COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

Evaluating the Trump Transparency Initiative

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Per capita health spending in the U.S. is more than twice the average of other rich countries.[1] These excesses are concentrated in the commercial sector—consisting mainly of employer-sponsored health plans—where prices are set in markets through annual bargaining between plans and providers. In virtually every other developed country, government-run or -supervised health systems set payment rates administratively, as do Medicare, Medicaid and the Veterans Administration. The prices paid by U.S. employer plans can be several times those found in Switzerland or France.[2] In 2017, commercial prices for a market basket of common procedures in the U.S. averaged 241 percent of Medicare rates.[3] In supporting Medicare-for-All and various "public option" proposals, many Democrats in Congress and on the presidential campaign trail implicitly question whether market pricing is viable in America's health sector.

Executive Order 13877, signed by President Donald Trump on June 24, 2019, provides a coherent counterpoint. It directs a constellation of initiatives designed to strengthen price signals, by reducing barriers to price and quality transparency; increasing the availability of such information to patients; enhancing patients' control over healthcare resources (e.g. through health savings accounts); and protecting against "surprise" medical bills by out-of-network providers in in-network hospitals. The E.O. also directs federal agencies to make de-identified patient data more widely available to researchers, health plans and providers.

To this end, on November 15, the Department of Health and Human Services (HHS) published a rule mandating a particularly aggressive version of hospital price transparency.[4] On the same day, HHS and the Departments of Treasury and Labor jointly released an even more ambitious proposal to require most health plans to disclose their in-network negotiated rates with all providers, including hospitals, physicians, out-patient and testing centers.[5] Both rules are scheduled to take effect in 2020.

In this article, we address the implications of medical price transparency for consumers, drawing in particular on New Hampshire's experience. We also address potential interaction of transparency with expanded federal data sharing. The latter will require implementing legislation, but could prove essential in eliminating the many inefficiencies that plague American medicine.

BACKGROUND

A. Hospital Rule

Beginning in January 2020 hospitals will be required to post a list of charges for selected bundled items and services. In its January 2019 update to section 2718(e) of the Public Health Services Act, requiring hospitals to make their standard charges public, HHS defined "standard" to mean gross charges—essentially disaggregated list prices for out-of-network care. Such lists, or "chargemasters", have as many as 30,000 items and are of little practical use to consumers. The new rule requires hospitals to disclose, on public websites and in other formats, gross charges plus bundled payer-specific negotiated charges for a minimum of 300 "shoppable" services. The rule mandates 70 such services, but leaves it up to hospitals to identify the rest, which can reflect their particular specialties. For each such item, disclosures are to include minimum and maximum negotiated charges (showing the range of discounts) and the cheapest discounted cash price a hospital is willing to accept. HHS predicts that the rule will "drive innovation, support informed, price-conscious decision-making, and promote competition in the healthcare industry …by…[creating] new opportunities for researchers, employers and other developers to build new tools to help consumers."[6]

A coalition of hospital trade groups, led by the American Hospital Association, argue that HHS has overstepped its legislative authority. They have already challenged the rule in court, citing a breach of free speech.[7]

B. Insurer Rule

The proposed insurance rule (at the time of this writing, in its 60 day comment period) would require individual market plans and non-grandfathered group plans (representing 78 percent of the employer market) to provide enrollees with their plan-specific cost-sharing liabilities associated with different providers. As with the hospital rule, this information would be provided to consumers via the internet and in other formats. In addition, the plans would have to publicly disclose every provider's in-network negotiated rates as well as allowed amounts for non-network providers. Researchers, employers and third-party developers would have access to this information through regularly updated machine-readable files.

Finally, the rule would let health plans count "shared savings" awards to enrollees who opt for cheaper providers—awarded in the form of gift cards, reductions in cost-sharing, or premium credits—against their medical loss ratios (MLR), a measure of the premium dollars spent on medical claims and quality improvements. Plans currently must give enrollees rebates if they undershoot their MLRs. The proposed rule would incentivize plans that foster and ultimately reward comparison shopping.

C. State Transparency Initiatives

Drawing on their insurance regulatory authority over fully insured (non-ERISA) health plans, 21 states require some form of price transparency. Seven run consumer-facing websites that allow the public to directly compare a version of provider prices for limited sets of services. Bowing to antitrust concerns, most states provide undiscounted (chargemaster) prices or blended averages that de-identify plans. In a 2015 letter to the managers of Minnesota's price-transparency legislation, the Federal Trade Commission (FTC) urged "…caution in mandating public disclosure of plan specifics and negotiated fee schedules between the Health Plans, hospitals, and physician service entities, which may harm

competition and consumers by facilitating coordination or outright collusion on prices or other terms, especially in highly concentrated markets."[8] The closest any state website comes to providing payer-specific negotiated rates is New Hampshire's NH HealthCost.

D. NH HealthCost

The NH HealthCost website debuted in 2007, and was re-launched in 2016 with significant technical upgrades. (It is managed by Milliman, a consultancy that tracks health costs.) Similar to the federal hospital rule, prices on this website cover common bundled services. Although NH HealthCost does not calculate patients' out-of-pocket liabilities, it is the only website we are aware of to provide a semblance of payer-negotiated rates to the general public—allowing providers and plans to take measure of each other's best price deals. According to the website, the rates reflect "the median amounts paid (by both the insurance carrier and the patient) using claims data from the New Hampshire Comprehensive Health Information System (NHCHIS) database based on the rate negotiated between health care providers and insurance companies, not the provider charges or 'retail value' of the health care service."[9] Claims data is backward looking, sometimes trailing current prices by years. Nevertheless, New Hampshire's experience provides a partial test for the efficacy of arguments both for and against the transparency called for in the HHS rules.

Figure 1 compares prices for arthroscopic shoulder surgery charged to fully insured group plans and the uninsured.[10] (Participation by self-funded employer plans is voluntary.) The same procedure that costs Anthem as little as $6,412 at Concord Ambulatory Surgery Center could cost an uninsured patient as much as $86,499 at Northeast Surgery Care of Newington (42 miles away). Within Anthem's network, prices vary by a factor of three. For this particular procedure, ambulatory care facilities were less costly, but not dramatically so—averaging $10,494 versus $14,261 for hospitals.

Figure 1
Payer-negotiated Rates, Group Plans: Arthroscopic Shouder Surgery

	Cigna	Harvard-Pilgrim	Anthem	Uninsured
Mary Hitchcock Memorial Hospital	17,393	-	-	54,480
Exeter Hospital	20,328	18,559	19,031	31,394
Wentworth-Douglas Hospital	25,201	-	9,831	46,024
Concord Ambulatory Surgery Center	-	-	6,482	31,847
Orthopedic Surgery Center Derry	-	19,660	8,443	-
Portsmouth Ambulatory Surgery Center	-	-	10,662	59,686
Hillside Surgery Center	-	-	10,737	23,735
Capital Orthopaedic Surgery Center	-	21,014	11,011	44,355
Bedford Ambulatory Surgery Center	-	13,878	12,546	66,885
Orchard Surgery Center	-	-	13,576	75,512
Southern NH Medical Center	-	18,234	13,920	35,615
Northeast Surgery Care of Newington	-	-	-	86,499
Average	**20,974**	**18,269**	**11,624**	**50,548**

Source: Comprehensive Health Care Information System. Accessed on August 10, 2019.

One would expect that with such a stark difference in costs between different providers, an uninsured patient might make a strong case for discounted services relative to the inflated rates shown on the website.

DISCUSSION

A 2018 study by University of Michigan economist Zack Brown found that early versions of New Hampshire's transparency regime—covering the period 2005-2010—had reduced the cost of listed imaging services by 3 percent compared to those not listed. Using statistical methods, Brown calculated that the price effects would have been at least six times stronger had the system been more widely used.[11] This is important because there is broad potential for comparison shopping. A 2016 study by the Health Care Cost Institute (HCCI), a think tank which manages the combined payment data of four national health insurers, found that 43 percent of medical services were "shoppable"—defined as common procedures that can be researched in advance, for which there are multiple competitors with discoverable prices.[12] To this end, many health plans offer comparison shopping tools to their enrollees, typically in combination with high deductibles and health savings accounts.

Despite the growing availability of such tools, price discipline in today's healthcare markets remains stubbornly the domain of insurers. Plans create much of their value by negotiating volume discounts with their network providers. Providers obligingly gouge out-of-network patients—often charging multiples of in-network rates. Underpinning this market structure is the practice of price discrimination. That is, providers are free to negotiate different rates with different payers, and vise-versa. This has given rise to wide price variation both within and across geographic markets.

Full price transparency disrupts this model, in the first instance, by superseding contract law, which holds confidentiality requirements in commercial price contracts to be enforceable. Such requirements are common in wholesale price contracts: For example, Walmart doesn't allow its suppliers to disclose what it pays for vacuum cleaners. The new rules would nudge medical price setting toward a retail model, where the best deals enjoyed by competitors become the starting point in annual negotiations. One likely effect would be less price variation.

But full transparency also might push up average prices. Today's health systems enjoy considerable unused monopoly power. Dartmouth Health Atlas groups the nation's 4,973 community hospitals into 3,436 Hospital Service Areas (HSA).[1] (In other words, at least half of HSAs have only one hospital.) Hospitals, meanwhile, increasingly are members of chains, allowing those in competitive markets to charge higher rates using an affiliate's leverage in monopoly markets. Further buoying provider pricing power has been the trend toward vertical integration, which has seen hospitals buy up, or partner with, physician practices and outpatient care centers. FTC fears that health systems in competitive markets would be more inclined to raise prices if they saw their competitors making more. Insurers, likewise, are concerned that price negotiations might become even more unbalanced than they are today.

Consumers might still benefit, however. FTC's concerns arise in part from the premise that prices for health services are the main determinant of premiums. A growing body of research suggests that efficiency also matters. Studies have found that wastefulness in the U.S. health system costs consumers and taxpayers upwards of $1 trillion a year.[13] If insurers competed more vigorously on the basis of efficiency, premiums might come down even as prices rose.

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[1] Dartmouth Health Atlas 1999, "Appendix on the Geography of Health Care in the United States": (Online.) The HSA designation reflected patterns of use according to Medicare enrollee ZIP Codes during 1992-1993. At the time, more than 51 percent of the population lived in HSAs where the localization index exceeded 70 percent.

Though less concentrated than hospital markets, many insurance markets are uncompetitive. For example, only one insurer serves New Hampshire's ACA marketplace. This concentration arises in part from the fact that the price-negotiation process tends to favor incumbents, who enjoy the benefit of existing relationships and high volumes. If there were less price variation, insurers would be better able to enter one another's markets. The most prominent example of competition in price discrimination-free healthcare markets is the Medicare Advantage (MA) program. These are privately run plans—typically based on the managed care model—that provide Medicare benefits and that can pay the same provider rates as traditional Medicare. MA plans have doubled their market share in recent years, mostly by providing more comprehensive coverage at a lower premium price.

A 2015 study by Mark Duggan and colleagues found that patients who lost coverage by managed care MA plans in the early 2000s (because the plans had closed) saw very large increases in their hospital utilization under traditional fee-for-service Medicare, with no indication of quality improvement.[14] This suggests that if competition were based on efficiency rather than price negotiation, care volume would fall. Falling care volume, in turn, would create slack in the market for (well paid) health professionals. Payrolls are the primary component in medical costs. A wider reliance on managed care in commercial insurance markets thus might help to contain both prices and volume.

Another intriguing possibility is that reduced price variation might prompt more providers to compete openly on prices, across larger geographical expanses. The poster child for this approach is Surgery Center of Oklahoma (SOC), whose cheap online price lists have attracted patients from across the U.S. and even Canada. (On November 30, 2019, its price for shoulder arthroscopy was $5,720.) According to the SOC's website, nearby hospitals have lowered their prices in response to transparent price competition.[15] Under such a model, health plans might broaden their networks to include more out-of-market destinations.

COMPARISONS TO NEW HAMPSHIRE

For the reasons noted above, New Hampshire provides an imperfect testing ground for the benefits of full price transparency. Even so, the results are discouraging. During 2007 to 2014, New Hampshire's per capita health expenditures grew faster than the national average—rising by 33.3 percent, compared to 26.4 percent for the nation as a whole.[16] Ranked among all states, New Hampshire rose from the 11th most costly in 2007 to the 9th most costly in 2014. Indeed, four out of the five states with the most expensive hospital rates allow patients to compare some version of hospital prices online.[17]

Consumer indifference has been a problem for both public and commercial health plan transparency websites. Brown estimates that only 8 percent of patients receiving MRI scans had availed themselves of the early version of NH HealthCost. Another study found that, in the 15 months following the introduction of a comparison shopping tool by California's Public Employees' Retirement System, 12 percent of patients had used it to research prices. A scant 1 percent of those who received an advance scan had conducted a price search.[18] Likewise, in a 2017 national survey, 13 percent of patients reported researching prices before receiving care.[19]

One factor suppressing usage is that health plan designs give patients little incentive to comparison-shop, especially for expensive procedures. In 2018, 29 percent of workers participated in "high-deductible" health plans, up from 8 percent in 2009.[20] But "high" is a relative term. Just 17 percent with family coverage had out-of-pocket maximums of $6,000 or more.[21] All of the prices displayed in Figure 1 exceed this amount. An Anthem enrollee would have needed a deductible above $6,483 in order to gain by choosing the lowest cost provider. If a patient had consumed other services, such as an MRI, their residual deductible would have been that much lower.

A second determining factor is the health of the patient. The most medically needy 10 percent of patients account for two-thirds of U.S. health expenditures.[22] These populations are the least prone to shop and travel. Almost all will exceed their annual insurance deductibles and/or out-of-pocket maximums early in a given plan year. In other words, the great preponderance of costs are incurred by relatively less mobile populations with little or no incentive to choose cost over convenience. That may be why, for example, Valley Regional Hospital, near Weathersfield, NH (not shown), can charge Anthem's group plan $2,531 for an MRI (shoulder/elbow/wrist) that is available for $472 at Four Seasons Imaging, in Bedford—68 miles away.[23] Many of its sickest patients are a captive market, and easy prey for price-gouging.

While patient access to comparative costs appears not to have dramatically reduced prices, neither has the ability of providers to shop each other's rates confirmed FTC's worst fears. The evolution of insurance plan design—for example, as shared-saving awards become more common—coupled with better patient education, could strengthen market responses. It nevertheless seems unlikely that, in the near term, a nationwide rule modeled on New Hampshire's transparency law would radically change market behavior on either side of the pricing equation.

THE OTHER TRANSPARENCY: DATA

Perhaps the best hope for full price transparency is that it would suppress price variation, leading in turn to more robust insurer competition based on efficiency. To realize that potential, the health plans who purchase health services need to know, precisely, which physicians prescribe unnecessary care, and in which settings. Here, more data sharing would help.

In the commercial sector, an employer plan typically covers only a small percentage of a provider's patients. Information from other plans is crucial to obtaining a clear picture of performance. Even under the new transparency rules, shared data will need to be de-identified, to prevent other plans from identifying the patients being described—a computationally intensive and time consuming process. Data scrubbers, meanwhile, must account for the ubiquity of new information from non-medical sources, such as credit card purchases and social media posts, which make re-identification easier. This means that much data from rural markets—where the small number of patients lends itself to easy re-identification—can't be shared. These hurdles fuel the case for monopoly: Healthcare organizations are free to analyze data collected in-house, where patient names are already known.

As data becomes more commercially valuable, insurers have fewer incentives to share it freely. Both public and private plans are gravitating toward value-based reimbursement—a data-intensive process that requires the matching of clinical activities with medical outcomes. To manage this burgeoning profit center, the major insurance companies have set up data subsidiaries, such as Blue Cross Blue Shield's Blue Health Intelligence or United Health Group's Optum.

Yet the biggest data hoarders are public. Nearly 40 percent of Americans receive their coverage through Medicare, state-run Medicaid programs and the VA. These programs operate under their own restrictive data regimes, with the result that few share data with private plans. In 2015, Congress set out to expand Medicare data sharing through the Qualified Entity (QE) program, permitting insurers and other qualified entities to combine Medicare data with commercial plan data, and to sell analyses and data for certain non-public uses. The results can be used only to provide feedback to providers, or to inform network formation and actuarial studies. They cannot be used in applications that enable consumers to shop for health services based on price, quality and safety. Additional legislation will be needed to broaden and harmonize federal data sharing.

COMMENT

While the transparency rules are laudable in their attempt to bring sunlight to a dark health world, they rely on the power of the state to compel disclosure of proprietary price discounts. This information is valuable to consumers, but represents a "taking" of sorts from an insurer who added value to the information (by collecting it in the first place) and who must incur costs in providing it free of charge to the public. It seems a better way to get to a more transparent system would be to require the Medicare, Medicaid, VA and other data already bought by taxpayers to be shared with private data aggregators who, in cooperation with private payers, would build and sell tools to consumers. That would not be a mandate or a taking. It would reflect a market way to facilitating better information on market prices.

Executive Order 13877 outlines a coherent, but incomplete, counterpoint to the view that only price regulation can lead to better value. Market-oriented reforms, such as transparency, will find little fertile ground in markets that are dominated by monopolistic health systems. As such, the administration's plans are, at best, a starting point for corralling the pricing excesses that have driven the health costs of working Americans to unreasonable highs.

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Timeline:Executive Order on Transparency

- Hospitals required to post charge information

- Treasury to issue guidance to make it easier for patients to select plans with HSAs that cover preventive care for people with chronic conditions

60 DAYS | **90 DAYS** | **120 DAYS** | **180 DAYS**

- ANPRM to solicit comments on how to disclose OOP costs to patients prior to care delivery

- HHS, Treasury, DOD, Labor, VA, OMB to increase access to de-identified claims data from taxpayer funded programs and group health plans for researchers and entrepreneurs
- Treasury to issue guidance to increase the amount of funds that can carry over without penalty at the end of the year for FSAs
- Report on laws and business practices impeding transparency
- HHS, Defense, VA to develop a health quality roadmap
- Treasury to issue regulations to treat direct primary care arrangements and healthcare sharing ministries as eligible medical expenses
- HHS to submit a report on additional steps to implement surprise billing protections

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The views expressed in this paper represent those of the authors and not necessarily those of CAHC's individual members.

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