An Approach to Transparency in Hospital Pricing: A Policy Analysis Memo

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Re: Transparency in Hospital Pricing

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Executive Summary

Health care costs in the United States are on the rise, and many consumers feel unable to attain financial burden that comes with basic medical care. This is, in part, due to the lack of transparency in medical costs leaving millions of Americans unaware of medical bills and the portion covered by insurance until after the treatment is given. America spends more on health care per year than any other country, and increasing the transparency in medical costs and quality is a potential approach to lowering health care costs across the medical field as a whole (Fung, Lim, Mattke, Damberg, & Shekelle, 2008). Key stakeholders that will be influenced by changes in the transparency in the cost and effectiveness of medical care are insurance carriers, pharmacy benefit managers, health care providers, health care manufacturers, policymakers, consumers, and employers. Although each stakeholder has reasons to resist the initial change to transparency policies, there is much they have to gain from it as well.

Three approaches to solve the problem are identified as the patient-targeted approach, the physician-targeted approach, and the policymaker-targeted approach, and each have specific benefits and drawbacks to each stakeholder. The patient-targeted approach focuses on mandating the use of price transparency tools for enrollees to inform them of total out-of-pocket costs for each insurance provider. The physician-targeted approach aims to require that EHRs (electronic health records) provide price data to physicians upon ordering laboratory and imaging services. The policymaker-targeted approach's goal is to gather and report hospital-specific prices using

state all-payer claims database (APCD) and make it accessible to the public. After thorough analysis, I recommend the policymaker-targeted approach, or option 3, as the best solution to increase transparency in hospital prices with the least adverse impacts on each stakeholder.

Problem Statement

What data organization system should be implemented to increase the transparency in the cost and quality of services provided to the privately insured consumer?

Background

Over 55% of the U.S. population has private health insurance. In 2017, the average family of four paid $18764 in insurance premiums through their employer. This was 55% more than 2007 premiums. (Kaiser Family Foundation, 2017). Most of the public's data comes from the analysis of the Medicare program, which covers less than 15% of the population. Medicare rates are set from data statisticians, and privately insured prices are set through different negotiations with hospitals and healthcare providers. It has traditionally been difficult to Because private health insurance claims data has been treated as commercially sensitive , it has been hard difficult to accurately inform consumers on the prices of their services before they receive the care (Cooper, Craig, Gaynor, & Reenen, 2019). Often, consumers may be charged a difference of hundreds to thousands of dollars from two hospitals located within miles of each other, and the consumers are unaware of the price variability and options until it is too late. For example, the U.S. Government Accountability Office (2005) analyzed health care claims data from the Federal Employees Health Benefits Program and found that hospital prices varied by 259% across metropolitan areas, and 300% across the state of Massachusetts (Coakley, 2011).

Transparency-of the costs, prices, quality, and effectiveness of medical services and products- has been identified as a key player in lowering costs and improving outcomes (Fung et al., 2008). Patients and consumers are now at an all-time disadvantage when it comes to the lack of transparency around the pricing and medical costs of healthcare products and services. For privately insured Americans, as the cost of health care increases and the economic climate worsens, employers are less able to absorb these costs. Significant increases in bankruptcy related to healthcare costs for insured middle-class Americans exemplifies the difficulties faced when trying to keep up with the ever-inflating prices of health care services (Yong, Saunders, & Olsen, 2010).

For the 37% of the population insured by Medicare or Medicaid, prices are publicly available and generally increase slowly. However, prices for the commercially insured population are privately negotiated, proprietary, and closely guarded by health plans. Commercial hospital prices are high relative to Medicare and vary considerably both within and between markets. These price discrepancies are larger than for physician services, are increasing over time, and are responsible for a large proportion of overall commercial insurance premium growth (Koller & Khullar, 2019). A 2018 study of physician payments from the Congressional Budget Office shows commercial-to-Medicare payment ratios of 110% for office visits, 130% for cataract surgeries, and 180% for knee replacement and colonoscopies, which were substantially lower than commercial-to-Medicare payment ratios for hospital services (Pelech, 2018). Between 2001-2014, commercial insurance prices for inpatient services increased 42% and prices for hospital-based outpatient care increased 25%, both of which were much greater than general inflation or the increase in Medicare or Medicaid prices during the same years, and this trend is suggested to be continuing (Cooper et al., 2019).

Commercial insurers have shown very little interest in revealing their rates. Many price analyses rely on voluntary claims databases, in which insurers decide the rules of disclosure. United Healthcare, for example, announced earlier this year that it will no longer submit data to the Health Care Cost Institute, leaving the database with only 3 national plans (Koller & Khullar, 2019). With limited access to hospital pricing, consumers are left relying on the doctors in collaboration with their insurance provider to have their best interest in mind, but this alone is not enough to ensure fair pricing. A large number of physicians have pharmaceutical, hospital and other financial relationships that consumers are unaware of but likely create influential fiduciary relationships in conflict with those of the consumer (McGlynn et al., 2003). Most current insurance benefit structures mute the effects of price in a normal market and do not provide the incentives for patients to choose lower-cost providers. Copayments, such as uniform dollar amount per hospital day or per admission or per physician visit, provide no incentive whatsoever, leading to consumers spending more of the insurance's money with no regard to how prices between providers may relate (Yong et al., 2010).

Healthcare organizations nationwide struggle to determine the actual cost of providing care to patients, partially explaining the lack of awareness among consumers. The information is necessary for successfully negotiating risk contracts and developing pricing strategies effectively, so the challenge is truly understanding the costs associated with care, both on an individual basis and in aggregate (Decker, 2019). The factors involved in setting prices include the direct cost of care delivery, but they also include location, hours of operation, staffing levels, expertise, numbers of patients served, and more. Price transparency is often dreaded because it might mean the need to compete with lower-fee providers who do not share the same cost structure. Patients may also feel pressured to choose lower-quality care if it is noticeably cheaper

than the higher-quality, more expensive counterpart. Hospitals fear transparency in pricing and many resist it heavily to avoid loss of patient flow to more affordable competitors (Pelech, 2018). For consumers, however, it is essential to fully understand health care pricing and be given the tools to adequately weigh cost benefits to their own personal needs. No patient should be put into financial crisis from health care related costs stemming from a lack of awareness on pricing. Transparency in hospital pricing must be refined to place the consumers at the highest priority, giving them understanding and peace of mind before receiving a high-cost procedure.

Landscape

The key stakeholders influenced by this issues are insurance carriers, pharmacy benefit managers (PBMs) health care providers, health care manufacturers, consumers, policy makers, and employers. While each stakeholder has reasons to resist transparency in medical prices and quality, they could also improve the overall functioning of America's health care system by disclosing costs more openly with the public.

Insurance Carriers

While insurance carriers are making progress in developing proprietary tools to advance transparency for plans and networks they offer, they often oppose transparency when it would require them to disclose the negotiated fees they pay providers to third parties ad emerging transparency specialty vendors whom they may view as competitors. Many view this as an opportunity for competitive advantage, while others may feel threatened by exposure of negotiated prices. Insurance providers have also expressed concern over the generalizability of each carrier's proprietary measure between plans. For example, if a given provider scores higher on one carrier's proprietary measure compared to that of a competing plan, the public and the

provider measured may feel uncertain to which result they should trust. Also, disclosure of negotiated prices paid by carriers to providers would expose the adverse impacts these arrangements may have on purchasers and consumers. (White, Ginsburg, Reschovsky, Smith, & Liao, 2014). While transparency poses potential changes in the current functioning of insurance companies, it provides an opportunity for great trust between consumers and their insurance providers and can assist American consumers in making financially responsible decisions.

Pharmacy Benefit Managers

Some PBMs have shown particular resistance to full disclosure in drug pricing, as the prices consumers pay can be astronomical with and without the help of insurance. The PBM market operates based on negotiated discounts off the wholesale price. Without knowing exact cost that the PBM is paying drug manufacturers, or the amount that the PBM is marking up that price when passing on a claim for the employer to pay (Yuenyongchaiwat, Pongpanit, & Hanmanop, 2018). With increased transparency, PBMS may feel obligated to sell their drugs for a lower cost to maintain healthy employer relationships, but this may decrease their annual revenue.

Health Care Providers

While a large majority of clinicians aim to provide the highest quality of care possible, many health care providers resist public reporting. This is likely due to the fear of the unknown. Providers may have anxiety towards the rating similar to the fear of being graded for the first time. They have no way of knowing if they will be graded as above average, average, or failing until the data becomes publicly released. They also may feel like they have nothing to gain through releasing this data, especially if they are already operating a successful and financially profitable business without full disclosure of their pricing (Coakley, 2011).

Also, some providers actually benefit from a lack of price or quality transparency. If a provider has dominant market share, they may charge higher fees in a negotiation with health plans because health insurance finds it more important to have their in-network providers reach a large number of patients. Without price transparency, the providers have the ability to make more annual income directly accounted for by the increased prices paid by consumers. There is also a distrust in the potential quality of the measures used to rate fairness in price and quality. Providers are worried they may not be represented in a positive light when compared to other providers in an area, and therefore are hesitant to take the risk.

If all providers were transparent with prices and quality of services, they could increase their confidence in their own work by using the standard measure of quality as it relates to price as a motivating force to provide the highest quality care for the lowest amount. With full disclosure, it would implement the laws of balance and supply and demand, giving all parties all necessary information to make the best decision for their unique needs. This would be a great way to increase service and create trusting alliances with insurance companies to provide more care to their beneficiaries (Koller & Khullar, 2019).

Health Care Manufacturers

Health care manufacturers provide medical devices and drugs and are often resistant to transparency in the cost and quality of their products. When introducing a new product to the market, and there is a lack of accurate measures on both the cost and relative outcomes of these new technologies compared to generics or alternatives, so the market has little to no option of rejecting once they have been approved by the FDA. This can result in inflated costs for the new treatments relative to the value of other existing options, even if the new FDA approved

technologies have unknown quality or safety issues. Dangerous drugs could take years before their flaws are discovered (Fung et al., 2008).

Policymakers

Policymakers have embraced transparency to some degree, including but not limited to the noteworthy progress made by the U.S. Department of Health and Human Services (HHS) and the Center for Medicare and Medicaid Services (CMS) in measuring and reporting hospital, physician, and nursing home quality (Wetzell, 2014). Government red tape, lobbyists, and separate alliances could all be to blame for the lack of transparency. The Affordable Care Act has tried to make great headway in disclosing costs charged by insurers, but it is still to be determined if the Affordable Care Act has actually made healthcare more robust or more affordable for end users. Some policymakers may also resist full cost transparency due to the potential costs associated with shifting from Medicare and Medicaid to private payers. Having full cost transparency could help Medicare and Medicaid provider reimbursement policy on the cost of private plans to be available for date collection. This could increase public pressure to fundamentally change how Medicare and Medicaid and the providers transact payments. It may even lead to large employers to begin advocating for policy changes that would guarantee their private plans access to the same fees that Medicare pays providers (Cooper et al., 2019).

Consumers

The consuming public has the most to gain through access to improved cost and quality information, but historically they have not demanded the tools they need to make knowledgeable, informed choices. This stems from a trust often found between a consumer and their primary doctor or hospital, and consumers typically have a bias and believe that their current treatment is the best. Also, some consumers dread the added responsibility and autonomy

that comes with making their own informed decisions on health care. A 2014 survey found that more than 50% of American workers prefer to have their employer take the responsibility of choosing a health plan for them (Wetzell, 2014).

A potential flaw in the transparency model is that many consumers do not want their personal information to be public. Although the Health Insurance Portability and Accountability Act (HIPPA) is concerned with immense consumer protection, some data privacy advocacy groups voice concern over public reporting of their personal health information. Although some groups of individuals are concerned with hospital transparency, a large majority of public consumers are being swayed towards increased transparency in pricing and quality of care to provide the tools for the most informed decisions based on each individuals financial and medical circumstances (Miller, 2012).

Employers

Employers have launched some promising initiatives like the National Committee for Quality Assurance and National Quality Forum to advance the transparency in pricing to their employees enrolled with their health plans. With more committees come more costs, which fundamentally passes those costs on to the consumer. These committees have fallen short of meeting the needs of the employers and those they provide coverage for (Fung et al., 2008). Health care is not a high priority in most companies' core values, and even if employers wanted to focus more on transparency, without total transparency throughout the entire system, it is a moot point. Growing concerns related to the impact of the Affordable Care Act combined with ongoing concerns over the cost and quality of health care has created a greater importance of the transparency in hospital pricing in the corporate world. To support this point, A March 2013 survey found that 93% of the CHROs reported to believe that effective transparency mechanisms

could help bend the cost of health care in a favorable direction, but only 8% of the companies felt that their own companies had fully effective transparency mechanisms in place (Wetzell, 2014). This demonstrates the need for transparency, yet the lack of policies in place in other sectors do not allow employers to successfully implement policies to meet this goal.

Option Analysis

Rising healthcare costs and the inability of many Americans to financially compensate, there must be a policy enforced in a timely manner to increase the transparency of the price and quality of care received from medical providers. There are several ways to approach this; require all private health plans to provide a price tool for enrollees, use federal requirements for electronic health records (EHRs) to make price data available to physicians in computerized order entry's, or gather and report hospital-specific prices using state all-payer claims database.

Option 1: Patient-Targeted Policy Intervention

This option's main focus is on mandating the use of price transparency tools for enrollees. The policy intervention would require that all private health plans provide all enrollees with data on out-of-pocket and total prices using three parameters: provider-specific, patient-specific, and service-specific. Provider-specific data would reflect the type of provider and the prices negotiated between the plan and the provider. Patient-specific data would consider the patient's plan and benefit design and spending to date, and service-specific data would reflect the specific medical service that the patient expects to receive. These out-of-pocket price data would be available through a toll-free telephone number, website, and mobile application.

Large purchasers like the Federal Employee Health Benefit Program could require that the health plans they contract with provide these tools to all enrollees, not just the enrollees

covered by large purchasers. Another approach is to pass a state law requiring all carriers with third-party administrators that contract with the state employee plan to provide a price tool to all enrollees. Another strategy is for Congress to pass federal legislation imposing the price-tool requirement on both self-funded plans and fully insured plans (White et al., 2014).

The estimated reduction in total health spending from this intervention would be $18 billion over 10 years. These savings would result from some patients choosing a lower-cost provider using the price tool. This tool would give consumers and employers large control over their own healthcare and the ability to choose providers that best suit their circumstances. Individuals with minor conditions can choose a lower-cost provider even with the risk of lower quality treatment if that fits their values at the time. Conversely, those with very critical medical conditions could seek the highest quality of care, even at a higher expense if that is what is important to them. Employers could save money through employees seeking lower cost care. Healthcare providers, insurance companies, PBMs, and manufacturers will still likely be resistant to providing transparency of this level to the public due to potential loss of fiscal gain on their end, but due to their large control over the prices in the healthcare market, it will likely not have a large impact on their overall monetary gain.

Option 2: Physician-Targeted Policy Intervention

This option's goal is to require that EHRs (electronic health records) provide price data to physicians upon ordering laboratory and imaging services. This policy option would help inject price data into the plethora of factors that physicians consider when making recommendations to patients and aims to help physicians focus on the question of medical necessity rather than just lowering unit prices. This option would add a new core requirement to stage III meaningful use criteria within the CMS for both hospitals and nonhospital-based patients. The additional

requirement would be that prices for laboratory and imaging services be present within standardized price data. Each service's price would be programmed into the computerized provider order entry (CPOE) by the HER vendor and would be based on the allowed amount under the Medicare fee schedule. Medicare allowed amounts would provide a benchmark and allow physicians to consider resource costs at the point of order entry.

Price displays might lead physicians to order fewer tests for several reasons. They would likely make physicians consider whether a test would provide useful clinical information before ordering it. It may also encourage providers to discuss costs with their patients more freely and become more sensitive to the financial burden on the patient. By increasing access to financial data to physicians, there would be more opportunity for patients to ask physicians about the cost of certain services. Costs would likely lower for consumers overall because physicians will likely become more financially aware and avoid expensive tests that may be unnecessary.

A potential downside would be reduced orders for manufacturers, resulting in less financial influx for employees of the manufacturers. Consumers would not be provided with the data directly, but the access to costs would be increased greatly compared to our current situation. PBMs would not be greatly influenced by this policy because it does not have a direct effect on the price of pharmaceutical drugs. Health Insurance companies would benefit from this option because they would spend less money on costly imaging and laboratory fees. The estimated 10-year savings from this policy option is $27 billion (White et al., 2014)

Option 3: Policymaker-Targeted Policy Intervention

This policy option would focus on gathering and reporting hospital-specific prices using state all-payer claims database (APCD). An APCD is a database created by state legislative mandate that typically includes data derived from medical, pharmacy, and dental claims,

combined with eligibility and provider files from private and public payers, including insurance carriers (Miller, 2012). APCDs can be used to measure a variety of outcomes, including the use of preventative services, the efficiency of individual physicians, and the prevalence of specific diseases (White et al., 2014). Using APCDs to measure and publicly report the prices that public health plans have negotiated with individual hospitals will provide comparisons of negotiated prices that are hospital specific. States with this type of APCD-based hospital price reporting include Massachusetts, New Hampshire, Maine, and Rhode Island (Decker, 2019).

Patients may occasionally reference APCD-based hospital prices, but the main audience are employers, health plans, and policymakers. Employers can use the price data to identify high-price providers to avoid recommending them as a provider to their employees. Health Insurance providers can work in collaboration with employers to identify the most cost-efficient health packages for their enrollees. Policymakers can use the price reports to assess the level of competition in the market for hospital care. Manufacturers may be swayed to provide supplies at a lower cost to remain competitive, further lowering the overall cost to the consumers. PBMs would likely be unaffected by this policy. By providing the data on a public platform, health insurance companies, employers, and consumers would largely benefit and increase their overall knowledge and understanding of market prices and increase their ability to make financially aware decisions. This intervention produces an estimated $61 billion reduction in health care spending over 10 years through increased employer interest in narrow-network and tiered-network benefit designs, increased pressure on high-price hospitals to either justify or reduce their prices, and increased discussion of policy options for controlling prices, such as all-payer rate setting (White et al., 2014).

Recommendation: Option 3

Option 3 is clearly the best option on the table as it will save the most money overall through a 10 year period, it provides obvious benefits to insurance companies, employers, consumers, and policymakers, with negligible influence on PBMs and manufacturers. By creating an extensive database including all relevant pricing information that anyone can access creates a platform for hospital-pricing to be reduced and reduce the cost gap within the market.

Although Option 1 and Option 2 are both feasible and would produce great benefit in the health care industry, their scopes are not as broad as Option 3. Option 1 focuses on the consumers accessing the data through health insurance companies but has little influence on physician's influence on prices. Option 2 focuses on the exchange of physicians and laboratory and suppliers, which would in turn reduce the costs of services but would not have as great of benefits to the consumers. Option 3, however, provides a database that could be of use to all parties and has the potential to aid future policymakers in reducing the rising cost of health care. The APCD-based hospital pricing database will allow consumers, providers, insurance companies, and manufacturers to make more educated decisions when setting and paying certain prices. Although this may influence manufacturers and PBMs ability to profit, it is the necessary first step America must take to reduce the overwhelming prices associated with receiving medical care.

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