Healthcare Price Transparency: Data Overview and Best Practice

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March 10, 2025

Note: Please see my 1st video for **research summary** and implications for **policy** and **employer strategy**.

Scope of the 2 Price Transparency Data

	Hospital Disclosed Data ¹	Insurer Disclosed Data ²
Federal regulation (effective date)	Hospital Price Transparency Rule (initial Jan 2021, updated on Jan 2025)	Transparency in Coverage (TIC) Final Rule (July 2022)
Who disclose price?	Hospitals	Commercial insurers/plans
Provider service setting	Hospital facility	Hospital and non-hospital facilities; Professional services
Typical procedures	CMS-designated 70 shoppable services; emergency room visits	Common hospital and non-hospital services, physician care
Type of price (by market segment)	Chargemaster (list) prices; Negotiated prices in commercial market, Medicare Advantage, and Medicaid Managed Care; Cash prices;	Negotiated prices in commercial market
Measure of price value	Hospital – Service – Insurer – Plan	Provider – Service – Insurer – Plan

Data Strengths

- 1. Enormous and representative price information ³
 - Hospital: 83% of the 5,000+ hospitals nationwide
 - TIC: 200+ insurers, including the 5 national carriers (BCBS, CVS, Cigna, Elevance, United Healthcare)
- 2. Granular price measure identifying individual 4
 - Provider (facility, clinician)
 - Service (DRG, CPT/HCPCS)
 - Insurer, plan
- 3. Publicly available; Up-to-date disclosure
- 4. Price values for common services consistent with commercial claims data ⁵

Data Limitations⁶

- 1. Subject to disclosure compliance, potential measurement errors
 - e.g. prices disclosed by providers not delivering such service (zombie rates)
- 2. Not all prices are directly comparable
 - not dollar-based prices, not fee-for-service mechanism
- 3. Lack of non-pricing information
 - utilization, quality, patient characteristics
- 4. Data has enormous size and complicated structure
 - require significant computational resources for data storage, process, and analysis

Best Practices for Analysis

- 1. Start with prices for common procedures, disclosed by major insurers, or larger hospitals ^{7,8,9}
- 2. Standardize prices at provider procedure insurer level, using median prices if multiple values^{9, 10,11} Then go to more granular level, if needed.
- 3. Trim-off extreme price values (e.g. top and bottom 1%) 8,9,12
- 4. Regression analysis:
 - Log-transformed model to address the right skewness of prices 8,12,13
 - Fixed effects at service, insurer, provider, or geographic level to adjust for covariates ^{7,8,10-13}

Best Practices for Analysis

- 5. Validation (price, provider, insurance). Merge with external data for non-pricing measures:⁷⁻¹³
 - Provider characteristics
 - Insurance enrollment
 - Utilization and quality outcomes
 - Aggregated area-level patient information

These practices also apply to general healthcare pricing analysis using other data sources (e.g. insurance claims).

Contact & Disclaimer

Contact me if you want to discuss more about data, research, or application:

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My research is funded by Arnold Ventures, and in collaboration with Dr. Ge Bai, Dr. Gerard Anderson, and other members from Johns Hopkins – Arnold Venture lowering private sector healthcare price grant.

Information and opinions expressed here are my own and not necessarily those of Johns Hopkins University or Arnold Ventures.

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