catalyst FOR PAYMENT REFORM

Action Brief
Price Transparency

INTRODUCTION

Strategies designed to bring health care costs under control remain a focus area for employers and other health care purchasers. Cost pressures have facilitated a movement by many employers to engage consumers – employees and their dependents - more fully in their health care decisions, including taking on a greater share of their health care costs. With this increase in financial responsibility, purchasers recognize consumers need information on both health care prices (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 both quality and price has become more transparent; however, meaningful information can still be difficult to obtain.[2] Purchasers, plans, and providers need to do more to advance price transparency, including showing price and quality data together, to help consumers assess their options when it comes to both providers and treatments.

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]

PRICE EXAMPLE:

An insurer has negotiated a rate of $1,000 with a particular in-network provider for a chest MRI. A consumer has $200 remaining to meet her deductible and the co-insurance is 20% or $160. Thus, the individual is responsible for $360 and the insurer pays $640. In this case the consumer's "price" for the MRI is $360. In this instance, price transparency exists when, prior to seeking care, a consumer knows her 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 it informs consumers about the total cost and price of specific health care services as they make decisions and seek care.

The price for a particular service depends on a number of variables including whether the 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 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 total payment for that care, and 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, it is important to note that maximizing the consumer benefits of price transparency will require attention to health literacy issues, including the fact that it can be very challenging for health care consumers to understand medical terms as well as how health care payment works, including their own insurance benefits and billing.

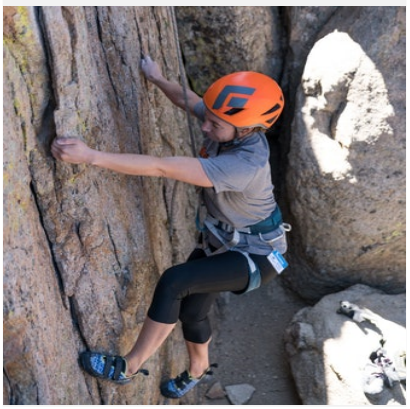
WHY SHOULD PURCHASERS SUPPORT TRANSPARENCY?

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.

POTENTIAL COST SAVINGS Based on a 2017 report, health care costs rose only 4.6% in 2017 due in part to lower utilization rates, benefit plan redesign, and increases in employee contributions. While single digit increases in health spend may be the "new normal," employers have anticipated a slight uptick in costs for 2018.[5] This stabilization in trend may be a testament to the impact of current efforts, yet 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.[6]

To address this, many purchasers are implementing a variety of cost containment strategies, including reference pricing, second-opinion services, bundled payments, and consumer-directed health plans. 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 pricing, cannot be implemented effectively without price transparency.[7]

Health care costs have been steadily rising over the last several decades.



SUPPORTING CONSUMERS AS THEY ASSUME GREATER FINANCIAL RESPONSIBILITY

Most purchasers are asking those whom they buy health care for to take on a greater share of their costs, including deductibles, health insurance premiums, and out-of-pocket expenses. According to the Peterson-Kaiser Health System Tracker, from 2006 to 2016, average payments to deductibles rose by 176% and total out-of-pocket spending rose by 54% while wages rose by only 29%.[8] Over the last five years, the percent of covered workers with annual deductibles of $1,000 or greater for single coverage has increased from 34% in 2012 to 51% in 2017.[9] According to PwC Health and Well-Being Touchstone Survey of major U.S. companies, 44% of companies offered high-deductible health plans as the only option for employees in 2014, a figure that fell to 28% in 2017. These trends, coupled with increases in health care expenditures, mean out-of-pocket costs for consumers have grown steadily since 1970. In 1970, out-of-pocket expenditures were $119 per capita ($590 in 2016 dollars); they averaged $1,093 per capita in 2016.[10]

Despite taking on a greater share of their health care costs, consumers cannot be prudent health care shoppers without information on the prices of health care services. Consumers research quality and prices regularly for a variety of goods and services, from cars and washing machines to mechanics and restaurants. Research – and common sense – indicates they need and want easy-to-understand price *and* quality 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 and compare data and make decisions about predictable services, unlike in emergency situations.[11] And consumers have proven that when they have price and quality information, they 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.[12]

REDUCING UNWARRANTED VARIATION Health care researchers have found significant price variation for hospital and physician services across markets and even within markets. Without transparency, those who use and pay for care may be unaware of the large range in potential prices for care, in turn leading to higher health care costs for consumers and purchasers. 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.[13]

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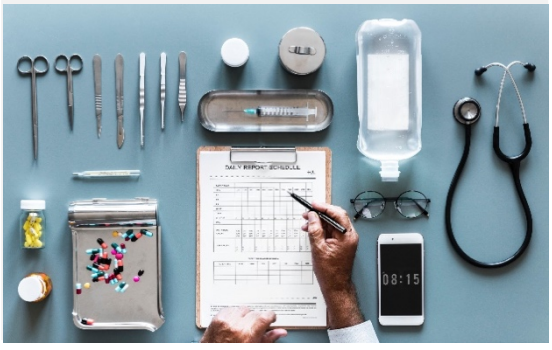


A Massachusetts report on price variation found payment to hospitals ranged 2.5 to 3.4 times greater for the highest-priced hospitals compared to lowest priced. Similarly,

physician payments for one large commercial carrier in MA ranged from $370 to $515 per-member-per-month.[14] Studies on price variation suggest that variation is largely due to provider market power but can also be impacted by differences in geography, costs of labor, the health of the patients, and the degree of consolidation and integration among providers.[15]

Recent reports from the Health Care Cost Institute observed increases in health care spending between 2012 and 2016 were entirely attributable to price increases. Prices increased each year among all services, though the greatest increases were in prescription drugs and inpatient services.[16] Without price transparency, it is difficult for anyone to understand the extent of price variation, its root causes, or for purchasers to address the problem.

The implementation of a transparency tool, followed by consumer use and behavior change, can reduce costs for purchasers. Coupling transparency with related benefit strategies has proven even more effective. CalPERS instituted price transparency and reference pricing with high-quality medical centers for hip and knee replacements. Its reference pricing program led to a reduction in average prices of 26% between 2010 and 2011, saving CalPERS over $5.5 million.[17]

WHAT ARE SOME EXISTING EFFORTS AT PRICE TRANSPARENCY?

Health plans, with their extensive data on claims, contractual reimbursement rates, provider credentialing, and quality information, may be best positioned to disclose price and quality information today. Almost all large national health plans offer members access to price transparency tools; however, many of these tools have limitations in their scope and in the specificity of provider prices. This is partly due to pressure from the providers with whom they negotiate to keep prices confidential and operational challenges with respect to the data. The presence of other independent vendors developing similar tools helps to spur the creation of better tools at a faster rate. States and the federal government are also taking steps to move price transparency forward.

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. The specifications fall into five categories:

1. Scope – the comprehensiveness of providers, including in-network and out-of-network providers, and service information, including price, quality, and consumer ratings.
2. Quality – the capability of the tool to facilitate consumer decision making based on price and quality through features that permit comparisons of health care providers' quality grounded in recognized measures. The ability to view quality and price information at the same time, and on the same page.
3. Price Accuracy – the extent to which consumers can rely on the information about prices for particular providers and services. Prices should be accurate and comprehensive, taking into consideration consumers' benefit designs and cost sharing requirements. Total prices for episodes of care should also be accessible.
4. Usability – the user-friendly nature of the tool and how intuitive it is, including search functionality and the availability of easy-to-find, easy-to-understand information. Consumer experience is convenient, consumers have ability to offer feedback and contact customer service.
5. Engagement- the extent to which health plans/vendors engage with consumers in order to change behavior, encourage and monitor utilization of the tool, and engage in regular reporting to the purchaser.

When well-designed databases collect the right information, they can transform data into valuable price and quality information.

HEALTH PLAN TOOLS AND PURCHASER DATA

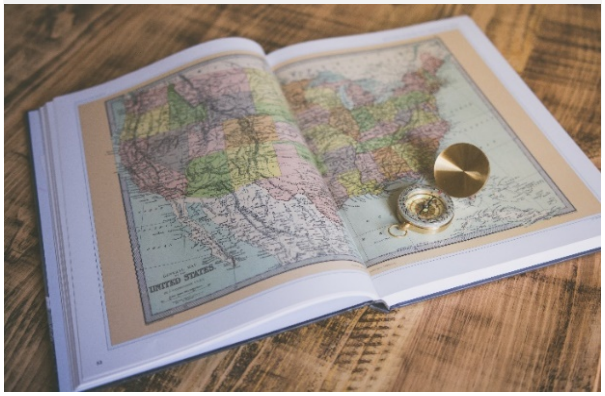
National health plans are heeding the call from purchasers to share price and quality information with consumers and have developed transparency tools for their patient members to help them access and understand these data. These tools widely vary in their functionality and price and quality comparison 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 have used third party vendors – separate from their health plans – to provide tools for their consumers.

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 toward the availability of robust, user-friendly tools.

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.



STATE ACTIVITY Currently, 34 states require reporting of hospital charges or reimbursement rates, and more than 30 states are pursuing legislation to enhance price transparency in health care.[18] 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.[19]

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" (APCDs) or "all-payer, all-claims databases," they are designed to support state-based cost containment and quality improvement efforts. According to the APCD Council, 20 states have APCDs in operation, five of these are voluntary efforts, and one operates on voluntary submission of data. Of states without APCDs in operation, five are in the process of implementing APCDs, eight have not demonstrated any interest to date, and 16 states that have demonstrated some degree of interest but have not taken significant action. Tennessee formerly operated an APCD, but the database is no longer active.[20] State laws can direct an APCD on what information it collects and reports. When well-designed databases collect the right data, they can transform it into valuable price and quality information.

States have taken additional steps to ensure that claims information is not restricted under contractual stipulations such as "gag clauses." For example, California 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."[21] In practice, the law will allow plans to share data with Medicare Qualified Entities- organizations certified by CMS to receive standardized claims data reporting for the purposes of evaluating provider performance.

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 CompareMaine respectively. Using these sites, both insured and uninsured individuals can compare the prices of various medical services for different providers.

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 individuals pay 100% of the cost of a drug when they are in the "donut hole" (after exceeding the initial prescription coverage and before reaching an annual maximum for out-of-pocket costs). For Part D, Medicare provides an online tool into which an individual beneficiary can enter their zip code, Medicare number, and last name, and a database will provide the beneficiary with personalized Medicare plan options, including cost estimates and coverage information. 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 payment 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.[22]

A 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."

WHAT ARE THE CHALLENGES TO ACHIEVING PRICE TRANSPARENCY?

While our health care system has made significant strides in publicly reporting data on provider quality, purchasers, plans, providers, other vendors, and policymakers need to do more to help price information flow freely. 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. 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.

UNINTENDED CONSEQUENCES OF PRICE TRANSPARENCY While price transparency can help purchasers design value-oriented benefits and address unwarranted price variation, there are well-founded concerns about potential unintended consequences. Although Americans are becoming more aware of the disassociation between price and quality of care, price transparency without quality information could perpetuate consumers' misconception that prices correlate with quality, with some consumers thinking higher-priced care is better.

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 2018 Aligned Sourcing and Contracting Toolkit includes **Health Plan Request for Information questions** and **Model Health Plan Contract Language**, and reference to CPR's Comprehensive Specifications for the Evaluation of Transparency Tools. Together, these tools will guide conversations with health plans and even help purchasers determine if they are better off providing a consumer-facing tool through an independent vendor; and,
    - Help educate consumers about the benefits of using such tools and their functionality.
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 bundled payment 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 a price estimate before receiving care, especially around referrals to specialists or lab services.
3. Be vocal about the need for effective price transparency:
    - 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,
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/;
    - 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.

ABOUT US

Catalyst for Payment Reform (CPR) is an employer-led, national nonprofit on a mission to catalyze employers, public purchasers and others to implement strategies that produce higher-value health care and improve the functioning of the health care marketplace.

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