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Insurance Service Rate Transparency to Consumers Likely to Dramatically Increase with Recent Federal Signaling

Why? What will this mean to healthcare providers?

Summary

On March 4, 2019, the U.S. Department of Health and Human Services (HHS) put out a proposed rule with public notice for comment[1] that could have earthquake sized implications for health markets. Embedded in the voluminous 21st Century Cures Act rule making publication was a request for public comment around future price transparency rules for providers. Discussed within the document is a push to require healthcare providers to publish the actual negotiated insurance reimbursement service rates by insurance plan. This would give healthcare purchasers/patients much more transparency into service costs and the variability among providers of these costs than what is currently widely available. At the core there are two questions this public notice is evaluating.

1. How much price transparency should be available to patients?
2. How should patients be able to access this price information?

The public response to these two questions, along with the subsequent HHS rule making, could dramatically impact how consumers purchase healthcare. This potential market disrupter means providers should follow this topic closely and begin developing a strategy for possible outcomes.

So Why the Concern About Price Transparency?

High deductible health plans (HDHP) have exploded in popularity. This has been driven by employers and individuals desire to purchase healthcare based on price. A HDHP has a higher deductible than a traditional insurance plan. In exchange for the higher deductible the plan's monthly insurance premium is lower. A high deductible plan (HDHP) can be combined with a health savings account (HSA), allowing the individual to pay for certain medical expenses with money free from federal taxes.[2] Over 40% of adults 18 to 64 with employment-based insurance are covered under an HDHP.[3] This is an increase from under 16% as recently as 2007. And employer sponsored insurance covers about 50% of the population in the U.S.[4] The volume of people subject to a HDHP is high.

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[1] Federal Register Vol 84, No 42. Department of Health and Human Services) 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program (2019 Mar 04). Regulations.gov. Retrieved 3/31/2019

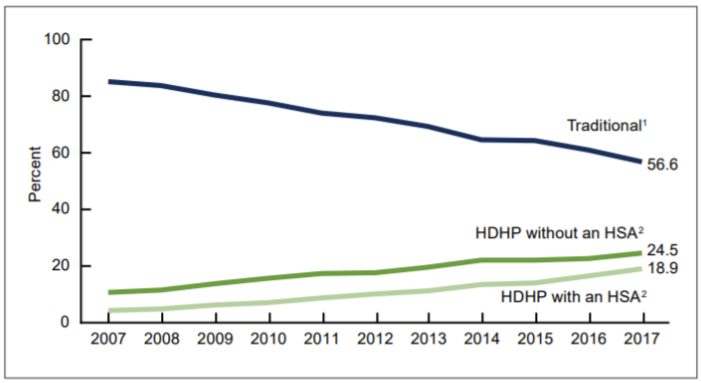
[2] Healthcare.gov. High Deductible Health Plan. https://www.healthcare.gov/glossary/high-deductible-health-plan. Retrieved 3/31/2019

[3] Cohen, Robin A, Zammitti, Emily. (August 2018) High-deductible Health Plan Enrollment Among Adults Aged 18–64 With Employment-based Insurance Coverage. https://www.cdc.gov/nchs/data/databriefs/db317.pdf. Retrieved 3/31/2019.

[4] Henry J Kaiser, Health Insurance Coverage of the Total Population 2017. https://www.kff.org/other/state-indicator/total-population. Retrieved 4/22/2019

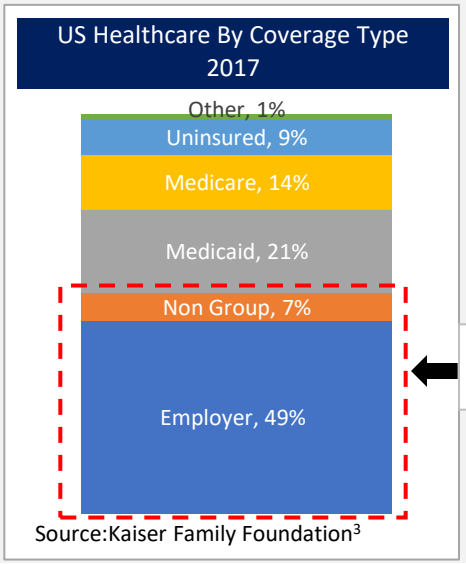
Among adults aged 18–64 with employment-based coverage, the type of coverage has changed over the past decade.

Figure 1. Percentage of adults aged 18–64 with employment-based coverage, by type of private coverage and year: United States, 2007–2017



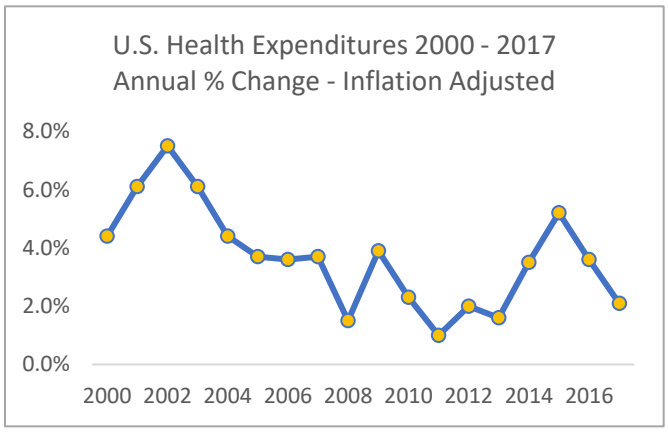
¹Significant linear decrease from 2007 through 2017 ($p < 0.05$).
²Significant linear increase from 2007 through 2017 ($p < 0.05$).
NOTES: HDHP is a high-deductible health plan. HSA is a health savings account. Estimates are based on household interviews of a sample of the civilian noninstitutionalized population. Due to rounding, percentages may not add up to 100 within each year. Access data table for Figure 1 at: https://www.cdc.gov/nchs/data/databriefs/db317_table.pdf#1.
SOURCE: NCHS, National Health Interview Survey, 2007–2017.

Over 55% of U.S. health coverage is in employer or individual plans, where HDHP have grown in popularity



Source:Kaiser Family Foundation[3]

HDHP growth has been spurred by efforts to stem the rising costs of healthcare. U.S. healthcare expenditures have consistently outpaced inflation.[5] The idea is that high deductible plans make plan beneficiaries more price conscious to their healthcare needs. The best outcomes of a more price conscious beneficiary are lower unneeded plan utilization, as well as to introduce a shopper mindset for beneficiaries. In this context, a shopper mindset is the idea that that beneficiaries will shop around for more affordable needed healthcare that still meets their quality needs.



U.S. health expenditures, while recently growing at a slower pace, are still well above inflation

Source: Peterson-Kaiser Health System Tracker[5]

[5] Healthsystemtracker.org. National Health Spending Explorer. https://www.healthsystemtracker.org/health-spending-explorer/?display=Annual%2520%2525%2520Change%2520. Retrieved 4/22/2019.

What Has Been the Result of HDHPs Thus Far?

The idea of what HDHPs are supposed to do and what is actually happening is complex. There is much debate on whether these plans reduce only unneeded healthcare utilization or if they also reduce needed healthcare utilization. Are people not going to the doctor for a simple common cold that would get better on its own? Or are they not going to the doctor when they have pneumonia and then the pneumonia turns into potentially deadly sepsis? There is ongoing research around this issue.

It's the second goal of HDHP, around creating a shopper mindset, that this HHS discussion around price transparency is trying to help. In order to fully flex the shopper mindset, beneficiaries need information on what services will cost them from different providers (cost in this article refers to patient out of pocket costs). Currently, getting this price information is largely manual and painful for beneficiaries. In most purchase decisions in life, consumers make trade-offs for cost vs. quality. Where perceived quality meets an acceptable price, a transaction is made. This quality vs. price trade off is done at an individual level, with each potential buyer independently evaluating a product or service's quality against its price. Different buyers have different constraints that influence this decision too, such as their amount of disposable income. Currently, in healthcare, there is limited but growing amount of information on group or individual provider quality. However, provider price is still largely a black box. Thus the price vs. quality tradeoff is nearly impossible to determine when purchasing healthcare. To compare currently buying healthcare to buying groceries, it is like shoppers go to the store, put things in their grocery cart, and when they get to the cashier hope they can afford it. Further, the ability to easily review prices from many different stores, to see who has cheaper avocadoes is incredibly limited.

Previous Efforts at Price Transparency

"We are just beginning on price transparency," CMS Administrator Seema Verma recently said. There have been some efforts around price transparency from Federal and State governments as well as well as private industry but so far these efforts have had limited results. Most recently, as of Jan 1, 2019, the Trump Administration is requiring that all hospitals post their chargemaster "sticker" prices online. These massive chargemasters are inflated prices, for every service, that no one actually pays. Each hospital creates their own charge master prices which typically have little connection to what negotiated rates are between provider and insurer. Other previous price transparency efforts include state all payer claims databases and some healthcare technology companies working with employers to help guide patients to cost effective providers. Both the all payer databases and the healthcare technology firms suffer from the difficulty in getting access to insurance plan negotiated rate price data by provider. Further, neither the all payer databases or technology offerings make their information available to the general public.

What Price Information is Currently Available?

Most consumers know their out of pocket costs will be less if they go to an in-network provider rather than an out of network provider. However, this is the extent of price due diligence for many. Many consumers don't realize that there is often a wide variance of contracted rates for the same service among in-network providers. Even if you think you are being a good consumer by only going to in-network providers, you could still be over paying. This is due to the balance of power in the insurer and provider relationship. Insurers negotiate contracted rates with each provider. Providers obviously want more and insurers want to pay providers less for services. Each party negotiates until they either come to an agreement or they don't and thus the provider is out of network on the plan.

A Personal Example on Negotiated Rate Variation

I recently needed a CT scan for minor preventative care. I visited my primary care physician who wrote the CT order and referred me to a radiology group within the same medical office building. I have a high deductible health plan similar to what is outlined above. I care about price, as I am on the hook for paying for everything up to my deductible. During the scheduling process, I learned what my out of pocket costs would be for the CT scan from that particular radiology group. As I have not hit the deductible on my insurance plan, I am paying the full negotiated insurance rate. Thinking the rate I was quoted was high, I called several other in network radiology centers. After a long drawn out process, requiring countless phone calls exchanging exact CPT service needs, I found a free-standing center with high reported quality, where the in network, same service insurance net provider rate was 3X LOWER in price. I was happy to pocket the ~$1,000 difference but frustrated by the lack of information transparency. I work in the healthcare industry and had difficulty navigating it. How many others struggle with the same thing? My health insurance company provided no support in directing me to providers it had better negotiated rates with, nor did the providers advertise their pricing to my specific insurance plan. How can we be a better consumer if we do not have access to basic price information necessary to be one?

What Should Providers Do to Prepare for Potential Price Transparency?

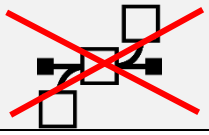
There is no boogeyman. Providers are in business to make money; insurance firms have the same goal. Both operate within the bounds of the current regulations. When these regulations change, they must adapt their business models to be successful. So, what can providers do to prepare for potential hyper price transparency driven by new federal regulations?

1. The first thing is to **write comments to HHS to shape the conversation.** Displaying price information will be a huge challenge and HHS needs to consider a host of issues. For example, will service items be standardized to enable price comparisons? Often there are multiple services billed as part of a course of treatment. How will bundled services and add on services be calculated? Also, patients don't often know the services they need until they are being seen by a provider, which would limit their ability to comparison shop. Further, price is not an exclusive determinant for healthcare purchasing. Consumers will evaluate the combination of price and quality. How would both be presented? Who will be responsible for the accuracy of this information? True price transparency will need to account for this complexity.

2. **Develop an understanding of where your organization is priced by major insurance plan**. Are you the high negotiated insurance rate provider in your market? Is this different by type of service and specialty? If so, articulating your organization's value proposition from differentiated quality or service level will become more important under increased price transparency.

Price transparency will likely impact some services and specialties more than others. Potential patients will shop for services they frequently need, can plan for, and where they don't feel the care quality differences matter. Highly utilized outpatient and ancillary services are most likely to face the most potential patient volume redirection based on price. Further, medical or surgical services that are non-life threatening, planned, and where there are relatively few collective services billed as part of the care plan are also expected to face patient price sensitivity. Some of the most impacted specialties would include Labs, Radiology, Gastroenterology, Primary Care, and Orthopedics.

Services less likely to see patient shopping include inpatient services, life threatening conditions, services where the care standard includes multiple bundled services thus making it harder for patients to price shop.

Services Most Likely to Be Impacted by Price Transparency	
Outpatient Services	
Planned Services	
Services Not Associated with Life Threatening Conditions	
Non Bundled Services	

When Could Changes Occur?

The release's public comment period allows for comments through May 3, 2019. HHS appears merely to be in the information gathering stage on price transparency. After receiving public comment, the agency is expected to evaluate submitted comments, and then propose rules after. The timing for this to occur is unknown, however we anticipate the duration to publish proposed rules (with additional comment period) will be relatively soon, and the implementation may take years to complete.

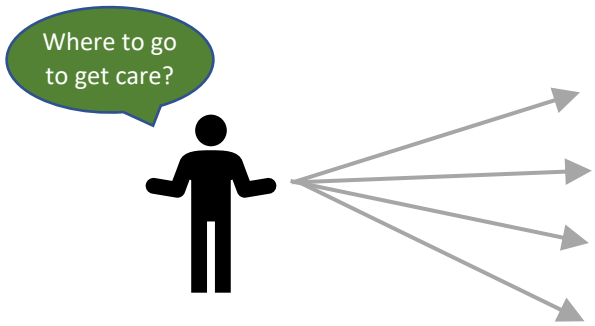
In Closing

A lack of price transparency is an acute issue impacting a healthcare consumer's ability to choose the most effective care. The price for the same service for the same insurer can vary widely from one provider to another. An increase in health insurance products where patients pay more of the costs (HDHP) has increased the need for transparency. Increasingly the Federal Government is creating regulations to mandate certain insurance price transparency. So far these regulations have been mostly ineffective but

it feels like the recent proposal to post health insurance net rate information is its most ambitious and potentially impactful to date. There is time for provider organizations to prepare but they need to start evaluating today.

The Challenge of Where to Get Care Most Efficiently?

Potential Patient



Potential Patient's Insurance	
Name	Acme Insurance
Deductible	$6,700 Annual
Deductible Met	No

Potential Providers for Service

Provider	Insurance	Service	Quality[1]	Service Net Insurance Rate
Provider 1	Acme Insurance	CPT 70492	Medium	$1,200
Provider 2	Acme Insurance	CPT 70492	High	$750
Provider 3	Acme Insurance	CPT 70492	Medium	$400
Provider …	Acme Insurance	CPT 70492	Medium	Varies

High — Public Information Availability — Low

1. Composite – e.g. Physician Compare, Hospital Compare, Leap Frog

APPENDIX

Health and Human Services - List of Questions Around Price Transparency

1. Price - What to show?	2. Price - Where to show?	3. Price - Challenges to showing?
Should prices reflect insurance plan negotiated rates and charge master pricing? Should patient responsibility also be reflected and broken out by type?	How real time should this price information be? Should this depend on the type of care received?	Would showing information violate any HIPAA concerns?
Should price information be shown by CPTs, Diagnosis Related Groups, and bundled prices?	How should price information be made available? Public websites, directly through providers, other?	Would the price information patients receive be binding? Who would be in responsible for this information's accuracy?
Should reference pricing be included? e.g. percent of Medicare		Does the technology currently exist to be able to post this information in a useful way for consumers?
How should value based risk sharing service arrangements be reflected?		
What types of providers would need to show price information? E.g. specialty, place of service		

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