

**Price Transparency in American Healthcare:  
Public Policies to Support Market-Based Solutions**

**Prepared by: Laura Mortimer  
Master of Public Policy Candidate  
The Sanford School of Public Policy  
Duke University  
Faculty Advisor: Peter Ubel**

*Disclaimer: This student paper was prepared in 2014 in partial completion of the requirements for the Master's Project, a major assignment for the Master of Public Policy Program at the Sanford School of Public Policy at Duke University. The research, analysis, and policy alternatives and recommendations contained in this paper are the work of the student who authored the document, and do not represent the official or unofficial views of the Sanford School of Public Policy or of Duke University. Without the specific permission of its author, this paper may not be used or cited for any purpose.*

**TABLE OF CONTENTS**

*Overview* .....3

*Part One: The Problem of Price Opacity* .....5

    I.    The Chaos and the Veil.

    II.   Healthcare Price Transparency

    III.  Impetus for Market Change

*Part Two: Public Policy Response*.....10

    I.    Rationale for Government Intervention

    II.   Federal Price Transparency Policy

    III.  State Policy Initiatives

*Part Three: Private Market Solutions*.....20

    I.    Market Overview

    II.   Strategic Goals and Data Challenges

*Part Four: Challenges Moving Forward*.....30

    I.    Patients as Consumers

    II.   Regulatory Barriers

    III.  Delivery System Challenges

Appendix.....37

## OVERVIEW

The United States has the most expensive healthcare system in the world. We pay more money per capita for care than any other country – around three times the OECD average.<sup>1</sup> Healthcare accounts for nearly a quarter of our federal budget, and the average family of four in America pays over \$20,000 out-of-pocket each year for care.<sup>2</sup> And yet, our health outcomes are no better than those of countries that spend far less money on care; we receive considerably less bang for our buck.

As prices rise and we spend both more public *and* private dollars on healthcare, policy makers and other stakeholders must find ways to build more rational economic decision-making into the system. Unfortunately, the fee-for-service model makes this change difficult because it fundamentally misaligns incentives between patients, payers, and providers. Absent a complete overhaul of fee-for-service, several regulatory reforms and market innovations are essential to bending the healthcare cost curve.

Health policy experts agree that lack of price transparency is a major part of the problem.<sup>3</sup> Patients often do not know the amount they will pay for care until they receive a bill, weeks or even months later. As consumer-driven healthcare becomes more the norm and patients pay more out-of-pocket for care, their ability to make value-based decisions is severely limited by the absence of treatment cost information. Functional, competitive markets require that all participants have access to complete, correct information regarding their choices. The American healthcare market is far from this ideal.

This paper reviews the price transparency problem in four parts. Part One explains the issue in more detail and provides a basic economic framework through which to understand the problem. Part Two presents an overview of government involvement in healthcare price transparency and includes policy initiatives at both the state and federal levels. Part Three covers private market involvement in the price transparency movement and shows how digital, cloud-based private market tools are making patients better healthcare consumers. Part Four looks ahead to future challenges in healthcare price transparency and outlines policy recommendations to ensure the movement's success.

The following chart summarizes these key policy recommendations. State governments may be better positioned to implement some of these changes, such as establishing all-payer claims databases, whereas federal policy makers should enact others, such as Medicare data disclosure guidelines. These policies can all support market-based healthcare price transparency reforms and effectively allow for public-private incentive alignment and collaboration. As long as fee-for-service payment remains in United States healthcare, these types of policies and partnerships are essential to creating more competitive markets and ultimately improving population health.

---

<sup>1</sup> OECD 2011 Health Data: "Total Health Expenditure Per Capita, US\$ PPP." Available at: <http://www.oecd.org/els/health-systems/oecdhealthdata2013-frequentlyrequesteddata.htm>

<sup>2</sup> 2012 Milliman Medical Index. Measures total cost of healthcare for a family of four earning median income and covered by a PPO. Available at: <http://www.milliman.com/uploadedFiles/insight/periodicals/mmi/milliman-medical-index-2012.pdf>

<sup>3</sup> Emanuel, Ezekiel, et al. "A Systemic Approach to Containing Health Care Spending." *The New England Journal of Medicine*. September, 2012.

*Policy Recommendations to Support Healthcare Price Transparency:*

- Mandate disclosure of physician quality and patient outcomes data alongside price information to illustrate value or cost-effectiveness
- Simplify payment models and offer clinical decision aids to help patients – particularly those with high deductible insurance plans – understand financial toxicity of treatment options and make decisions as savvy consumers
- Use value-based insurance design to better align payers' and patients' incentives and nudge patients towards higher value care
- Ban gag clauses in contractual agreements between insurers and providers
- Establish mandatory all-payer claims databases in every state
- Revise the Qualified Entity program under ACA Section 10332 to ensure all entities – public, private, or nonprofit – access to Medicare claims data
- Standardize public disclosure process and clarify data management guidelines to prevent abuse and misunderstanding of medical claims data
- Limit time period or scope of financial data released to prevent provider collusion around healthcare prices
- Provide additional resources to study the effects of price transparency on patients' treatment and insurance purchasing decisions

## PART ONE: THE PROBLEM OF PRICE OPACITY

### I. The Chaos and the Veil

Princeton health economist Uwe Reinhardt has described healthcare pricing in the United States as “chaos behind a veil of secrecy.”<sup>4</sup> Unregulated and anticompetitive price discrimination characterizes this chaos, and proprietary pricing schemes – which some claim as trade secrets – form the veil. Price discrimination is the practice of charging different payers different prices for the same products or services. Many industries price discriminate. Airlines, for example, charge consumers different prices for tickets on the same flight, usually depending on when they purchase tickets. Price discrimination allows companies to maximize profit by charging higher prices to consumers who have more inelastic demand for goods (e.g. the businessman who pays a heftier fee to fly to an important meeting the next day).

The American healthcare industry uses price discrimination in much less straightforward and competitive ways, however. Journalist Steven Brill drew attention to this situation in his 2013 *Time Magazine* cover story, “Bitter Pill: Why Medical Bills Are Killing Us.” Brill urged readers to step back from the oft-debated question of *who* should pay for healthcare, and instead focus on the underlying issue of why medical bills are so high – why the same treatments cost far more in America than they do in other countries, why prices for the same treatments vary considerably even within the U.S., and why few consumers know this and even fewer can make healthcare decisions based on cost.<sup>5</sup>

*Healthcare prices in America generally reflect providers’ market power, not the quality of care they provide*

One answer to Brill’s questions is that healthcare prices in America generally reflect providers’ market power, not the quality of care they provide. Varying degrees of market power lead to varied prices, another characterization of the chaos. Consumers pay different prices for the same services in different markets, and even different prices *within* markets.

Experts agree that healthcare price variation results mainly from physician behavior, unlike in more competitive markets where consumer demand drives prices.<sup>6</sup> “While acting in patients’ interest is an ideal,” explains Duke health economist Frank Sloan, “in practice, professional norms operate imperfectly because the strong financial motives to supply profitable services may lead some physicians to take advantage of patients by exploiting the information asymmetry.”<sup>7</sup>

*Patients have very limited access to price information at the point of care*

Patients have very limited access to price information at the point of care, so establishing a fair market price or going rate for medical services is nearly impossible. The Pacific Business Group on Health states the problem in this way: “The lack of information about price and quality prevents purchasers and

<sup>4</sup> Reinhardt, Uwe. “The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy.” *Health Affairs*. Vol 25, No 1. January/February 2006.

<sup>5</sup> Brill, Steven. “Bitter Pill: Why Medical Bills Are Killing Us.” *Time Magazine*. March 2013.

<sup>6</sup> Newhouse, J, and Garber, A. “Geographic Variation in Medicare Services. *The New England Journal of Medicine*. 368: 1465-1468.

<sup>7</sup> Sloan, Frank, and Hsieh, Chee-Ruey. *Health Economics*. Cambridge, MA. 2012. 16

consumers from being able to answer the most basic questions when they purchase services: Who does a good job? What does it cost?"<sup>8</sup>

This lack of price transparency for consumers is the veil that shrouds the chaos. Closed-door negotiation between private insurers and providers, along with heretofore undisclosed Medicare claims data, leads to information asymmetry. Non-governmental healthcare stakeholders are hesitant to release data publically because harboring that information provides them with a competitive advantage.<sup>9</sup> In perfectly functioning, competitive markets, however, all participants have access to complete and correct information. Perfect information means consumers – patients – having open access to prices and quality metrics for all providers. Most consumers in U.S. healthcare markets have neither.

## II. Healthcare Price Transparency

The definition and goals of price transparency often vary by context. This paper defines transparency in two ways – from the individual and societal perspectives.<sup>10</sup> First, for individual consumers, price transparency is the free availability of provider-specific out-of-pocket price information for specific healthcare services. Prices should account for all costs associated with clinical services and include any discounts associated between third party payers and providers. The societal perspective considers the total cost of care (not just consumer out-of-pocket costs) and, in this paper, primarily means Medicare costs.

*Price transparency is the free availability of provider-specific out-of-pocket price information for specific healthcare services*

Healthcare price transparency discussions typically do not include pharmaceuticals purchased outside of clinical settings. Pharmacies make drug prices easily available, so consumers know the prices they pay out-of-pocket at pharmacy counters. The problem of price opacity occurs more frequently at the point of care, so transparency focuses mainly on physician and hospital services, treatments, tests, and procedures.

Several institutional barriers make it difficult for patients to obtain accurate price information at the point of care. These barriers include the difficulty of predicting healthcare service needs in advance, confusing health insurance benefits structures (particularly coinsurance), inconsistent provider billing practices, laws preventing hospital price disclosure, and contractual agreements – known as gag clauses – between providers and insurers.<sup>11</sup> Additionally, coding and price manipulations may occur in the billing process that make prospective patient out-of-pocket price estimations nearly impossible.

Making matters more challenging, healthcare providers have little incentive to make prices transparent to consumers. Most providers do not consider cost containment their

<sup>8</sup> Policy Brief: Price Transparency. Pacific Business Group on Health. 2013. Available at [http://www.pbgh.org/storage/documents/Policy\\_brief\\_transparency\\_2013.pdf](http://www.pbgh.org/storage/documents/Policy_brief_transparency_2013.pdf)

<sup>9</sup> Ibid.

<sup>10</sup> United States Government Accountability Office Report: Healthcare Price Transparency. September 2011. Available at <http://www.gao.gov/assets/590/585400.pdf>

<sup>11</sup> Ibid.

responsibility and prefer not to discuss cost of care with their patients.<sup>12,13</sup> Regardless, physicians may have just as much trouble accessing patient out-of-pocket costs as patients themselves do, depending on the health system and insurance benefits.

*Several institutional barriers make it difficult for patients to obtain accurate price information at the point of care*

The current healthcare price transparency movement has goals from both the individual and societal perspectives. First, it seeks to provide individual consumers (patients) with information necessary to make better decisions about their healthcare – decisions that take into account possible financial toxicity of treatment, as well as other side effects.

These patients pay some portion of their healthcare bill out-of-pocket and generally have private health insurance. Second, the movement hopes to bend the healthcare cost curve and reduce overall societal costs. Economic theory suggests that greater access to price information will ultimately enable consumers to exert more market power and choose healthcare that provides greater value. As consumers make more economically rational decisions about care and demand better value, the price of care should eventually decrease.

Lack of price transparency poses problems for Medicare, in addition to private pay patients. Although estimates vary, the GAO reports that around ten percent of Medicare dollars are spent improperly and considered waste, fraud, or abuse.<sup>14</sup> Even though the HHS Office of the Inspector General conducts periodic provider audits, the opacity surrounding specific use of Medicare funds still leads to inefficient use of public tax revenue.<sup>15</sup> And, since Medicare fee schedules often serve as a benchmark for private insurers, unnecessarily high Medicare costs could contribute to inflated rates from all payers.

### III. Impetus for Market Change

The movement to make United States healthcare prices more transparent has experienced a strong resurgence recently due to consumer-driven healthcare, robust technological innovation, and the need for healthcare cost containment. Policy makers and health economists often see consumer-driven care and health information technology as possible sources of cost containment. Web and cloud-based innovations could provide tools that help patients become better consumers of care. More complete financial information can empower patients to make value-based decisions similarly to consumers in other markets. Without widely available price and quality metrics, however,

*Without easily accessible price and quality information, consumer-driven healthcare places unreasonable expectations on patients*

<sup>12</sup> Tilburt, Jon et al. "Views of US Physicians About Controlling Health Care Costs." *The Journal of the American Medical Association*. Vol 310, No 4. 2013.

<sup>13</sup> Shrank, William. "Physicians' Perceived Knowledge of and Responsibility for Managing Patients' Out-of-Pocket Costs for Prescription Drugs." *The Annals of Pharmacotherapy*. Vol 40, No 9. 2006.

<sup>14</sup> "Fraud Detection Systems: Centers For Medicare and Medicaid Services Needs to Ensure More Widespread Use." Government Accountability Office. June 2011. Available at <http://www.gao.gov/new.items/d11475.pdf>

<sup>15</sup> See *Consumer's Checkbook v. HHS* (D.C. Cir. 2009) dissenting opinions.

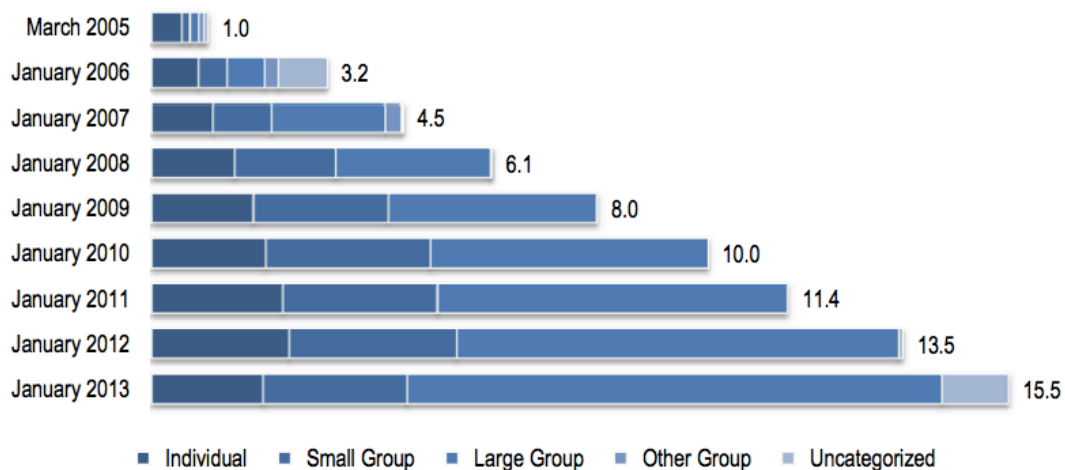
consumer-driven healthcare places unreasonable expectations on patients: it expects them to behave like rational consumers without having information necessary to do so.

**Consumer-Driven Healthcare**

The concept of consumer-driven healthcare has become increasingly prominent in health insurance design over the past fifteen years. It involves a shift in decision-making power from third party payers and other management entities, to patients.<sup>16</sup> Payers and policymakers hope consumer-driven care will help solve what many argue is a moral hazard problem: patients spend third party payers’ money less judiciously than they spend their own. High-deductible health plans, the hallmark insurance plans of consumer driven healthcare, may mitigate this problem by increasing patient cost-sharing and making patients pay more for care before insurance covers bills.

Consumer-driven health plans have gained significant market share over the last decade (see Figure 1). The percentage of large employers offering high deductible health plans with a savings option jumped from 8 to 43 percent between 2005 and 2013.<sup>17</sup> Employers, insurers, and other third party payers who support high-deductible or consumer-driven health plans believe increasing patients’ financial “skin in the game” will help contain costs since patients will purchase less low-value care.

**Figure 1.** Growth of HSA-Qualified High-Deductible Health Plan Enrollment, Covered Lives (Millions), March 2005 to January 2013



Sources: AHIP Center for Policy and Research, 2005 – 2013 HSA/HDHP Census Reports.  
 Notes: For this census, companies reported enrollment in the large- and small-group markets according to their internal reporting standards, or by state-specific requirements for each state. The “Other Group” category contains enrollment for companies that could not break down their group membership into large- and small-group categories within the deadline for reporting. The “Uncategorized” category was necessary to accommodate companies that were able to provide information on the total number of people covered by HSA/HDHP policies, but did not provide a breakdown by market category within the deadline for reporting. HSAs were authorized in 2003 and entered the market in January 2004.

<sup>16</sup> National Business Group on Health. Report: “What Are Consumer-Driven Health Care Plans?” Available at <http://www.businessgrouphealth.org/pub/f315acf5-2354-d714-51ed-8a85aa7ebea0>  
<sup>17</sup> Kaiser Family Foundation. Employer Health Benefits, 2013 Annual Survey. Exhibit 8.3.



The 1970s RAND health insurance study showed that greater patient cost-sharing led patients to use fewer healthcare services, suggesting that financial “skin in the game” decreases moral hazard.<sup>18</sup> But researchers have conducted very few other studies to show correlation between increased cost-sharing and decreased moral hazard in third party payment systems.

Supporters of consumer-driven healthcare argue that, by forcing consumers to pay more upfront and out-of-pocket, high-deductible plans will make the American healthcare market more closely resemble more functional and competitive markets. So-called “free market medicine” would theoretically bring prices down over time as prices more accurately reflect production costs.<sup>19</sup> Many health economists question this theory, however, arguing that too many differences exist between healthcare markets and other markets for free market medicine to function in this way.<sup>20</sup>

*Price transparency in high-deductible health plans makes competitive free market medicine a more realistic possibility. Still, uncertainty surrounding individual medical needs makes information asymmetry unavoidable*

Three key differences are the prices elasticity of demand for healthcare services, the availability of information to healthcare consumers, and the way healthcare prices are set. Unlike in other markets where elasticity of demand generally remains consistent for individual consumers (absent income changes), a consumer’s demand for healthcare may remain relatively elastic until the consumer experiences a negative health event.<sup>21</sup> At that point, her demand for healthcare may instantaneously become very inelastic, as she needs immediate medical care. Such rapid and often unforeseen changes in demand elasticity make price discrimination in healthcare unfair for consumers.

*“In the high deductible health plan ideal, prices would be set not through negotiations with health plans, but based on consumers’ willingness to pay.”*

Asymmetric information in the form of price opacity also constitutes a major difference between this market and competitive markets. Finally, consumer-driven healthcare is currently limited by the complicated way in which healthcare prices are set. Because they have greater market power, third party payers typically exert more control over prices than individual consumers do. According to health policy experts Paul Ginsburg and James Robinson, “In the high deductible health plan ideal, prices would be set by doctors and hospitals, not through negotiations with health plans, but based on their assessment of consumers’

<sup>18</sup> RAND’s Health Insurance Experiment (HIE). Conducted 1971-1986. Available at: <http://www.rand.org/health/projects/hie.html>

<sup>19</sup> Howard, Paul. “Free Market Medicine.” *National Review Online*. 20 August, 2008. <http://www.nationalreview.com/articles/225363/free-market-medicine/paul-howard>

<sup>20</sup> CRS Report for Congress: “Does Price Transparency Effect Market Efficiency? Implications of Empirical Evidence in Other Markets for the Healthcare Sector.” 29 April, 2008. Note 9, at 9.

<sup>21</sup> Liu, Su, and Chollet, Deborah. “Price and Income Elasticity of Demand for Health Insurance and Health Care Services: A Critical Review of the Literature – Final Report.” Mathematica Policy Research, Inc. 24 March, 2006.

willingness to pay.”<sup>22</sup> Third party payment drives a wedge between price and quality, making consumer-driven care difficult.

### *Technological Innovation*

A second key driver of the price transparency movement is the significant advancement in health information technology (HIT) since the late 1990s. This change differentiates the current movement from previous efforts in important ways. From the electronic health record and its virtual patient portal, to telemedicine and remote health monitoring tools, technological innovations play an increasingly prominent role in patient care.<sup>23</sup> Cloud-based patient support tools and information databases, in particular, shift control from providers to patients. As HIT continues to reduce information asymmetry between physicians and patients, patients will acquire the resources to participate as more actively in treatment decisions.

Patient activation (or engagement) is an important clinical goal. Activated patients participate more in shared decision-making, experience better health outcomes, and report better healthcare experiences than less engaged patients.<sup>24</sup> Still, researchers remain unsure about how patient activation affects patients’ decisions around healthcare costs. Even engaged patients may still lack the information necessary to act as rational consumers. Clinical conversations between patients and providers typically do not include discussions of financial burden or cost, although many experts argue that they should.<sup>25</sup> As patient cost-sharing increases, however, these conversations about treatment cost become more important.

Advances in HIT could help facilitate these conversations. Mobile applications, cloud-based data hubs, electronic health record patient portals, and other online platforms all have the capacity to translate and transfer health information to patients securely. Aside from data acquisition and disclosure barriers, the greatest challenges surrounding healthcare price transparency involve formatting and presenting information in ways that patients find useful and can easily understand. Many experts agree that HIT does not lack data, but rather lacks information that patients actually find useful when making medical decisions.<sup>26</sup> Patients’ increasing reliance on and access to mobile technology makes healthcare systems ripe for mobile innovations around price transparency.

*Patients’ increasing reliance on and access to mobile technology makes healthcare systems ripe for mobile innovations around price transparency.*

---

<sup>22</sup> Robinson, James, and Ginsburg, Paul. “Consumer-Driven Healthcare: Promise and Performance.” *Health Affairs*. Jan 2009.

<sup>23</sup> Jayanthi, Akanksha. “10 Biggest Technological Advancements for Healthcare in Last Decade.” *Beckers Hospital Review*. 28 January, 2014. <http://www.beckershospitalreview.com/healthcare-information-technology/10-biggest-technological-advancements-for-healthcare-in-the-last-decade.html>

<sup>24</sup> Hubbard, Judith and Greene, Jessica. “What the Evidence Shows about Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data on Costs.” *Health Affairs*. February 2013.

<sup>25</sup> Ubel, Peter, et al. “Full Disclosure: Out-of-Pocket Costs as Side Effects.” *Journal of the American Medical Association*. 369: 16. 17 October, 2013.

<sup>26</sup> Stewart, Will. General Partner, Rogers Venture Partners. Interview. Available at <http://www.rogersvp.com/news/company-news/pokitdok/interview-with-lisa-maki-will-stewart/#.UxjpiPSwKeV>

## PART TWO – PUBLIC POLICY RESPONSE

### I. Rationale for Government Intervention

Both federal and state governments have important roles to play in facilitating healthcare price transparency. While conservative politicians typically favor less government regulation in markets, policies to increase consumers' access to healthcare cost information have recently received bipartisan support. For example, the *Healthcare Price Transparency Promotion Act of 2013* promoted market transparency and was sponsored by legislators from both sides of the aisle.<sup>27</sup> Most politicians in Washington D.C. recognize the market failure of asymmetric information in healthcare and support some public policies to help correct this failure. The price transparency movement promotes regulatory changes that will facilitate innovative, technology-based solutions to this problem.

#### *Fiscal Responsibility to Taxpayers*

Two main arguments support government intervention. First, federal and state governments, as large healthcare payers, have an obligation to taxpayers to make optimal use of public funds. As noted in Part One, greater price transparency in healthcare may lead to more competitive pricing, which would allow both payers and patients to receive greater value for every dollar spent. The federal government pays the largest share of the nation's medical bills, so it has a vested interest in purchasing the highest value care possible. In addition to promoting competition, transparency also enables better government oversight of dollars spent on healthcare. In an amicus curiae brief for a landmark 2009 healthcare price transparency case, the American Association of Retired Persons (AARP) called federal fiscal responsibility the strongest argument for policies promoting transparency:<sup>28</sup>

*Transparent  
healthcare markets  
make better use of  
taxpayer dollars*

*“Transparency of health care quality and cost information is essential to improving oversight of the federal government’s operations and activities, particularly its use of Medicare funds. As the agency responsible for administering health coverage for 43 million Medicare beneficiaries, HHS has the obligation to assure taxpayers and the public that Medicare spends its funds appropriately and efficiently.”*

Dozens of other leading national member organizations and advocacy groups submitted similar briefs, indicating widespread public support for government action. These organizations hold the government accountable for fulfilling this fiscal obligation. Especially as CMS increasingly adopts value-based purchasing strategies for Medicaid and Medicare, the federal government should come under greater scrutiny for waste, fraud, and abuse in healthcare spending.

<sup>27</sup> *Healthcare Price Transparency Promotion Act of 2013*. (HR 1326) 113<sup>th</sup> Congress. Introduced 21 March, 2013.

<sup>28</sup> Amicus Curiae Brief of AARP, et al., filed in *Consumers Checkbook Center for Study of Services v. HHS*, 554 F. 3d 1046 (D.C. Cir. 2009)

CMS has complete information regarding Medicare payments to providers and could easily share that information. Releasing this price data into the public domain could provide the information infusion necessary to stimulate broader information release at the state level, particularly through all-payer claims databases. Part Four describes challenges and important considerations associated with CMS data releases.

### *National Priority: Access to High Quality Care*

*Supporting price transparency initiatives should present minimal risk for those in political power*

The second argument for government involvement in healthcare price transparency connects economic value to national priorities around population health. The Department of Health and Human Services set forth national health and healthcare goals in its Healthy People 2020 initiative. While cost containment is not an explicit, stand-alone goal, most of the plan's objectives seek greater economic value in healthcare, reduce overuse of low-value care, and promote access to high value care.<sup>29</sup> Meeting these national objectives means making healthcare markets more competitive and reducing costs to make quality care more financially accessible for patients.

Supporting price transparency initiatives should present minimal risk for those in political power. Healthcare transparency laws and initiatives have garnered widespread, bipartisan political support at the federal level, as well as in many states.<sup>30</sup> Conservatives support price transparency as a market-based approach to increase efficiency in the medical marketplace. Liberals also value that greater efficiency could lower prices and create a more equitable marketplace by making high quality care more accessible to all consumers.

## **II. Federal Price Transparency Policy**

The federal government can significantly affect price transparency in healthcare markets because of its unique role as both a purchaser of care and regulator of payment policy. Public dollars fund nearly half of all healthcare spending in the United States, so the government wields tremendous market power – not unlike large private insurers.<sup>31</sup> As with insurance companies, CMS maintains provider claims data, hospital charge data, and reimbursement information. Unlike other insurance companies, however, CMS would not risk losing a competitive market advantage by sharing that data. As discussed in Part One, payers typically use Medicare reimbursement rates as a benchmark for establishing their own rates. The federal government therefore has a unique opportunity to impact market dynamics by making Medicare payment rates publically available.

*Transparency promotes efficient government spending by helping to prevent and expose waste, fraud, and abuse in Medicare and Medicaid*

<sup>29</sup> Healthy People 2020. "Topics and Objectives." Available at:

<http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx>

<sup>30</sup> Catalyst for Payment Reform. "Report Card on State Price Transparency Laws." 25 March, 2014.

Available at: <http://catalyzepaymentreform.org/images/documents/2014Report.pdf>

<sup>31</sup> CMS. "National Health Expenditures: 2012 Highlights." Available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf>

*The AMA has long fought to keep provider-specific Medicare payment rates out of the public domain*

The greatest barrier to this information exchange has traditionally been lack of provider willingness to share data. Medicare fee schedules, or payment rates, to hospitals are based on several factors, beginning with diagnostic-related group (DRG) codes and including other information such as geographic location. The Relative Value Scale Update Committee (RUC), an American Medical Association group composed mainly of specialty physicians, ultimately recommends hospital payment rates to CMS, and these rates largely determine doctors' salaries.<sup>32</sup> Many experts, including past CMS administrators, have criticized the RUC and the way Medicare sets its fee schedule.<sup>33</sup> In short, payments are based on the relative costs to physicians of providing care – not the value of that care to patients.<sup>34</sup>

Since the establishment of Medicare fee schedules in the early 1990s, CMS has not made provider-specific payment rates publically available. Providers, bolstered by the strong AMA lobby, have fought to maintain this secrecy, claiming the proprietary nature of the information as reason not to disclose it.<sup>35</sup> The federal government has made several legislative attempts to lift this veil and promote price transparency. The following pages contain a brief history of those efforts.

### ***Freedom of Information Act (1966)***

President Lyndon B. Johnson passed the Freedom of Information Act (FOIA) in 1966 to provide greater public access to previously undisclosed government information and documents. FOIA aims to enable greater private scrutiny that will, in turn, advance government oversight. Under FOIA, federal agencies must fulfill public requests for information, unless that information is protected from public disclosure by one of nine exemptions, or by one of three special law enforcement record exclusions.<sup>36</sup> Therefore, if a third party (patient, media, etc) requests information regarding individual physician Medicare payments, CMS must disclose that data unless an exemption applies. The Florida Medical Association case (1979) established this exemption, as described in the next section, rendering FOIA inapplicable in Medicare physician payment cases.

### ***Florida Medical Association Inc. v. Department of Health, Education and Welfare (1979)***

In 1979, the federal government planned to release a list of all physicians and providers who received Medicare reimbursement the previous year, as well as the amount paid to each physician. Prior to the release of payment data, the Florida Medical Association (FMA), along with six individual physicians and the American Medical Association, filed to enjoin what was then the Department of Health, Education, and Welfare (HEW) from releasing this data or any

---

<sup>32</sup> "Overview of Resource-Based Relative Value Update Scale." American Medical Association. Available at <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/medicare/the-resource-based-relative-value-scale/overview-of-rbrvs.page>

<sup>33</sup> Scully, Tom. "Medicare Physician Payments: Understanding the Past So We Can Envision the Future." Testimony before the Senate Finance Committee. Available at <http://www.finance.senate.gov/imo/media/doc/Scully%20Statement.pdf>

<sup>34</sup> Reinhardt, Uwe. "How Medicare Pays Physicians. *New York Times*. 3 December, 2010.

<sup>35</sup> See *Florida Medical Association v. Department of Health, Education, and Welfare* (M.D. Fla. 1979).

<sup>36</sup> *Freedom of Information Act* (1966). United States Department of Justice. [www.foia.gov](http://www.foia.gov)

similar reimbursement data in the future.<sup>37</sup> The FMA argued that physician payment data constituted an exemption to FOIA under the Privacy Act and therefore should not be made public.

Under considerable political pressure, HEW responded to the Florida injunction in 1980 with a policy prohibiting CMS physician payment disclosure, claiming that it would violate physicians' right to privacy: "Public interest in individually identified [provider] payment amounts is not sufficient to compel disclosure in view of the privacy interests of physicians."<sup>38</sup> This no-disclosure policy remained in place for nearly three decades, backed by a powerful AMA lobby and other physician groups whose competitive advantage in medical markets relied heavily on restricted public access to payment information.

*Florida v. HEW made FOIA inapplicable in Medicare physician payment cases, preventing public access to claims data*

### ***Consumer's Checkbook v. Department of Health and Human Services (2007)***

In the 2007 *Consumer's Checkbook* case, a D.C. district court ordered HHS to disclose similar Medicare payment data. The court later reversed its decision, claiming that the respondents had "not provided any evidence of alleged fraud that the requested data would reveal" that would outweigh physicians' privacy interests.<sup>39</sup> This decision tied the plaintiff's hands since he could not have proven fraud without the requested data. One D.C. Circuit judge disagreed with the court's decision, arguing that CMS should disclose the data regardless of whether or not fraud occurred. Judge Judith Rogers presented a persuasive dissenting opinion in favor of price disclosure:<sup>40</sup>

*Consumer's Checkbook v. HHS challenged the Florida ruling and set the legal stage for overturning it*

*[T]he requested data would shed light on HHS's fraud-detection and fraud-prevention efforts. For instance, the data could identify providers who perform a suspiciously large number of procedures in a given time period or submit claims for procedures that are outside [their] own practice areas. The data could therefore facilitate public monitoring of HHS detection and prevention of fraud. Additionally, to the extent that consumer choice could be enhanced by knowing which physicians are potentially responsible for wasteful or even fraudulent claims, release of physician-identifying data is consistent with HHS's goal of improving consumers' decisions about which medical providers to patronize. The public could utilize the requested information in determining whether HHS is fulfilling this stated goal.*

While *Consumer's Checkbook* did establish that third parties had the right to challenge the 1979 Florida injunction in cases where existing evidence proves fraud and abuse occurred, Judge Rogers' opinion advanced the argument even further by asserting that third parties should challenge the injunction regardless. This case helped set the stage for data disclosure

<sup>37</sup> *Florida v. HEW* (1979).

<sup>38</sup> 45 Fed. Reg. 79172 (November 28, 1980).

<sup>39</sup> *Consumer's Checkbook v. Department of Health and Human Services* (2007)

<sup>40</sup> *Consumer's Checkbook*, 1062.

initiatives that would occur over the next few years, culminating in Florida lifting the 1979 injunction in May 2013.

### ***CMS Health Data Initiative (2010)***

Meanwhile, the Obama Administration made efforts to establish a more open and transparent culture around public data sharing. The CMS Health Data Initiative is a central component of President Obama's 2009 Open Government Initiative, which aims to make government data resources available for public use. The CMS Initiative lays the foundation for Medicare physician payment data sharing, and promotes transparent, innovative, and safe use of that data. HHS ultimately intends for such data disclosure to raise awareness of community health and health system performance, and to facilitate private oversight of public programs. In this way, the CMS Initiative shares many of FOIA's goals around public-private partnerships and data use. According to the Obama Administration:<sup>41</sup>

*The CMS Health Data Initiative made price transparency a federal policy priority*

*Our goal is to unleash the power of private-sector innovators and entrepreneurs to utilize HHS data to create applications, products, services and features that help improve health and health care -- while also helping to create jobs of the future at the same time. By opening up our data, the idea is to help catalyze the emergence of a decentralized, self-propelled 'ecosystem' of innovators across America who leverage HHS data to help consumers, care providers, employers, journalists, local policymakers and others in ways that no one organization could possibly even imagine -- let alone build, deploy and scale.<sup>1</sup>*

As part of the Health Data Initiative, CMS has released an unprecedented amount of aggregated hospital payment data. In May 2013, CMS released charge data for the hundred most common inpatient procedures at three thousand of the nation's hospitals. The agency released additional, provider-specific Medicare claims data in March 2014 and will continue sharing data in the coming months and years. This data does not exist in a format easily accessible to patients. Rather, CMS intends for researchers, actuaries, and other health informatics specialists to use the data for oversight and performance monitoring purposes. Data management and abuse prevention remains a chief concern, so CMS needs more explicit guidelines around data use.

### ***Patient Protection and Affordable Care Act (2010)***

While not focused primarily on data sharing or price transparency, the *Affordable Care Act* does include provisions that promote disclosure and make health information less proprietary. The law authorizes CMS generally to transition from fee-for-service payment systems to pay-for-performance, or value-based reimbursement.<sup>42</sup> This monumental change will require significant data sharing and data analysis, in addition to payment reform through restructuring providers' financial incentives. The law couples payment reforms with more

<sup>41</sup> "Unleashing the Power of Data and Innovation to Improve Health." U.S. Department of Health and Human Services. [www.healthdata.gov](http://www.healthdata.gov)

<sup>42</sup> *Patient Protection and Affordable Care Act*. 111<sup>th</sup> Congress. March 2010.

robust and consistent health outcomes reporting. Measures such as thirty-day hospital readmissions rates and HCAHPS patient survey data will facilitate better provider quality transparency, but the ACA contains few explicit provisions regarding price transparency.<sup>43</sup>

*The ACA includes few explicit price transparency provisions*

The *Physician Payments Sunshine Act (Sunshine Act)* stands as an exception within the ACA. The *Sunshine Act* requires drug, medical device, and biologics manufacturers who participate in federal health care programs to report financial kickbacks or other items of value given to physicians and teaching hospitals.<sup>44</sup> Manufacturers must submit these reports to CMS annually, after which point FOIA presumably governs their accessibility and disclosure. While the *Sunshine Act* does serve as a form of price transparency, the data it regulates does not affect consumers as directly as other healthcare payment information, such as Medicare claims data.

### ***Health Care Price Transparency Promotion Act of 2013 (HR 1326)***

Representative Michael Burgess (R-TX) introduced the *Health Care Price Transparency Promotion Act of 2013* to the United States House of Representatives in early 2013. This bill would amend Title XIX of the *Social Security Act* to require all state Medicaid plans to disclose hospital charges to the public domain.<sup>45</sup> More importantly for consumers, it would also require Medicaid plans to provide all beneficiaries with estimated out-of-pocket cost information for healthcare services. While operationalizing this charge could prove difficult, especially in states whose Medicaid programs have very limited resources, the bill nevertheless represented a major bipartisan step towards price transparency promotion at the state level. The bill died in committee in March 2013, but its goals and objectives will likely reemerge in future sessions.

### ***Medicare Data Access for Transparency and Accountability Act (HR 2843)***

Another bipartisan price transparency effort, the *Medicare Data Access for Transparency and Accountability Act (2013)*, aimed to disclose Medicare claims data in a free, online public database.<sup>46</sup> Data would be organized by specialty or provider type, and searchable by provider or treatment. Importantly, the bill mandated that the database include a disclaimer stating that aggregate price data does not reflect provider or treatment quality. This disclaimer would essentially clarify to consumers that price and quality do not correlate with each other in American healthcare. The bill died in committee in June 2013, but still demonstrated bipartisan support for healthcare price transparency, and underscored the need for information databases to present quality metrics alongside price data.

*The Health Care Price Transparency Promotion Act and the Medicare Data Access for Transparency and Accountability Act both received strong bipartisan support in 2013*

<sup>43</sup> Ibid.

<sup>44</sup> *Physician Payments Sunshine Act*. Final Rule. Federal Register. Vol 78, No 27. 8 February, 2013.

<sup>45</sup> *Healthcare Price Transparency Promotion Act of 2013*. (HR 1326) 113<sup>th</sup> Congress. Introduced 21 March, 2013.

<sup>46</sup> *Medicare Data Access for Transparency and Accountability Act*. HR 2843. 113<sup>th</sup> Congress. Introduced 25 July, 2013.



*Florida Injunction Lifted (2013)*

Finally, in the summer of 2013, Florida District Court Judge Marcia Morales Howard lifted the 1979 injunction that prohibited the release of physician-specific Medicare payment data. This decision represented a major legal breakthrough in healthcare price transparency. The Dow Jones Company, a parent of the *Wall Street Journal*, along with the Center for the Public Interest and other stakeholders fought for access to this data for years. In its testimony during the 2013 judiciary effort to vacate the 1979 injunction, the Dow Jones Company stated:<sup>47</sup>

*“There is no legally supportable justification for maintaining a sweeping and obsolete injunction that for over thirty years has prevented the American public from knowing the true extent of Medicare waste, fraud, and abuse.”*

The *Wall Street Journal* subsequently published a newspaper series entitled *Secrets of the System*, in which it raised questions about whether the government was effectively data mining the system to detect waste, fraud, and abuse in Medicare.<sup>48</sup> The series also illuminated regulatory loopholes and perverse economic incentives that encouraged doctors to pursue unnecessarily expensive courses of treatment that may not have been in patients’ best interest.

After the Florida court vacated this injunction, CMS solicited public comments on the most appropriate policy regarding disclosure of physician payment data. These comments offered many different data management and disclosure strategies, but nearly all agreed that CMS should make Medicare data stewardship a top priority.<sup>49</sup> On January 17, 2014, HHS issued a notice modifying FOIA regulation of physician payment disclosure. CMS will now make case-by-case determinations as to whether the FOIA exemption applies to Medicare payment disclosure requests.<sup>50</sup> While price transparency advocates had hoped for a more open disclosure agreement, CMS can easily broaden the regulation since the Florida injunction no longer limits disclosure.

*The Wall Street Journal’s testimony played a key role in lifting the Florida court’s 1979 injunction*

<sup>47</sup> Dow Jones and Company, Inc.’s Motion to Intervene. *Florida Medical Association, Inc., et al. v. Department of Health, Education, and Welfare, et al.* U.S. District Court, Middle District of Florida, Jacksonville Division. Available at

<http://www.dowjones.com/pressroom/presskits/secrets/MotiontoIntervene12511.pdf>

<sup>48</sup> “Secrets of the System.” *Wall Street Journal*. Available at: <http://topics.wsj.com/subject/S/secrets-of-the-system/6281>

<sup>49</sup> Public Comment on the Release of Medicare Physician Data. Available at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Public-Comment.html>

<sup>50</sup>Federal Register, Vol 79, No 12. (January 17, 2014).

### III. State Policy Initiatives

While the federal government can foster price transparency through CMS data sharing, physician payment policy reform, and broad initiatives aimed at changing healthcare culture, states also have a crucial role to play in this effort. Thirty-four states currently have some type of healthcare price transparency policies in place. These policies vary significantly in scope and requirements, and typically do not mandate provider-specific data disclosure.<sup>51</sup> Unfortunately, most states have done little in the way of meaningful transparency legislation, regulation, or oversight to truly help consumers incorporate cost into healthcare decisions.

*Thirty-four states currently have some type of price transparency policies in place, but many of these policies are ineffective*

The nonpartisan group Catalyst for Payment Reform (CPR) studied state transparency initiatives in 2012 and evaluated them based on scope of price, services, and providers covered by state laws. CPR analysts focused on out-of-pocket price accessibility for individual consumers, and scored states based on subsequent criteria.<sup>52</sup> The report then graded states (A through F) based on how well they fulfilled CPR's criteria. Only two states – Massachusetts and New Hampshire – received A's, and well over half the states failed the assessment. The group conducted a second assessment in 2013 using slightly revised criteria, and found that states performed even worse than previously thought. The map in Appendix 1 shows CPR's state price transparency ratings, indicating the dire need for state level reforms across the country.

*State governments should work with providers and insurers to create transparency reform plans*

Since few states have implemented meaningful price transparency initiatives at the time of this report, health policy leaders have many opportunities to test different state reform models. State officials may be better positioned than their federal counterparts to evaluate local reform efforts, and to monitor consumer responses to market

changes such as increased access to provider price information. States governments should work with insurers and providers to create transparency reform plans that include short and long run policy goals, implementation strategies, and evaluation plans. The remainder of this section outlines promising, state-based policy options to achieve these healthcare improvement objectives.

#### *All-Payer Claims Databases*

Many health policy experts and health economists recommend that states establish all-payer claims databases (APCDs) to serve as state clearinghouses for medical claims data. APCDs aim to catalogue all medical payments made by third party payers to healthcare providers in a state. Fourteen states currently have APCDs, and more will likely develop them as consumer-driven healthcare and value-based payment models increase the demand for accessible, reliable, and complete payment data.<sup>53</sup>

<sup>51</sup> Catalyst for Payment Reform. *Action Brief: Price Transparency*. Submitted to Leapfrog Group. Available at <http://www.leapfroggroup.org/media/file/PriceTransparencyActionBrief.pdf>

<sup>52</sup> *Report Card on State Price Transparency Laws*. Catalyst for Payment Reform. March 2013. Available at <http://www.catalyzepaymentreform.org/images/documents/reportcard.pdf>.

<sup>53</sup> Ibid.

In addition to providing virtual health data hubs, APCDs can also serve as platforms for HIT innovation and data analytics. According to SAS health data analysts, “Building an APCD is a great way to launch a state’s health care improvement efforts because claims data is the most structured type of health data available, and it provides the broadest view of how health care services are delivered.”<sup>54</sup> APCDs can help states harness big data to analyze cost, price, quality, accessibility, and utilization of a state’s healthcare resources. Using these analytics to evaluate and understand a state’s healthcare landscape should be the first step in crafting a reform plan to improve population health and system efficiency.

*“Building an APCD is a great way to launch a state’s health care improvement efforts because claims data is the most structured type of health data available, and it provides the broadest view of how health care services are delivered.”*

While APCDs offer tremendous potential for health analytics, they also present challenges. Depending on how a state uses its APCD, the greatest database development challenge may be translating raw data into meaningful information for consumers. Unless a state only intends for academic researchers, insurers, and healthcare administrators to use the data, the state should invest the resources necessary to create easily searchable, consumer-friendly

*APCDs should translate raw data into meaningful, useful information for consumers*

websites for claims data. Establishing APCDs will cost money, and cash-strapped states that struggle to balance their budgets may not believe the benefits of these databases justify the costs. Lastly, APCDs may face opposition from some providers and payers, depending on how information shared through the database could affect their competitive advantage.

### ***Selective Disclosure Requirements***

Some states require hospitals to publicly disclose selective price data, rather than all claims. Selective disclosure often serves as a more politically feasible or transitional reform in states where insurers or providers strongly oppose APCDs. For example, New Mexico mandates that hospitals disclose Medicare claims data for the fifty most common DRGs.<sup>55</sup> North Carolina instituted an even more comprehensive disclosure rule in 2013, requiring hospitals and ambulatory surgery centers to publicly disclose claims from all payers for 140 different services and procedures.<sup>56</sup> Such selective disclosure policies can provide statutory and operational gateways for fuller price disclosure in the future, so progress happens incrementally.

### ***Prohibition of Gag Clauses***

Contracts negotiated between private insurers and healthcare providers have traditionally included confidentiality agreements, or so-called “gag clauses” to keep price information

<sup>54</sup> Tailor, Krista. “Big Data in Health Care Is Here: What’s Next for States Governments?” *Healthcare IT Connect*. 8 November, 2013. Available at <http://www.healthcareitconnect.com/big-data-in-health-care-is-here-whats-next-for-state-governments-3/>

<sup>55</sup> CPR State Price Transparency Report Card (2013)

<sup>56</sup> *Health Care Cost Reduction and Transparency Act of 2013*. North Carolina General Assembly. Session Law 2013-382. House Bill 834.

private between the two parties.<sup>57</sup> These clauses prevent competition by labeling negotiated prices trade secrets, which are legally protected from public disclosure. By making disclosure illegal, gag clauses foster anticompetitive collusion between payers and providers, and leave consumers even more in the dark regarding healthcare prices. Most health policy experts recommend that states ban gag clauses from provider-insurer contracts. Some states have already taken this important policy step. California, for example, recently implemented a law stating:<sup>58</sup>

*Gag clauses prevent market competition by labeling negotiated healthcare prices trade secrets*

*No health insurance contract in existence...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.*

Gag clauses are a relatively low-hanging fruit in state healthcare price transparency reform. Politicians on both sides of the aisle generally support their prohibition, as do patient advocacy groups and others who favor patient-centered, market-based reforms.

### **Provider Comparison Websites**

Several states have established publicly accessible healthcare provider comparison websites, similar to CMS's Hospital Compare.<sup>59</sup> These sites aim to provide consumers with information that will enable them to make better decisions about medical care. Unfortunately, CPR and other analysts have found these state sites seriously lacking in user-friendliness and general accessibility.<sup>60</sup> Sites often lack complete enough information for consumers to actually compare provider options, or they may not present information that consumers value.

Unless states partner directly with providers and payers, or have mandatory APCDs, gaining access to all the financial and health outcomes data necessary to build a useful website may be extremely challenging. States should consider contracting price transparency startup companies, like the ones discussed in Part Three, to create provider comparison websites. This type of public-private partnership would leverage companies' data visualization and information access strategies to advance states' goals around price transparency reform.

*States should partner with price transparency companies and leverage their analytic and data visualization capabilities to promote state health reform goals*

<sup>57</sup> D. Andrew Austin and J. G. Gravelle, "Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Health Sector," CRS Report for Congress, July 24, 2007. Available at: <http://www.fas.org/sgp/crs/misc/RL34101.pdf>

<sup>58</sup> California Legislative Information. SB1196. [http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=201120120SB1196](http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120SB1196)

<sup>59</sup> CMS Hospital Compare Website. Available at: <http://www.medicare.gov/hospitalcompare/search.html>

<sup>60</sup> Catalyst for Payment Reform. *Action Brief: Price Transparency*. Submitted to Leapfrog Group. Available at <http://www.leapfroggroup.org/media/file/PriceTransparencyActionBrief.pdf>

### *State-Based Health Insurance Marketplaces*

States that establish their own health insurance marketplaces under the ACA may have more leeway to pursue price transparency initiatives than states where the federal government administers marketplaces. If a state has more regulatory control over its insurance market, as in a state-based marketplace, then state insurance commissioners should have more autonomy to tailor reforms to specific marketplace needs. Banning gag clauses, establishing APCDs, and implementing other price transparency policies could happen more efficiently if regulatory control resides locally and states have the right incentives to change.

## PART THREE – PRIVATE MARKET SOLUTIONS

While legal and regulatory actions around price transparency can significantly broaden the healthcare data landscape, public policy alone will not ensure adequate consumer access to useful information. Translating raw data into understandable, patient-friendly information is key to price transparency in consumer-drive healthcare. Part Two focused on policy levers that promote public access to cost and claims data. Part Three explores ways that the private market can harness and package that data, deliver it to patients, and help them make decisions as active consumers of care, rather than passive receivers.

### I. Market Overview

The market space for healthcare transparency companies is extremely dynamic, as new companies emerge frequently, healthcare markets change constantly, and the regulatory structures around healthcare data continue to evolve. Most transparency companies are venture capital-backed startups, ranging in size from two or three employees to nearly two hundred. While many operate just on the west coast, these companies exist in various locations around the country, from Salt Lake City to Durham, North Carolina. Some, such as HealthInReach, provide information primarily for their local geographic regions, whereas others, like Healthcare Blue Book, maintain broad national databases.

The entrepreneurs who found healthcare transparency startups usually have technology industry backgrounds, and partner with medical and health information technology (HIT) experts. For example, the former HHS Chief Technology Officer, along with a medical doctor and a venture capitalist, founded Castlight Health, now an industry leader, in 2008.<sup>61</sup> Former Microsoft executives founded pricinghealthcare.com and PokitDok. These companies leadership teams typically include medical, technological, marketing, and management expertise. Healthcare price transparency companies need this combination of knowledge and experience to navigate their complicated and evolving market space. Since public policy, at both the state and federal levels, may significantly impacts companies' business models, successful industry leaders also stay abreast of policy changes around price transparency.

*Public policy can significantly impact price transparency companies' business models, since policy regulates access to the data they need*

Companies' clients and target markets vary as well, but generally fit into one of three categories: insurance providers, large businesses that self-insure, or individual consumers. Several healthcare transparency companies offer their products and services to insurers as a way to translate and transfer medical provider information to individual plan holders. Healthsparq, for example, works primarily with small, regional health insurance plans and businesses in the northwest (Washington and Oregon) to deliver treatment cost estimations and other information to plan policy holders.<sup>62</sup> Castlight Health targets its product line

<sup>61</sup> Castlight Health. <http://www.castlighthealth.com>

<sup>62</sup> Healthsparq. <http://www.healthsparq.com/about-healthsparq/>

towards large businesses that self-insure their employees, such as Kraft Foods Group, Liberty Mutual, and several universities.<sup>63</sup> In contrast, the Consumer Reports Hospital Advisor tool bypasses insurers and provides hospital charge information directly to Consumer Reports subscribers.<sup>64</sup>

The chart in Appendix 2 provides additional information on ten top price transparency companies. This chart outlines companies' basic operating strategies, data sources, and partners.

## II. Strategy and Consumer Outreach

Regardless of business model or operational differences, healthcare transparency companies all share the same general goal of supplying consumers with information about medical providers to help them make better healthcare decisions. Most companies aim to provide consumers with out-of-pocket price information for specific treatments and services, often alongside provider quality ratings. Consumers need both price and quality or outcomes information to make well-informed decisions. Acquiring this information often presents major challenges to companies, particularly those not directly affiliated with insurers or providers.

*Some apps display physician or facility-specific information, whereas others show “fair prices” for specific geographic regions. Since prices can vary within regions, patients may find provider-specific information most helpful*

Companies obtain financial data from various sources, including patient surveys, insurance claims data, and, less often, directly from providers. They then aggregate the data, translate it into consumer-friendly information, and share it with consumers through digital applications (apps) or other cloud-based platforms. Some companies, such as Medlio, offer provider-specific information, while others, like Healthcare Blue Book, offer average or “fair prices” for particular regions in which providers practice.<sup>65</sup> Tools owned by or affiliated with insurers – such as United Health Care’s myEasyBook or Aetna’s WellMatch – offer provider price information specific to patients’ health insurance plans. The prices that patients see when using these tools may be more precise than prices available through other tools, since insurance tools incorporate maximum allowable rates for specific treatments and procedures performed by specific providers. Other tools may not have access to these rates, so they provide consumers with broader price ranges instead of specific amounts.

Data collection poses perhaps the greatest operational challenge for many of these companies. Tools such as PokitDok that rely directly on providers for data must offer physician practices a sufficient value proposition to incentivize data disclosure. For example, Medlio CEO David Brooks believes that providers will derive economic value from partnering with Medlio. Brooks contends that consumers are more likely to pay healthcare bills if they

<sup>63</sup> Castlight Health. <http://www.castlighthealth.com/customers/>

<sup>64</sup> Consumer Reports Hospital Advisor. <http://www.consumerreports.org/cro/2012/10/how-we-rate-hospitals/index.htm>

<sup>65</sup> Health Care Blue Book. <https://www.healthcarebluebook.com/>

use price transparency tools, such as his company's Common Cents cost estimator.<sup>66</sup> Knowing prices prior to treatment, Brooks argues, makes consumers more likely to factor cost into treatment decisions and less likely to purchase treatment they cannot afford.

### *Provider Partnerships*

Several other companies market their products to healthcare providers using the same strategy. This value proposition likely carries more weight with providers whose patients do not return for follow-up visits. Studies have shown many patients do not return for follow-up visits due to healthcare costs.<sup>67</sup> These patients may be less likely than returning patients to pay medical bills, since they are clearly price-sensitive, and subsequent visits provide additional opportunities for practices to collect payment. If patient awareness of cost increases the likelihood that patients will pay for medical care, then providers – particular those whose patients may not return for follow-up visits – have greater incentive to partner with healthcare price transparency companies to convey out-of-pocket price information to consumers.

*Patients may be more likely to pay medical bills and more satisfied with their medical experiences if they use transparency tools. This is great news for doctors.*

In addition to financial incentives through more consistent patient bill payment, providers should also consider patient satisfaction as an incentive to partner with price transparency companies and share charge data. Transparency tools enable patients to be more active and engaged in healthcare decision-making. Studies show that engaged patients tend to rate the care they receive more highly and express greater overall satisfaction with healthcare experiences.<sup>68</sup> As payers increasingly tie reimbursement to quality metrics – including patient satisfaction – the correlation between price transparency tool use and patient satisfaction should create a strong incentive for providers to use these tools. Providers could benefit with minimal costs, since partnering with transparency companies requires physician practices to do little more than share charge data and allowable insurance rates.

Still, many providers – particularly those who charge higher prices – remain reluctant to share financial data, since keeping that data proprietary helps them maintain competitive advantage over others. More expensive providers and those who do not provide high-value care have less incentive to disclose their data. Patients with high-deductible health plans need access to medical prices, though, and may take their business elsewhere if practices do not share data prospectively.

### *Meeting Consumer Needs*

Tools need reliable data sources and consumer-relevant price information to succeed in the price transparency market. CMS will increasingly provide Medicare claims data, which helps companies that cater to patients with Medicare Advantage insurance plans. But companies need partnerships with private insurers and/or medical providers, depending on disclosure

<sup>66</sup> Brooks, David. Personal Interview. 18 Feb, 2014.

<sup>67</sup> Maskew, M, et al. "Lost to Follow-Up: Contributing Factors and Challenges in South African Patients on Antiretroviral Therapy." *South African Medical Journal*. September 2007.

<sup>68</sup> Hibbard, Judith, and Greene, Jessica. "What the Evidence Shows about Patient Activation: Better Outcomes and Care Experiences; Fewer Data on Costs." *Health Affairs*. Feb 2013.



rules, to access more complete data best serve consumers. The most useful transparency tools provide bundled price estimates (not line item costs) for specific treatments, at specific facilities, and for specific insurance plans. Additionally, they should assess in real time how much consumers have paid towards their deductibles and annual out-of-pocket maximum amounts. Providing this information requires advanced technological interoperability and savvy business partnership.

*Consumers need plan-specific, out-of-pocket price information in user-friendly formats.*

Different application formats and various functionalities make transparency tools accessible and helpful in many ways. A large market research firm recently conducted a study to determine which specific tool components health insurers find most useful to their consumers. The firm surveyed 186 executives at 117 different insurance companies and asked them to rank different tools based on relative value. Respondents valued treatment cost estimators and plan-specific patient out-of-pocket cost information most highly – both tools that allow consumers to know and compare costs between providers.<sup>69</sup>

*They also need to know transparency tools exist.*

Transparency companies should emphasize to insurers and other customers the importance of educating consumers about newly available transparency apps. Lack of consumer awareness may result in patients not using potentially helpful tools. According to Suzanne Delbanco at the Catalyst for Payment Reform, “Many of these tools are clunky and hard to find. Others can be very effective for patients who use them and know they’re there.”<sup>70</sup> Insurers and self-insured businesses that use transparency tools should make consumer outreach a top priority.

### ***RWJF Hospital Price Transparency Challenge***

The Robert Wood Johnson Foundation (RWJF), a major private supporter of healthcare innovation, also recognizes the value of price transparency and has supported market research to develop more useful tools. In 2013, RWJF challenged HIT entrepreneurs to create new virtual applications to help consumers better understand healthcare costs. The RWJF Hospital Price Transparency Challenge awarded prizes for best data visualization, and best apps and electronic tools. The foundation’s ultimate goal was to “improve healthcare decision-making or otherwise foster efficiency” by opening information channels to more stakeholders.<sup>71</sup>

Consumer Reports created the winning app, called the *CR Hospital Advisor: Hip and Knee*. The tool combines Consumer Reports hospital quality data with Medicare cost data to create value-based provider recommendations. This tool effectively leverages both cost and quality data from multiple sources and presents that data in a consumer-friendly format, but its usefulness is limited by only having cost data from one payer (CMS). Still, RWJF rated the

<sup>69</sup> Healthsparq Research Report.

<sup>70</sup> Beck, Melinda. “How to Bring the Price of Health Care into the Open.” *Wall Street Journal*. 24 February, 2014.

<sup>71</sup> Robert Wood Johnson Foundation Hospital Price Transparency Challenge. 2013. More information available at: <http://www.health2con.com/devchallenge/rwjf-hospital-price-transparency-challenge/#requirements>

Consumer Reports app highly because of its user-friendly format and clear data presentation.<sup>72</sup> RWJF used similar criteria to the Catalyst for Payment Reform in judging transparency tools. Both groups consider impact, innovation and usefulness of data among the most important criteria, and generally judge tools based on how well they meet consumers' needs.<sup>73</sup>

### *CMS Data Release and Private Market Innovation*

Obtaining complete and reliable provider price data poses the greatest challenge to healthcare price transparency companies. CMS's ongoing Medicare claims data release will significantly impact this market, as companies have easier – and free – access to a growing supply of information. This huge influx of data has the potential to change the American healthcare payment landscape in several ways. For example, industry leaders at athenahealth believe that Medicare claims data releases “will trigger a proliferation of new technological tools to help physicians and patients make well-educated care decisions...these technologies, already common in nearly every other sector of our data-driven economy, are desperately needed in health care”<sup>74</sup>

Healthcare transparency companies could use CMS data in several ways. If companies work with insurers or patients who have Medicare Advantage plans (Medicare Part C), price transparency tools can incorporate Medicare claims data into applications to help consumers compare prices the same way the tools would help other privately insured patients. If, on the other hand, companies do not target their products towards Medicare beneficiaries, they may find less value in CMS claims data.

*“Medicare claims disclosure will trigger a proliferation of new technological tools to help physicians and patients make well-educated care decisions. These technologies are desperately needed in healthcare”*

Regardless, the CMS data release contributes significantly to the price transparency movement by setting a precedent for public information sharing of claims data. This decision by CMS should exert pressure on other healthcare financial information holders to follow suit. In this way, the government can address the information asymmetry problem and make healthcare markets more competitive without imposing additional regulation.

At least one major statutory obstacle exists for companies' use of CMS data, however. The Qualified Entity program under Section 10332 of the Affordable Care Act states that CMS claims data may only be used to create free public reports on provider cost and quality.<sup>75</sup> The law intends for data to serve primarily as a means of provider performance measurement, not as a gateway to healthcare price transparency. The ACA mandate that CMS data be available only for free public use creates a de facto prohibition on for-profit companies incorporating

<sup>72</sup> *Ibid.*

<sup>73</sup> *Report Card on State Price Transparency Laws*. Catalyst for Payment Reform. March 2013. Available at <http://www.catalyzepaymentreform.org/images/documents/reportcard.pdf>

<sup>74</sup> Public Comment on the Release of Medicare Physician Data. Athenahealth response. Available at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Public-Comment.html>

<sup>75</sup> *Patient Protection and Affordable Care Act* (2010). Section 10332. Availability of Medicare Data for Performance Measurement. Available at: [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/QEMedicareData/downloads/ACA\\_Section\\_10332.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/QEMedicareData/downloads/ACA_Section_10332.pdf)

*The ACA mandate that CMS data be available only for free public use creates a de facto prohibition on for-profit companies incorporating that data into price transparency tools*

that data into price transparency tools. Companies may find it difficult to incorporate CMS claims data into their business models if this policy does not change. To create more open markets and promote innovation, CMS should allow all entities – public, private, and nonprofit – equal access to claims data, and permit data use for any purpose that falls within CMS guidelines.

The federal government has a unique opportunity to promote innovative, market-based solutions to address a complicated market failure. CMS could effectively partner with healthcare price transparency companies and provide them with the information necessary to build better tools for decision-making consumers. This type of public-private partnership offers a promising and politically feasible approach to the price transparency challenge. By allowing any entity to harness and use Medicare claims data, CMS could create a channel through which HIT entrepreneurs help solve the information asymmetry problem. This channel would lessen the need for top-down regulation and anticompetitive solutions.

## PART FOUR – CHALLENGES MOVING FORWARD

Providing consumers with healthcare price information is a necessary but not sufficient step towards making healthcare markets more competitive and ensuring that patients and payers receive the most value for every dollar spent on care. Transparency changes the game, so players must choose new strategies to optimize outcomes. This means payers working with providers and patients to reconfigure benefit designs and create truly patient-centered incentive structures. It means flipping clinics to meet patients where they are financially, technologically, and even geographically. Healthcare price transparency may lift the veil, but consumers – patients – will need additional support to successfully navigate the chaos behind it.

The price transparency movement cannot succeed in a vacuum. Leaders in this movement – both on the private and public sides – recognize that a slew of additional market and delivery system reforms and innovations must happen soon to best leverage newly available financial information. Hundreds of public comments on the 2013 CMS claims data disclosure decision show stakeholders’ support for price transparency, as well as their strong opinions about other reforms that should occur simultaneously.<sup>76</sup> This section outlines those outstanding challenges and issues that the United States healthcare system must address for price transparency to be most useful.

### I. Patients as Consumers

#### *Challenge: Bounded Rationality of Patients*

Insights from behavioral economics suggest that patients may not make optimal healthcare decisions when faced with high out-of-pocket costs.<sup>77</sup> “The fundamental problem with the consumer-driven healthcare approach,” explains health economist Russel Korobkin, “is that it assumes a heroically implausible level of decision-making ability on the part of patients faced with treatment choices at the time of illness.”<sup>78</sup> Patients’ limited cognitive ability makes relying on high-deductible health plans a risky approach for cost containment. Baicker et al agree: “Patients may be stymied by the cognitive demands of making many price comparisons,” a dilemma that often leads patients to make economically irrational or lower value decisions.<sup>79</sup>

This problem will likely be even more pronounced with consumers who purchase and use insurance for the first time, as with newly insured individuals under the Affordable Care Act.

---

<sup>76</sup> Public Comment on the Release of Medicare Physician Data. 2013.

<sup>77</sup> Baicker, Katherine, and Chandra, Amitabh. “Aspirin, Angioplasty, and Proton Beam Therapy: The Economics of Smarter Healthcare Spending. Harvard University and NBER. Prepared for Jackson Hole Policy Symposium. 2011. Available at: <http://www.kansascityfed.org/publicat/sympos/2011/2011.BaickerandChandra.paper.pdf>

<sup>78</sup> Korobkin, Russel. “Comparative Effectiveness Research as Choice Architecture: The Behavioral Law and Economics Solution to the Health Care Cost Crisis.” *Michigan Law Review*. Vol 112. February 2014. 532.

<sup>79</sup> Baicker, Katherine, et al. “Saving Money or Just Saving Lives? Improving the Productivity of US Health Care Spending.” *The Annual Review of Economics*. 2012. 4:33-56.

Behavioral economics research shows that people make better choices the more chances they have to make a choice – practice makes perfect, in decision-making as in other pursuits. Absent this continued practice, “intuitive judgment is often the only practical method for assessing uncertainty.”<sup>80</sup> Those new to high-deductible plans may not have had the chance to develop this judgment. Many consumers do not even understand their health insurance benefits structures, not to mention price or quality data, and this misunderstanding makes optimal decisions nearly impossible.

- ***SOLUTION: Simplify payment models and offer clinical decision aids to help patients – particularly those with high deductible insurance plans – understand financial toxicity of treatment options and make decisions as savvy consumers***

Value-based insurance design (VBID), bundled payment structures, and clinical decision aids can all help solve this problem. VBID increasingly relies on payment bundles and consumer decision aids to nudge patients towards higher value treatment and care options. The next sub-section discusses this innovative insurance design in more detail. Bundling payments for entire episodes of care – as opposed to itemizing treatment – makes price information more understandable and meaningful to consumers.<sup>81</sup> It also facilitates better decision-making by reducing the number of comparisons and calculations consumers must make between options, essentially providing them with more usable heuristics.

Some experts recommend focusing price transparency initiatives on healthcare services whose quality tends not to vary.<sup>82</sup> Similarly to bundling payments, this approach simplifies consumers’ decision-making process by removing a potentially complicated decision point. On the other hand, holding quality constant also limits the scope of treatments for which patients can use price information to make decisions, which limits this solution’s scalability.

Several healthcare decision aids and consumer education campaigns also exist to help patients synthesize information and make better decisions. Choosing Wisely, Wiser Together, and Families USA, among other nonprofit organizations, offer free, online decision aid to healthcare consumers.<sup>83</sup> The Affordable Care Act established a health insurance “Navigator” program, which provides grants to organizations and individuals to help consumers navigate new health insurance marketplaces.<sup>84</sup> The price transparency movement, however, focuses more on consumer choice at the point of care – not the preceding choice of insurance plan. CMS should partner with campaigns like Choosing Wisely to provide consumers with additional decision aids and price navigation tools after they have purchased insurance.

---

<sup>80</sup> Tversky, Amos & Kahneman, Daniel. “Extensional Versus Intuitive Reasoning: The Conjunction Fallacy in Probability Judgment.” *Psychological Review*. Vol 90, No 4. Oct 1983.

<sup>81</sup> Baicker. “Saving Money or Just Saving Lives?”

<sup>82</sup> Robinson, James. *Price Transparency and Value-Based Purchasing in Health Services*. Berkeley Center for Health Technology. University of California, Berkeley. Available at <http://bcht.berkeley.edu/presentations/Price-Transparency-Value-Based-Purchasing.pdf>

<sup>84</sup> *Patient Protection and Affordable Care Act*. Section 1311.

<http://dhhs.nv.gov/HealthCare/Docs/exchanges/TheRoleOfNavigatorsInExchangesPerTheACA.pdf>

### ***Challenge: Insurance Design Lags Behind Innovation***

Most health insurance plans do not incentivize value-based purchasing. As discussed in Part One, third party payment can result in moral hazard and overutilization of low-value care when insurance benefit design does not nudge patients to select higher value alternatives. As patients gain increasing access to provider value information through transparency tools, insurance companies should leverage this information and incorporate it into plan design. Misalignment between patients' economic incentives and their insurance design may lead patients to choose less cost-effective care, raising costs for everyone.

- ***SOLUTION: Use value-based insurance design to better align payers' and patients' incentives and nudge patients towards higher value care***

Many healthcare experts believe that value-based insurance design (VBID) offers a promising solution to this problem. VBID encourages consumers to select higher value healthcare services and discourages selection of low-value services by strategically structuring cost-sharing arrangements. Compared to managed care systems, which may not promote competitive markets and are often considered overly paternalistic, VBID relies more heavily on market forces and consumer choice to promote value.<sup>85</sup> Tiered provider networks for different health plans appear frequently in VBID, as do reference pricing schemes. Relative value health insurance, similar to VBID, provides another potentially helpful insurance benefit design structure.<sup>86</sup>

VBID could also help address legal issues by using price transparency and cost-effectiveness information to clarify contractual language in insurance plans. Panels that review treatment coverage denial appeals currently base their decisions solely on medical benefit standards.<sup>87</sup> Explicitly incorporating cost-effectiveness language into insurance plans could help standardize the appeals process and bring panel decisions in line with competitive market dynamics. Appeals panels could use cost-benefit analysis, rather than just benefits, to decide cases. All of these innovative strategies rely on healthcare price transparency to ensure better consumer decision-making. Thoughtful, innovative insurance design can help bend the nation's healthcare cost curve through nudging individual consumers to make economically savvy choices.

---

<sup>85</sup> Lee, Joy, et al. "Value-Based Insurance Design: Quality Improvement But No Cost Savings." *Health Affairs*. Vol 32, No 7. July 2013.

<sup>86</sup> Korobkin.

<sup>87</sup> *An Update on State External Review Programs, 2006*, AHIP Center for Policy. July 2008. Available at: [www.ahip.org/PDFs/StateExternalReviewReport.pdf](http://www.ahip.org/PDFs/StateExternalReviewReport.pdf)

### ***Challenge: Quality Transparency***

Price transparency alone, without corresponding provider quality metrics, may not help consumers, since very little relationship exists between cost and quality of care in the United States. Determining cost-effectiveness, or value, requires both cost and outcomes data. Experts agree that providing consistent and reliable quality data may be even more challenging than providing cost data, since key quality metrics can vary, depending on perspective.<sup>88</sup> Patients may define high quality care differently than payers or providers. For example, CMS has started using the 30-day hospital readmissions standard as a Medicare provider quality metric. Medicare patients, however, may equate quality care more with metrics such as satisfaction with overall medical experience.

Reliance on guidelines rather than performance measure also creates challenges. Physicians follow clinical guidelines when providing care, but converting guidelines to concrete performance measures poses several challenges. For example, performance measures rely on quantitative tools to assess outcomes, involve rigid criteria for right and wrong practice, and do not account for medical complexity and patient preferences as well as guidelines do.<sup>89</sup>

➤ ***SOLUTION: Mandate disclosure of physician quality and patient outcomes data alongside price information to illustrate value or cost-effectiveness***

Providers should use standard, stakeholder-aligned quality measurements to track and share quality data with consumers. The U.S. Department of Health and Human Services and CMS have started aligning healthcare quality metrics with patient-centered outcomes. The government is working closely with the National Quality Forum (NQF), a public-private healthcare partnership, to identify the next generation of quality measures and establish a National Quality Strategy.<sup>90</sup> This comprehensive strategy includes six quality dimensions (safety, care coordination, clinical care, population and community health, patient experience and engagement, and cost and efficiency), which will rely on continuous feedback loops to improve care.

Disclosure of physician quality data should follow the healthcare data release standards set by the NQF. The NQF's Measurement Applications Partnership provides the federal government with upstream, rule-making input on the selection of healthcare quality measures.<sup>91</sup> Transparency tools should present these quality data alongside price data, and use simple cost-effectiveness algorithms to rank providers according to value whenever possible. Ideally, tools would weight data based on individual consumer preferences, so that provider rankings reflect patient values.

---

<sup>88</sup> McGlynn, Elizabeth. "Six Challenges in Measuring the Quality of Health Care." *Health Affairs*. Vol 16, No 3. May/June 1997.

<sup>89</sup> Walter, Louise, et al. "Pitfalls of Converting Practice Guidelines Into Quality Measures: Lessons Learned from a VA Performance Measure." *Journal of the American Medical Association*. Vol 291, No 20. 26 May, 2004.

<sup>90</sup> Conway, Patrick, et al. "The Future of Quality Measurement for Improvement and Accountability." *Journal of the American Medical Association*. Vol 309, No 21. 5 June, 2013.

<sup>91</sup> National Quality Forum. Measurement Applications Partnership. Available at <https://www.qualityforum.org/map/>

## II. Regulatory Barriers

### *Challenge: Gag Clauses*

Contractual agreements between insurers and healthcare providers often include provisions known as gag clauses, which prohibit price information disclosure. Gag clauses are anticompetitive measures because they promote information asymmetry in healthcare markets. Some stakeholders have argued that prices negotiated between payers and providers are essentially trade secrets, which makes their disclosure illegal.<sup>92</sup> The federal government and many states governments, however, disagree with that claim and support the prohibition of gag clauses.

- ***SOLUTION: Ban gag clauses in contractual agreements between insurers and providers***

States should ban gag clauses, as well as other contractual barriers to medical price data disclosure. Many of the nation's leading healthcare experts, including Ezekiel Emanuel and others in Obama Administration, expressed their strong agreement with this solution in a 2012 *New England Journal of Medicine* article: "gag clauses and other anticompetitive clauses must be prohibited."<sup>93</sup> States have the authority to regulate their health insurance markets in this way and have a responsibility to citizens (consumers) to promote market competitiveness. States that allow these contractual restrictions on information disclosure do not uphold their fiscal responsibilities to taxpayers.

### *Challenge: Limits on CMS Claims Data Disclosure*

The Qualified Entity program under Section 10332 of the Affordable Care act does not allow use of CMS paid claims data for purposes other than free public reports on cost and quality.<sup>94</sup> This prohibition severely limits the potential of CMS data to spur needed innovation that could make healthcare markets more competitive. The pioneering healthcare management company athenahealth calls this de facto prohibition on for-profit entities a "huge deterrent to the very innovation that has the potential to control costs in health care."<sup>95</sup> Section 10332 intends for "qualified entities" to use claims data for Medicare performance measurement. Paradoxically, the law creates a regulatory barrier to entry for private companies that could also monitor performance, since those companies may charge user fees for their products. By limiting Medicare claims data usage, CMS creates an unnecessary roadblock for the price transparency movement.

---

<sup>92</sup> *Healthcare Price Transparency*. GAO Report to Congress. September 2011. Available at: <http://www.gao.gov/assets/590/585400.pdf>

<sup>93</sup> Emanuel, Ezekiel, et al. "A Systemic Approach to Containing Health Care Spending." *The New England Journal of Medicine*. Vol 367, No 10. Sept 2012.

<sup>94</sup> ACA Section 10332.

<sup>95</sup> Public Comment on the Release of Medicare Physician Data. 2013.



- ***SOLUTION: Revise the Qualified Entity program under ACA Section 10332 to ensure all entities – public, private, or nonprofit – access to Medicare claims data***

CMS should reverse this policy and ensure that all entities – public, private, or nonprofit – can access Medicare claims data for the benefit of patients, consumers, and other stakeholders. Section 10332 does allow for possible exceptions to the data use rule, if the HHS Secretary “determines that use of such alternative measures would be more valid, reliable, responsive to consumer preferences, cost-effective, or relevant to dimensions of quality and resource use not addressed by such standard measures.” Instead of approving alternative data use on an ad hoc basis, the Secretary should prospectively allow any entity that abides by the aforementioned alternative standards to use CMS data. The Secretary could also broaden the definition of “qualified entity” to include private companies that exist in the healthcare price transparency market.

As discussed in the next sub-section, CMS should include appropriate safeguards and data release guidelines to ensure accuracy and prevent misuse of data. The Secretary should clarify data stewardship rules whenever expanding public access to CMS claims data. Providing open access to claims data allows price transparency companies to more easily incorporate this information into their transparency tools. More robust tools could foster more competitive healthcare markets, and serve as an additional channel through which to measure and reward provider performance.

### ***Challenge: Data Stewardship and Management***

Data stewardship, objectivity, and abuse prevention are all extremely important and sensitive issues in healthcare price transparency. Many healthcare stakeholders have expressed concerns about financial data disclosure. Some argue that cost data alone, without the context of risk adjustment or panel size, could lead consumers to draw inaccurate conclusions or misuse the data.<sup>96</sup> Others worry that data disclosure could breach patient privacy concerns, despite explicit mandates that payers de-identify patient data.<sup>97</sup> Many physician groups have lobbied against data disclosure on the grounds that healthcare prices constitute proprietary information – essentially, the trade secret argument. Physician concerns regarding data accuracy may present more pressing and valid data management challenges for CMS than arguments regarding the proprietary nature of claims data.

- ***SOLUTION: Standardize public disclosure process and clarify data management guidelines to prevent abuse and misunderstanding of medical claims data***

CMS should standardize the process for releasing Medicare payment data and present data in a consistent, searchable format. Section 10332 mandates that reports generated from claims data include “understandable descriptions” of all reported metrics.<sup>98</sup> Additionally, CMS should use the public comments on the physician payment data release decision to establish guidelines and best practices for future HHS data sharing. These public comments overwhelmingly favor greater price transparency, and include many instructive

<sup>96</sup> Public Comment on the Release of Medicare Physician Data. Lumeris, Inc. 2013.

<sup>97</sup> Public Comment on the Release of Medicare Physician Data. IMS Health. 2013.

<sup>98</sup> ACA Section 10332

recommendations from healthcare experts on how to effectively manage data. Formatting and distribution strategies should ensure that data is displayed clearly and disseminated fairly.

Medicare datasets should contain certain basic information for all claims. These metrics include a unique provider identifier (NPI), date and place of service, diagnosis, service(s) provided, and payments for all care delivered.<sup>99</sup> CMS should follow the data reporting standards similar to those used by the National Quality Forum, which advises the federal government on quality reporting measures.<sup>100</sup>

States should adopt similar guidelines for healthcare data management. State governments maintain closer relationships with local health insurers and healthcare providers than the federal government does, so states should leverage those relationships to create guidelines that meet state-specific needs. As discussed in Part Two, state-sponsored all-payer claims databases (APCD) can provide excellent storage and dissemination platforms for healthcare cost and price information. States should allocate sufficient funding to establish and maintain these databases, and work closely with contractors to ensure that data management meets state guidelines.

---

<sup>99</sup> Public Comment on the Release of Medicare Physician Data. Castlight Health. 2013.

<sup>100</sup> National Quality Forum. Report: "Measuring Performance."

[http://www.qualityforum.org/Measuring\\_Performance/Measuring\\_Performance.aspx](http://www.qualityforum.org/Measuring_Performance/Measuring_Performance.aspx)

### III. Delivery System Challenges

#### *Challenge: Provider Collusion*

Some experts express concern that greater price transparency will incentivize healthcare providers to collude in efforts to keep prices high.<sup>101</sup> Economic game theory suggests that providers may seek to avoid competition and collude to set prices if they know each other's negotiated rates with payers. Greater price transparency through claims data disclosure and price transparency tools could facilitate this system gaming. In providers do this new information to collude, price transparency could backfire and cause healthcare costs to remain higher than they would in a competitive market.

- ***SOLUTION: Limit time period or scope of financial data released to prevent provider collusion around healthcare prices***

Regulations around healthcare price data disclosure could help prevent the problem of provider collusion. Two potential regulatory strategies are to limit either the time period or the scope of data released. Economist Paul Ginsburg recommends that CMS release older data and not real time data, to avoid a market “stalemate” in which no providers lower their prices.<sup>102</sup> Instituting a standard lag time in data release would limit providers' ability to monitor each other's prices and avoid competition by colluding. Providers could still use older data and price trends to estimate current market rates, however, which could provide sufficient information for them to game the system.

The second selective disclosure approach involves limiting the scope or specificity of data released. Some experts recommend only releasing price data for care bundles, or estimates for whole episodes of care, rather than prices for all specific items in a treatment bundle.<sup>103</sup> This approach could prevent provider collusion by limiting data sharing to aggregate amounts, instead of sharing all itemized treatment components and allowing providers to more easily compare prices. While releasing bundled price data offers the added benefit of making information more consumer-friendly, as discussed previously, it still risks establishing price comparison points on which providers could collude.

#### *Challenge: Emergency Care*

Emergency department (ED) care presents a unique problem in consumer-driven healthcare and price transparency. When people need emergency care, they often do not have the option to act as savvy consumers; they need the closest, quickest care, regardless of price. Accordingly, ED patients may have little or no control over decisions such as which facility or provider they use. While they may ordinarily have more elastic demand for healthcare services and prefer to “shop” for affordable care, they may not have the time or ability to shop

---

<sup>101</sup> Robinson, James. *Price Transparency and Value-Based Purchasing in Health Services*. Presentation for Berkeley Center for Health Technology. Available at: <http://bcht.berkeley.edu/presentations/Price-Transparency-Value-Based-Purchasing.pdf>

<sup>102</sup> Ginsburg, Paul. Academy Health Conference. Washington D.C. January, 2014.

<sup>103</sup> Robinson.

for care during an emergency. Hence, patients' demand for services quickly becomes inelastic in emergencies. Their willingness to pay may inadvertently increase as choice of providers decreases, rendering price transparency less important.

- ***SOLUTION: Provide additional resources to study the effects of price transparency on patients' insurance purchasing decisions***

While patients may not find price transparency immediately helpful during medical emergencies, transparency could still facilitate better consumer behavior and lead patients to pay less out-of-pocket for emergency care. Greater awareness of healthcare costs – particularly for ED visits – may influence consumers to purchase health insurance when they might otherwise not. Even a minimal level of coverage provides considerably more protection against catastrophic financial risk than going without insurance does. To the extent that price transparency nudges consumers to purchase this protection, it can serve as an effective market-correcting mechanism even in emergency situations. Healthcare decision-making researchers should conduct studies to learn more about price transparency's effects on consumers' insurance purchasing decisions.

## SUMMARY

Strategic policy decisions around healthcare price transparency can make healthcare markets more competitive and ultimately help bend the cost curve in American medicine. Regulators should continue seeking public comment on data disclosure methods and data stewardship to prevent abuse and misunderstanding of information. Both federal and state governments have important roles to play in ensuring consumer access to useful and accurate healthcare data. State governments should consider partnering with healthcare price transparency companies to establish all-payer claims databases and present out-of-pocket price information to consumers in user-friendly formats. Competitive markets rely on open access to information. As the United States gradually shifts from a fee-for-service, third party payer system, to a more value-based, consumer-driven system, price transparency will become increasingly important to all stakeholders. Public policies to support price transparency are needed to support market-based solutions.

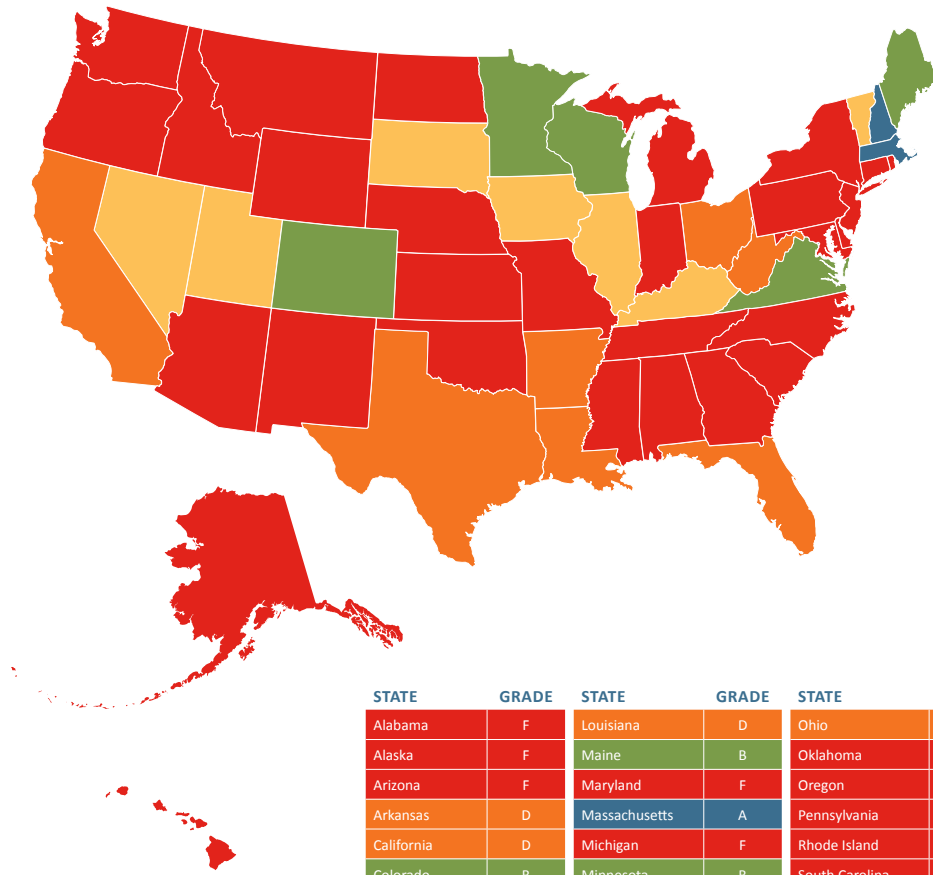
Appendix 1

Catalyst for Payment Reform: 50 State Price Transparency Report Card, 2013.

Available at: <http://www.catalyzepaymentreform.org/images/documents/reportcard.pdf>

II. 50 STATE REPORT CARD ON PRICE TRANSPARENCY LAWS

Figure 1: Map Overlay



STATE	GRADE	STATE	GRADE	STATE	GRADE
Alabama	F	Louisiana	D	Ohio	D
Alaska	F	Maine	B	Oklahoma	F
Arizona	F	Maryland	F	Oregon	F
Arkansas	D	Massachusetts	A	Pennsylvania	F
California	D	Michigan	F	Rhode Island	F
Colorado	B	Minnesota	B	South Carolina	F
Connecticut	F	Mississippi	F	South Dakota	C
Delaware	F	Missouri	F	Tennessee	F
Florida	D	Montana	F	Texas	D
Georgia	F	Nebraska	F	Utah	C
Hawaii	F	Nevada	C	Vermont	C
Idaho	F	New Hampshire	A	Virginia	B
Illinois	C	New Jersey	F	Washington	F
Indiana	F	New Mexico	F	West Virginia	D
Iowa	C	New York	F	Wisconsin	B
Kansas	F	North Carolina	F	Wyoming	F
Kentucky	C	North Dakota	F		

**Appendix 2**

Top Healthcare Price Transparency Companies

Company Name	Founding	Operations Strategy	Data Access	Notable Partners	Customers	Notes
Medlio	Durham, NC (2013)  David Brooks, CEO (Durham, 2/18)	App is a mobile insurance card that shows consumers their insurance benefits information (including co-pays and deductible balances); includes appointment check-in function, provider maps, and payment portal; cost transparency tool (Common Cents) has not launched yet	Insurance claims data, “working on it”		Individual patients (mainly insured)	“Mobile Insurance Card” will manage real time insurance information for consumers
Castlight Health	San Francisco, CA (2008)	Delivers customer-friendly healthcare “shopping platform” to patients searching for care. Offers cost and quality data	Directly from PPO partners;	CalPERS- Anthem Blue Cross (PPO)	Large companies that self-insure (HR departments); CalPERS	Anthem Blue Cross, CalPERS, and CL implemented reference pricing for hip and knee replacements
PokitDok	Lisa Maki, Ted Tanner (2011) – former Microsoft employees  San Mateo, CA	Mobile app and online service that lets consumers search for providers in their area, then compare price quotes; if no quotes available, users fill out a form and describe payment mode (cash, insurance, or HAS) and get a quote from providers	Directly from primary care providers and independent specialists (no hospitals yet)		Individual patients (all payment types)	- Focuses on primary and elective care - Making some inroads with hospitals re bundled payment prices
Healthcare Blue Book	Nashville, TN (2008)  Jeffrey Rice, CEO	Allows free public access to hospital list prices; provides range of available prices as well as “fair price” for procedures and medications; premium version is available to consumers via health plan or employer	“Fair price” is rough average of prices paid by insured patients		Individual patients, self-insured, uninsured, small businesses	

Company Name	Founding	Operations Strategy	Data Access	Notable Partners	Customers	Notes
Consumer Reports Hospital Adviser: Hip and Knee	CR team (2013) (led by Chris Baily)	Combines CR hospital quality ratings with Medicare cost data to create “High Value Recommendations” for consumers; goal is to help consumers make best hospital/surgeon choices for hip and knee surgery, based on value (rational)	Quality information comes from CR data; cost from CMS	Consumer Reports; RWJF	CR subscribers (mainly older patients looking for hip/knee replacement info)	CR plans to add additional DRGs over next few years (starting with elective surgery)
Pricinghealthcare.com	Salt Lake City, Utah (2012)  Randy Cox	Asks users to anonymously supply information from their own medical bills, in effort to compile list prices, cash prices, and negotiated rates for common medical procedures	Average negotiated rates for 500 procedures in 11 states		Mainly employers	Incentive for users to submit data? Concern about skirting providers
HealthSparq (subsidiary of Cambia Health system; acquired ClarusHealth Solutions)	Portland, OR (2013, 2006) Scott Decker, CEO	Partners with small, regional health plans [as opposed to going around them] to help plan members comparison shop for providers; shows various costs and times involved in procedures; shows price and quality of different providers; 60 plans, 60m users		SaaS-based IT platform	Small, regional health insurance plans (60 plans that cover 60 million members)	Quality measurements?  Impressive data collection and evaluation efforts
myEasyBook (United Healthcare), or myHealthcare Cost Estimator	Tom Paul (Chief Consumer Officer, United Healthcare); Nick Martin (VP of Innovation and R&D)	Software calculates OOP cost to user based on his/her specific United Healthcare plan and searches multiple providers by condition (data includes >500 services at in-network facilities); piloted in Phoenix (2013), launch in Dallas and Denver (early 2014)	Claims data available internally through United Healthcare		United Healthcare enrollees with HDHPs (especially those with HSAs/HRAs)	Data includes negotiated rates and estimated OOP cost

Company Name	Founding	Operations Strategy	Data Access	Notable Partners	Customers	Notes
Wise Health (from WiserTogether, Inc.)	Shub Debgupta, CEO (2008)	Offers both a cloud-based cost transparency tool (from Traven) and consumer decision support tools (from Wiser Together)	Crowd-sourced data from consumers and physicians	Traven Health Analytics	Employers and healthcare plans	Accounts for personal preferences and financial constraints
HealthinReach	Los Angeles	Free online service that allows user (presumably uninsured) to find lowest prices for doctors and dentists, then book appointments online; attractive to doctors because it eliminates insurance middle man (even though it functions somewhat similarly to an insurer)			Uninsured patients; patients seeking elective/cosmetic services not covered by insurance; dental	Also covers dental; offers provider discounts