Published in final edited form as:

JAMA. 2014 October 22; 312(16): 1631–1632. doi:10.1001/jama.2014.7105.

Providing Price Displays for Physicians: Which Price is Right?

Kevin R. Riggs, MD MPH^{1,2} and Matthew DeCamp, MD PhD^{1,2}

¹Division of General Internal Medicine, Johns Hopkins University School of Medicine, Baltimore, Maryland ²Johns Hopkins Berman Institute of Bioethics, Baltimore, Maryland

Price transparency is gaining momentum as one way to address the cost crisis in U.S. health care. Attention frequently focuses on patients' awareness of prices.¹ Less attention has been given to initiatives designed to increase physicians' awareness. Recent research demonstrates that displaying prices to physicians reduces expenditures^{2,3} and is well-received by physicians.³ Price displays are also being used to teach cost-consciousness in medical education.⁴

However, prices are notoriously variable, and "price" can have multiple potential meanings (e.g., cost of service provision, cost plus profit, charges, or expected reimbursement, among others). To illustrate, consider three general sources that might be considered for displaying the "price" of certain tests (Table). In this example, potential displayed amounts vary as much as tenfold.

Which "price" is right? Implementing price displays requires more than knowing only whether doing so effectively decreases expenditures. In this Viewpoint we suggest that several ethical values should be considered to guide the design and implementation of providing price displays to physicians. While recognizing its sometimes ambiguous use in this context, we refer simply to "price" throughout; our goal is to offer ethical clarity on choosing an amount to display.

Price Displays in Practice

In an ideal world, physician price displays may represent an attractive way to help control costs. Providing physicians with prices of interventions, tests, and treatments they order could facilitate physicians' increasingly recognized obligation to provide cost-effective, high-value care.⁵ Physicians already consider prices, but often with insufficient knowledge.⁶ Integrating price displays into computerized physician order entry (CPOE) at the point-of-care could help remedy this knowledge gap. Price displays also could potentially lead to reduced use of marginally beneficial interventions, thereby helping to prevent overtreatment, harms to patients from adverse events, or unnecessary costs. This information could facilitate physician-patient shared decision-making about treatment options and their potential effects on patients' health and non-health related values, including out-of-pocket

Correspondence Kevin R. Riggs, 2024 E. Monument Street, Room 2-612B, Baltimore, Maryland, 21287, kriggs3@jhmi.edu, Telephone: (443) 287-8517, Fax: (410) 955-0476.

The authors have no potential conflicts of interest to declare.

costs (i.e., the dollar amount they will ultimately pay). Also, because physicians retain control over the ordering decision, price displays should neither infringe physicians' professional autonomy nor impede fiduciary obligations to their patients.

The real world is far from ideal. Although price displays may preferentially decrease orders for harmful or marginally beneficial care, they could risk reducing beneficial care as well. In addition, although prices might be discussed with outpatients, such discussions may be less feasible or appropriate in settings (e.g., certain inpatient units, intensive care units, or emergency departments) where patients are potentially severely ill, the volume of orders is high, and patients' out-of-pocket responsibility is uncertain. In these acute care settings price displays operate at the physician level, encouraging clinicians to "think twice" before ordering daily labs, X-rays, etc., on patients' behalf. Nevertheless, several ethical values could guide decisions about which price to display and how.

Transparency

Independent of the price chosen, transparency requires informing physicians of the source of the price (eg, list price, Medicare fee). At the very least, reference to the source of the price should be shown alongside the price display. Ideally, health care organizations should also engage physicians in decisions about implementing price displays and other cost-containment initiatives.

Informing Patients

Because patient care could be affected by price displays, patients will be sensitive to the use of prices in clinical decision-making. Protecting patient autonomy requires informing patients that price displays are being used. This should ideally occur through physician-patient shared decision-making, in which the price of a service and its potential influence on a patient's out-of-pocket costs are discussed in conjunction with relevant clinical information, such as potential benefits and risks. Patients may be most concerned about these out-of-pocket costs; it may be desirable to program CPOE systems to display these out-of-pocket costs (analogous to current capabilities displaying patients' prescription drug formularies). Even patients not made aware of the use of price displays through shared decision-making (e.g., due to illness acuity) should be aware that such displays are in use generally. This could be accomplished via notification upon hospital admission, general notices within clinical settings, and/or other methods, perhaps as part of broader patient engagement efforts.

Protecting Well-being

If physicians order ever fewer tests as the amount of the displayed price increases, displaying higher prices creates a greater risk of patients not receiving beneficial services. For instance, a physician may order fewer daily chest X-rays when shown a price of \$385 as compared to a price of \$29. Protecting patients' well-being and physicians' obligations of beneficence may require an upper limit on the amount displayed. Although health care organizations might consider displaying the highest possible price to reduce utilization, physicians and patients could perceive this as dishonest; this may reduce the long-term

effectiveness of price displays. For example, list price may be easily programmable into an organization's CPOE; however, because this price is systematically and substantially higher than most other options (and is rarely, if ever, actually paid), displaying this price could create serious concerns about its use to change ordering practices.

Ensuring Fair Treatment

Fairness mandates that price displays should not systematically disadvantage certain patient groups. This is a concern for options that would display different amounts for different patients. Consider an organization that chooses to display the amount expected to be reimbursed from each patient or from his/her insurance company. These amounts will generally be lower than list prices, decreasing the risk of reducing potentially beneficial care, but will vary between patients. If displaying these prices affects ordering, certain patients could be unfairly treated. For example, if a physician ordering blood counts is shown amounts of \$11 for a Medicare patient, \$23 for a privately insured patient, and \$142 for an uninsured or self-pay patient, the uninsured patient may be least likely to receive the test, and this would violate fairness.

Variable pricing is particularly concerning when shared decision-making is more difficult (e.g., the ICU). In acute care settings, where discussions with patients about prices may be less feasible or appropriate, implementing prices displays may require special attention to fairness. Here a case might be made for displaying a standard reference price, such as the Medicare fee, for all patients. These amounts are publicly available and explicitly designed to represent true costs incurred by the hospital.⁷ Displaying the same amount for all patients could help ensure they are treated fairly.

Conclusion

Providing physicians with price displays that are transparent, inform patients, protect well-being and ensure fairness may be effective in helping to contain costs. A single "price" may not suit all clinical circumstances. Unanswered questions remain, such as whether displaying prices for all orders will cause physicians to ignore them eventually (limiting effectiveness) and should be limited to only specific orders (e.g., those ordered frequently or associated with high cost or marginal benefit). Future research should explore how physicians use different displayed prices across diverse clinical settings, including their influence on core ethical values.

Acknowledgments

The authors gratefully acknowledge helpful comments on previous drafts by Ruth Faden, PhD MPH, Craig Pollack, MD MHS, Alan Regenberg, MBe, and Jeremy Sugarman, MD MPH MA, all at Johns Hopkins University in Baltimore, MD. No compensation was received for their contributions.

All authors were responsible for the content and drafting of the manuscript. Dr. Riggs' work on this manuscript was funded by NIH Grant T32HL007180-38 and a Hecht-Levi Fellowship in Bioethics. The funding sources had no role in the design and conduct of the study, analysis or interpretation of the data, and preparation or final approval of the manuscript prior to publication.

References

1. Reinhardt UE. The disruptive innovation of price transparency in health care. *JAMA*. 2013; 310(18):1927–1928. [PubMed: 24219941]
2. Feldman LS, Shihab HM, Thiemann D, et al. Impact of providing fee data on laboratory test ordering: a controlled clinical trial. *JAMA Intern Med*. 2013; 173(10):903–908. [PubMed: 23588900]
3. Horn DM, Koplan KE, Senese MD, Orav EJ, Sequist TD. The Impact of Cost Displays on Primary Care Physician Laboratory Test Ordering. *J Gen Intern Med*. 2014; 29(5):708–714. [PubMed: 24257964]
4. Post J, Reed D, Halvorsen AJ, Huddleston J, McDonald F. Teaching High-value, Cost-conscious Care: Improving Residents' Knowledge and Attitudes. *Am J Med*. 2013; 126(9):838–842. [PubMed: 23968904]
5. Snyder L. American College of Physicians Ethics Manual: sixth edition. *Ann Intern Med*. 2012; 156(1 Pt 2):73–104. [PubMed: 22213573]
6. Reichert S, Simon T, Halm EA. Physicians' attitudes about prescribing and knowledge of the costs of common medications. *Arch Intern Med*. 2000; 160(18):2799–2803. [PubMed: 11025790]
7. Lee JS, Berenson RA, Mayes R, Gauthier AK. Medicare payment policy: does cost shifting matter? *Health Aff (Millwood)*. 2003; (Suppl Web Exclusives):W3-480–W3-488.

Table

Examples of possible prices (rounded to the nearest dollar)

Example Test / Order (CPT code)	Amount Displayed as the "Price"		
	List Price ^a	Reimbursed Amount ^b (<i>e.g., private insurer</i>)	Medicare Fee ^c
Complete Blood Count with Automated Differential (85025)	\$142	\$23	\$11
Urine Culture (87088)	\$163	\$40	\$11
Chest X-ray Two Views (71020)	\$385	\$56	\$29
MRI Brain With and Without Contrast (70553)	\$4704	\$1,183	\$538

^aFrom a Midwestern medical center with publicly reported list prices.^bBased on the "Fair Price" in the Healthcare Blue Book, which approximates an average amount from major insurance carriers (https://healthcarebluebook.com/page_Default.aspx)^cBased on 2013 Medicare National Limit Price (for the labs, <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html>) or the 2013 Medicare fee schedule for that locality (for the radiology studies, <http://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx>)
All sites last accessed June 9, 2014.