

REPORT CARD ON STATE PRICE TRANSPARENCY LAWS

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Roslyn Murray, MPP | Lea Tessitore, MBA, MSB

Andréa Caballero, MPA | Suzanne Delbanco, PhD | Amy Gu, JD | Jaime King, JD, PhD



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Dear Colleagues,

It has been a while, but Catalyst for Payment Reform (CPR) and the Source on Healthcare Price and Competition, at the University of California Hastings College of Law, are once again shining a spotlight on the efforts states across the country are making to help consumers readily find health care price information. We are pleased to announce the **sixth installment of the Report Card on State Price Transparency Laws**.

Since releasing the last [Report Card](#) in 2017, we looked forward to seeing how states would work to advance price transparency. Given that legislation and the development of transparency websites can take time, we were hopeful a hiatus in releasing Report Cards would give states time to progress – and we were not proven wrong!

A total of 16 states received passing grades, up from only seven in 2017. Ten states – Arkansas, California, Colorado, Connecticut, Florida, Massachusetts, Minnesota, New Mexico, Utah, and Washington – scored at least one letter grade higher in 2020 than they did in 2017 because they since passed price transparency legislation and/or created or improved a state-mandated transparency website. However, two states (Oregon and Vermont) fell by one letter grade since 2017 but still received passing grades.

To create the 2020 Report Card on State Price Transparency Laws, we leveraged The Database of State Laws Impacting Healthcare Cost and Quality ([SLIHCQ](#)), which we launched in 2019. SLIHCQ catalogues state legislation to contain health care costs and improve quality in a publicly searchable and sortable format. These laws impact provider market power, provider payment, provider networks, benefit design, and price transparency.

Lastly, we recognize that the landscape of price transparency is evolving and provides opportunities beyond just facilitating consumer shopping. The emergence of laws targeting surprise and balance billing, providing incentives for consumers to shop, increasing access to state APCD data, and shining a light on bad actors, among others, provide new ways for transparency legislation to benefit consumers and health care markets. While we have used our original criteria from prior versions for the 2020 Report Card, we plan to revamp the scoring criteria to reflect this ever-evolving landscape and ensure future Report Cards capture the latest trends and intentions of new price transparency legislation.

Sincerely,

Suzanne F. Delbanco, Catalyst for Payment Reform

Jaime S. King, University of California Hastings College of Law

INTRODUCTION

Consider the following:

8% The average share of U.S. household budgets devoted to health care in 2017.

18% The share of U.S. GDP spent on health care services in 2017.

55% The increase in average commercial premiums for a family of four from 2008 to 2018.

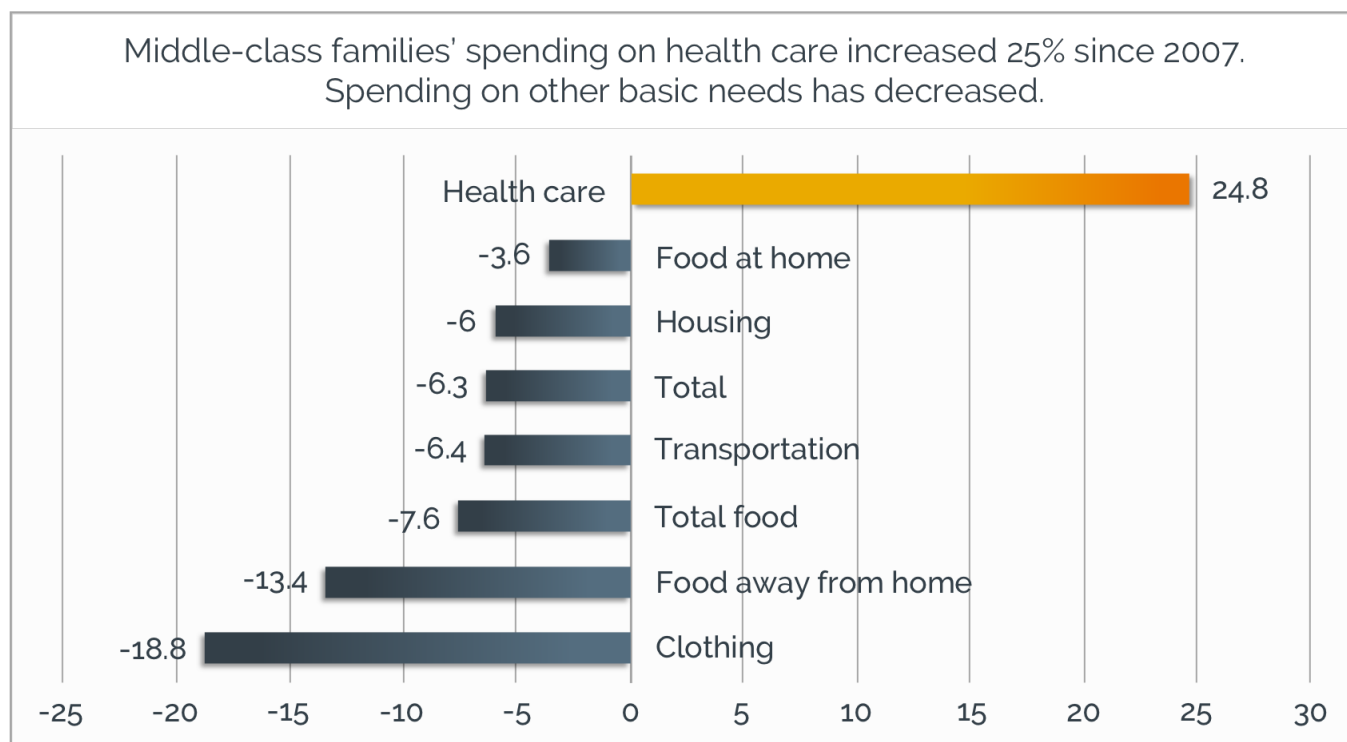
If there is one way these numbers are going, it is not down. Health care expenditures are rising, consuming a greater share of the U.S. gross domestic product (GDP) and American household budgets. Moreover, the U.S. spends far more on health care than other developed countries. In 2017, the U.S. spent 17.9% of GDP on health care services.¹ In comparison, Switzerland, the country with the second highest share, spent only 12%.²

On average, other developed countries spend about half as much per capita on health care than the United States.³ Health expenditures are also consuming a growing share of Americans' household funds. The average share of U.S. household budgets devoted to health care has increased from 5.2% to 8.2% over three decades, with premiums consuming a sizable portion.⁴ The average commercial health insurance premium for a family of four has increased 55% from 2008 to 2018, reaching \$19,616.⁵

Increasing health care expenditures are also affecting Americans' access to care, for both the insured and uninsured. In 2018, approximately 40% of Americans could not cover an unexpected \$400 expense without selling assets or borrowing money.⁶ In 2017, roughly 7% of insured adults and 28% of uninsured adults stated that they delayed or did not receive medical care due to cost.⁷ This trend will only continue to intensify Americans' financial burden, leaving little room for other critical needs, such as housing and food (Figure 1 below).



Figure 1. Percent Change in Middle-Income Household Spending, 2007-2014



Source: Brookings Institution analysis of Consumer Expenditure Survey, Labor Department

Research has uncovered, or perhaps confirmed, that prices in the commercial sector are the main driver of growing health care expenditures. The gap in spending between the U.S. and other high-income countries appears to be driven by the higher prices the U.S. pays for health care services.⁸ Further, the Health Care Cost Institute found that utilization in the commercial insurance sector declined by 0.2% between 2013 and 2017, while prices increased 17.1% – or 4% per year.⁹ Studies have highlighted the divergence of commercial sector prices from Medicare. In the late 1990s, inpatient prices in the commercial sector were 110% of Medicare's rates.¹⁰ In a 2019 RAND Hospital Price Transparency Study, researchers found commercial prices for hospital care up to 400% of Medicare payments, while the prices paid to hospitals for commercial patients averaged 241% higher than Medicare.¹¹

Commercial sector prices also vary widely from one another. A report CPR commissioned in 2010 found that average inpatient hospital payment rates ranged from 147% to 210% of Medicare across six cities; but, in some outlier cases, inpatient rates were as much as five times what Medicare paid.¹² Prices also vary significantly within states, markets, and hospitals. Average inpatient and outpatient prices in Colorado ranged from 159% of Medicare to 327% in 2017. Within Indiana, they ranged from 160% to 417%.¹³ Another study found that the hospital in the 90th percentile of prices in Philadelphia was more than two times as expensive as the hospital in the 10th percentile. The study also found substantial

price variation within hospitals for undifferentiated procedures where the provision of care should not vary across providers (e.g. lower limb MRIs).¹⁴

Research has pointed to an unprecedented growth in provider mergers and acquisitions starting in the 1990s, leading to high hospital market concentration, significantly reducing competition. More than 2,000 hospital mergers occurred in the last two decades.¹⁵ The market power that hospitals and health systems have amassed through these mergers gives them sizable leverage in price negotiations. Although Medicare and Medicaid set provider rates, providers can command higher prices from the commercial sector. As commercial sector prices continue to rise, Americans face an ever-increasing financial burden, passed on through cost sharing in the form of higher health insurance premiums and out-of-pocket costs.

In the **sixth installment of the Report Card on State Price Transparency Laws**, we highlight state approaches to make price information available to consumers and facilitate price shopping, as well as some key attributes of states with all-payer claims databases (see Appendices). However, we recognize that price transparency serves additional purposes, such as exposing extreme price variation, shaming grossly overpriced providers, promoting competition, and potentially lowering prices and generating savings for consumers. In future iterations we plan to incorporate criteria to assess states' efforts beyond promoting consumerism.

THE UTILITY OF PRICE TRANSPARENCY

Several studies have demonstrated that price shopping can promote competition and generate savings for consumers, but **consumer shopping is not the silver bullet** for America's health care cost issue.

As health care prices increase and consumers bear a growing financial burden, arming them with price information allows them to "shop" for lower priced providers or services. Theory suggests that providing consumers with information about how much they need to pay for any given choice will encourage them to select lower cost providers or services,

thus promoting healthy competition among providers and leading higher-priced physicians and hospitals to lower prices to avoid losing patient volume and market share.

Several studies have demonstrated that price shopping can promote competition, lead to price declines, and generate savings for consumers. A recent study examined the effect of New Hampshire's state-based website on prices and cost savings for outpatient medical imaging visits, finding that individuals saved \$7.9 million and insurers saved \$36 million over five years. The savings realized in New Hampshire were mostly generated by efforts on the part of high-priced providers to lower their prices to remain competitive.¹⁶ Further, in another study, when an insurer introduced transparency for elective advanced imaging procedures, the average cost of an MRI decreased by \$220 (18.7%). Plan members began receiving MRIs at facilities with lower average costs.¹⁷ Another study found that price transparency led to a 1% to 4% reduction in provider prices for homogenous services (e.g. lab tests) but no price response for differentiated services (e.g. office visits).¹⁸

While consumer shopping may put some downward pressure on costs, it is unlikely to lead to substantial system-wide savings. A recent survey found that only 3% of respondents compared provider costs before receiving care.¹⁹ This may be due to a lack of awareness that these tools exist, inadequate capabilities of these tools, or the fact that patients most often prioritize their physicians' referrals. Additionally, the availability of price information alone does not guarantee the consumer will make a cost-effective choice – when prices are not paired with quality information, consumers may assume a higher price equates to higher quality care. Even if consumers use price transparency tools, consumer shopping is not the silver bullet for America's health care cost issue.

ENCOURAGING GREATER USE AND SAVINGS

Benefit designs that offer transparent prices and incentivize consumer shopping could create incentives for consumers to use transparency tools. For example, the California Public Employees' Retirement System (CalPERS) implemented a reference pricing program that establishes a reasonable price for hip and knee replacements and requires public employees and retirees to pay the difference if they receive care from a provider that charges more than that price. A study evaluating CalPERS' program found that, after being exposed to the prices for joint replacement surgery, the number of enrollees who chose low-priced hospitals increased by 21.2% and those who chose high-priced hospitals declined by 34.3%.²⁰

Several states have started to implement "Right-to-Shop" laws, which offer financial incentives to encourage consumers to use price transparency tools when selecting providers or services. Rather than putting patients at financial risk for paying the difference, right-to-shop laws require that health plans offer consumers incentives to seek care from

lower cost, higher quality providers. Consumers that select lower cost providers can receive premium or out-of-pocket cost reductions.²¹ As these laws are only beginning, the jury is out on whether they will improve consumer use of transparency tools or generate cost savings, but this is likely an area to examine in future reports.

IMPORTANT COMPONENTS OF PRICE TRANSPARENCY LAWS

States continue to make efforts to provide more robust price information to consumers that they can use to shop. **States with high price transparency grades have rich data sources and supply meaningful price information** on a wide range of procedures and services through an accessible, publicly available website. They also meet the following characteristics:

RICH DATA SOURCE

States with rich data sources either compel providers and/or health plans to share price information or mandate an all-payer claims database (APCD) by law to procure health care price data. APCDs typically collect data from multiple payers, including commercial health plans, state employee health benefit programs, Medicaid, and Medicare (if available to the state), and sometimes self-insured employer plans,¹ among other sources. APCDs are widely considered to be superior data sources because they include actual paid amounts, not charges, which often differ significantly due to contracted or negotiated rates between payers and providers. In the absence of an APCD, providers typically only share charged amounts with states or consumers, making the information significantly less useful for comparisons.

¹ The Employee Retirement Income Security Act preempts APCD laws from applying to self-insured employer plans, so self-insured employers are not required to contribute data to state APCDs. Missing this information can prevent APCDs from accurately reporting market prices. In some states, self-insured employers voluntarily contribute claims data.

MEANINGFUL PRICE INFORMATION

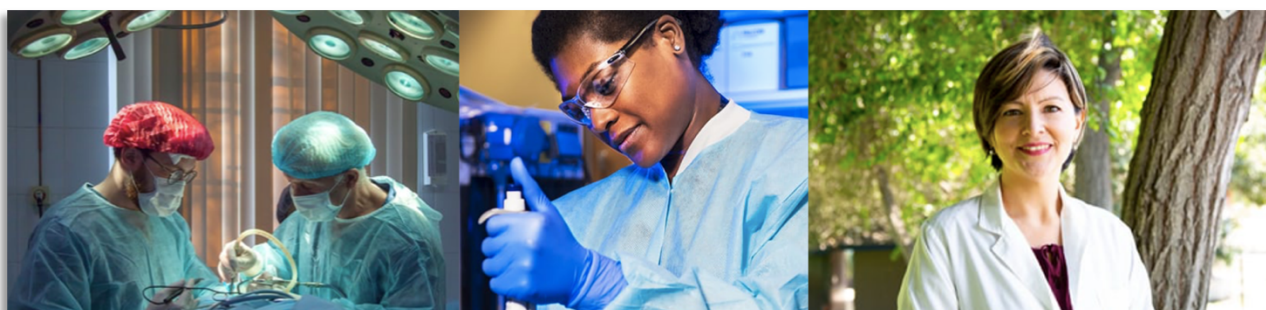
One criterion we use to grade states is based on the scope or the meaningfulness of their price data (we refer to this as “scope of prices” in our scoring). The amounts that payers actually pay providers – paid amounts – are much more meaningful than provider charges. In some cases, hospital charges can be ten times their costs.²² Therefore, payments are often negotiated discounts off of provider charges, so charges seldom reflect the true prices paid for services. Paid amounts reflect the actual price paid for the service and provide a more accurate basis for the full price or cost sharing the consumer will face.

SCOPE OF PROCEDURES AND SERVICES

A robust set of price data will include information on a wide range of inpatient and outpatient procedures and services, instead of just one or the other, or only a limited list of procedures and services. The availability of price information on a broad range of health care services makes it more likely that consumers will find information relevant to their specific needs.

SCOPE OF PROVIDERS

A robust set of price data will include information on physicians and hospitals, instead of just one or the other, or a subset of either (called “scope of provider” in our scoring). It is also more meaningful to see the entire price for a health care event or episode than to see only a hospital or facility price, or only a physician price for a specific service. A transparency resource that collects and displays only one or the other does not provide data complete enough to help consumers make informed decisions.



ACCESSIBLE, MANDATED WEBSITE

Having accurate and comprehensive price information is crucial, but consumers will not benefit if that information is not easily obtainable or is not presented in a consumer-friendly format. Some states require only that price information be provided through a report, or that the data be turned over to consumers only upon request. In contrast, accessible transparency resources will make the collected data available on a public website, and great ones will ensure that the website's content is current and online tools are intuitive and easy to use. In addition, websites mandated by legislation are less subject to the varying priorities or funding of the agency publishing it.

SCORING METHODOLOGY

To evaluate state price transparency laws and their implementation, we distilled the best practices described above into scoring guidelines. Please see **Appendix A** for the complete scoring matrix.

POTENTIAL AREAS FOR FUTURE CONSIDERATION

The landscape of price transparency is evolving and provides opportunities beyond just facilitating consumer shopping. While we have used our original criteria from prior versions for the 2020 Report Card, we plan to revamp the scoring criteria to reflect this ever-evolving landscape and ensure **future Report Cards capture the latest trends and intentions of new price transparency legislation.**

As states have recognized a variety of uses for health care pricing data that extends beyond consumer shopping tools, we will begin to evaluate state price transparency initiatives on a wider range of criteria. States have become very innovative in how they use APCD data and how they promote transparency. Below we list some of the criteria we plan to consider in future transparency Report Cards.

The 21 states with APCDs vary considerably in how they utilize their APCD data. Some APCDs only collect claims information but have little to no dissemination practices. Others display price information on state-based websites for consumers to use. Some allow researchers and policymakers to use the data to examine trends in health care utilization or prices, expose price variation, develop policy, or examine how the market is functioning. These and other use cases are highlighted in **Appendix B**.

Further, ease of access and affordability of APCD data can help researchers and policymakers expose the drivers of health care expenditures and the variation in prices, which can be important inputs for policymaking and for assessing the impact of policies. States have varying approaches to make data accessible for policy or research purposes. Based on research we conducted on the data access process, most of the 21 states with an APCD require those wanting to use the data to submit a request or application outlining how they intend to use it, which is reviewed and approved by the overseeing entity. Once approved, the requester must sign a data use agreement. The process can take anywhere from a few weeks to several months. There is also variability in the level of data accessible to researchers and policymakers (e.g. observations at the provider level). Some states have tighter restrictions on access to and use of APCD data in response to concerns about how data will be shared, making these states' APCDs less helpful for research or policy purposes.

In addition, CPR may also consider the following in future Reports Cards, acknowledging that there are unique challenges associated with tracking and grading these aspects:

- Laws targeting surprise and balance billing;
- Laws creating incentives for consumers to shop (e.g. right to shop laws);
- State activity to draw attention to outliers on price and anticompetitive activity;
- Whether data are available to researchers at the provider level; and
- Examples of how states are using APCD data to inform policy.

THE GRADES

The states that scored high in this year's Report Card are those with **robust price transparency laws in place and useful resources for consumers**, such as mandatory websites that display price information at no charge and in a consumer-friendly format.

HIGH SCORERS

This year, six states were high scorers, receiving an A or a B. These states have consistently scored high in past Report Cards. **Maine** and **New Hampshire** both received an A this year, as they had in 2017. **Maryland** also received the same score – a grade of B – as it did in 2017. Three states – **Colorado**, **Connecticut**, and **Massachusetts** – improved their scores from 2017, earning themselves a B for this year's Report Card. Colorado and Connecticut improved their scores from a C and an F, respectively. Colorado improved its consumer-facing website, earning it a grade higher than in 2017. Connecticut has since passed legislation mandating a consumer-facing website. Its website provides a reliable and easy to use source of health care prices for consumers, boosting its score to a B. Massachusetts also received a B this year because the state re-implemented its consumer-facing transparency website, which was out of commission for several years.

MIDDLE OF THE PACK

Ten states received a C or a D this year. Most of the grade improvements (from an F) were due to the implementation of a state all-payer claims database and whether the state had a consumer-friendly, state-mandated website. **Minnesota**, for example, has had an APCD in place for some time, but it finally established a consumer-facing website using the APCD data, earning it a C. **New Mexico** only just established an APCD in 2019, bumping the state's grade up to a C. While New Mexico has had a state-mandated website for some time, the website only displays Medicaid data; however, there seem to be intentions to add commercial data as well. **Oregon** dropped from a B to a C due to the increased granularity of CPR's website grading process this year. **Virginia's** grade, a C, did not change.

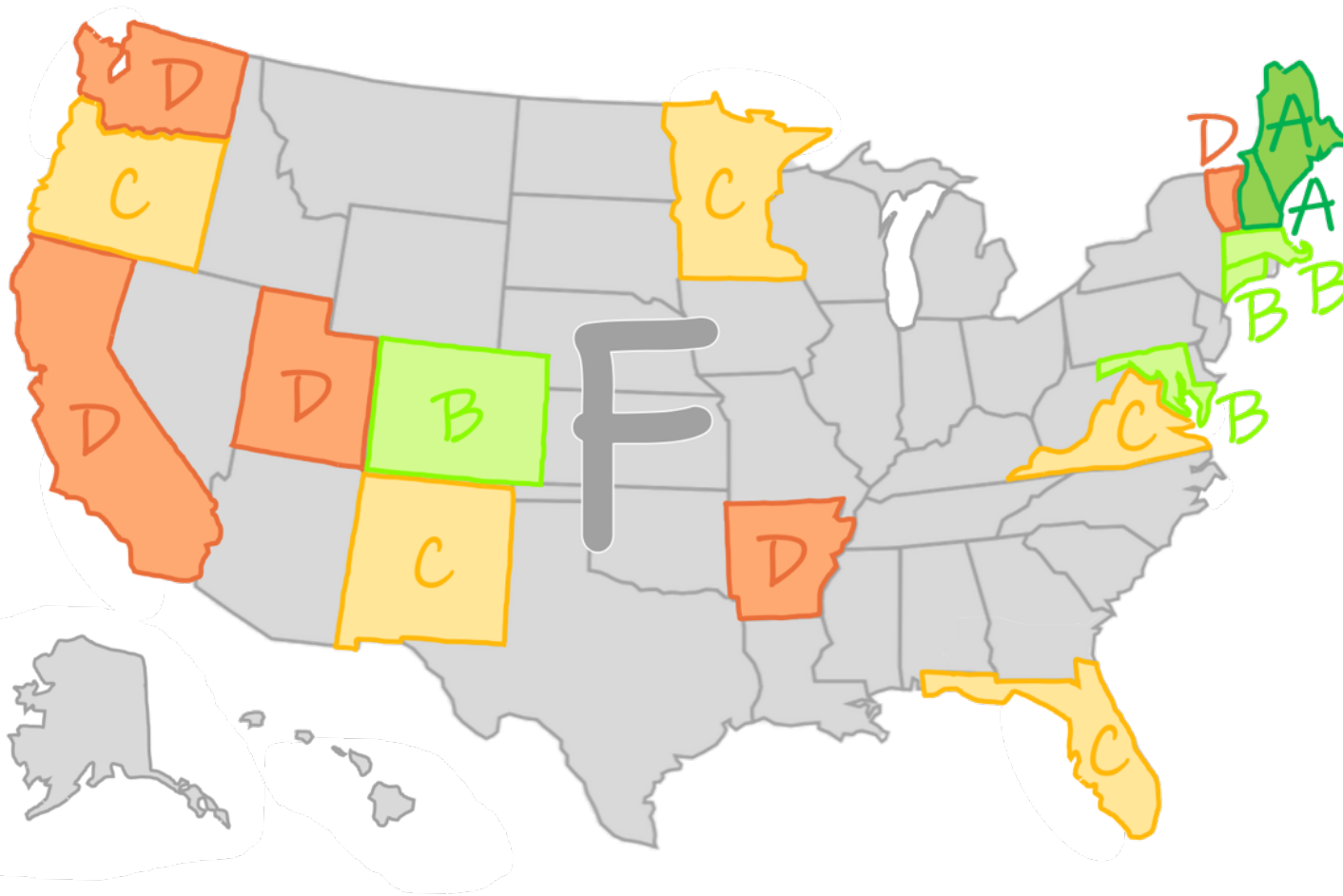
Arkansas, California, Utah, and Washington all improved from an F to a D (or an F to a C for Florida) this year because they either established an APCD or they instituted a state-based website through legislation. Vermont lost a letter grade (from a C to a D) because the consumer-facing website went dark.

FAILING STATES

A total of **34 states received failing letter grades** because they either did not have an APCD or they did not mandate consumer-friendly, public-facing price transparency websites.

GRADE	STATES	
A	Maine New Hampshire	
B	Colorado Connecticut Maryland Massachusetts	
C	Florida Minnesota New Mexico Oregon Virginia	
D	Arkansas California Utah Vermont Washington	
F	Alabama Alaska Arizona Delaware Georgia Hawaii Idaho Illinois Indiana Iowa Kansas Kentucky Louisiana Michigan Mississippi Missouri Montana	Nebraska Nevada New Jersey New York North Carolina North Dakota Ohio Oklahoma Pennsylvania Rhode Island South Carolina South Dakota Tennessee Texas West Virginia Wisconsin Wyoming

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GRADE	STATES	
A	Maine	
	New Hampshire	
B	Colorado	
	Connecticut	
	Maryland	
	Massachusetts	
C	Florida	
	Minnesota	
	New Mexico	
	Oregon	
	Virginia	
D	Arkansas	
	California	
	Utah	
	Vermont	
	Washington	
F	Alabama	Nebraska
	Alaska	Nevada
	Arizona	New Jersey
	Delaware	New York
	Georgia	North Carolina
	Hawaii	North Dakota
	Idaho	Ohio
	Illinois	Oklahoma
	Indiana	Pennsylvania
	Iowa	Rhode Island
	Kansas	South Carolina
	Kentucky	South Dakota
	Louisiana	Tennessee
	Michigan	Texas
	Mississippi	West Virginia
	Missouri	Wisconsin
	Montana	Wyoming

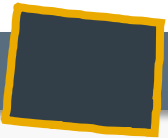
APPENDIX A – LEGISLATION SCORING RUBRIC

To evaluate state price transparency laws and their implementation, we distilled the best practices described above into scoring guidelines.

TOTAL SCORE FOR STATE PRICE TRANSPARENCY	150
LEGISLATION SCORING RUBRIC	
State has legislation that mandates the creation of an APCD	50
State makes any form of health care price information available to consumers	50
Ability for patient to request price information prior to rendering of services	10
Scope of price	4
Paid amounts (4) Charges (1)	
Scope of services	3
All IP and OP (3) All IP or OP (2) Most common IP or OP (1)	
Scope of health care providers	3
All hospitals and physicians (3) All hospitals or physicians (2) Subset of hospitals / physicians (1)	
Provision for publishing a public report on health care prices	10
Scope of price	4
Paid amounts (4) Charges (1)	
Scope of services	3
All IP and OP (3) All IP or OP (2) Most common IP or OP (1)	
Scope of health care providers	3
All hospitals and physicians (3) All hospitals or physicians (2) Subset of hospitals / physicians (1)	
Provision for posting health care prices on a public website	30
Scope of price	12
Paid amounts (12) Charges (3)	
Scope of services	9
All IP and OP (9) All IP or OP (6) Most common IP or OP (3)	
Scope of health care providers	9
All hospitals and physicians (9) All hospitals or physicians (6) Subset of hospitals / physicians (3)	
WEBSITE SCORING RUBRIC	
State has a publicly accessible, mandated website	50
Scope of Content: Contains broad scope of price, providers, and services	12.5
Ease of Use: User-friendly interface, intuitive design	12.5
Utility: Facilitation of provider selection	12.5
Timeliness / Accuracy: Reliability and currency of data	12.5

APPENDIX B – STATE APCD USE CASES

States are using APCD data in a variety of ways – not just to develop consumer price-shopping tools. These other uses can help inform stakeholders about cost, utilization, and quality trends. They can also help policymakers when designing legislation, or researchers or payers when evaluating a particular reform or program. Some examples of these use cases are provided below, although the list is not comprehensive. This information is sourced from the All-Payer Claims Database Council's APCD Showcase (<https://www.apcdshowcase.org>).



COLORADO

Beyond general cost, utilization, and quality reports, Colorado uses its APCD to assess price variation across the state.²³ In addition, the Center for Improving Value in Health Care (CIVHC) used APCD data to assess what commercial insurers pay hospitals as a percentage of Medicare. CIVHC found tremendous variation across counties – ranging from 115% to 576% for inpatient and outpatient services. Their analysis was based on the RAND Hospital Price Transparency Study.²⁴



MARYLAND

Maryland used its APCD data to assess the impact of a law implemented to reduce patients' financial burden when they receive care from out-of-network providers, called the Assignment of Benefits and Reimbursement of Nonpreferred Providers law (enacted July 1, 2011).²⁵



MASSACHUSETTS

The Massachusetts Health Policy Commission (HPC) uses APCD data to review market transactions and to monitor health care cost growth. The HPC conducts Cost and Market Impact Reviews, which are reports that assess the market impact of proposed mergers, acquisitions, or new affiliations. These reports inform the Massachusetts Attorney General or other state agencies.²⁶ Further, the HPC conducts Annual Health Care Cost Trends Reports, which examine annual trends in health care spending and delivery in Massachusetts, evaluate areas of progress, and recommend strategies to increase health care quality and efficiency.²⁷



MINNESOTA

The state of Minnesota is primarily using its APCD to analyze cost, utilization, and quality variation, as well as to evaluate certain state reforms or programs.²⁸ For example, the state uses the APCD to evaluate the performance of its patient-centered medical home initiative, the Health Care Homes program.²⁹ The state also used the APCD to evaluate the State Innovation Model (SIM) testing grant, which provided funding to support Minnesota's efforts to improve health care payment and delivery systems. The evaluation found that the SIM grant expanded the state's Medicaid accountable care organization project and increased the number of providers participating in alternative payment models.³⁰



NEW HAMPSHIRE

According to an interview that we conducted with the New Hampshire Department of Insurance, the state developed network adequacy laws – using the APCD – to see which providers are performing certain services, which kinds of providers can perform them (e.g., nurse practitioners, behavioral health providers, etc.) and how far people are traveling to seek care from those providers. The state also developed laws around balance billing. It considered using the data for the state's Certificate of Need program, but New Hampshire repealed the law in 2016.



OREGON

The Oregon Health Authority – the entity operating the state's APCD – is required by law to evaluate the effectiveness of the state's efforts to promote and sustain an adequate health care workforce. The state contracted with The Lewin Group to study Oregon's efforts, finding that its programs increased the size and longevity of the provider workforce in rural areas. The state is also required to use the APCD to develop payment recommendations for services that patients receive out-of-network at in-network facilities.³¹



WASHINGTON

Washington used its APCD data to develop a health measures dashboard, which compares statewide and community-level performance on certain HEDIS measures related to prevention, access, and overuse. It also examines the prevalence of certain chronic conditions in the state and the relationship between certain socioeconomic characteristics and health.³² The Washington Health Alliance also used APCD data to track commercial patient utilization of the 47 most overused treatments. It found that approximately 45.7% of services (\$282 million) were deemed wasteful or likely misused.³³



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