EVOLUTION IN PRICE TRANSPARENCY

Presentation to San Francisco Health Service Board, September 9, 2021

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FOR PAYMENT REFORM

About CPR

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An independent non-profit corporation **working to catalyze employers, public purchasers and others** to implement strategies that produce higher-value health care and improve the functioning of the health care marketplace.

15M+ covered lives, $80B+ annual health care spend

- 32BJ Health Fund
- Aircraft Gear Corporation
- Aon
- Arizona Health Care Cost Containment System (Medicaid)
- AT&T
- CalPERS
- Compassion International
- Covered California
- Equity Healthcare LLC
- General Motors
- Group Insurance Commission, MA
- Hilmar Cheese Company, Inc.
- The Home Depot
- Independent Colleges and Universities Benefits Association
- Mercer
- Miami University (Ohio)
- Ohio Department of Medicaid
- OhioPERS
- Pennsylvania Employees Benefit Trust Fund
- Pitney Bowes
- Qualcomm Incorporated
- San Francisco Health Service System
- Self-Insured Schools of California
- South Carolina Health & Human Services (Medicaid)
- Teacher Retirement System of Texas
- TennCare (Medicaid)
- Unite Here Health
- Walmart Inc.
- Washington State Health Care Authority
- Wells Fargo & Company
- Willis Towers Watson

CPR Goals and Offerings

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Effective Payment Reform
Effective Purchasers
Effective Marketplace

EDUCATION

Online courses, webinars, and virtual summits

TOOLS & SUPPORT

Plug-and-play tools and resources

COORDINATION

Collaboratives, membership, and aligned sourcing

RESEARCH

Scorecards, report cards, and white papers

Why do We Need Transparency into Health Care Prices?

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EMPLOYEES: Consumers have the right to know, though they may not use the information. Some, though few, are motivated to use it to seek care from more efficient, higher-quality providers.

PURCHASERS: Purchasers face rising health care costs and need to make informed decisions about benefit designs, provider network designs and payment models. Plus, many have asked plan members to take on more financial responsibility.

PROVIDERS: Providers could make more informed referrals to minimize total cost of care.

POLICYMAKERS: Prices and quality are unrelated – we need to expose when price variation is unwarranted and due to an imbalance of market power and determine whether policy intervention is needed.

Progress…but Health Plan Tools Still Fall Short

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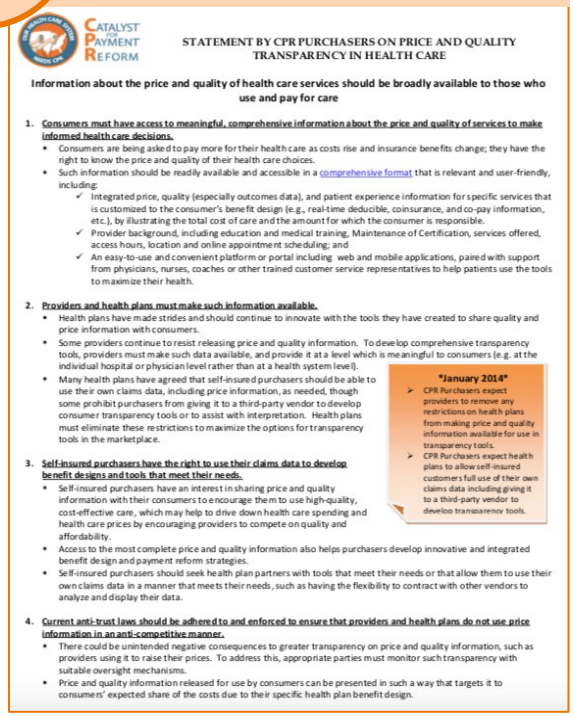
Purchasers such as CalPERS and Safeway wanted to implement reference-based pricing, but health plan tools didn't meet members' needs.

In 2012, CPR issued a call to action



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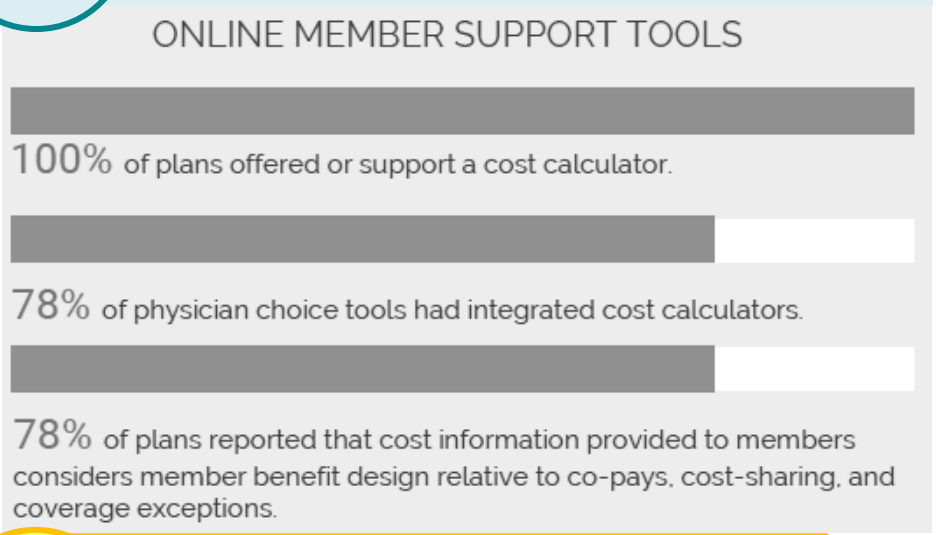
STATEMENT BY CPR PURCHASERS ON PRICE AND QUALITY TRANSPARENCY IN HEALTH CARE

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

1. **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 comprehensive format that is relevant and user-friendly, including:
     - ✓ Integrated price, quality (especially outcomes data), and patient experience information for specific services that is customized to the consumer's benefit design (e.g., real-time deducible, 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.
2. **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.

   "January 2014"
   - ➢ CPR Purchasers expect providers to remove any restrictions on health plans from making price and quality information available for use in transparency tools.
   - ➢ CPR Purchasers expect health plans to allow self-insured customers full use of their own claims data including giving it to a third-party vendor to develop transparency tools.
3. **Self-insured purchasers have the right to use their claims data to develop benefit designs 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.
4. **Current anti-trust laws should be adhered to and enforced 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 such a way that targets it to consumers' expected share of the costs due to their specific health plan benefit design.

In 2018, CPR surveyed health plans on their tools



A secret shopping exercise during summer 2018 revealed pervasiveness of missing data

Where Do Employers Turn to Fill the Void?

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wellbe evive care thread alight

caremerge klara

Castlight CHANGE HEALTHCARE

cureatr

Independent vendors with transparency tools, navigation support, second opinion services, etc.*

But health plans restrict the data they will share with these vendors.

Grand Rounds Health Wellframe Patient IO KYRUUS

HEALTHSPARQ PATIENTPING Welkin Health referral md

amino Healthcare Bluebook curaspan® a naviHealth company

*CPR does not endorse vendors

Few State Laws Ensure Access

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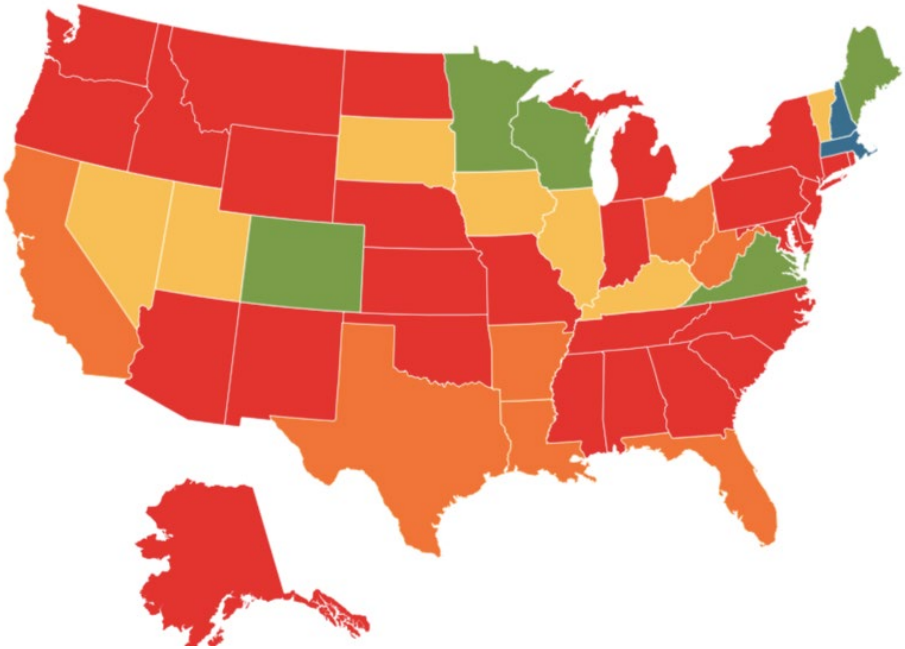
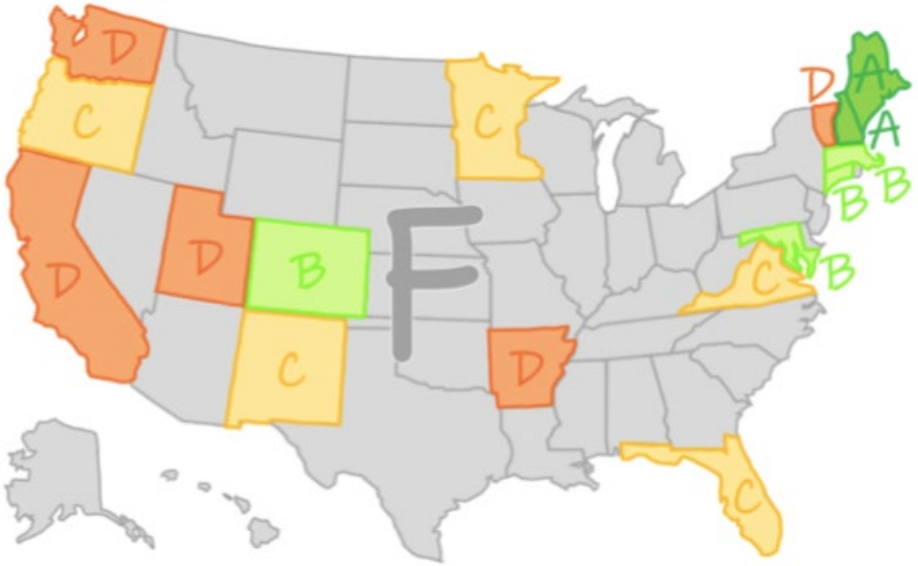
At the state level, there has been progress, but most states still receive an "F" per our report cards on state price transparency laws.

2013



2020



Blue = A, Green = B, Sand = C, Orange = D, Red= F

California has led in some areas

2011-2013 California banned gag clauses in provider contracts

2017 CA implemented surprise billing protections, setting payments for out-of-network doctors at the greater of 125% of the Medicare rate or the insurer's average contracted rate

2018 CA established the intent to create an *all payer claims database* – now called the "Health Care Payments Data Program" - by July 1, 2023.

2021 Settlement on antitrust case against Sutter finalized; *no longer allow to hide prices* or interfere with benefit or provider network designs.

Federal Action on Transparency - Hospitals

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In November 2019, CMS issued its final rule: "Price Transparency Requirements for Hospitals to Make Standard Charges Public" which includes **payer-specific negotiated charges…**
But few are complying.

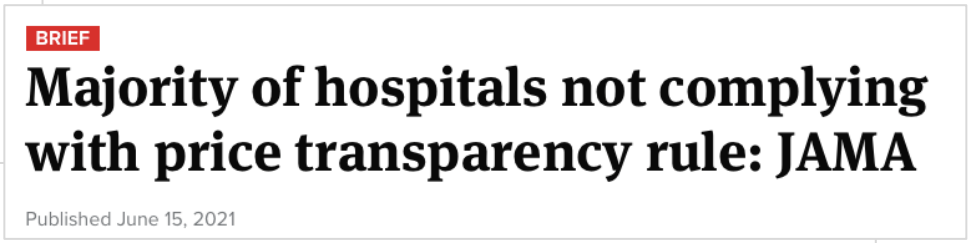

HEALTH AFFAIRS BLOG

RELATED TOPICS:
HOSPITALS | INSURANCE MARKET REGULATION | REGULATION | MARKETS | CODE OF FEDERAL REGULATIONS | RESEARCHERS

Low Compliance From Big Hospitals On CMS's Hospital Price Transparency Rule

Morgan Henderson, Morgane C. Mouslim

MARCH 16, 2021


BRIEF

Majority of hospitals not complying with price transparency rule: JAMA

Published June 15, 2021


Hospitals

CMS sent out warnings to hospitals failing at price transparency. Some still

by Dave Muoio | May 10, 2021 3:03pm


Hospitals Fall Shor
Transparency Rule Compliance

Hospital dissatisfaction with the Price Transparency rule now includes failure to comply with the regulation's provisions.


JUL 19 | MORE ON QUALITY AND SAFETY

Just 5.6% of hospitals are compliant with price transparency rule

Failing to follow through on price transparency requirements could alienate a large swath of a given health system's customer base.

Jeff Lagasse, *Associate Editor*

Federal Action on Transparency – Health Insurers

In November 2020, HHS, the Department of Labor, and the Treasury finalized the "Transparency in Coverage Rule" requiring health insurers and group health plans to create an **online member-facing price comparison tool**, and publicly post machine readable files including **in-network negotiated rates**, among other payment amounts.

Deadline for posting machine readable files is July 1, 2022.

Deadline for price comparison tool with the first 500 services is January 1, 2023 and January 1, 2024 for full compliance.

Good faith estimates and advanced EOBs must be provided to insured and uninsured by providers and facilities by January 1, 2022, though the federal government will not enforce compliance right away.

Federal Action on Transparency – Health Insurers

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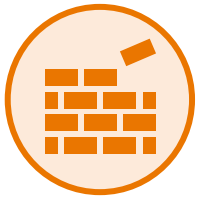
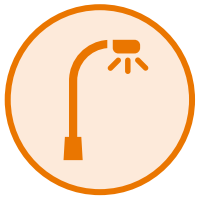
As of Dec 27, 2020, the Consolidated Appropriations Act (CAA) **prohibits insurers from agreeing to gag clauses** on prices or quality.

As of Jan 1, 2022 (section 116, division BB, CAA) provider directories must be up to date regarding network status; **no balance billing allowed if participant is incorrectly told provider is in network**, meaning cost sharing must be as it would have been in network.

Necessary Purchaser Action



Combat the barriers health plans erect when it comes to sharing data with purchasers and/or other vendor partners.



Shine the spotlight on providers that aren't complying with federal laws.

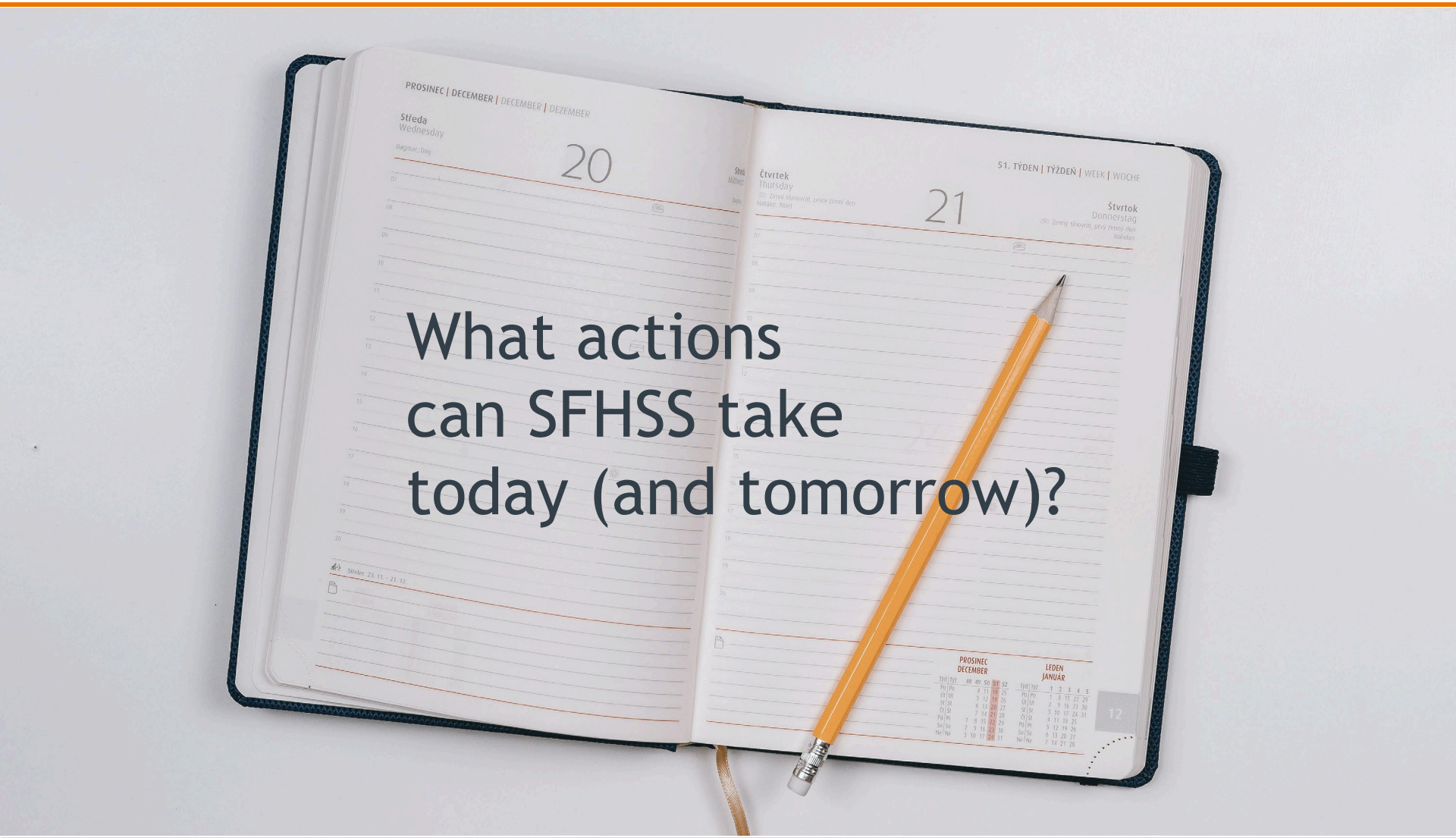
- Potential to educate plan participants on provider price variation for frequently sought-after services.

Hold health plans accountable for their compliance with federal laws.

- Ask for updates and workplans to ensure plans are working to become fully-compliant by required dates.

Don't forget about transparency on provider quality (and quality variation)!

Questions and Discussion



THANK YOU

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Key Provisions of Recent Federal Regulations

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The No Surprises Act (applies for plan years on or after January 1, 2022)

- No balance billing for out-of-network (OON) emergency care, certain services provided by OON provider at an in-network (IN) facility (e.g., anesthesiologist), and OON care provided at IN facility without patient's informed consent.
- If plan covers IN air ambulance services, IN cost-sharing applies to deductible and out-of-pocket maximum; air ambulance providers cannot balance bill.
- Upon request, plans must send plan participants an advanced explanation of benefits (EOB) before scheduled care. There are specific timing and content requirements.
- Price comparison tool must factor in participant cost-sharing based on plan year, geography, and participating providers. Guidance must be available via phone.
- Provider directory information must be verified at least every 90 days. Plan must respond to phone inquiries within one business day.

Source: https://www.truckerhuss.com/2021/01/an-overview-of-the-group-health-plan-provisions-of-the-consolidated-appropriations-act-and-the-final-transparency-in-coverage-regulations/

Key Provisions of Recent Federal Regulations

The Consolidated Appropriations Act

- Removal of provider gag clauses with plans that prohibit publishing of price or quality information for referring providers, plan sponsors, business associates, and individuals.
- Reporting and analysis on direct or indirect compensation by broker-consultants, Mental Health Parity and Addiction Equity Act, and drug prices.

Source: https://www.truckerhuss.com/2021/01/an-overview-of-the-group-health-plan-provisions-of-the-consolidated-appropriations-act-and-the-final-transparency-in-coverage-regulations/

Key Provisions of Recent Federal Regulations

Transparency in Coverage Regulations

- Effective for Plan Years after January 1, 2022, plans must publicly post three machine-readable files and update them monthly:
  - Negotiated rates and fee schedules with IN providers
  - Historical allowed amounts for covered items and services by OON providers
  - Negotiated rates and historical net prices for drugs provided by IN providers
- Upon request from participant, plans must disclose cost-sharing estimates for covered services from a particular provider:
  - Applicable to a specific list of 500 items/services by January 1, 2023
  - Applicable to all items/services by January 1, 2024
  - Specific content and timing requirements for disclosure

Source: https://www.truckerhuss.com/2021/01/an-overview-of-the-group-health-plan-provisions-of-the-consolidated-appropriations-act-and-the-final-transparency-in-coverage-regulations/