catalyst FOR PAYMENT REFORM

Action Brief
Price Transparency

INTRODUCTION

Employers and other health care purchasers place a high priority on strategies that help them to reduce spending on health care. The pressure of rising health care costs has compelled many purchasers to offer health insurance options that require consumers – i.e., their plan members – to assume a larger portion of health care costs (through higher deductibles, co-insurance, or co-pays) and encourage them to compare prices and the quality of care to make informed health care choices. When good information is coupled with the right incentives, consumers may be more likely to select high-value providers and services. In recent years, information about both quality and price has become more widely available, especially with the passage of new federal transparency guidelines; however, the influx of price and quality data does not always translate into information that is both meaningful and actionable for consumers.

WHAT IS PRICE TRANSPARENCY?

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."[1]

Price is defined as "an estimate of a consumer's complete health care cost for 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)."[2]

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 several variables including whether the consumer is insured or uninsured, whether the provider who performs the service is "in-network" or "out-of-network, and the setting in which the provider delivers the service." 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 seeing an in-network provider, the price that the consumer pays will often represent only part of the total payment for that care, and the health plan will pay the remainder. Regardless, the "price" refers to the amount for which the consumer is responsible. It is important to note that maximizing the consumer benefits of price transparency requires attention to health literacy issues: understanding medical terminology, the mechanics of health care payment, and navigating their own insurance benefits and billing can be very challenging for health care consumers.

WHY SHOULD PURCHASERS SUPPORT EFFORTS TO IMPROVE PRICE TRANSPARENCY?

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

DEVELOPING STRATEGIES TO CONTAIN HEALTH CARE COSTS

Self-insured purchasers should have access to information such as provider-specific pricing information such as gross charges (i.e., the list price for services as codified in the provider's chargemaster), de-identified payer-specific in- and out-of-network negotiated charges, minimum and maximum negotiated charges, and discounted cash prices for various sets of items and services (including ancillary services and prescription drug prices).

Based on a 2022 report, health care costs rose 6.3% in 2021, continuing to rise faster than general inflation. While single-digit increases in health spending have become the "new normal," 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.[3] The record high CPI inflation in 2022 may be the one exception to this decade long trend. Recent reports from the Health Care Cost Institute observed that increases in health care spending between 2015 and 2019 were largely attributable to price increases. Prices increased each year among all services, though the greatest increases were in professional services and outpatient visits and procedures.[4]

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

To address this unsustainable trend, many innovative purchasers are implementing a variety of cost containment strategies, including reference pricing, centers of excellence networks, navigation and/or second-opinion services, and high-performance network designs. 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.[5]

PROVIDING DECISION SUPPORT TO HEALTH CARE CONSUMERS

Most purchasers have asked their plan members to take on a greater share of their costs of care, including deductibles, health insurance premiums, and out-of-pocket expenses. According to the Peterson-Kaiser Health System Tracker, from 2006 to 2016, average payments toward deductibles rose by 176% and total out-of-pocket spending rose by 54% while wages rose by only 29%.[6] Over the last five years, the percent of covered workers with annual deductibles of $1,000 or greater for single coverage has increased from 51% in 2017 to 58% in 2021.[7] According to the Kaiser Family Foundation 2021 Survey of Employer Health Benefits, the percentage of covered workers in a high-deductible health plan has increased over the last decade. In 2011, 17% of covered workers were enrolled in a high-deductible health plan compared to 28% in 2021.[8] 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 $115 per capita ($603 in 2019 dollars); they averaged $1,240 per capita in 2019.[9]

Consumers research prices and quality regularly for a variety of goods and services, from cars and washing machines to mechanics and restaurants. However, consumers still underutilize information on the prices and quality of health care services, despite taking on a greater share of their health care costs. A 2017 study examined the use of a price transparency tool offered by employers to their employees. The study found that 11% of employees used the tool at least once in the first 12-months after its release, and only 1% used it at least 3 times in those 12 months.[10] While these statistics indicate that consumers are not making use of the resources available to them, it is still critically important for employers to make the effort to educate consumers on price and quality information.

REDUCING UNWARRANTED VARIATION Health care researchers have found significant variation in prices for hospital and physician services across markets, within markets and even among hospitals and service lines within the same health system. According to the 2020 RAND Nationwide Evaluation of Health Care Prices Paid by Private Health Plans report, 2018 commercial prices by state varied widely relative to Medicare. Specifically, commercial prices for inpatient and outpatient services range from 200% of Medicare rates in Arkansas, Michigan, and Rhode Island to nearly 325% of Medicare rates in Florida, Tennessee, Alaska, South Carolina, and West Virginia.[11] Studies on price variation suggest it is largely due to provider market power but can also be impacted by differences in geography, labor costs, and the health status of patients.[12] As an extreme case, there are a few different hospitals that command almost 6,000% of what Medicare pays for hospital inpatient services, and over 1,000% of what Medicare pays for hospital outpatient care. The study also found that prices within a single hospital system can range from 233% to 292% of what Medicare pays.[13]

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Without transparency, purchasers and their plan members may be unaware of the large range in prices for care, which risks higher health care costs for consumers and purchasers.

Price variation can exist for certain services provided in hospital-owned facilities compared to those in a free-standing ambulatory surgical center (ASC). For example, Self-Insured Schools of California (SISC) instituted a reference pricing program in which plan participants who sought care for specific procedures at ASCs would receive full benefit, but if they obtained the procedures at a hospital-owned facility, they would be subject to paying out of pocket for any amount over the reference price. The procedures SISC selected for the program included arthroscopy, cataract surgery, colonoscopy, upper GI endoscopy with and without biopsy. Its reference pricing program led to a reduction in procedures performed at hospital-owned facilities by 30% to 61% depending on the procedure, and aggregate savings by procedure ranging from just under $67,000 to $1.5 million in 2018.[14]

Without price transparency, it is difficult to ascertain the extent of price variation, its root causes, or for purchasers to address the problem by developing and implementing high-value strategies.

The implementation of referenced pricing can reduce costs for purchasers. SISC instituted a reference pricing program in which plan participants who sought care for specific procedures at free-standing ASCs would receive full benefit. Its reference pricing program led to aggregate savings from just under $67,000 to $1.5 million depending on the procedure.

WHAT ARE SOME EXISTING EFFORTS AT PRICE TRANSPARENCY?

FEDERAL ACTIVITY

In November 2020, the Departments of Health and Human Services, Labor, and Treasury released the Federal Hospital and Health Plan Price Transparency Final Rules or the Transparency in Coverage Rule, which contains provisions intended to increase price transparency for purchasers and consumers. The regulations require hospitals and health insurers (including self-funded purchasers) to release publicly available machine-readable files (MRFs) and offer consumer price shopping tools on their websites.[15,16] MRFs are a digital representation of data or information in a file format that can be uploaded or read into a computer system. Hospitals are required to post a list of charges for shoppable services and estimates of out-of-pocket costs.

Hospital Price Transparency Final Rule

Effective January 1, 2021, federal regulations require hospitals to release a MRF with comprehensive information on a publicly available website that includes the charges for all items and services, inclusive of ancillary services and prescription drug prices. Specifically, the publicly available MRF must include five types of standard charges, such as gross charges (i.e., the list price for services as codified in the provider's chargemaster), de-identified payer-specific in- and out-of-network negotiated charges and minimum and maximum negotiated charges, and discounted cash prices. Furthermore, hospitals must update the MRF monthly.[17]

Hospitals must also offer a public, consumer-friendly display of shoppable services on their website. The website must include the five standard charges listed above for at least 300 shoppable items or services (inclusive of ancillary services) that the hospital provides. If a hospital provides fewer than 300 services, then it is required to list as many as possible. Shoppable services are defined as services that a healthcare consumer can schedule in advance. Examples of shoppable services include imaging and laboratory tests, medical and surgical procedures, outpatient clinic visits, and hospital fees.[18] The consumer-friendly display may be a list of standard charges for shoppable services or, alternatively, the hospital may decide to develop an online price estimator tool.[19]

CMS will enforce a civil monetary penalty for non-compliance depending on the size of the hospital. For instance, hospitals with 30 or fewer beds that are non-compliant will receive a $300 fine per day, and hospitals with more than 30 beds will receive a $10 fine per bed per day. The maximum penalty per day will be capped at $5,500, and $2 million per hospital for a full year of non-compliance. In addition, CMS may request a corrective action plan and may conduct an audit. Note, the aforementioned actions for compliance may not necessarily occur in that order.[20]

Health Plan Price Transparency Final Rule

Effective July 1, 2022, health insurers (including self-funded purchasers) are also required to post a comprehensive MRF on the costs of covered items and services (including ancillary services) on a publicly available website. The MRF must contain negotiated in-network rates, allowed amounts, charges billed by out-of-network providers, and negotiated prices for prescription drugs. However, the details on the requirements for the pharmacy MRF is pending further rulemaking.[21] Health insurers

and self-funded purchasers must update the MRF monthly.

In addition, insurers (and self-funded purchasers) must offer a consumer price comparison tool on their website that includes member cost-sharing estimates for specific items or services (including prescription drug prices) and providers. This tool must also list at least 300 shoppable services. The number of shoppable services presented will increase to 500 items and services beginning on January 1, 2023, and all items and services on January 1, 2024. Similarly, the same shoppable services examples outlined in the Hospital Price Transparency Final Rule section above also apply to health plans.[22] The tool must allow consumers to search by billing codes or descriptions, provide cost comparisons between in-network and out-of-network providers, other factors that impact cost (i.e., service location), and offer cost estimates in paper format upon request.[23]

STATE ACTIVITY

In addition to federal activity, many state legislatures have taken independent measures to require greater price transparency. Currently, more than a dozen states are pursuing legislation to enhance health care price transparency. The structure and requirements of the laws and pending legislation vary widely by state.[24,25]

Some states have required by law more than what is required in the Hospital Price Transparency Rule. Notably, the Connecticut Office of Health Strategy compiles data that measures increases in hospital expenditures compared to their revenue to assess whether the expenditure increases are justified. In addition, Connecticut utilizes the data to answer crucial questions, such as how much responsibility a hospital bears for satisfying its debt commitments, paying its employees and vendors, and providing high-quality care to patients.[26] These data also assist the state with evaluating mergers and acquisitions, increases in capital costs, and the variation between increases in expenses and revenues. Collecting this information not only allows the state to assess hospitals' financial viability, but also supports state efforts to create cost containment policies. Oregon is another state moving beyond the federal requirements. In 2014, the Oregon Health Authority began collecting hospital financial data and publishing quarterly reports to document the impact of hospital costs on premiums and compare them against federal health care cost data.[27]

States have established databases that collect health insurance claims from health care payers into statewide repositories. Such repositories are known as "all-payer claims databases" (APCDs) or "all-payer, all-claims databases," and are designed to support state-based cost containment and quality improvement efforts. According to the APCD Council, 18 states have mandatory APCDs in operation, and five have voluntary ones. Of the remaining states, about two-thirds are either poised to launch an APCD or have introduced legislation proposing to build one. State laws can set rules on what information an APCD can collect and what it can report publicly.[28] Well-designed databases can transform data into valuable price and quality information for purchasers and consumers.

In many cases, states that maintain an active APCD use the data to administer price transparency tools for consumers. To date, nine states maintain price transparency websites to provide consumers with access to cost and quality data.[29] Using these sites, both insured and uninsured individuals can compare the prices of various medical services for different providers.

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 CHALLENGES REMAIN IN PRICE TRANSPARENCY?

While the Federal Hospital and Health Plan Price Transparency Final Rules should increase price transparency for health insurers, self-funded purchasers, and consumers, as well as promote competition among hospitals and health plans, on their own these rules will not produce comprehensive or fully usable price transparency.

HOSPITAL COMPLIANCE WITH AND EXECUTION OF FEDERAL REGULATIONS Most hospitals have delayed complying with CMS' new Hospital Price Transparency Final Rule. In 2021, a study published in the Journal of General Internal Medicine found that in the first five months after the Rule took effect, 55% of U.S. hospitals were non-compliant. Furthermore, the study revealed extensive variation by state. Specifically, at least 75% of hospitals were compliant in Washington, D.C., Rhode Island, Hawaii, Indiana, and Michigan. In comparison, only about 25% of hospitals were compliant in Delaware, Maryland, Washington, and Louisiana.[30] A hospital's willingness to comply with the Rule may depend on multiple factors such as having a strong information technology infrastructure, access to financial resources, and most importantly, the compliance of competitors in their region or state.[31]

Just because a hospital complies with the letter of the Hospital Price Transparency Final Rule doesn't mean the hospital has made the data easily accessible to the public. A study conducted by the Peterson Center on Healthcare and the Kaiser Family Foundation observed that the consumer-price comparison tools and MRFs were challenging to access and navigate on hospital websites. The study cited that while some hospital websites had specific price transparency pages with downloadable files, others required consumers to search through billing and insurance pages and sub-pages to find the files.[32]

The study also revealed that hospitals vary in how they measure and report on price: some offer estimates, others post average charges, some publish standard rates (i.e., hospital's chargemaster).[33] The lack of standardization of price data across hospitals makes it nearly impossible for purchasers and consumers to create apples-to-apples comparisons, and defeats the Rule's intention to promote competition and consumerism.

COMBINATION OF QUALITY DATA WITH PRICE DATA Although multiple studies demonstrate the disassociation between the price and quality of health care services in the United States, many health care consumers believe that higher-priced care indicates better quality – if they pay attention

to prices at all.[34,35,36] Price transparency can shine a spotlight on unwarranted price variation, but purchasers and consumers need price and quality data in combination to determine which providers are high-value (i.e., higher quality, lower cost). Transparency tools should include provider price information alongside care outcomes, such as performance against nationally-recognized quality measures, patient-generated reviews and outcomes, special recognition by health plans, and/or an overall value rating or designation.

ACTIONS PURCHASERS CAN TAKE TO DRIVE TRANSPARENCY

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

1. Demand that hospitals comply with the Federal Hospital Price Transparency Final Rule:
   - Support health plans and other vendors who offer transparency tools by sending the message to providers that transparency is important to you and your consumers – their patients.

2. Work with your health plan or third-party administrator to make price information available to plan participants in compliance with the Federal Health Plan Price Transparency Final Rule:
   - Purchasers and health plans should collaborate to ensure the price transparency data is displayed in a way that is easily understood by plan members.

3. Use CPR's *Purchaser Tools for Breaking Barriers to Data Ownership, Access, & Use* to confirm your ownership of your data and enhance the access to and use of it as Plan Fiduciary:
   - Use the Health Plan Self-Assessment and RFI Questionnaire to understand your health plan or third-party administrator's current data policies.
   - Use the third-party administrator administrative services only agreement addendum to confirm your data ownership, access, and usage rights as Plan Fiduciary.

4. Educate consumers on the price information available to them on hospital websites or through a consumer price transparency tool, and illustrate how they can use these data to make more informed health care decisions:

- Conduct consumer education sessions to help them navigate how to use the price transparency information on hospital websites or through a consumer price transparency tool.
- Encourage consumers to ask their providers and health plan for a price estimate before receiving care, especially around referrals to specialists or lab services.

5. Contribute claims data to a regional APCD to enhance its comprehensiveness, accuracy and utility:

- Statewide data collection efforts can improve access to credible price and quality information. The All-Payer Claims Database Council's website has a wealth of information, including state efforts at implementing and maintaining APCDs.
- If gag clauses or other contractual provisions between health plans and providers create barriers to the release of price and quality information in your area, consider creating a public campaign that draws attention to particularly high-priced providers that do not have quality data demonstrating significant superiority to lower-priced providers.

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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