



Commonwealth of Massachusetts

Health Policy Commission

Health Care Cost Trends Hearing 2013





Examination of Health Care Cost Trends and Cost Drivers

Pursuant to G.L. c. 6D, § 8

OFFICE OF ATTORNEY GENERAL MARTHA COAKLEY

ONE ASHBURTON PLACE • BOSTON, MA 02108

Health Care In Massachusetts

We benefit from:

- Shared responsibility of employers, individuals, health plans and providers
- Highly rated health plans and hospitals
- Model for health care reform

We are challenged by:

- Trends in health care spending exceeding economic growth
- Lack of price transparency
- Lack of incentives for right care at right location

Massachusetts Is a National Leader in Health Care Reform

YEAR	MASSACHUSETTS HEALTH CARE REFORM	
2006	Chapter 58 – Health Reform	
	<ul style="list-style-type: none"> • Individual Mandate • Employer Responsibility 	<ul style="list-style-type: none"> • Medicaid Expansion • Insurance Exchange
2008	Chapter 305 – Cost Containment Legislation I	
	<ul style="list-style-type: none"> • AG Authority to Examine Cost Trends 	
2010	Chapter 288 – Cost Containment Legislation II	
	<ul style="list-style-type: none"> • Transparency • Tiered/Limited Network Products • Reform of Unfair Contracting Practices 	
2012	Chapter 224 – Cost Containment Legislation III	
	<ul style="list-style-type: none"> • Oversight of Payment Reform & Provider Registration • Benchmark Health Spending to Gross State Product • Price Transparency for Consumers 	

AGO Cost Trend Examination

Examined recent market efforts designed to improve health care cost and use:

1. How are purchasers responding to new health plan designs and transparency?
2. How are health plans moving to incent purchasers and providers to make value-based decisions?
3. How and why are provider groups realigning to deliver care?

1. PURCHASERS

Employers and individual health care purchasers have increasingly:

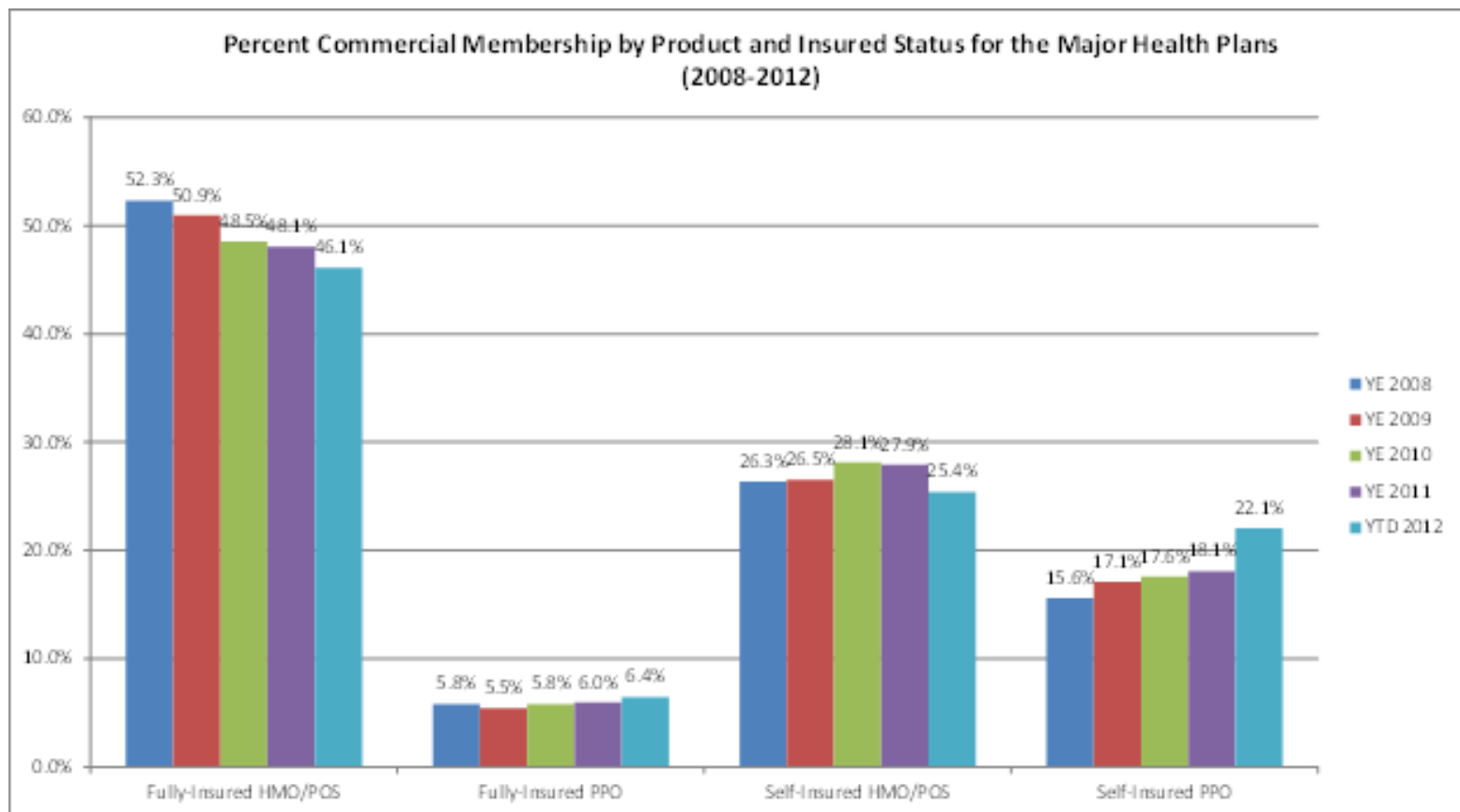
- Moved to health insurance products with tiered networks
- Moved to PPO products and away from HMO products
- Moved to high-deductible health plans

Purchasers Increasingly Moving to Tiered and Limited Network Products

Growth in Tiered v. Limited Network Membership

	YE 2008		YTD 2012	
	Tiered	Limited	Tiered	Limited
BCBS	12,987	0	168,656	0
FCHP	0	34,402	13,142	40,169
HPHC	47,490	0	88,938	3,852
THP	108,693	1,848	154,177	8,666
Total	169,170	36,250	424,913	52,687

Purchasers Have Increasingly Moved To PPO Products, Including Self-Insured PPO Products, And Away From Fully-Insured HMO Products



Purchasers Have Increasingly Moved To High-Deductible Products

- From 2008 to 2010, proportion of individual market enrolled in high-deductible products increased from 45% to 55%.
- During same time period, small group plan enrollment in high-deductible products increased from 2% to 27%.
- Trends in Massachusetts are consistent with national trends.

Purchaser Decisions Affect Health Plans and Providers Implementing Risk Contracts

- Increased enrollment in PPO impacts provider performance under risk and PPO/HMO revenue streams.
- Consumer incentives under products that encourage value-based purchasing may come into tension with provider incentives.
- Products designed to help consumers make value-based decisions can also help providers direct patients to the appropriate care at the appropriate location.

2. HEALTH PLANS

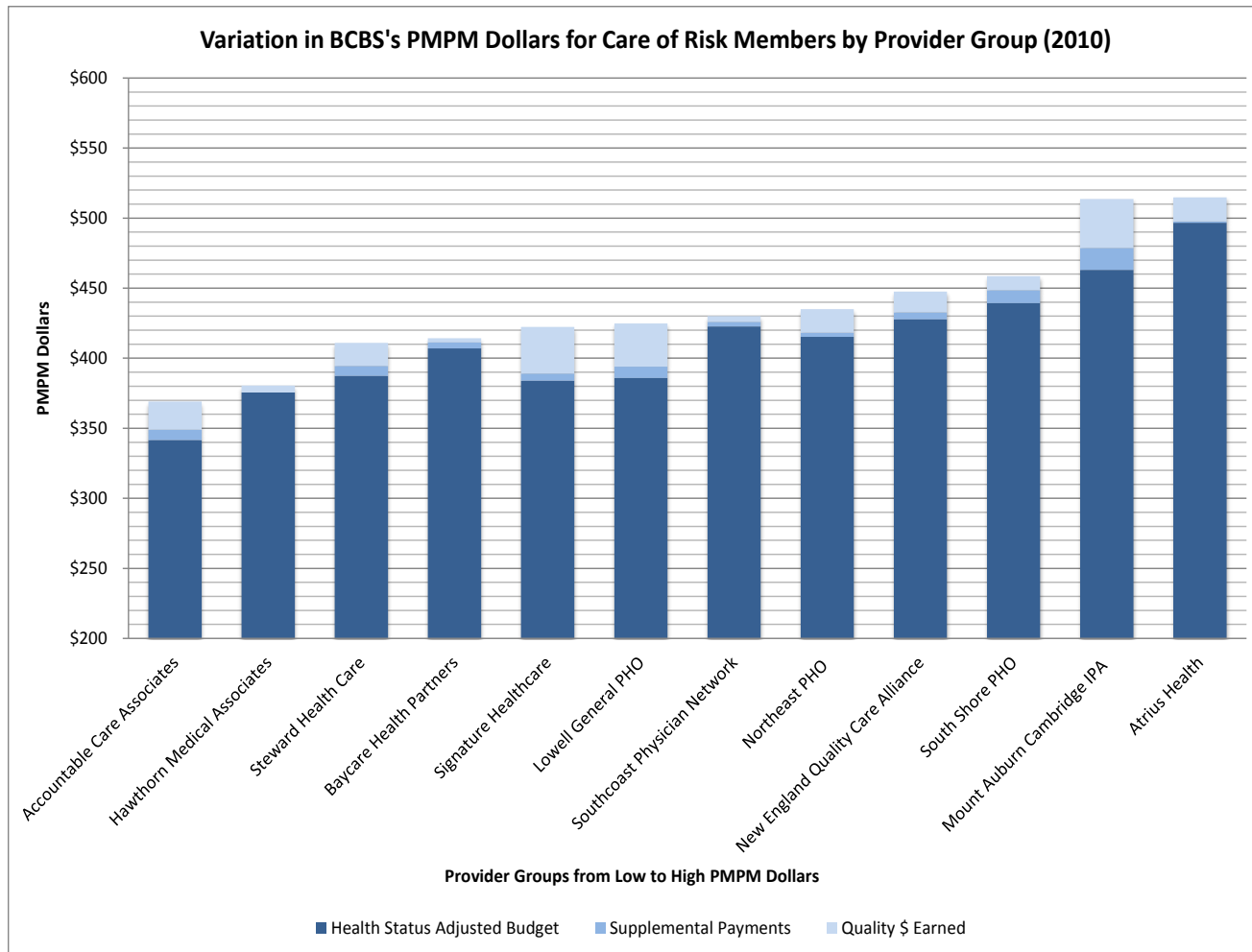
Health plans negotiate different amounts with providers to care for patients of comparable health, reflected in variation in:

- Risk budgets
- PPO and HMO payment rates
- Across providers serving different populations that vary by health status and geographic area

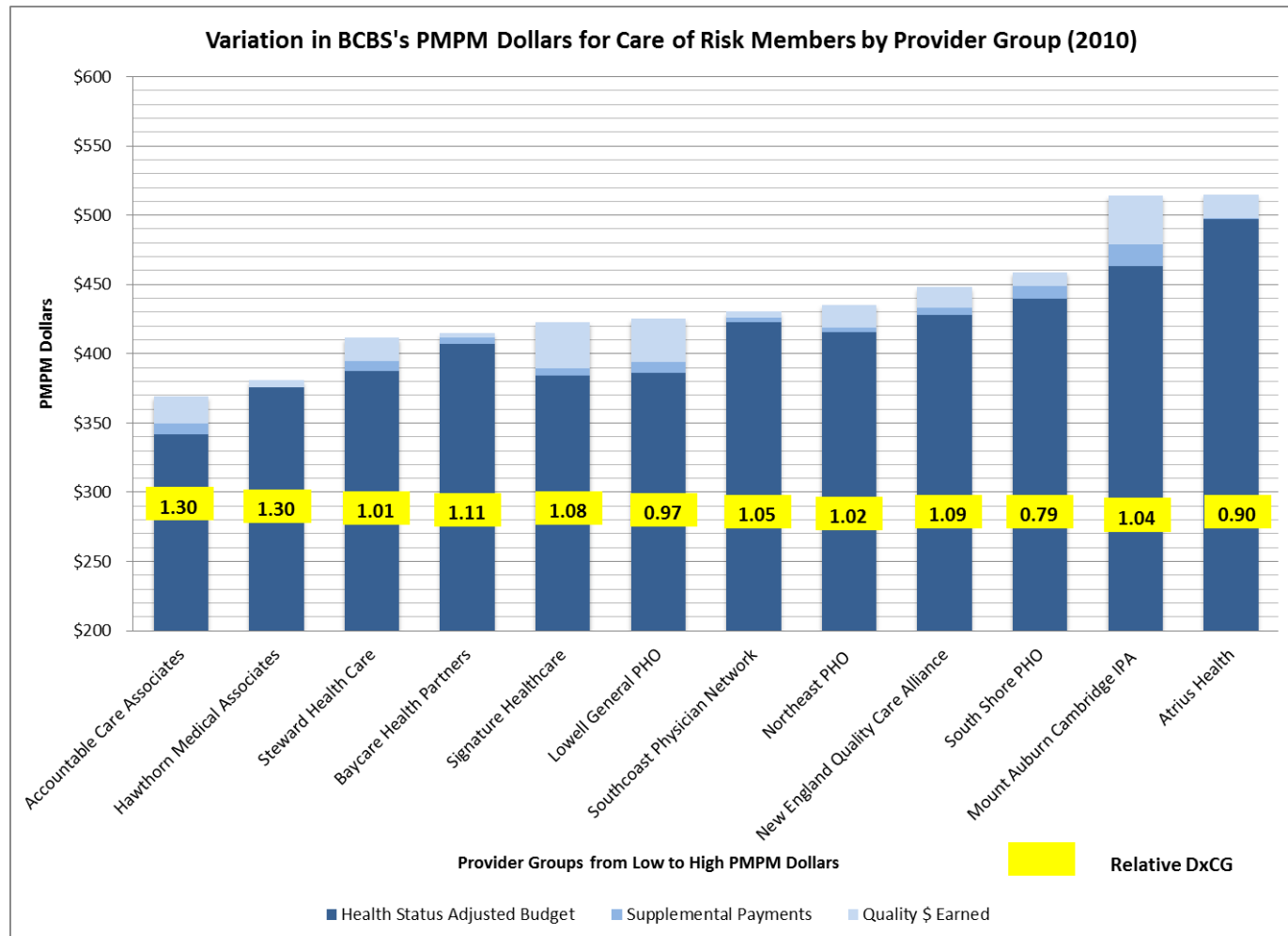
Health plan product designs impact:

- Risk selection (consumer purchasing based on health)
- Total medical spending
- Care management

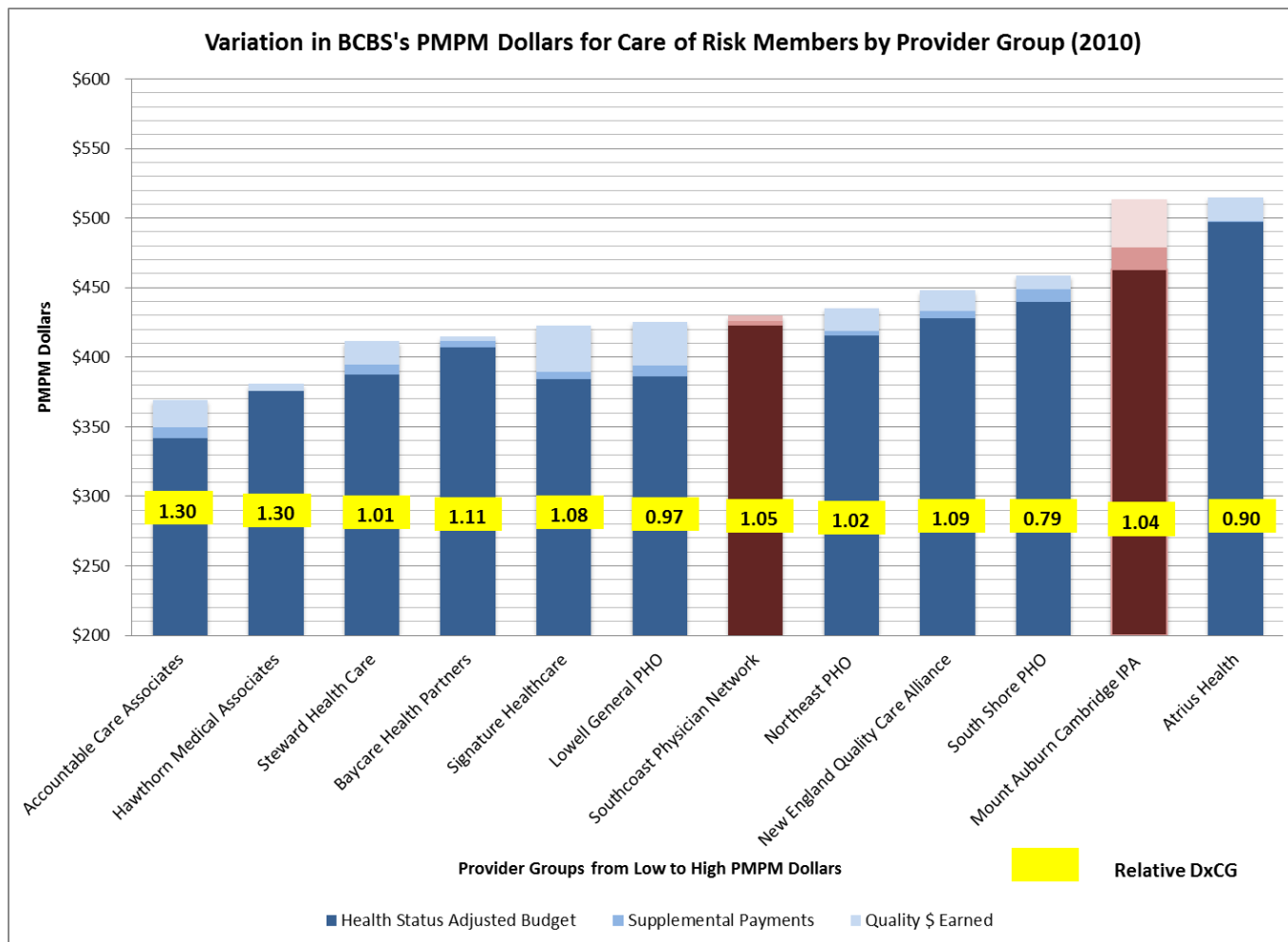
Variation in Risk Budgets Not Explained by Health Status of Populations Being Care For



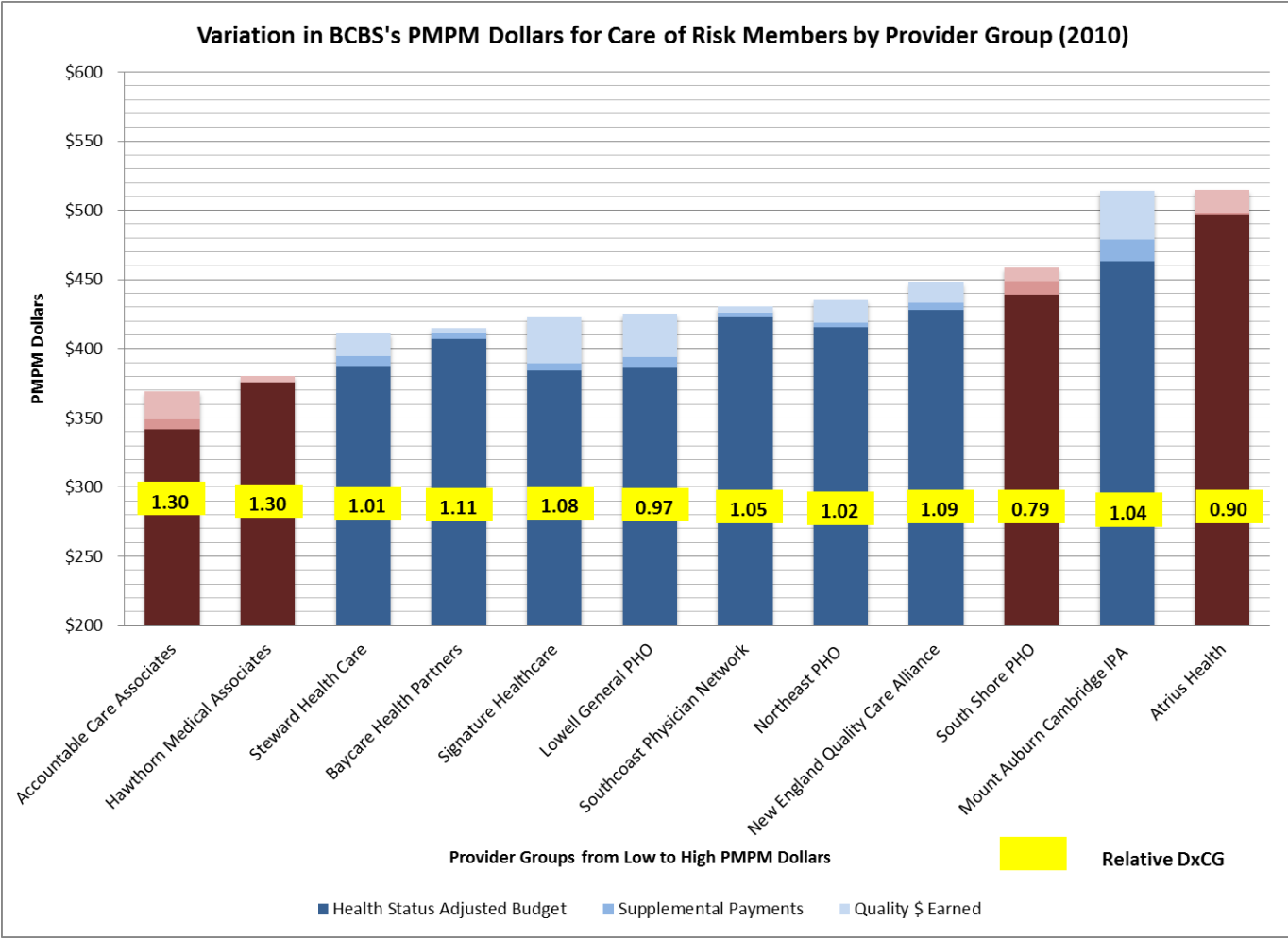
Providers Care for Very Different Populations Under Risk Contracts



Budget Variation Significant Even for Providers Caring for Populations of Equivalent Relative Health Status (1.04-1.05)

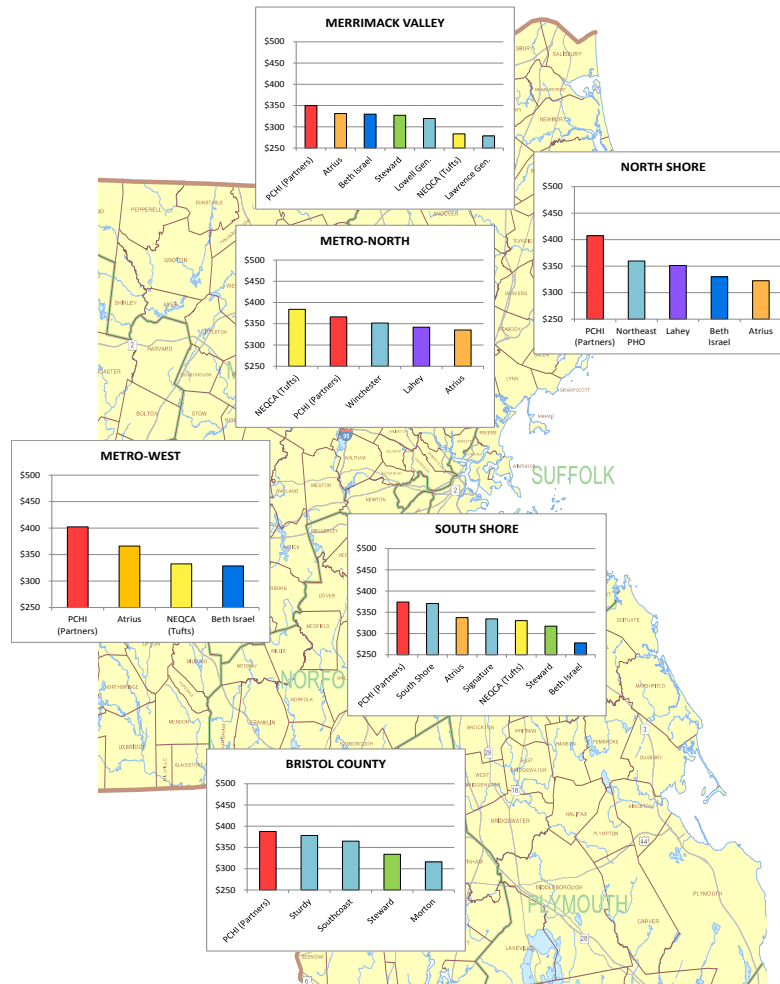


Budget Variation Significant for Providers Caring for Very Different Populations

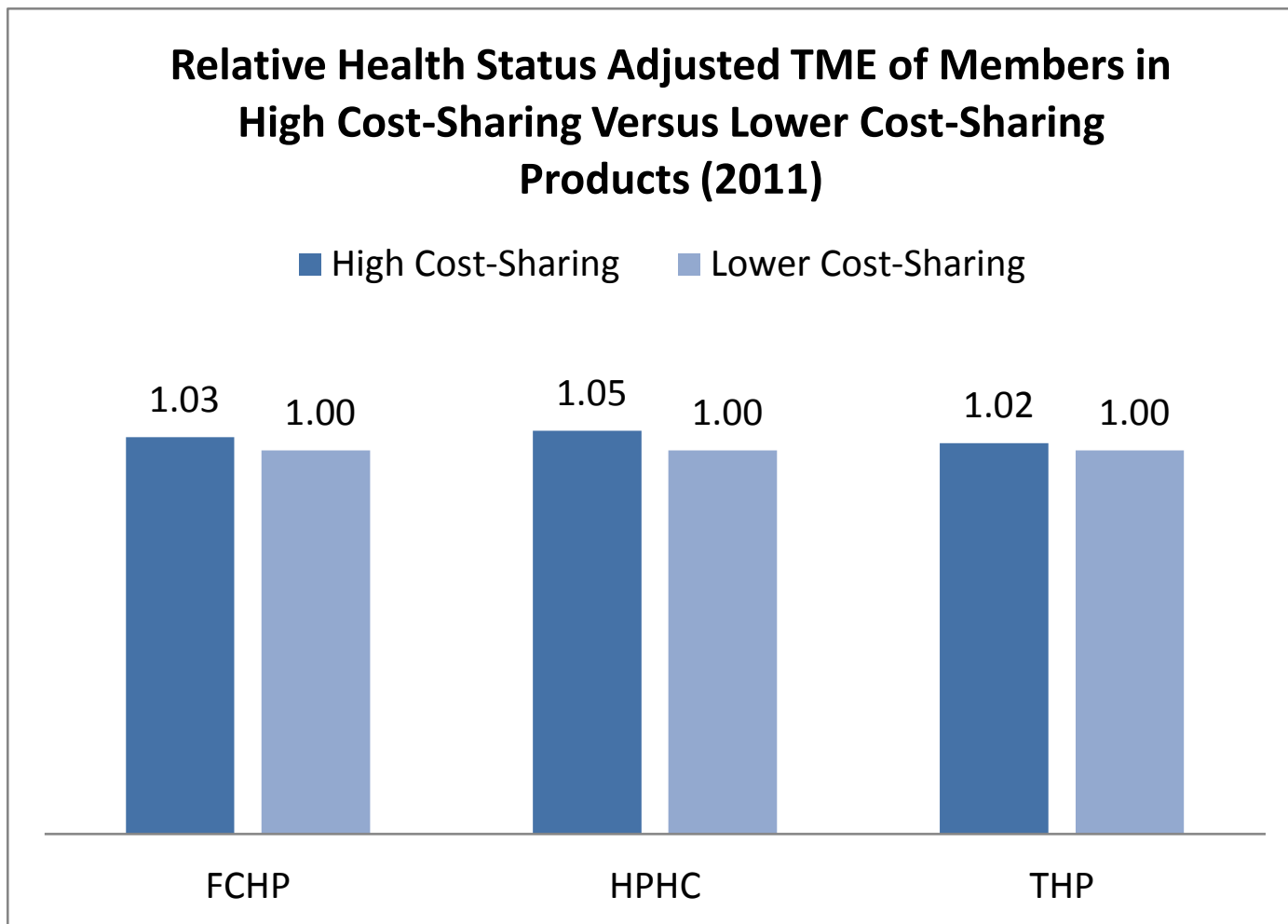


Variation in Provider TME Exists Across Massachusetts and Within Separate Geographic Areas

Variation in a Major Health Plan's Provider Group TME by Region (2011)



Certain Products Appear to Be Associated with Lower Medical Spending on a Health Status Adjusted Basis



Health Plans Can Support Prudent Purchasing and Incentivize Efficient Care Delivery

- Risk contracts and other payment arrangements can encourage efficient, high quality care delivery if reimbursement is tied to value.
- Products can encourage consumers to seek appropriate care at the appropriate location.
- We should continue to examine the performance of different products to assess their impact on costs and care delivery.

3. PROVIDERS

- Providers are entering new risk contracts and are taking on increased insurance risk without consistent mitigation by health plans.
- Provider consolidations and alignments are taking place without adequate analysis of the potential benefits and cost implications.

Providers Are Taking On Increased Insurance Risk Without Consistent Mitigation By Health Plans

ADJUSTMENTS PRESENT IN 2012 RISK CONTRACTS				
	BCBS	HPHC	THP	CMS (P-ACO)
Health Status	Yes	Sometimes	Sometimes	No
Mandated Benefits	Sometimes	No	No	Yes
Unit Price	Sometimes	No	No	n/a

The Impact of Provider Alignments Should Be Measured and Monitored

- Providers serve patient populations that vary by health status and size:
 - 2011 health status scores of provider systems with the least healthy populations ranged from 1.7 to 2.3 times that of provider systems with the healthiest populations for three major MA health plans.
 - Acton Medical Associates manages roughly 6,100 risk lives under three commercial risk contracts.
 - Larger systems manage more than 50,000 risk lives under individual risk contracts.
- Potential benefits of provider alignments should be balanced against concerns of increasing market leverage and reducing consumer options.

Providers Can Support Prudent Purchasing Decisions and Efficient Care Delivery

- Providers should support prudent purchasing decisions by directing patients to obtain the right care at the right location.
- Providers should support efficient care delivery through internal efforts to coordinate care and by directing care to more efficient providers when appropriate.

Data Accuracy

- Data Sources
 - Publicly Available
 - Information received directly from carriers and providers
- Importance of Data Accuracy
- Data Improvements

Working Together

- We must continue to work with purchasers, health plans and providers to promote a value-based health care market.
- We need timely and accurate information to monitor and address tensions and unintended consequences that may result from efforts by purchasers, health plans and providers to change how we use and pay for health care services.

Protecting Consumers

- The Office of the Attorney General will continue to use its authority to promote appropriate transparency to empower consumers to make value-based decisions.
- We will continue to use our authority to protect consumers from unfair practices that restrict access to necessary health care services, including behavioral health care services, or result in inflated costs.

RESOURCES

- Attorney General's Examinations of Health Care Cost Drivers:
 1. <http://www.mass.gov/ago/docs/healthcare/2011-hcctd-full.pdf>
 2. <http://www.mass.gov/ago/docs/healthcare/final-report-w-cover-appendices-glossary.pdf>
 3. <http://www.mass.gov/ago/docs/healthcare/2013-hcctd.pdf>
- Massachusetts Health Care Cost Containment Legislation:
<http://www.malegislature.gov/Laws/SessionLaws/Acts/2010/Chapter288>
<http://www.malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224>
- Center for Health Information & Analysis Reports:
<http://www.mass.gov/chia/docs/r/pubs/13/ar-ma-health-care-market-2013.pdf>
<http://www.mass.gov/chia/docs/r/pubs/13/relative-price-variation-report-2013-02-28.pdf>

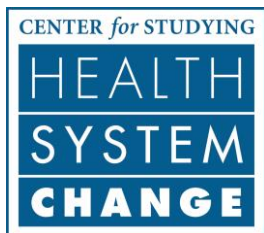


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Addressing Impact of Provider Consolidation

Paul B. Ginsburg, Ph.D.

Testimony presented to Massachusetts Health
Policy Commission, October 2, 2013

Powerful Trend towards Provider Consolidation

- Understanding the Trend
 - Context of Consolidation
 - Drivers of Consolidation
- Impact of Trend
- Particular Impact of Hospital-Physician Consolidation
- Policy Responses

Trends in Provider Consolidation

- Hospital consolidation is on the rise:
 - Over 1,000 hospital mergers since mid-90s (Gaynor)
 - Consolidation slowed in the past decade, but has picked up recently
 - Most urban areas are now dominated by 1-3 large hospital systems

Drivers of Provider Consolidation

- Increased leverage/revenue
- Respond to push for coordinated and integrated care
 - HIT and quality reporting requirements
- Future requirements appear daunting to smaller hospitals and medical practices
 - Motivating mergers with larger organizations
- Advocates of coordinated care:
 - Accept some additional consolidation
 - Put in place mechanisms to contain price increases

Impact of Provider Consolidation

- Research shows that consolidation drives up prices (Gaynor, Kleiner, Schneider, Dafny)
 - Hospitals mergers have led to price increases of 3.5-53 percent (Gaynor)
- Range of increase is affected by availability of competitive options
- Providers with “must have” status have substantial leverage even when concentration is low
- Higher prices lead to higher insurance premiums
 - Burden to consumers, employees, employers, governments

Recent Challenge of Hospital-Physician Consolidation (1)

- Hospital acquisition or affiliation with physician groups and employment of physicians
 - The most active area of consolidation
 - Strong direct effects on prices
 - Hospitals negotiate much higher prices for services of employed physicians
 - Addition of a facility fee
 - Indications of higher hospital prices as well

Recent Challenge of Hospital-Physician Consolidation (2)

- Challenges for purchasers beyond price increases
 - Obstacle to insurers' steering of patients to high-value providers
 - PCPs and specialists locked into referring to system
 - Discourages development of physician organizations
 - Reduced potential for competition in ACO/risk contracting market

Care Coordination with Less Consolidation

- Small physician practices can join IPA or larger group instead of becoming hospital employees
- Hospital can develop contractual relations looser than ownership
 - Not only physician organizations, but other providers
 - For example, rather than purchase post-acute providers, hospitals can identify those worthy of contractual relationship

Need for Steps to Limit Impacts on Prices

- Market approaches
 - Steps by employers/insurers to engage patient/consumer to seek lower-priced providers
 - Incentives
 - Information
- Government efforts to facilitate market approaches

Better Information on Price and Quality for Enrollees

- Online tools for enrollees
 - Customize to relevant insurance product and enrollee's deductible/account
- Scope will grow with increasing deductibles
 - But most opportunities on outpatient side
 - Inpatient pricing much more complex
 - Other approaches involving less price data have more promise

Limited Networks

- Fewer providers in network leads to lower prices in two ways: steering and increased leverage
- Public more receptive now than in 1990s
 - Affordability challenges are larger
 - ACA exchanges and subsidies create ideal incentive structure
 - Absence of “one size fits all” requirements that apply to employer-sponsored insurance
- Potential regulatory obstacles from network adequacy

Tiered Networks

- Potential for broader appeal than limited networks
 - Less of a commitment by enrollee
 - Potentially more effective if done by service line
- But prominent hospitals can block through refusal to contract

Reference Pricing

- More aggressive approach to tiers
 - Stronger patient incentives
 - But applies to relatively small share of spending
- Works best with discrete outpatient procedures
 - Colonoscopy
 - MRI
 - Cataract surgery
- Carriers split on priority to give to approach

Fostering Physician Organizations (1)

- Potential upside
 - More competitive hospital market
 - Reduce attractiveness of hospital employment
 - Protect use of incentives to steer patients to higher-value hospitals and specialists
 - Results from AQC evaluations
 - Potentially more effective performance under global payment incentives than hospital-led organizations
 - Less conflicted incentives

Fostering Physician Organizations (2)

- Financial/technical assistance to organizations
 - BCBSNC HIT subsidies for practices
 - CareFirst BCBS PCMH initiative
 - Global incentives and information provision for PCPs
 - Pods for small PCP practices
- Purchase of physician organizations
 - Insurers (United purchase of Monarch IPA)
 - Others (e.g. DaVita purchase of HealthCare Partners)
 - Capital injections support expansion

Government Actions to Foster Market Approaches (1)

- Regulation of hospital contracting practices
 - Prohibit demands for tier placement
 - Prohibit all or none system contracting
- Require plans to provide real-time price data for enrollees
- Support for physician organizations
 - Loans/grants to establish infrastructure
 - Easier requirements for ACOs (Medicare)
 - Eliminate higher Medicare payments for physician services in hospitals (MedPAC proposal)

Government Actions to Foster Market Approaches (2)

- Broader access to physician-specific data for profiling
 - Medicare Part B claims data
 - State all-payer claims data

Conclusions

- Strong trend towards provider consolidation in response to challenging environment
 - Potential to facilitate integration and coordination, but also potential for higher prices
- Both private sector and government can take steps to address increasing provider leverage on prices through market approaches
- Degree of success will determine whether direct regulation is pursued



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CATALYST
FOR
PAYMENT
REFORM

EMPOWERING PURCHASERS: ADVANCING TRANSPARENCY, INFORMATION, AND INCENTIVES

Suzanne Delbanco, Ph.D.
Executive Director
October 2, 2013



Who We Are

Catalyst for Payment Reform (CPR) is an independent, non-profit corporation working on behalf of large employers and public health care purchasers to catalyze improvements in how we pay for health services and to promote higher-value care in the U.S.

- 3M
- Aircraft Gear Corp.
- Aon Hewitt
- Arizona Health Care Cost Containment System (Medicaid)
- AT&T
- Bloomin' Brands
- The Boeing Company
- CalPERS
- Capital One
- Carlon
- Comcast
- Dow Chemical Company
- eBay, Inc.
- Equity Healthcare
- GE
- Group Insurance Commission, Commonwealth of MA
- The Home Depot
- Ingersoll Rand
- IBM
- Marriott International, Inc.
- Ohio Dept. of Jobs and Family Services (Medicaid)
- Ohio PERS
- Pennsylvania Employees Benefit Trust Fund
- Pitney Bowes
- Safeway, Inc.
- South Carolina Health & Human Services (Medicaid)
- TennCare (Medicaid)
- Verizon Communications, Inc.
- Wal-Mart Stores, Inc.
- The Walt Disney Company
- Wells Fargo & Company



What We Focus On

Shared Agenda

Payment designed to cut waste or reflect/support performance

- Value-oriented payment that creates incentives to improve quality and contain costs
- 20% by 2020 as measured by National and Regional Scorecards

Special Initiatives

- Price transparency
- Reference and value pricing
- Maternity care payment reform

Environment

- Provider market power
- Private-public alignment
- Alternative routes to value
- Critical mass and a consistent ask



What We Do: CPR's Two-Pronged Strategy

Market-Based Action

- Aligned purchaser agenda – short-term wins, longer-term bold approaches
- Clear signals to plans – RFIs, contracts, user group discussions and metrics, transparency tool specs
- Toolkit for local action – health plan user group toolkit, Market Assessment Tool, regional scorecards, action briefs, joint pilots, etc.

Shine Light on Urgency to Spur Reform

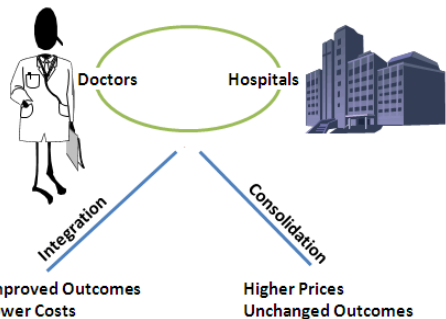
- Accountability: National Scorecard and Compendium on Payment Reform
- Raise visibility of payment variation
- Price Transparency State Report Card & statement
- Highlight provider market power issues & potential solutions



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Market-Based Reforms with Wind in their Sails Across the Nation

Provider Consolidation – vertical and horizontal



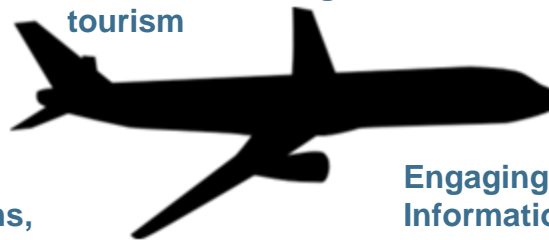
Payment Reform “Arms Race”



Delivery Reform – ACOs, PCMH, high-intensity primary care, group visits



Employers Shaking Up the Market – high-performance networks, direct contracting, medical tourism



New Markets for Insurance – Private exchanges, state reforms, state exchanges

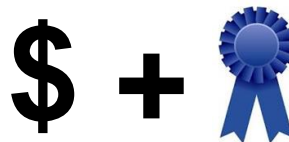


Engaging Consumers with Information: open notes, shared decision making, true informed consent, comparative effectiveness



ACA

Engaging Consumers with Incentives: VBID, reference pricing, tiered networks





What are Purchasers Trying Today?

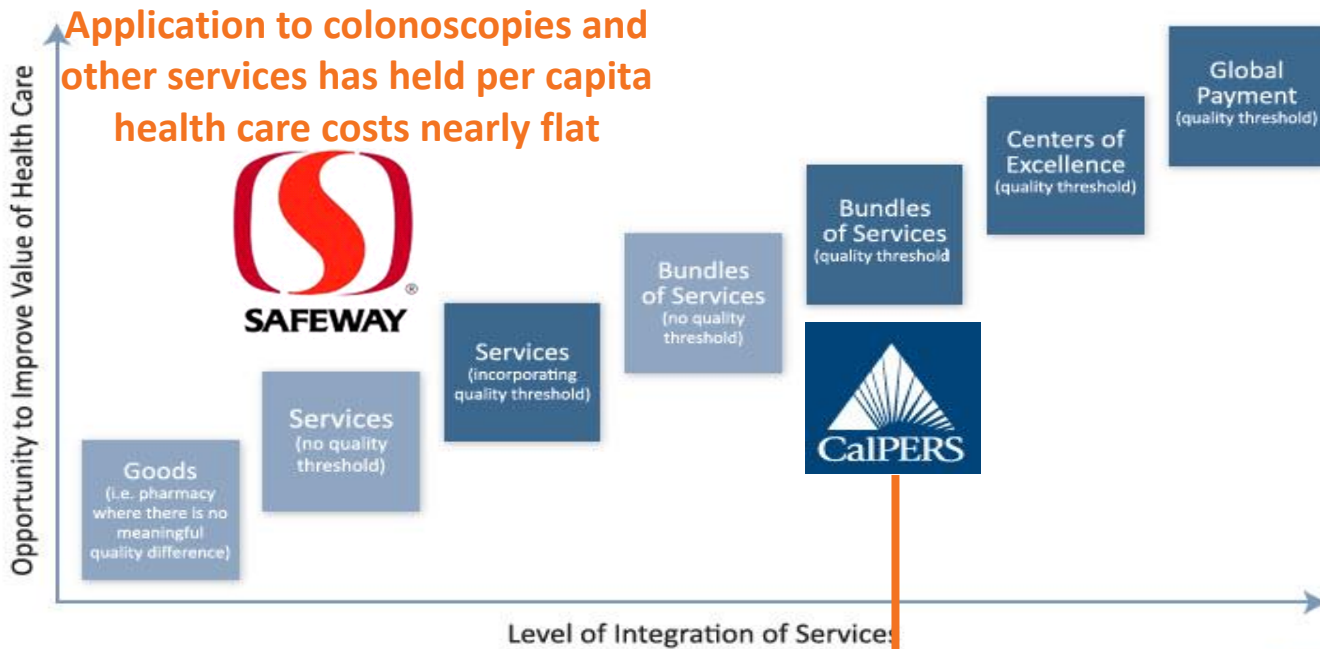
Consumerism, Benefit design, and Decision Support Tools:

- Consumer Directed Health Plans/Account-Based Plans
- Cost Sharing and Centers of Excellence
- Evidence-Based Plan Designs & Value-Based Insurance Designs
- Employee Cost Sharing
- Reference Pricing
- Reward/Penalize Health Improvement Activities
- Aggressive Management of Pharmacy Benefits
- Transparency
- Shared Decision Making
- Participation in ACOs and PCMHs



From Reference to Value Pricing

Spectrum of Reference Pricing



Reference Pricing establishes a standard price for a drug, procedure, service or bundle of services, and generally requires that health plan members pay any allowed charges beyond this amount.

Value Pricing is when quality is also taken into consideration in addition to the standard price.

Growing in Popularity Among Purchasers Nationally: 5% in 2013; 15% in 2014*

**NBGH/Towers Watson*

Over \$3 million in savings in first year of hip/knee replacement program; some high-priced providers renegotiated

Incorporates Quality Measures
No Quality Measures

- Signal to providers that payment variation isn't tolerable

- Engages Consumers



What are Purchasers Trying Today?

Network design, alternative sources of care:

- Limited, narrow, tiered or customized high-performance networks (e.g. Group Insurance Commission)
- Onsite, Near Site, or Mobile Clinics
- Telehealth
- Direct contracting



Provider Market Power: Bringing Issue to Forefront

Price is the leading driver of health care cost growth today



**Improved Outcomes
Lower Costs**

**Higher Prices
Unchanged Outcomes**



Provider Market Power in
the U.S. Health Care Industry:
Assessing its Impact and
Looking Ahead

Consolidation pushes payments 3% higher nationwide



What are Purchasers Trying Today?

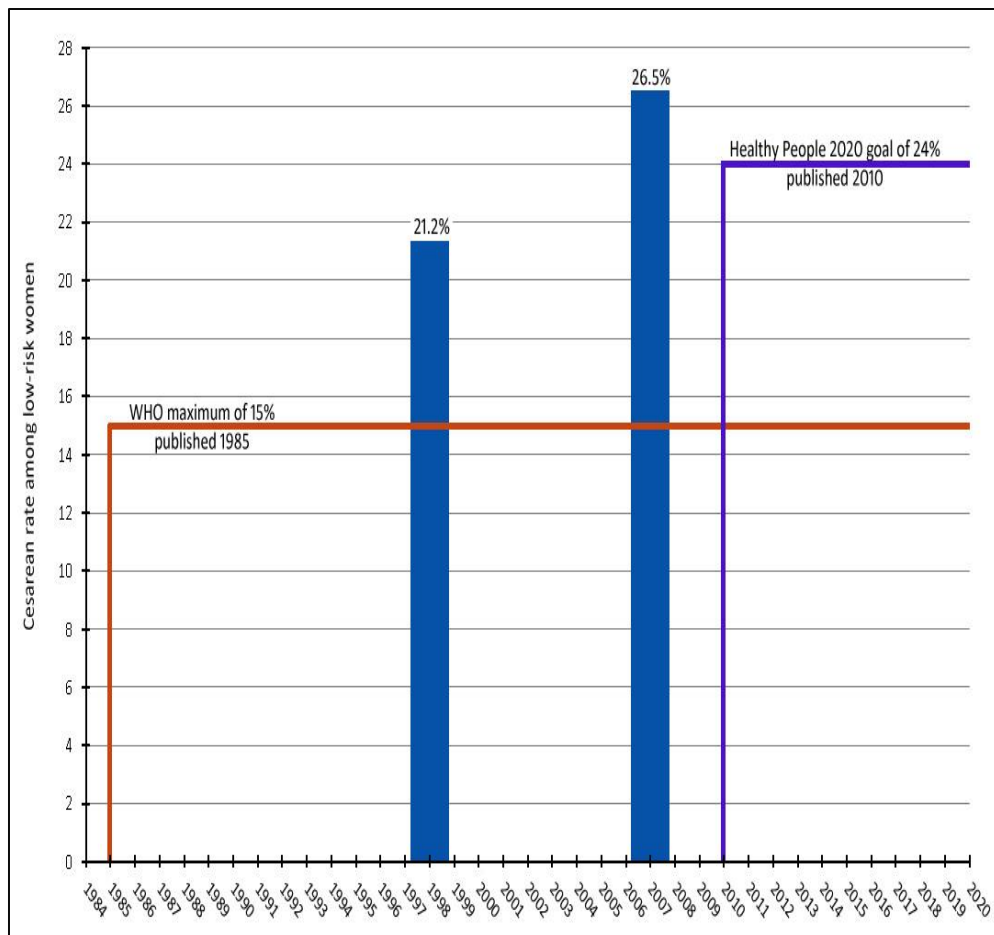
Payment Reform

- PCMH
- ACOs
- Bundled payment
- Non-payment for care that doesn't follow guidelines



Fix How we Pay for Maternity Care

- **Practice patterns straying from the evidence**
 - Pre-term elective births
 - Unnecessary intervention
 - Worse outcomes and higher costs
- **The way we pay today creates incentives for unnecessary intervention**
 - Need to insert right incentives
 - Blended, bundled payment
 - Non-payment for early elective deliveries



US is moving farther away from goals



What are Purchasers Trying Today?

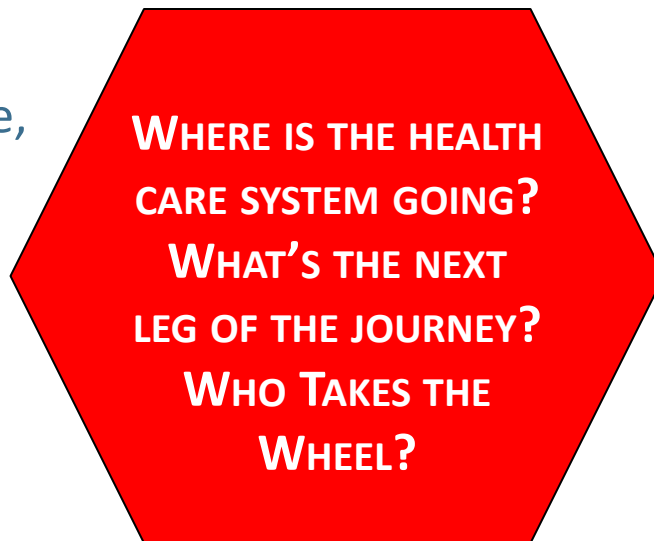
Efforts to improve employee health:

- High-Cost Case Management Programs
- Financial Incentives for Health Improvement
- Require Employee Engagement to Receive Health Benefits



Road Map

- **Leg 1:** Discounts in return for volume
- **Leg 2:** Unfettered access, insulation from costs
- **Leg 3:** Awareness of variation and poor value, engaging consumers, transparency, creating incentives, seeking alternative sources of care

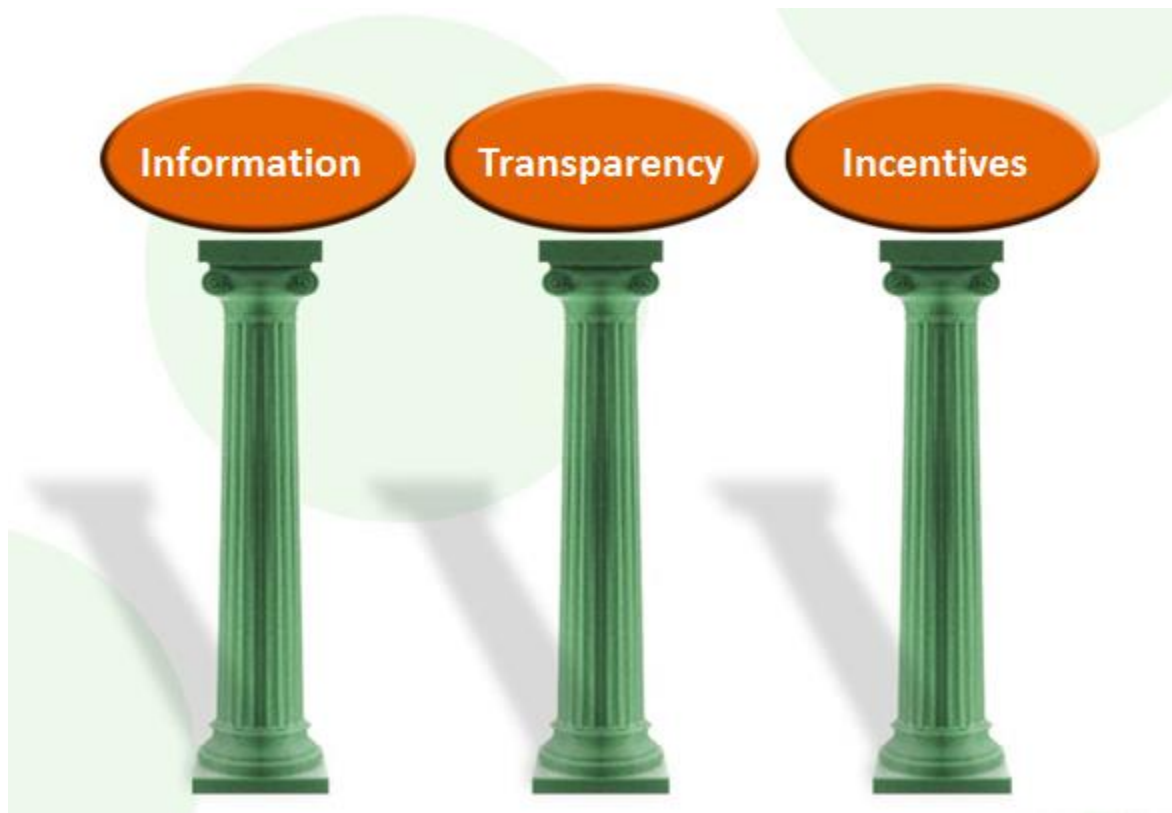


- **Leg 4:** Shaping provider and consumer behavior with a stronger market, identification of best overall value, payment varying with quality and cost, willingness to select select providers, public and private exchanges...





Three Pillars





Huge quality variation

- Quality Measures would be different if set by purchasers: measures on areas of performance where improvement could lead to the greatest reduction in harm, with the greatest variation on quality and price, areas of greatest cost
- Instead we have measures that are easy to collect and show little variation across providers and meaningless to consumers
- But we know enough to know there are massive failures

HSPH News

Home > HSPH News > Press Releases > Pregnant women's likelihood of cesarean delivery in Massachusetts linked to choice of hospitals

Pregnant women's likelihood of cesarean delivery in Massachusetts linked to choice of hospitals



Boston, MA – There is wide variation in the rate of cesarean sections

	ADVENTIST MEDICAL CENTER 115 MALL DRIVE HANFORD, CA 93230 (559) 582-9000	AHMC ANAHEIM REGIONAL MEDICAL CENTER 1111 W LA PALMA AVENUE ANAHEIM, CA 92801 (714) 774-1450	ALTA BATES SUMMIT MEDICAL CENTER - ALTA BATES CAMP 2450 ASHBY AVE BERKELEY, CA 94705 (510) 204-4444
Rate of readmission for heart attack patients	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate
Death rate for heart attack patients	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate
Rate of readmission for heart failure patients	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate
Death rate for heart failure patients	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate



Huge payment variation (amounts)

Table 6: Observed Prices for Selected High-Volume Maternity DRGs by Severity of Illness, 2009

APR-DRG and severity	Minimum price	Median price	Average price	Maximum price	Difference between maximum and minimum price	Ratio of maximum price to minimum price
Cesarean delivery (540)						
Severity 1	\$3,244	\$7,598	\$7,859	\$15,915	\$12,671	4.9
Severity 2	\$2,828	\$8,718	\$9,338	\$20,424	\$17,596	7.2
Severity 3	\$3,621	\$11,389	\$13,266	\$26,018	\$22,397	7.2
Severity 4	\$9,600	\$17,134	\$19,156	\$30,660	\$21,059	3.2
Vaginal delivery (560)						
Severity 1	\$1,810	\$4,990	\$5,225	\$11,066	\$9,256	6.1
Severity 2	\$2,182	\$5,692	\$5,884	\$12,177	\$9,995	5.6
Severity 3	\$2,812	\$6,450	\$7,656	\$20,446	\$17,634	7.3

Source: Mathematica Policy Research analysis of private insured and self-insured fee-for-service claims for Massachusetts residents.

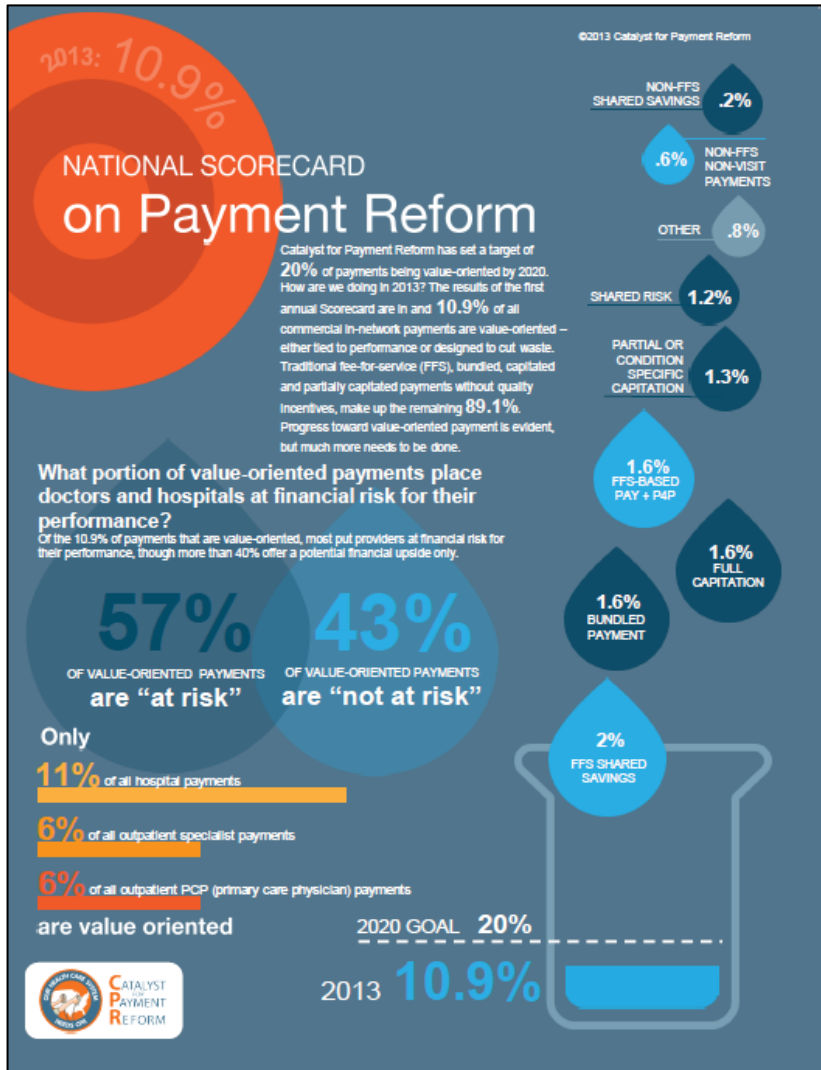
Note: Payments include patient cost-sharing in fee-for-service coverage. Payments made under managed care contracts are not included.

Huge payment variation (methods)

- See CPR's Scorecards...



National Scorecard on Payment Reform: Baseline



- 2010 estimate was 1-3% of payments were tied to performance
- 2013 Scorecard found 10.9% of commercial in-network payments are value-oriented
- 57% of the value-oriented payment is considered “at-risk”
- 11% of payment to hospitals is value-oriented
- 6% of outpatient specialist and PCP payment is value-oriented
- Scorecard results possibly biased upward



National Scorecard on Payment Reform: Benchmark Metrics

Benchmarks for Future Trending

Attributed Members



Percent of commercial plan members attributed to a provider participating in a payment reform contract, such as those members who choose to enroll in, or do not opt out of, an Accountable Care Organization or a Patient-Centered Medical Home.

2% NATIONAL AVERAGE

Share of Total Dollars Paid to Primary Care Physicians and Specialists

Of the total outpatient payments made to physicians and specialists, 75% is paid to specialists and 25% is paid to PCPs. Over time, this figure will show if there is a rebalancing of payment between primary and specialty care.



Non-FFS Payments and Quality

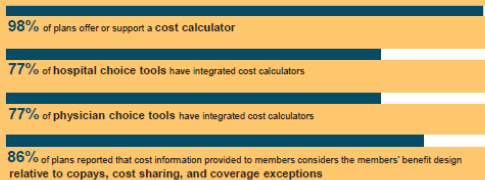
Quality is a factor in only **35%** of non-FFS payments



Quality is *not* a factor in **60%** of non-FFS payments

* Unclassified

Transparency Metrics



Only **2%** of total enrollment use these tools

Hospital Readmissions*



* Derived from data submitted to eValue used NQDA's all-cause readmission measure. Not an official NQDA Benchmark.



Slow Progress On Efforts To Pay Docs, Hospitals For 'Value,' Not Volume

Health Affairs

AT THE INTERSECTION OF HEALTH, HEALTH CARE, AND POLICY

Payment Reform: A Promising Beginning, But Less Talk And More Action Is Needed

The Washington Post

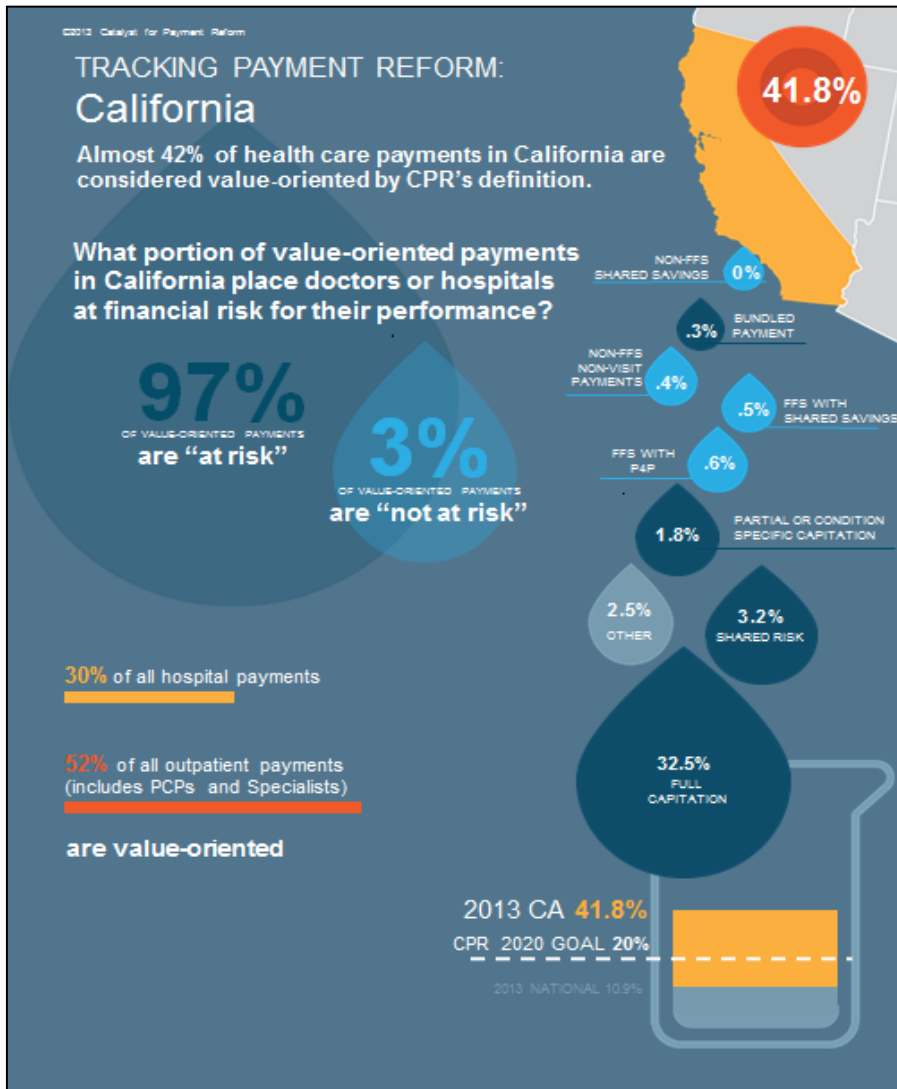
How Fortune 500 companies plan to cut health costs: Act like Medicare

ModernHealthcare.com

Value-based insurance plans gain momentum



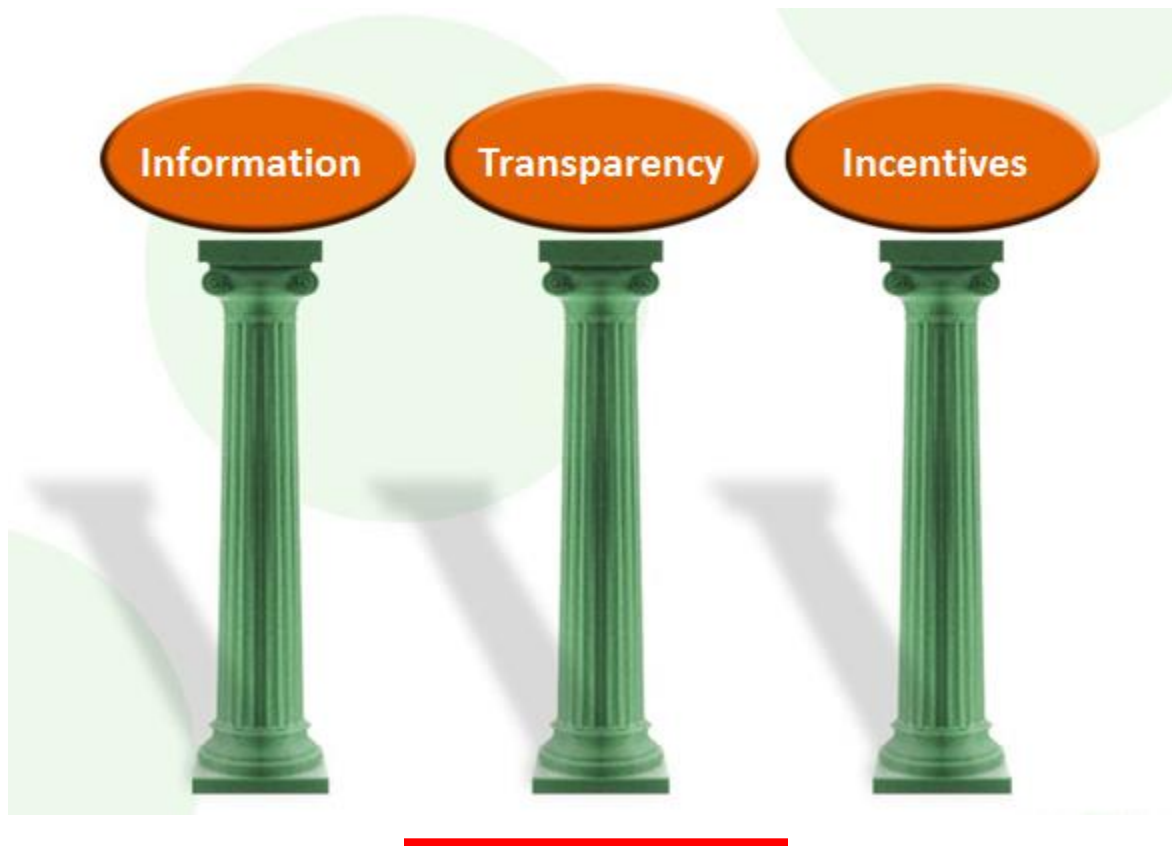
California Scorecard on Payment Reform: Released 9/27/13



- 41.8% of commercial in-network payments are value-oriented
- 97% of the value-oriented payment is considered "at-risk"
- 32.5% of California's payment is capitation with quality
- 36% of commercial health plan members are "attributed"
- CA's health care spending per capita (\$6,238) is 9th lowest in the nation
- But, huge variation across payers, examples of poor quality: maternal mortality, cesarean deliveries, flu vaccines and diabetes screenings
- **Where's the value in value-oriented?**



Three Pillars





Transparency

Quality Transparency

- Head start, especially for hospitals
- Voluntary efforts will fall short – Leapfrog Group

Price Transparency

- Private and public efforts (34 states with laws)
- Medicare has some tools
- Private sector competing for appetite

Best Overall Value

- Combining quality with price information
- Consumers will make the right choices



CATALYST FOR PAYMENT REFORM

Understanding the Cost & Value of Care

Action Brief

Price Transparency An Essential Building Block for a High-Value, Sustainable Health Care System

INTRODUCTION

A health care costs continue to rise, purchasers remain focused on ways to bring costs under control. These pressures have led to more purchasers to engage consumers – their employees – more fully in their health care decisions, including talking on a granular level. In that effort to engage costs, health care purchasers, like and others, recognize consumers need information on both health care costs and quality of care. This information is needed to help consumers make better decisions about their health care. This information is needed to help consumers make better decisions about their health care. This information is needed to help consumers make better decisions about their health care.

WHAT IS PRICE TRANSPARENCY?

Depending on who you talk to, health care “price transparency” can have many different definitions. For the purposes of this Action Brief, Catalyst for Payment Reform has defined price transparency as “the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties.”

Price is defined as “the estimate of a consumer’s complete health care cost on a health care service or set of services that (1) reflects any negotiated discounts, (2) includes all out-of-pocket costs associated with a service or services, including hospital, provider and fees, and (3) identifies the consumer’s out-of-pocket costs (such as copay, coinsurance and deductibles).”

The price a consumer pays for a particular service depends on a number of variables:



Comprehensive Specifications for the Evaluation of Transparency Tools

INTRODUCTION

As health care costs continue to rise, consumers, including employers and dependents, are taking on a growing share of their health care expenses. In that effort to engage costs, health care purchasers, like large employers and states, recognize they need to provide consumers with both price and quality information with consumers to seek higher-value care systems. Health care purchasers need information about quality more transparently than more work needs to be done to advance price transparency (a particularly consumer-expected out-of-pocket contribution) and outcome measure and other measures of safety, effectiveness, timeliness, equity and patient-centeredness data to capture overall value. That work needs to be done to advance price transparency (a particularly consumer-expected out-of-pocket contribution) and outcome measure and other measures of safety, effectiveness, timeliness, equity and patient-centeredness data to capture overall value. That work needs to be done to advance price transparency (a particularly consumer-expected out-of-pocket contribution) and outcome measure and other measures of safety, effectiveness, timeliness, equity and patient-centeredness data to capture overall value.

To help purchasers evaluate and compare available tools, CPR developed optimal transparency tools. These specifications include price, information, consumer engagement, treatment-decision support, CPR understands that these tools will evolve over time based on demands and that current tools are unlikely to include all of the specifications that will support purchasers working with health plans to develop tools that meet their needs and those of consumers. The tool developers of transparency tools to include the scope of price and quality data available.

CPR developed these specifications after reviewing the capabilities and with consideration of others developed by other organizations and stakeholders. The specifications fall into three categories:

- Scope** – the comprehensiveness of providers, including in-network providers, and service information, including price consumer ratings.
- Utility** – the capability of the tool to facilitate consumer decision-making that meets comprehensive health care provider/patient care settings.
- Accuracy** – the extent to which consumers can rely on the price benefit information.
- Consumer Experience** – the ease/flexibility of use of the tool, but of mobile applications and easy-to-find, user-friendly interface.
- Data Exchange, Reporting and Evaluation** – the extent to which exchanged with purchasers according to all privacy laws, the use of the data with third-party vendors, regular reporting to ongoing improvement of the tool, and the ability of users to

ABOUT US

Catalyst for Payment Reform is an independent, non-profit corporation working on behalf of large employers to catalyze improvements in how we pay for health services and to promote better and higher-value care in the U.S.



STATEMENT BY CPR PURCHASERS ON PRICE AND QUALITY TRANSPARENCY IN HEALTH CARE

Information about the price and quality of health care services should be broadly available to those who use and pay for care

- Consumers must have access to meaningful, comprehensive information about the price and quality of services to make informed health care decisions.**
 - Consumers are being asked to pay more for their health care as costs rise and insurance benefits change, they have the right to know the price and quality of their health care choices.
 - Such information should be readily available and accessible in a [user-friendly format](#) that is relevant and user-friendly, including:
 - Integrated price, quality (especially outcome data), and patient experience information for specific services that is customized to the consumer's benefit design (e.g., real-time deductible, coinsurance, and co-pay information, etc.), by illustrating the total cost of care and the amount for which the consumer is responsible.
 - Provider background, including education and medical training, Maintenance of Certification, services offered, access hours, location and online appointment scheduling and
 - An easy-to-use and convenient platform or portal including web and mobile applications, paired with support from physicians, nurses, coaches or other trained customer service representatives to help patients use the tools to maximize their health.
- Providers and health plans must make such information available.**
 - Health plans have made strides and should continue to innovate with the tools they have created to share quality and price information with consumers.
 - Some providers continue to resist releasing price and quality information. To develop comprehensive transparency tools, providers must make such data available, and provide it at a level which is meaningful to consumers (e.g. at the individual hospital or physician level rather than at a health system level).
 - Many health plans have agreed that self-insured purchasers should be able to use their own claims data, including price information, as needed, though some prohibit purchasers from giving it to a third-party vendor to develop consumer transparency tools or to assist with interpretation. Health plans must eliminate these restrictions to maximize the options for transparency tools in the marketplace.
- Self-insured purchasers have the right to use their claims data to develop benefit design and tools that meet their needs.**
 - Self-insured purchasers have an interest in sharing price and quality information with their consumers to encourage them to use high-quality, cost-effective care, which may help to drive down health care spending and health care prices by encouraging providers to compete on quality and affordability.
 - Access to the most complete price and quality information also helps purchasers develop innovative and integrated benefit design and payment reform strategies.
 - Self-insured purchasers should seek health plan partners with tools that meet their needs or that allow them to use their own claims data in a manner that meets their needs, such as having the flexibility to contract with other vendors to analyze and display their data.
- Consumer self-costs must be adjusted to and adjusted to ensure that providers and health plans do not use price information in an anti-competitive manner.**
 - There could be unintended negative consequences to greater transparency on price and quality information, such as providers using it to raise their prices. To address this, appropriate parties must monitor such transparency with suitable oversight mechanisms.
 - Price and quality information released for use by consumers can be presented in a way that targets it to consumers' expected share of the costs due to their specific health plan benefit design.

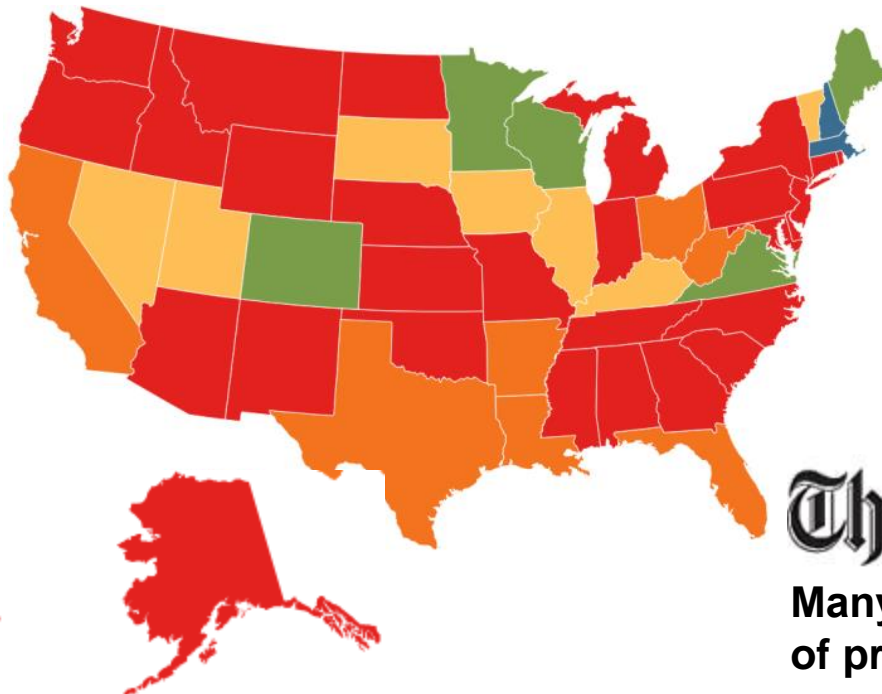


Fall 2013 Evaluation of Consumer Transparency Tools Report on State of the Art of Transparency Tools Updated Specifications for Transparency Tools



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2013 Report Card on State Price Transparency Laws



Forbes

Health Care Prices Remain A Mystery In Most States

The Washington Post

Many states don't require disclosure of prices for medical procedures

THE WALL STREET JOURNAL.

Most of U.S. flunks health price transparency test: study

GRADE	FROM	TO
A	60%	100%
B	50%	59%
C	40%	49%
D	30%	39%
F	0%	29%



Best Practices: Massachusetts

For Physicians & Providers

For Insurers & Employers

MyHealthCareOptions™



A Health Care Resource Provided by the Commonwealth of Massachusetts Health Care Quality and Cost Council

- One of only two states in the nation to receive and A grade (in addition to New Hampshire) – **but on a scale!**
- Myhealthcareoptions – *only* most common inpatient and outpatient services and procedures and no user customization
- Will this progress or stop short here?

Choose a Topic

- Patient Safety
- Influenza Vaccination
- Patient Safety
- Serious Reversible Events
- Surgical Care
- Patient Experience
- Patient Experience
- Bone and Joint Care
- Back Procedure
- Hip Fracture
- Hip Replacement
- Knee Replacement
- Cardiovascular Disease
- Angioplasty
- Bypass Surgery
- Coronary Screening Tests
- Heart Attack
- Heart Failure
- Heart Valve Surgery
- Stroke
- Digestive System
- Gall Bladder
- Intestinal Surgery
- Weight Loss Surgery
- Obstetrics
- Cesarean Section
- Normal Newborn
- Ultrasound
- Vaginal Delivery
- Outpatient Diagnostic

Angioplasty

Angioplasty (also called "percutaneous cardiovascular intervention" or "PCI") is a procedure that helps increase blood flow to the heart and is sometimes recommended for individuals with heart disease. This procedure helps reopen any blocked blood vessels. Angioplasty can help prevent heart attacks. (more)

Diagnostic classification: Angioplasty only (APR-DRG 174); Angioplasty with heart attack, heart failure or shock (APR-DRG 175)

Summarized Report | View Detailed Report | View Strategic Procedure Costs

Quality of Care (more)

	Both Israel Deaconess Medical Center	Massachusetts General Hospital	Mount Auburn Hospital	St. Elizabeth's Medical Center
Quality Rating	★★★★	★★★	★★★	★★★★
Statistical Significance	Not Different from State Average Quality	Above State Average Quality	Not Different from State Average Quality	Not Different from State Average Quality

Cost of Care (more)

	Both Israel Deaconess Medical Center	Massachusetts General Hospital	Mount Auburn Hospital	St. Elizabeth's Medical Center
Cost Rating	\$\$\$	\$\$\$	\$	\$\$\$
Statistical Significance	Above Median State Cost	Above Median State Cost	Below Median State Cost	Above Median State Cost

Both Israel Deaconess Medical Center | Massachusetts General Hospital | Mount Auburn Hospital | St. Elizabeth's Medical Center

State	Level of Transparency	Scope of Providers			Scope of Price			Scope of Services			Grade
		Both Practitioners & Facilities	Health Care Practitioner or Facility	Subset of Either Practitioner or Facility	Both	Paid Amounts	Charges	All IP & OP	All IP or OP	Most common IP or OP	
MA	State Only	✓			✓			✓			A
	Upon Request				✓				✓		
	Report		✓				✓	✓			
	Website	✓				✓				✓	



Best Practices: New Hampshire

Detailed estimates for Vaginal Birth and New Baby (inpatient)

Procedure: [Vaginal Birth and New Baby \(inpatient\)](#)

Insurance Plan: CIGNA, Preferred Provider Organization (PPO)

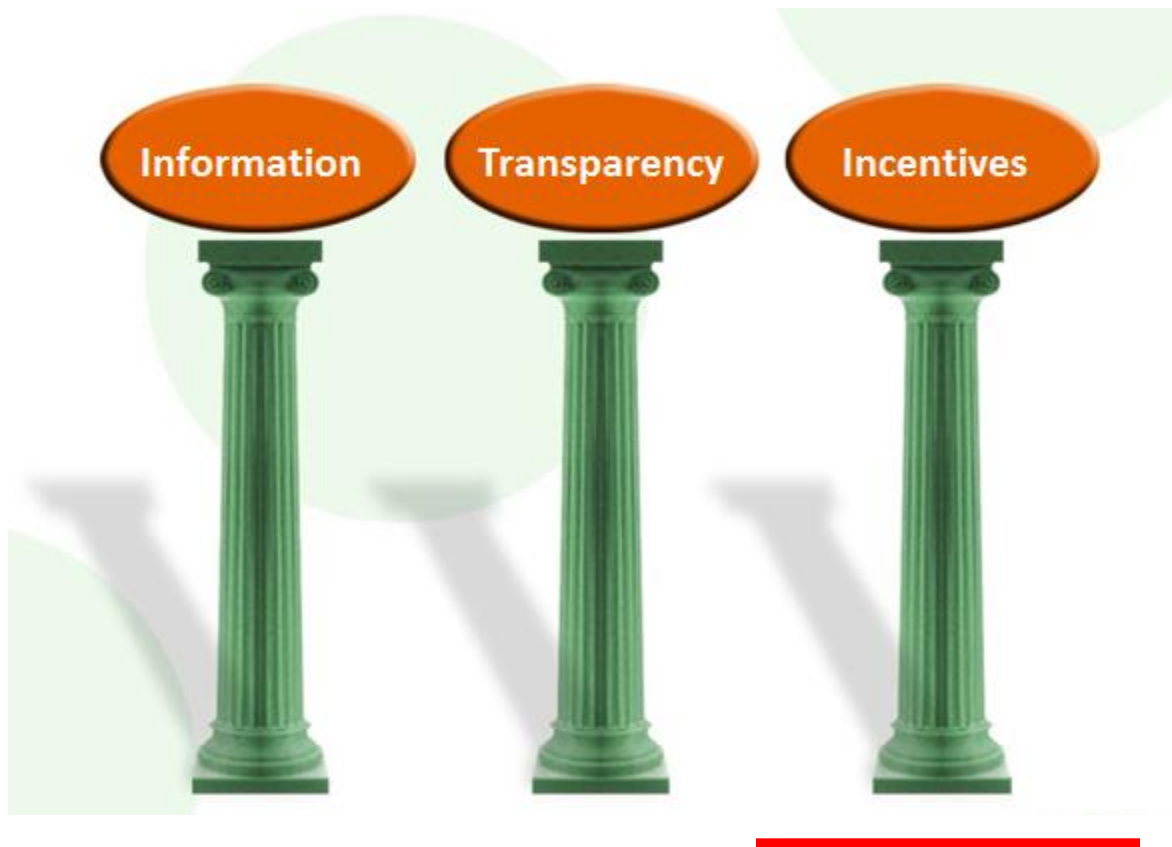
Within: 50 miles of 03301

Deductible and Coinsurance Amount: \$1,500.00 / 20%

Lead Provider Name	Estimate of What you Will Pay	Estimate of What Insurance Will Pay	Estimate of Combined Payments	Precision of the Cost Estimate	Typical Patient Complexity	Contact Info
ALICE PECK DAY MEMORIAL HOSPITAL	\$2342	\$3372	\$5714	LOW	MEDIUM	ALICE PECK DAY MEMORIAL HOSPITAL 603.448.3121
SPEARE MEMORIAL HOSPITAL	\$2447	\$3792	\$6239	MEDIUM	VERY HIGH	SPEARE MEMORIAL HOSPITAL 603.536.1120
MONADNOCK COMMUNITY HOSPITAL	\$2683	\$4732	\$7415	LOW	LOW	MONADNOCK COMMUNITY HOSPITAL 603.924.7191
PARKLAND MEDICAL CENTER	\$2995	\$5980	\$8975	LOW	MEDIUM	PARKLAND MEDICAL CENTER 603.432.1500
ST JOSEPH HOSPITAL	\$3054	\$6219	\$9273	LOW	HIGH	ST JOSEPH HOSPITAL 603.882.3000
ELLIOT HOSPITAL	\$3062	\$6249	\$9311	HIGH	HIGH	ELLIOT HOSPITAL 603.669.5300
CATHOLIC MEDICAL CENTER	\$3121	\$6487	\$9608	HIGH	HIGH	CATHOLIC MEDICAL CENTER 800.437.9666
CHESHIRE MEDICAL CENTER	\$3218	\$6876	\$10094	HIGH	MEDIUM	CHESHIRE MEDICAL CENTER 603.254.5400



Three Pillars





Big Picture

There is momentum behind transforming payment to providers and incentives for consumers. . .

- Health Reform Included Several “Game Changers” - Some Will Take Time And They Will Be Disruptive
- Focus On Specific Models – But Is There Some ‘Irrational Exuberance’ At Work?
- We Still Know Very Little About What Works
- Our Current System Will Be Around For A While - And We Shouldn’t Ignore It



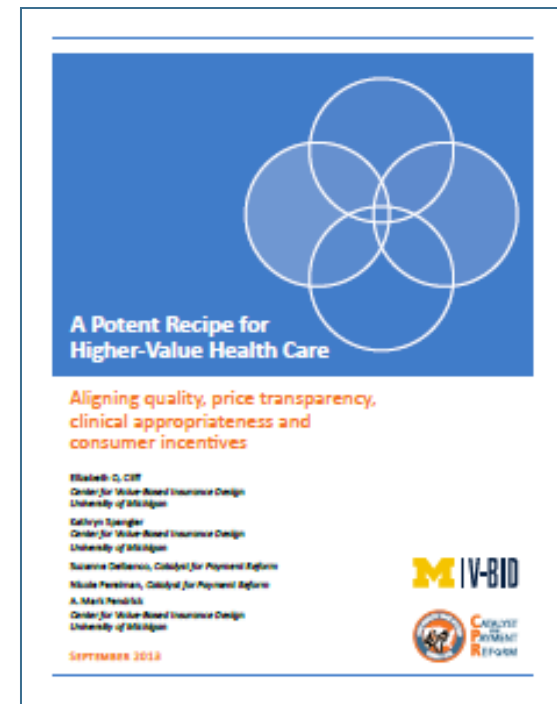
Provider Incentives

- Migration from carrots to carrots & sticks
- Any carrots have to be sustainable
- Savings don't reach the end users
 - Many approaches being modeled, but translation of savings to purchasers and affordability hasn't happened – at the end of the day, it's about the price
- Competition can be its own incentive



Consumer Incentives

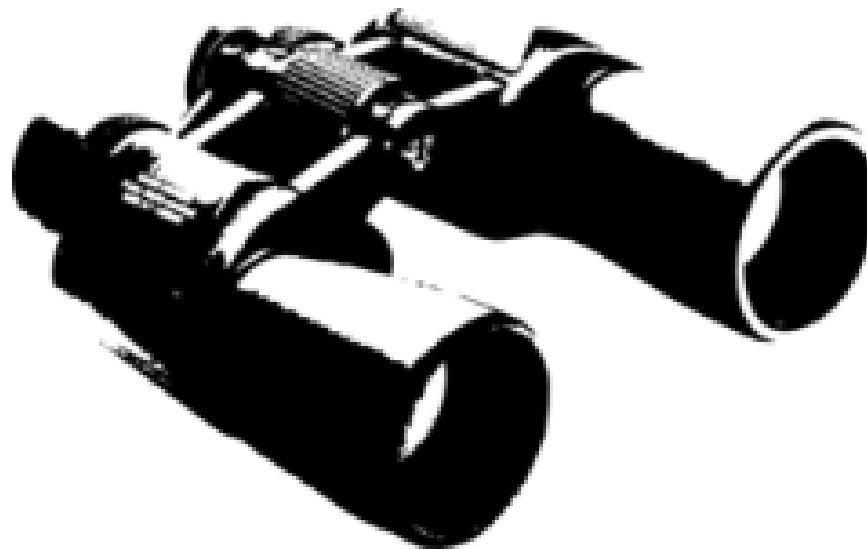
- Information must be paired with incentives
- Examples: Reference pricing, select provider networks, centers of excellence, value-based insurance design
- With the right information, consumers will choose a high-quality provider (defined as lowest price with best quality) 80 to 90 percent of the time





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All Eyes on Massachusetts





Questions to Ponder

- How will the patient experience change over the next 5-7 years as a result of these trends?"
- How will provider behavior change as they are increasingly at financial risk for their performance on cost and quality?
- What will be the role of the health insurer?
- Will employers use their potential leverage to drive reforms to make health care higher-quality and more affordable?

What could shift the current direction of reforms?



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Commonwealth of Massachusetts

Health Policy Commission

Health Care Cost Trends Hearing 2013

