CATALYST FOR PAYMENT REFORM

Price Transparency

An Essential Building Block for a High-Value, Sustainable Health Care System

Action Brief

INTRODUCTION

As health care costs continue to rise, purchasers remain focused on strategies that can help to bring costs under control. These pressures have facilitated a movement by many purchasers to engage consumers – their employees and their dependents – more fully in their health care decisions, including taking on a greater share of their health care costs. In their efforts to manage costs, health care purchasers, including large employers and states, recognize consumers need information on both health care price (particularly a consumer's expected out-of-pocket contribution) and quality (especially outcomes measures and other measures of safety, effectiveness, timeliness, efficiency, and equity),[1] along with the right incentives to seek higher-value care. In recent years, information about quality has become more transparent; however, meaningful price information is still difficult to obtain.[2] Purchasers, plans, and providers need to do more to advance price transparency and to marry price and quality data together to help consumers assess their treatment options.

What is price transparency? Why should purchasers push to make price and quality information public? What are some of the existing tools and strategies in the current marketplace and their limitations? This Action Brief examines these questions and provides purchasers with concrete ways they can foster transparency, which in turn can help catalyze much needed reform in our health care system.

WHAT IS PRICE TRANSPARENCY?

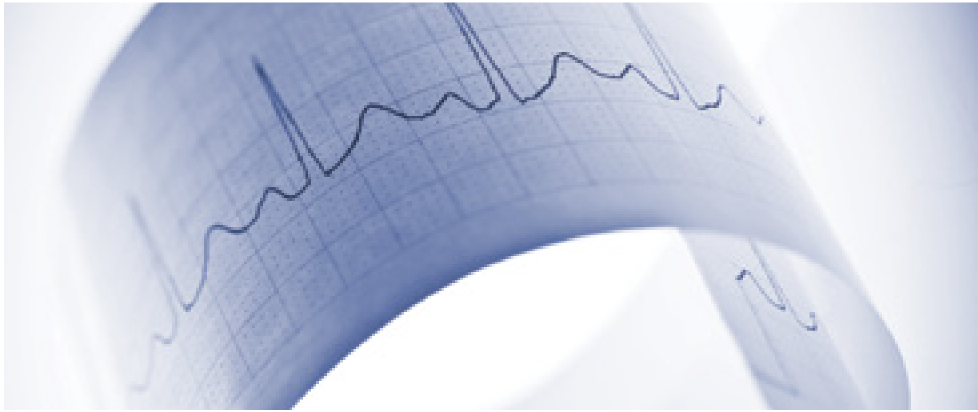
Depending on who you talk to in health care, "price transparency" can have many different definitions. For the purposes of this Action Brief, Catalyst for Payment Reform (CPR) defines price transparency as "the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties."[3]

Price is defined as "an estimate of a consumer's complete health care cost on a health care service or set of services that 1) reflects any negotiated discounts; 2) is inclusive of all costs to the consumer associated with a service or services, including hospital, physician and lab fees; and, 3) identifies the consumer's out-of-pocket costs (such as co-pays, co-insurance and deductibles)."[4]

The price a consumer pays for a particular service depends on a number of variables

PRICE EXAMPLE: An insurer has negotiated a rate of $1,000 with a particular in-network provider for a chest MRI, and therefore, the cost is $1,000. A consumer has $200 remaining to meet his/her deductible and the coinsurance is $160; the individual is responsible for $360 and the insurer pays $640. In this case the consumer's "price" for the MRI is $360. Price transparency exists when, for example, prior to seeking care, a consumer knows his price will be $360 for that particular provider and can compare the price for chest MRIs with other providers.

It is also important for consumers to understand the total payment for the service, including what the plan (or purchaser) pays and the remaining price they owe for that service. This broader context is important as we inform consumers about the total cost and price of specific health care services as they make decisions and seek care in the health care system.



Some of the most promising payment reform approaches such as reference and value pricing cannot be implemented effectively without price transparency.

including whether that consumer is insured or uninsured and whether the provider who performs the service is "in-network" or "out-of-network." For uninsured consumers, the price for a service is always the same as the total payment a provider receives. For insured consumers who have not yet met their deductible or are visiting an out-of-network provider when their health plan has no out-of-network benefit, the price of care is also the same as the total payment to the provider. However, for insured consumers visiting an in-network provider, the price of care will often represent only part of the payment for that care; the insurance plan will pay the rest. Regardless of the arrangement, the "price" as understood herein is the amount of payment for which the consumer is responsible. Despite one's insurance status, however, it is important to note that maximizing the consumer benefits of price transparency will require attention to medical literacy issues, including the fact that it can be very challenging for most health care consumers to understand medical terms as well as how health care payment works, including their own insurance benefits and billing.

WHY SHOULD PURCHASERS SUPPORT TRANSPARENCY?

Purchasers and consumers need transparency for three primary reasons: (1) to help purchasers contain health care costs; (2) to inform consumers' health care decisions as they assume greater financial responsibility; and, (3) to reduce unknown and unwarranted price variation in the system.

PURCHASER COST SAVINGS Based on a 2012 report, health care costs rose only 5.4% in 2011 because of benefit plan redesign and increases in employee contributions. Without changes to plan design and increases in employee contributions, "average cost trends would have been 8% in 2011 and anticipated to be only slightly lower (7.4%) next year."[5] Another recent report indicates that large employers expect health care costs to rise by 7% in 2013.[6] While this stabilization in trend may be a testament to the impact of current efforts, health care costs are still growing at about twice the rate of the general Consumer Price Index; in fact, health care cost trends have outpaced wage growth for more than a decade.[7]

To address these trends further, many purchasers are implementing a variety of cost containment strategies, including care management of high-cost patients, reference pricing, centers of excellence for high-cost, complex services, and other strategies including wellness incentives and more extensive coverage of preventive care. Purchasers aiming to manage health care costs by implementing these payment reforms and benefit design changes will find price transparency essential to their strategies. Some of the most promising approaches such as reference and value pricing cannot be implemented effectively without price transparency.[8]

SUPPORTING CONSUMERS AS THEY ASSUME GREATER FINANCIAL RESPONSIBILITY As health care costs continue to rise, most purchasers are asking their consumers to take on a greater share of their costs, including both health insurance premiums and out-of-pocket expenses. According to the Kaiser Family Foundation, consumers pay 47% more for coverage than in 2005 while wages have only increased by 18%.[9] Furthermore, 34% of employer-sponsored plans have a deductible of $1,000 or more for single coverage, more than three times the average in 2006. Enrollment in consumer-driven health plans (CDHP), such as health savings accounts (HSAs), has risen to 19% of all employer-sponsored plans, making them the second most popular plan type after traditional PPOs.[10] According to an American Association of Preferred Provider Organizations (AAPPO)-commissioned analysis of the Mercer National Survey of Employer-Sponsored Health Plans, 61% of *large* employers and 48% of *all* employers expect to offer CDHPs five years from now. These trends, coupled with overall increases in health care expenditures, mean consumers now spend $312 billion out-of-pocket annually.[11] Even with the Patient Protection and Affordable Care Act's (PPACA) pending guidelines on the maximum deductible and out-of-pocket expenditures for family coverage at $4,000 and $11,900 respectively, these trends will still continue.[12]

Despite taking on a greater share of their health care costs, consumers cannot be prudent health care shoppers without information on quality and price. Consumers research quality and prices regularly for a variety of goods and services, from cars and washing machines to mechanics and restaurants. Research[13] – and common sense – indicates they need and want easy-to-understand, quality *and* price information about their care. Consumers seeking non-urgent care would benefit the most from access to price and quality information because they have time to examine data and make decisions about predictable services, unlike in emergency situations.[14] And consumers have proven that when they have price and quality information, they in fact make strong decisions based on value. Research shows that when they have access to well-designed reports on price and quality, 80% of consumers will select the highest-value health care provider.[15]

REDUCING UNWARRANTED VARIATION Several health care researchers have examined the topic of price variation and found that significant price variation exists for hospitals and physician services across markets and even within markets. Without transparency, those who use and pay for care may be unaware of the range in potential costs and what little relationship price has to quality. In extreme cases, some hospitals command almost 500% of what Medicare pays for hospital inpatient services, and more than 700% of what Medicare pays for hospital outpatient care.[16] Variation in payment to providers can be as much as ten-to-one for services like colonoscopy and arthroscopy

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The implementation of a transparency tool with consumer adoption and behavior change can provide cost reductions for purchasers. For example, a purchaser with a median health care cost trend and 20,000 consumers could expect to save $6.7 million of health care spending over three years. This projection is based on consumer adoption rates of 10% in the first year to 50% by the third year.[17] Coupling transparency with related benefit strategies has proven even more effective. CalPERS instituted limited price transparency and reference pricing with high-quality medical centers for hip and knee replacements and estimated $16 million in savings in 2010.[18]

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in a single geographic area.[19] Studies on price variation suggest that it is largely due to provider market power resulting from "must have" status in a network, unique service offerings, and/or size.[20] The recent trend in provider consolidation has given some provider systems even greater market power relative to their peers.[21] Recent reports from the Health Care Cost Institute show a 4.6 percent increase in private spending over 2010-2011, due almost wholly to higher prices, not utilization or the intensity of services.[19] Without price transparency, it is difficult for anyone to understand the extent of price variation, its causes, or the ability of purchasers to address the problem.

WHAT ARE SOME OF THE EXISTING EFFORTS ON PRICE TRANSPARENCY?

Health plans, with their extensive data on claims, contractual reimbursement, credentialing and quality information, may be best positioned to disclose price and quality information today. Some health plans are trying to offer members access to shopping and transparency tools; however, many of these tools are currently limited in their scope and in the specificity of provider prices. This is partly due to pressure from the providers with whom they negotiate, operational challenges with respect to the data, and limitations of existing consumer portals. The additional presence in the market of other independent vendors developing similar tools is also likely spurring the creation of better tools at a faster rate. States and the federal government may also take steps to move price transparency forward in a comprehensive and meaningful way.

KEY ELEMENTS OF COMPREHENSIVE TRANSPARENCY TOOLS FOR CONSUMERS

CPR has developed a comprehensive set of specifications to help purchasers evaluate existing health care transparency tools. Such tools must provide access to broad information about providers and the services they offer. The best tools will present information intuitively so consumers can easily use it to decide where to go for care. Ideally, information would be on a single integrated platform of web and mobile applications and paired with trained support personnel such as nurses, coaches, or other customer representatives.

CPR developed these specifications after reviewing the capabilities of existing tools and with consideration of criteria developed by other organizations. The specifications fall into five categories:

1. **Scope** – the comprehensiveness of provider, including in-network and out-of-network providers, and service information, including price, quality, and consumer ratings.
2. **Utility** – the capability of the tool to facilitate consumer decision making through features that permit comparisons of health care providers' prices, quality, and care settings.
3. **Accuracy** – the extent to which consumers can rely on the provider, service, and benefit information.
4. **Consumer Experience** – the user-friendly nature of the tool, including the availability of mobile applications and easy-to-find, easy-to-understand information.
5. **Data Exchange, Reporting and Evaluation** – the extent to which claims data are exchanged with purchasers according to all privacy laws, the ability of purchasers to use the data with third-party vendors, regular reporting to the purchaser, ongoing improvement of the tool, and the ability of users to rate the tool.

HEALTH PLAN TOOLS AND PURCHASER DATA National health plans are heeding the call from purchasers to share price and quality information with consumers and are developing transparency tools for their patient members to help them access and understand these data. Some plans have had tools for several years, while others just months. Even in the most sophisticated tools, precise price transparency is still relatively rare. CPR's review of the current cost calculators or estimators offered by some of the largest health plans[23] found they provide varying levels of price transparency for select services. The Pacific Business Group on Health also recently performed a "secret shopper" study of the tools developed by major health plans.[24] The results demonstrate wide variation in their functionality and cost comparison capabilities. Examples of differences include variation in the number of services for which price information is available and the ability to compare prices across care settings. In response, some purchasers are turning to third-party vendors – separate from their health plans – to create tools for their consumers. However, this requires health plans to release purchasers' data to a third-party vendor, which many health plans have not yet agreed to do.

OTHER VENDORS' ACTIVITIES Like health plans' tools, other vendors' tools vary in functionality and in the scope of information they offer. Many tools focus solely on price, or estimates of price. Others exclusively present quality and patient-submitted reviews. Some tools even alert consumers about opportunities to lower their out-of-pocket costs and can be customized to individual benefit designs. Only a few comprehensively provide information on quality, price, patient experience, network providers, and benefit design.

These transparency tools also have their limitations. Other vendors typically do not have access to real-time data for their tools as health plans do. They may also have to obtain medical, pharmaceutical, behavioral and other clinical claims data from multiple sources to populate the tool. Despite these limitations, other vendors' tools play a valuable role, particularly when health plan tools do not meet the needs of purchasers and consumers. Their presence in the market enhances competition and spurs innovation to make more robust, user-friendly tools available.

STATE ACTIVITY Currently, 34 states require reporting of hospital charges or reimbursement rates[25] and more than 30 states are pursuing legislation to enhance price transparency in health care.[26] The structure and requirements of the laws and pending legislation vary widely by state and some only include pilot programs and pre-implementation steps. While most states have some disclosure requirements in place, these statutes generally do not cover the actual prices specific providers charge for performing specific treatments.[27]

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In recent years, several states, such as Massachusetts, Maryland, and Utah, have also established databases that collect health insurance claims from health care payers into statewide repositories. Known as "all-payer claims databases" (APCD) or "all-payer, all-claims databases," they are designed to inform policymakers and other stakeholders about various state-based cost containment and quality improvement efforts. According to the APCD Council, nine states operate mandatory APCDs,[28] three states are currently implementing mandatory APCDs,[29] and two states have voluntary APCDs.[30, 31] State laws can direct an APCD on what information it collects and reports. When well-designed databases collect the right information, they can transform data into valuable price and quality information.

California has a new voluntary, multi-payer claims database managed by the Pacific Business Group on Health. The new platform, a nonprofit entity called the California Healthcare Performance Information System (CHPI), will pool claims and other data from California health plans and CMS. CHPI is applying to be deemed a Medicare Qualified Entity so that it can include Medicare claims data (on California's Medicare beneficiaries). CHPI will produce physician, group and hospital performance ratings using quality, efficiency, and appropriateness measures.

States have taken additional steps to ensure that claims information is not restricted under contractual stipulations such as "gag clauses." California recently signed into law SB1196 which states, "No health insurance contract in existence or issued, amended, or renewed on or after January 1, 2013, 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."[32] In practice, the law will allow plans to share data with Medicare Qualified Entities.

Some states have developed their own price transparency tools for consumers. Both New Hampshire and Maine have posted health care costs on state-sponsored websites called New Hampshire Health Cost and Maine HealthCost respectively. Using these

A 2010 Commonwealth Fund report states that "APCDs are proving to be powerful tools for all stakeholders in states where they are being used, filling in long-standing gaps in health care information. They include data on diagnoses, procedures, care locations, providers, and provider payments, and offer both baseline and trend data that will guide policymakers and others through the transitions that health care reform will bring in years to come. As with all data sets, there are limitations to APCD data, but capturing information from most if not all of the insured encounters in a state can still create a powerful information source." The report also indicates the challenges APCDs face, despite some positive results. "While APCDs have undeniably proven to be valuable where they are in use, their development and implementation require states to resolve the numerous political and technical challenges associated with large-scale information systems. Such challenges include engaging and educating all major stakeholders, determining governance and funding, identifying data sources, and determining how the data will be managed, stored, and accessed."

sites, both insured and uninsured individuals can compare the prices of various medical services for different providers. Similarly, Minnesota state officials unveiled a new tool for insured consumers to gain access to *average* negotiated rate information on the website, Minnesota Health Scores.

FEDERAL ACTIVITY The federal government can also play a role in transparency. One of the best examples of price transparency in a federal program is the disclosure of drug prices in the Medicare Part D program, signed into law in 2003. For most individuals, the Part D benefit is structured so that an individual pays 100% of the cost of a drug when he or she is in the "donut hole" (after exceeding the initial prescription coverage and before reaching an annual maximum for out-of-pocket costs). Medicare provides an online tool where an individual beneficiary can enter the name and dosage of the drug and a database will provide the beneficiaries with their expected out-of-pocket costs.

Medicare also offers a Hospital Compare website, which allows Medicare beneficiaries to compare the quality of hospitals in their area. The website provides a "snapshot" of hospital quality and includes six aspects of care: timely and effective care; readmissions, complications and death; use of medical imaging; survey of patients' experiences; number of Medicare patients; and Medicare payment. By making this information available on the federally-managed Hospital Compare platform, the federal government has taken a step in the right direction. However, to make the site truly valuable for patients, Medicare needs also to share price data. Finally, the Patient Protection and Affordable Care Act (PPACA) of 2010 includes a provision that requires hospitals to provide charge information to the public annually.[33]

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WHAT ARE THE CHALLENGES TO ACHIEVING PRICE TRANSPARENCY?

While our health care system has made significant strides in publicly reporting data on provider performance and quality, purchasers, plans, providers, other vendors, and policy makers need to do more to help price information flow freely, both overall and for specific services. A number of obstacles to achieving this goal exist, including the complexity of the health care marketplace itself. Our health care system has enormous variation in care delivery, different approaches for measuring outcomes, and wide-ranging products and services. The diversity of payers in a market that contract with providers at different rates and serve different populations (e.g. Medicare, Medicaid, individual, group) compounds the complexity. As purchasers, providers and policymakers pursue change, lack of provider competition, health plan restrictions on data use, and policymakers' concern about the "unintended consequences" of price transparency also pose challenges.

LACK OF PROVIDER COMPETITION Lack of provider competition in a market, particularly among hospitals and specialists, makes it easy for some providers to refuse to reveal prices to consumers. The major health plans have attempted to address this by removing so-called "gag clauses" from their contracts or by working with facilities outside of the normal contracting cycle to seek permission to share their price information in transparency tools. Much effort has been made to remove such contractual barriers to transparency, but there are still gaps in the information accessible to consumers, particularly in markets like California. Legislation, such as the California example above, can address this issue – essentially preventing providers from entering into contracts that don't allow plans to share data with plan members or a Medicare Qualified Entity.

HEALTH PLAN RESTRICTIONS ON DATA USE Due to restrictions from health plans, many self-funded purchasers face challenges with using their own claims data to build transparency tools for their consumers. These purchasers receive information and data

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from contracted health plans and their data vendors, but still may wish to contract with other parties to build price transparency tools for their consumers. However, some health plans do not allow purchasers to give information to other vendors about the prices the plan paid to providers for the purpose of price transparency, arguing that price information is proprietary and confidential, even though it was the purchaser's funds that paid these claims. With third-party vendors increasing the options in the market, more purchasers are raising the issue of "who owns the data" in private and public dialogues.

This controversy may be less about the law, and more about health plans' interests. Self-funded purchasers, insurers, and third-party data vendors must all adhere to applicable privacy laws and regulations, including HIPAA, ERISA and HITECH. The transfer of data between such parties is protected under these laws and regulations. Health plans, in their effort to be responsive to market demands for greater transparency, are developing more sophisticated and proprietary transparency tools using the claims data. Their investment in these tools is significant and they have concerns that providing claims data to other vendors will introduce or support competing products.

Unfortunately, with this restriction on the data, purchasers and consumers may be losing out. Purchasers who conclude that a plan's tool is not robust or consumer-friendly or meeting their needs in some other way, may want to pursue other options. Purchasers largely believe data about their funds paid to providers belongs to them and that they have the right to provide it to whoever can perform the services they need. Furthermore, purchasers believe that, in the long run, more competition among those developing and offering transparency tools will promote innovation and better serve the needs of consumers.

UNINTENDED CONSEQUENCES OF PRICE TRANSPARENCY While price transparency can help purchasers design value-based benefits and address unwarranted price variation, there are well-founded concerns about the potential unintended, negative consequences of price transparency. For instance, price transparency without quality information could perpetuate consumers' misconception that prices correlate with quality, with some consumers thinking higher-priced care is better. Furthermore, while standard economic theory suggests that price transparency leads to lower and less varied prices, price transparency also has the potential to generate higher prices and anti-competitive provider behavior.

For example, Hospital A could analyze Hospital B's prices across town and decide to negotiate for increases if Hospital B seems able to charge more without sacrificing

volume. Similarly, physicians and hospitals could use price information collectively to set the level of discounts to negotiate with health plans. Further, if all prices are public, it could dilute a health plan's ability to negotiate favorable volume discounts. This could result in higher health care costs for purchasers and consumers, at least in the short term. And finally, price transparency could cause confusion among the general public, at least initially, as individuals' out-of-pocket costs vary with their insurance status, source of coverage (private, public, uninsured), and benefit design. One market-based solution to mitigate this potential unintended consequence is to make sure that consumers have access only to their own relevant pricing information based on their health plan and specific benefit design.

Policymakers can also take steps to remedy these problems. Policymakers can and should use existing laws to monitor marketplace behavior, as they do in other industries, to ensure that providers do not use price data in an anti-competitive manner.

When plans limit access to the claims, price, or reimbursement data necessary to populate robust consumer shopping tools, they disadvantage purchasers and consumers. To minimize or avoid unintended consequences, sharing data to develop transparency tools must be done carefully and constructively. The more health plans and other vendors there are offering tools to meet the demand from large employers and purchasers, the more competition there will be to produce better tools. When plans control the data for competitive or proprietary reasons, they restrict the strategies and tools purchasers can use to control health care costs and enable consumers to maximize their benefits and engage in informed decision-making. As providers, health plans and purchasers make more information on price and quality accessible, consumers will become more educated about value, learning that more expensive care isn't always best.

Policymakers can and should use existing laws to monitor marketplace behavior, as they do in other industries, to ensure that providers do not use price data in an anti-competitive manner.

ACTIONS PURCHASERS CAN TAKE TO DRIVE TRANSPARENCY

Purchasers can and should play a central role in ensuring consumers and their families have access to comprehensive, easy-to-use tools that provide understandable information about health care quality and price. Purchasers can:

1. **Require their contracted health plans to:**
   - Provide easy-to-understand price and quality comparison tools to consumers. (CPR's Health Plan Request for Information, Model Health Plan Contract Language, and Specifications can support and guide this conversation);
   - Help educate consumers about the benefits of using such tools and their functionality; and,
   - Allow purchasers to share their claims data with third-party vendors for building a transparency tool for consumers or for help with claims data analysis and interpretation.
2. **Educate their consumers about how price transparency tools can help them make important decisions about their health care and how to use them:**
   - Use the PBGH cost-calculator "Tip Sheet" to identify tactics to encourage consumers to register for and use their plan's cost calculator tools;
   - Build on price transparency tools with innovative benefit designs and payment reform programs, such as reference pricing and packaged-pricing for specific services like maternity care that will make the price information highly relevant; and,
   - Encourage consumers to ask their physicians and other providers for an estimate of what they will charge before receiving care.

3. **Be vocal about the need for effective price transparency:**
    - Endorse CPR's "Statement on Transparency" and stand behind it in the sourcing, contracting and management of health plans and other vendors (sign on here);
    - Support health plans and other vendors who are developing these tools by sending the message to providers that transparency is important to you and your consumers – their patients; and,
    - Use CPR's Specifications for transparency tools in the development of a new tool or in the evaluation and comparison of existing tools.
4. **Take part in statewide data collection efforts:**
    - Statewide data collection efforts can improve access to credible quality and cost information. A fact sheet prepared by the All-Payer Claims Database Council provides background information. Their website also lists state efforts: http://apcdcouncil.org/;
    - California purchasers can visit www.pbgh.org/CHPI to learn more about the California Healthcare Performance Information System, the new multi-payer claims database in California; and,
    - If gag clauses or other contractual provisions between health plans and providers create barriers to the release of quality and price information in your area, support efforts – voluntary or legislative – to make that information transparent. Write a letter to the involved parties (e.g. hospital CEOs) indicating that you and your consumers want them to make this information available.

CONCLUSION

Purchasers believe making quality and price information transparent to consumers is a powerful building block for supporting them in making more value-oriented choices, which can improve quality and reduce costs for everyone. Yet barriers to price transparency remain, including pushback from providers and limitations on data-sharing by the health plans. Purchasers will continue to encourage health plans to develop robust, consumer-friendly transparency tools and to share data with other vendors so they can do the same. CPR's health plan RFI questions and model contract language can help purchasers to push plans on transparency and related payment reform strategies. Purchasers can also engage in advocacy and regional efforts to collect data, such as all-payer claims databases. Finally, purchasers can use CPR's specifications to compare existing transparency tools and select one that meets their needs. Using these tools, purchasers can foster transparency, driving the health care marketplace closer to meeting the needs of those who use and pay for care.

ABOUT US

Catalyst for Payment Reform is an independent, non-profit corporation working on behalf of large employers to catalyze improvements in how we pay for health services and to promote better and higher-value care in the U.S.

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