Let's Put an End to What Blocks Providers and Patients from Controlling Health Care Costs

written by Theresa Hush | June 19, 2025

We often blame providers for not controlling health care costs. We also put the onus on patients who overuse care inappropriately and make bad choices. But the fact is that control of health care costs is extremely complicated, and we have effectively blocked both providers and patients from controlling health care costs.

Since the birth of managed care, providers and commercial health plans have been sparring over money and access to patients. Every health plan renegotiates its payment rates with providers on a contract schedule. Insurers try to hold down the payment rates based on a variety of factors—how important the provider is in the local market, the provider's cost profile, quality, and so on. Providers gauge the importance of the payer to their revenues, evaluate payer claims denials, and calculate related administration costs.

Price Negotiations and Lack of Price Transparency Have Cost Us All

Providers and payers have alternately won and lost in negotiating prices, but the negotiation process itself has cost plenty—to patients, employers, government, and society. It has driven health systems and the health insurance industry each to consolidate, in order to overcome the advantage gained by the other, raising and not lowering costs. It has also raised administrative costs for the whole system to manage the rate structures, contract management, billing, coverage and medical necessity policies, patient eligibility, and administrative machinery.

For several years, the system of rate negotiations between payers and providers has also stood in the way of two key paths to control the cost of health care. The first is price transparency to patients, necessary for making decisions about their care. Insurers don't want patients to have access to that information because true transparency would reveal their negotiated rates, which would damage their negotiating position and standing with employers.

The second problem is insurers' unwillingness to provide detailed digital claims data to providers for all services generated for their patients, so that providers can better create strategies to control the cost of patient care. This is data that would help everyone achieve the benefits of lowered costs, but that's not a priority for insurers, because making that data available to providers would be a disadvantage to rate negotiations.

Let's examine what makes this negotiated data so important for providers to be able to control costs.

Value-Based Care Requires Data-Driven Strategies to Control Costs

Every aspect of Value-Based Care depends on using data to measure and improve performance, whether in cost or quality.

Payers (except for CMS for specific value-based payment models), resist providing digital claims data that extends beyond the services of the specific provider. They often have dedicated payer portals whereby providers look up reports on their costs, and often this data is aggregated and benchmarked. It does not permit line-item cost details that could be plugged into providers' databases and integrated with EHR data.

Providers are blind to services outside their own and often blind to diagnoses and other conditions that patients may have. Although large EHR companies, like Epic and Health Information Networks, have created capacity to identify patients across systems, this is lacking in cost information and details of service that would help providers identify cost drivers, see complications and other detail in patients' histories, and import this data into Value-Based Care platforms used for managing costs. The data is geared to individual clinician management of patients at point of care, not for analysis of care costs.

As a result, providers' ability to develop cost strategies is impaired, and they cannot fully evaluate cost drivers, utilization, complications, and comorbidities in their patient data.

Key Elements of Data-Driven Cost Strategies

Managing cost of care through data-driven strategies is novel for providers. In the past, cost reduction strategies focused on inputs to care, not the cost to payers and patients. Addressing input costs (e.g., salaries, medications, anesthesia, equipment) can help reduce overall costs, but these are usually one-time fixes. They also don't transfer to pricing or negotiated payments of providers for patient care. Health care costs equal those paid out by payers *and* patients, collectively known as the total cost of care (TCoC), or per patient costs of care (PPCC).

Lowering TCoC requires reducing resource use through *improvement* in patient care. It's a complex process to ferret out the causes of escalating costs. It is not helpful to compare pricing, which bears a tangential relationship to the direct cost of care for any patient. The most effective way to analyze TCoC is to compare actual patient cases for a given condition, treatment, or procedure, in order to evaluate the differences in costs and the component costs. Episodes of care, the analytics vehicle for looking at patient cases, requires longitudinal clinical data from the EHR and complete transactional claims data for the patient.

Without claims data from payers, providers are missing a huge piece of information for analytics that see cost and patient outcomes in the same episode. This is critical because a second, ineffective method to reduce resources is to provide poor care. Poor care will result in higher costs, either immediately or over time, as evidenced by patient safety events, unsupported diagnoses, complications, and disease progression.

The broad adoption of EHRs and mandatory quality reporting has increased adoption of digital health records throughout the health systems, and fortified providers with high quality clinical data. This empowers providers to use analytics and data-driven solutions.

But if providers can't see the full picture of a patient's health, they are hampered from tackling costs along with quality. The cost and services detail that comes from payer claims completes the patient profile by adding history, other provider information, and services. Clinical and claims sources together unlock the power of provider strategies to control cost of care.

Three Possible Solutions to Break the Impasse

Both payers and providers could benefit from reducing cost of care, but they're stuck. Providers have the most to gain by trying to resolve the issue, since risk reimbursement will put them at a huge disadvantage without the tools to manage costs. Here are three strategies that may help

1. Use a third party to aggregate the payer data.

Your data vendor already has your trusted EHR data. If that vendor also has the experience and ability to craft Value-Based Care Episodes in a way that can satisfy payer concerns by bundling some of the Episode costs without destroying integrity of the cost investigation, this is much to your advantage.

2. Use standardized fee schedules, like CMS, for cost data.

This option is of much lower value to cost investigation. But it does enable the development of clinically focused episodes based on EHR clinical and transactional information, so that analytics can be very informative to physicians on cost variation and other outcomes data. Patient admissions and ER use will still be included in the same record, as will prescribed medication data, but without cost data. Regardless, it is a good beginning step because the construction of an episode is complicated, requiring many decisions on inclusions and exclusions of data. Creating such episodes and later incorporating claims data is an advantageous strategy.

3. Negotiate specialty projects with payers for collaboration over shared claims data for patients in project cohorts.

This could be a solution for specialty-rich organizations to streamline and collaborate on specialty cases that frequently have claims denial issues. If providers can work out a solution to payer issues and achieve the ability to build cost control strategies based on improved dialogue and agreement on clinical pathways, this could provide an opportunity for both providers and payers. It might also help to chip away at payer hesitation to share claims data in the future.

The current CMS administration has reinforced the concept of price transparency for patients for both payer and provider data. Does this signal that, perhaps, current payer resistance to price transparency will no longer be tolerated? Probably so. Now is a good time for providers to be seriously waging a new collaboration with payers. It would be in everyone's best interests.

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