators
Federal-Level Policies	Assert employer rights to access and use their own claims data
	Use incentives to encourage states to take steps to improve transparency

II. What Type of Price Information is Needed?

Consumers and purchasers need access to the actual negotiated rates paid to providers for a specific service as opposed to simply the "charges" published by providers.

Consumers and purchasers need access to information on the actual prices they would pay to providers for specific services to make meaningful distinctions among their options. There has been a heightened focus on "charges,"—the amount providers publish prior to negotiation with the health plan—sparked by Steven Brill's article in *Time* magazine. However, the information relevant to most consumersⁱ is the actual amount they will have to pay—meaning the price the insurer has negotiated with the provider, the "allowed amount," minus any portion of the price the insurer covers.

Take the example of a consumer who is seeking information on the cost of a colonoscopy. Their insurer has negotiated a rate of \$2,000, from the posted charge of \$4,000, with a particular in-network clinician who performs colonoscopies. The consumer has \$200 left in their deductible and the co-insurance for remaining costs is 20 percent. Therefore, the individual is responsible for \$560 ($\$200 + 20\% \times [\$2,000 - \$200]$) and the insurer pays the remaining \$1,440 for the total price of \$2,000. If prices were transparent, the consumer would be able to see, prior to seeking the procedure, that their price would be \$560 for that particular provider and could compare this price for a colonoscopy against that of other providers.

Price information should:

- Reflect negotiated discounts
- Include all costs associated with a service or services
- Identify the consumer's out-of-pocket costs

ⁱ A segment of patients will incur the full charges because they are uninsured or the provider they select is not part of the insurer's contracted network.

The price to the consumer will depend on whether they are insured and, if insured, what type of plan and benefit design they have. Building off the colonoscopy example, a patient without insurance would be presented with the full charge amount of \$4,000. A patient in an HMO plan with no deductible would simply have to pay the designated co-pay—the same amount regardless of what in-network provider they choose. In the PPO plan model above, the patient would owe \$560 for that in-network provider or more if they selected a provider out of the plan’s network.

Purchasers, policymakers, and regulators also need access to price and quality information to address cost containment. They need to understand the negotiated prices for individual visits, tests, or procedures as well as the bundled price for a related set of services. To identify high and low performers, purchasers and policymakers need to have price information compared by geography and by payer type.

The following types of price information are most useful for purchasers, consumers, and others seeking to make value-based choices about care:

AUDIENCE(S)	TYPES OF PRICE INFORMATION NEEDED	EXAMPLE
Purchasers	The total price of individual tests and procedures, including both professional and facility fees where applicable	Price of a routine colonoscopy incorporating the amount paid to the doctor and to the facility
Purchasers	The total price of bundled services, including both professional and facility fees where applicable, for use in contracting with Centers of Excellence and for reference pricing	Price for a joint replacement, including the hospital admission combined with the price of pre-operative and follow-up services
Purchasers	The total price of capitated contracts for patients with certain clinical conditions, including primary care and specialist fees, inpatient care, pharmacy, etc.	Price of managing a patient with diabetes over time
Consumers, Providers	Out-of-pocket price to consumers based on their type of insurance benefit	Price of an office visit, test, or procedure based on the specific cost-sharing arrangement
Policymakers/ Regulators	Trends in prices within and across geographies and payer type	Bundled price of a spinal surgery associated with providers across California, distinguished by payer type

III. How Would Price Information be Used?

Price transparency supports consumer choice and gives clinicians and the public tools to drive down health care costs.

As indicated in the table above, a number of audiences could use price information to suit their particular purpose—for designing benefits, care selection, or market monitoring.

Purchasers and payers Employers, through their health plans, seek price and quality information to monitor provider performance and identify and reward high-performing providers. Plans can then implement value-based insurance designs, such as tiered networks, to reward consumers who select a high-value option. These tiered

products vary the price to the consumer (via differential deductibles, copays, and coinsurance) based on the cost and quality of the provider delivering the service.

Consumers Consumers could use the data on out-of-pocket costs, ideally paired with quality data, to select the best-performing provider at the best price to meet their needs for a particular service. This information is most meaningful when consumers face significant cost-sharing variability as it helps them interpret their true cost after taking into account any deductible, co-insurance, co-payment, tiered network, or other benefit design that impacts what a consumer pays.

Consumers can best take advantage of price information when they are choosing a provider for a specific elective procedure that can be easily compared. Examples of these "shop-able" services include routine colonoscopy, non-emergent CT or MRI, and mammogram. Consumers should make decisions based on price *and* quality when that information is available.⁶

Figure 1: Sample View of Price and Quality Information

	Consumer Ratings of Provider	Provides Excellent Preventive Care	Your Price
Provider A	★★	★★	\$20
BEST VALUE! Provider B	★★★★★	★★★★★	\$50
Provider C	★★★★	★★	\$180
Provider D	★★	★★★	\$510

With this information in the public domain, consumer, purchaser, and provider choice could transform the market into one that supports more consistently affordable, high-quality care. In one example, when Safeway revealed the widely variable prices of colonoscopy services and told employees they would need to pay the difference if they selected a service above a certain price, the number of employees who selected a higher-cost provider went from 30 percent to 11 percent.⁷ The California Public Employees' Retirement System (CalPERS), which provides benefits to more than 1.6 million individuals, instituted a similar transparency program for hip and knee replacement surgeries and saw costs go down by an average of 30 percent.⁸

Referring physicians Clinicians could also benefit from understanding the price their patients would have to pay for drugs, tests, devices, referrals, and procedures before they submit the order. Without knowing the prices of alternative providers, clinicians are unable to select a lower-cost, equally effective option for their patients. In one recent experiment, revealing lab test price information to physicians resulted in savings of more than \$400,000 over six months stemming from fewer lab orders.⁹ In a shared savings or capitated arrangement, clinicians especially gain from having information on the most cost-effective services to help manage their costs.

Regulators and policymakers The ability to aggregate and monitor price trends within and across communities and payers can highlight problem areas that require intervention. For example, if policymakers could identify providers who are price outliers, they could examine the cause, such as an unfair market power advantage, and target interventions to correct the issue. Such aggregate reporting is also useful to build general awareness of the high cost of health care and price variation—information that forms the basis for generating change. The public would also benefit from the ability to compare the pricing of provider payments in the public sector (Medicare and Medicaid) with that of the private sector to limit cost shifting.

IV. What are the Main Obstacles to Price Transparency?

Despite a trend in favor of performance measurement, a number of health plans and providers are blocking the public release of data on prices.

The main challenge to price transparency is that many of the stakeholders controlling the data are hesitant to release it publicly due to their perceived concerns about losing competitive advantage. One way providers block use of their price data is by inserting "gag clauses" into their contracts with health plans. These gag clauses forbid disclosure of pricing, and sometimes quality, information to the public.

Some health plans assert that the prices they pay to providers are proprietary. They are concerned that if they reveal the rates they have negotiated with providers in a given community, their competitors will take advantage of that information and undercut them. Remarkably, even self-funded employers often cannot use or get access to their own pricing information, as many of their third party health plan administrators determine the data is proprietary.¹⁰

Market power dynamics play a significant role in the availability of information and the impact of transparency.¹¹ Dominant providers have the most leverage to limit the release or use of their data as described above. Additionally, payers have little leverage to negotiate lower prices or eliminate them from plan provider networks. If dominant providers are made aware that another provider in the area is being paid at a higher rate, they would attempt to match that price.¹² This was borne out in Massachusetts, where an academic medical center requested and received higher rates after data were published, revealing the disparity in payments across providers.^{13,14} Lower-priced hospitals in California had a similar reaction when a report released their relative actual costs. Therefore, any price transparency effort must also proactively address unintended consequences due to imbalanced market dynamics.

A second set of barriers relate to the limited number of meaningful performance measures based on price. Historically, cost of care measures focused only on one part of the cost equation—utilization. These measures use a standardized price multiplied by utilization to get an estimate of total resource use. A health plan can apply its own prices to utilization statistics to understand its total cost of care and some plans have taken positive steps to share this information with their members. Even so, getting to an exact price is not always

easy due to the complexity and lack of uniformity of provider–health plan contracts, each requiring a different pricing methodology.

Price information is seldom available for measures based on "bundles" of services or "total cost of care" for a patient or a group of patients. These bundles are needed in two forms to support patients considering a particular doctor, clinic, lab, pharmacy, hospital, or combination of providers. For episodic care needs, such as a surgery or treatment of acute bronchitis, the bundle needs to include the average total costs typically incurred for all care until the episode ends, including drugs, lab tests, and follow up visits. For chronic care needs, such as ongoing diabetes management, the bundle needs to include the average annual total costs for similar patients with that chronic condition.

Part of the challenge in developing price or cost measures and reports is the lack of infrastructure to collect, aggregate, analyze, and report the data. All-Payer Claims Databases (APCDs) are entities designed to collect health insurance claims across an entire state and can convert the claims data into information that can be used to monitor market trends and identify high- and low-price providers. Yet most states do not have an APCD. Efforts to build APCDs are hampered by a lack of funding, and in some cases, health care industry opposition to data sharing.

Key challenges:

- Contractual prohibitions on data use
- Market power imbalance
- Few meaningful performance measures focused on price
- Lack of infrastructure to aggregate and analyze price trends
- Misconception that price correlates with quality

Even when price information is available, challenges arise in providing support to users so they can interpret it correctly. If the price of a service is presented without any corresponding quality information, some consumers falsely assume that a higher price means a higher-quality service.¹⁵ Given the complexity of benefit designs and other variables impacting the price of a service, there will need to be a sophisticated education campaign surrounding any release of price data.

V. Policy Proposals: Advancing Price Transparency

State and federal governments must work with the private sector to ensure health care markets support consumers and purchasers using price information to make decisions.

Government has a role to play in correcting the market failures that have left consumers and purchasers without information they need to make smart health care decisions. The following principles should guide the development and implementation of any public policies related to transparency:

- Market forces (incentives, healthy competition, and consumer choice) are the engine for improvement, but there are important roles for government.
- Healthy competition among providers based on cost, patient experience, and health outcomes is the best way to drive innovation and improvement.
- A fundamental redesign of incentives for providers and consumers is needed; the current incentive structure does not promote accountability of actions that improve health and limit costs.

STATE-LEVEL POLICY SOLUTIONS

States have particular authority to address many of the barriers to price transparency. The following are specific policies states should pursue, based on the principles above:

Prohibit gag clauses States can ban contract provisions that forbid the disclosure of pricing information. In one example, California recently instituted a law stating:

No health insurance contract in existence ... between a health insurer and a provider or a supplier shall prohibit, condition, or in any way restrict the disclosure of claims data related to health care services provided to a policyholder or insured of the insurer or beneficiaries of any self-insured health coverage arrangement administered by the insurer.¹⁶

In another effort, they eliminated contractual barriers to the disclosure of price data to Qualified Entitiesⁱⁱ that report information publically.¹⁷

Create APCDs States can pass legislation to support the development of databases that require the provision of claims data with paid amounts, such as an APCD. More information can be found from the All-Payer Claims Database Council (<http://apcdcouncil.org>).

Require plans in the state insurance marketplace to submit claims data For states that do not have an APCD law, Qualified Health Plans participating in state insurance marketplaces or "exchanges" can be required to submit data to private databases in their state for the purpose of monitoring price variation, such as a regional health care improvement collaborative.

ii Qualified Entities are those [certified](#) to obtain standardized extracts of Medicare Parts A, B, and D data for the purposes of evaluation and reporting on the performance of health care providers and suppliers.

The link between price transparency and market power:

Health plans and providers in highly concentrated markets have leverage to raise prices and restrict the level of transparency. Effective policy solutions, therefore, need to both free price data and strengthen market competition.

Require plans in the state insurance marketplace to provide cost calculators One of the most effective tools available for consumers to understand their out-of-pocket costs are plan-specific cost calculators. These calculators produce estimates of provider-specific bundled prices to the consumer for whatever service the consumer is seeking.¹⁸ The [Catalyst for Payment Reform](#), working on behalf of purchasers to promote higher-value health care, provides a resource to ensure these and other transparency tools are most effective.¹⁹

Prohibit other anti-competitive practices Besides gag clauses, other problematic contractual terms include “most favored nation” clauses where health plans require hospitals to give the insurer the best price, and in some cases, to charge plan competitors much higher prices.²⁰ Providers have also leveraged this clause to charge plans higher prices if they contract with competing facilities.²¹ States can also take legislative action to ban “anti-tiering” clauses in provider contracts that prevent health plans from offering lower-cost products²² or require the plans to include all entities within a health delivery system in the top tier. States could also take on a market monitoring role and ask entities to justify rate increases above a certain benchmark, as is included in the new Massachusetts law.²³ Antitrust litigation is another strategy to prevent or break apart harmful market leverage.²⁴

FEDERAL-LEVEL POLICY SOLUTIONS

The federal government can help provide clarity regarding self-funded employers' access to their claims data. They can also use financial incentives to encourage states pursuing price transparency. More specifically:

Assert employers' rights to access and use their own claims data Self-funded employers assume they own the claims data relevant to their covered population, but some health plans have blocked employers' access to their claims data. The federal government could declare that self-funded employers have access to their own paid claims data under the Employee Retirement Income Security Act, thus invalidating provider gag clauses and health plan proprietary interests that prevent the sharing of price data with self-funded employers.

Use financial incentives to encourage states to improve transparency The Centers for Medicare & Medicaid Services (CMS) could offer grants or other financial incentives to states that take steps to improve price transparency by addressing anti-competitive practices or setting up infrastructure like an APCD. The federal dollars would reflect a national commitment to providing consumers with the information they need to make smart health care decisions.

There are additional actions federal and state governments could take to use price information to support the goal of cost containment. For example, CMS could publish episode-based total cost measures (based on Medicare paid claims) that reveal high- and low-performing providers. Once available, Congress could give CMS authority to revise payment to providers and design incentives for beneficiaries to catalyze a shift towards more efficient providers that deliver good health care.

VI. Required Complementary Purchaser and Health Plan Actions

Price transparency is necessary but not sufficient—purchasers and payers need to implement complementary incentives for consumers and providers.

While necessary, revealing the price of health care services will not be enough to drive the magnitude of change required to improve health care outcomes and reduce costs.²⁵ Price transparency is instead a foundational element that needs to be combined with the appropriate consumer and provider incentives. If consumers lack

adequate support and incentive to choose more efficient providers, they could choose instead on the basis of convenience or reputation.

Health plans should offer benefit designs that take advantage of price transparency and reward consumers for choosing the most cost-effective providers and treatments. Examples of such value-based benefit designs include reference pricing and tiered benefit structures. Reference pricing occurs where the health plan contributes a set amount toward the cost of a service and the beneficiary pays the remainder if they select a more expensive option. Tiering offers lower co-payment when consumers select providers or services that meet quality and cost-efficiency standards. Employers can facilitate the transition to value-based insurance designs by demanding such designs from plans that serve their employee population and showing a willingness to adopt them.

VII. Examples of Beneficial Uses of Price Information

Price transparency has already delivered value to areas that have successfully revealed prices to the public.

A number of states, private sector purchasers, health plans, and vendors have charted the path to price transparency for the rest of the nation. These practices should be expanded and built upon.

State examples The Catalyst for Payment Reform recently released public report cards on state legal efforts to reveal price information to consumers—only Massachusetts and New Hampshire received a grade of “A” and 29 states have no transparency laws.²⁶

- **Massachusetts** Through its MyHealthCareOptions website, Massachusetts allows consumers to compare prices and quality of physician practices and hospitals based on location or specific conditions and procedures.²⁷ Complementary legislation requires the collection and public reporting of cost and quality data for procedures and diagnostic tests.²⁸
- **New Hampshire** New Hampshire's Health Cost website provides the median price paid by a specific insurer to a specific provider for procedures related to preventive health, emergency visits, radiology, surgery, and maternity.²⁹ Research suggests that for such an effort to bring down prices, however, there needs to be greater market competition and benefit designs that reinforce a consumer's choice of a high-performing provider.³⁰

Employer examples Large employers have recognized the growing costs of health care and have made changes to their benefit designs to encourage high value choices.

- **Safeway** Safeway instituted a reference price in response to wide variation in the price for colonoscopies (ranging in California from \$900 to \$7,200). The employer reported saving an estimated 35 percent of costs by “encouraging employees to shop for similar quality, yet lower-cost colonoscopies.”³¹ Safeway estimates that comparably-sized, self-funded employers can conservatively save \$525 million over five years by pursuing similar reference pricing and other price transparency initiatives.³² Due to its early success, Safeway expanded reference pricing practices to advanced imaging and lab tests.
- **CalPERS** CalPERS identified more than a seven-fold difference in the price of hip and knee replacements across providers in its service region. Facing continuous price increases, CalPERS partnered with Anthem Blue Cross to develop a reference pricing design for knee and hip replacement surgery for beneficiaries in its PPO program. Preliminary analyses indicate that price per procedure decreased by more than 38 percent and volume at preferred providers increased by more than 19

percent.³³ Not only did employees migrate to the lower-cost providers but high-priced hospitals began to drop their prices, indicating healthy market competition.³⁴ CalPERS also expanded reference pricing to additional procedures including colonoscopies, cataract surgery, and arthroscopy conducted in outpatient hospitals.

Health plan and vendor examples Health plans and third party vendors have developed cost calculator tools to help consumers navigate the complex world of health care pricing.

- **Health plan cost calculators**³⁵ UnitedHealthcare provides a high-quality cost calculator that offers customized fee estimates across entire episodes and individual components for approximately 100 medical services. Aetna also has an online “payment estimator” that helps members understand provider-specific quality and estimated out-of-pocket costs for a more limited set of services.
- **Vendor cost calculators** Vendors such as Castlight, Compass, and ClearCost Health provide tools for employers, employees, and others to monitor the price variation in their populations and identify high-quality, low-cost plans and providers.³⁶

Each of these initiatives has raised the bar for providing critical information to consumers on the price and quality of care. However, none will have maximum impact alone. To realize true improvement requires a comprehensive solution that delivers the right price and quality information to consumers, purchasers, and providers, with the appropriate education and incentives, and a market that is primed to encourage healthy competition on the basis of performance.

For more information

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About the Pacific Business Group on Health

Founded in 1989, Pacific Business Group on Health (PBGH) is one of the nation's leading non-profit business coalitions focused on health care. We help leverage the power of our 60 large purchaser members who spend 12 billion dollars annually to provide health care coverage to more than 3 million employees, retirees and dependents in California alone. PBGH works on many fronts to improve the quality and affordability of health care, often in close partnership with health insurance plans, physician groups, consumer organizations, and others concerned about our health care system. To learn more please visit www.pbgh.org.

