

Healthcare Data Transparency Basics 2016

Why is healthcare data transparency important?

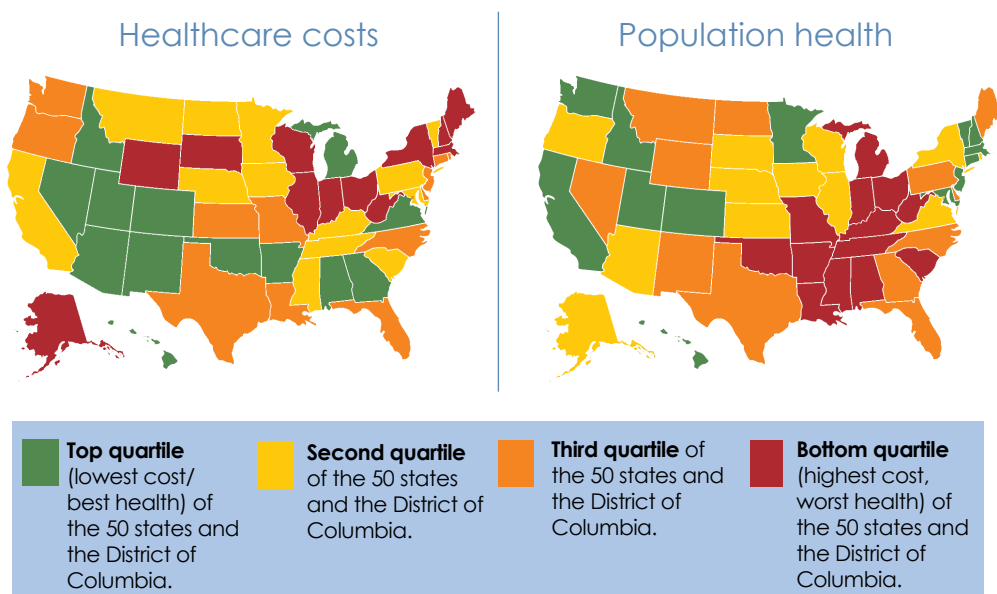
In 2013, per-capita healthcare spending in the U.S. was more than two times that of other economically-developed nations.¹ Yet, compared to those nations, the U.S. had poorer health outcomes.² In Ohio the situation is even more dire, as Ohioans are living less healthy lives despite spending more on health care than people in most other states (see figure 1).³

Numerous studies have documented substantial geographic variations in healthcare spending across the United States, though there is little evidence suggesting that higher spending correlates with better health outcomes.⁴ While there are many factors, such as socioeconomic and physical conditions, that contribute to healthcare spending and outcomes, healthcare price and quality are key elements. However, accessing and evaluating price and quality data can be extremely difficult. As a result, there is significant momentum at the local, state and federal levels — in both public and private sectors — to implement programs and policies that increase healthcare data transparency.

To drive effective decision-making, healthcare price information should ideally be coupled with reliable quality data. However, due to the complexity of quality data reporting, discussion in this publication focuses on price transparency. This brief explores the rationale for healthcare price transparency, the challenges it presents and potential policy approaches at the state level to increase transparency.

In 2012, HPIO released its first Transparency Basics publication and, as interest in the topic continued to grow, the Institute hosted a forum on the subject in December 2015 and created this publication to update policymakers on the issue.

Figure 1. **State quartile rankings for healthcare cost, population health**



Source: HPIO 2014 Health Value Dashboard

Potential policy levers

1. Encourage, incentivize or require health plans to provide tools with patient-, provider- and plan-specific estimates of price. West Health Policy Center estimated that requiring health plans to provide personalized out-of-pocket price data to enrollees could reduce total health spending \$18 billion over the next 10 years.
2. Create a statewide all-payer claims database (APCD). West Health Policy Center estimated that state APCDs could reduce spending by \$61 billion over the next decade.⁵ Ohio should look to states such as Colorado, New Hampshire and Wisconsin, which have created APCDs, to learn about their approaches. However, a pending U.S. Supreme Court case could nullify state APCD statutes.

HPIO forum explores healthcare transparency

In December 2015, HPIO hosted a forum exploring the rationale for greater transparency, as well as the challenges and potential policy approaches for increasing transparency. The forum included presentations from Lynn Quincy, Director, Health Care Value Hub and Associate Director for Health Policy, Consumers Union; Dr. Chapin White, Senior Policy Researcher, RAND Corporation; and Denise Love, Executive Director, National Association of Health Data Organizations and Co-Chair, APCD Council. The forum also included a panel discussion involving Ohio stakeholders. Below are comments from each of the panelists:

“Organizationally, the issue we're struggling with (in regards to transparency) is that physicians only have bits and pieces of data. Unless (data) is organized in a comprehensive way, it is very challenging.”

— **Todd Baker, Co-Chief Executive Officer, the Ohio State Medical Association**

“Consumers need to be organized to play a role in pushing against drivers of healthcare costs... The real reason we need transparency in price and quality is to figure out how we can get to a fair price.”

— **Cathy Levine, former Executive Director, Universal Health Care Action Network Ohio**

“Seeing change, like with the (patient-centered medical home model) for example, won't happen overnight. We will need to make incremental change. And if transparency has a role, population health has to be part of the conversation.”

— **Miranda Motter, President and CEO, Ohio Association of Health Plans**

“If transparency leads to more engagement, leads to better outcomes, then it is a good thing. The best patient is the informed patient. If I can get someone to better engage in their care, it's better for the provider.”

— **Scott Borgemenke, Senior Vice President Advocacy and Communications, Ohio Hospital Association**

Why price transparency matters

Access to healthcare price information allows consumers, particularly those enrolled in high deductible health plans (HDHPs), the ability to compare prices across providers or facilities to make informed decisions about where to seek affordable care. In addition, having price information prior to receiving services allows consumers to plan appropriately for future financial outlays rather than being surprised by unexpected medical bills. According to a 2015 TransUnion Healthcare survey, 80 percent of respondents said that upfront cost estimates are a factor in choosing a provider, while 79 percent said they were more likely to pay their bills if they received a price estimate prior to receiving care.⁶ Notably, surveyors also found that only 44 percent of respondents requested an estimate before treatment and only 30 percent were offered price estimates.⁷

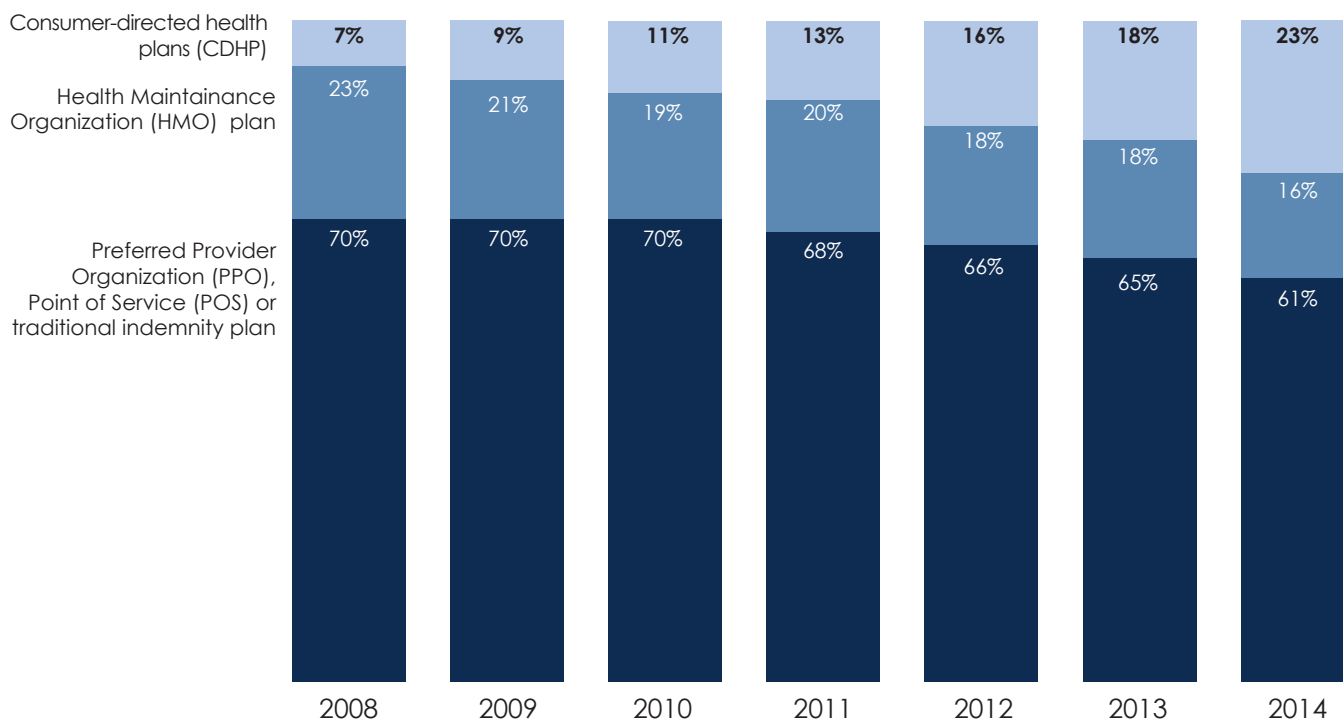
The rise of high-deductible health plans

There has been a recent trend toward HDHPs in which consumers are asked to shoulder greater financial responsibility for the healthcare services they receive. The Internal Revenue Service defines any plan as an HDHP if it has a minimum deductible of \$1,300 for an individual and \$2,600 for a family.⁸

Between 2008 and 2014, Mercer estimates that the number of covered employees enrolled in an HDHP (also known as a consumer-directed health plan [CDHP]) rose from 7 percent to 23 percent (see Fig. 2).⁹ A similar survey by Kaiser Family Foundation found that more than one in five Americans with private insurance is enrolled in an HDHP.¹⁰

For consumers enrolling via a state or federal health insurance exchange marketplace for

Figure 2. Percentage of employees covered in plan types, U.S.



Source: Mercer. "National Survey of Employer-Sponsored Health Plans," 2014. <http://www.mercer.com/newsroom/modest-health-benefit-cost-growth-continues-as-consumerism-kicks-into-high-gear.html>

2015, 60 to 80 percent of the plan options were high-deductible plans.¹¹ While employers often couple an HDHP with a health savings account (HSA), marketplace plans do not come with an HSA.

The impetus for this shift to HDHP is two-fold. First, as healthcare costs have risen, employers have sought ways to reduce their financial liability. Second, some believe that consumer cost sharing in health plans gives enrollees greater incentive to make cost-conscious decisions about using health care, including reducing excess utilization, seeking care in appropriate settings and improving personal health behaviors, all of which may in turn drive down overall healthcare costs. (See box on page 4 for additional data.)

The impact on consumers has been significant. As of 2014, 61 percent of employees in small firms and 41 percent of workers overall had a deductible over \$1,000.¹² Out-of-pocket costs for premiums and deductibles doubled between 2003 and 2013 to nearly 9.6 percent of household income.¹³ By 2014, 13 percent of Americans were spending 10 percent or more of their income on out-of-pocket health care expenses.¹⁴

Limitations of price transparency

Limited audience for "shoppable" services

Shopping around for care based on price is only practical in the case of discretionary services such as imaging, elective procedures and non-emergency

services. Recent data presented by Lynn Quincy, Director, Health Care Value Hub and Associate Director for Health Policy, Consumers Union at an HPIO forum in December 2015 (see box on page 2) revealed that, at most, 10 percent of overall health spending is "shoppable" and paid out of pocket by consumers.

In addition, in order for price transparency to impact consumer purchasing decisions in a way that reduces spending, consumers must have an incentive to use existing transparency tools. Price data is most useful to consumers who are uninsured or those covered by an HDHP where there is significant upfront responsibility for out-of-pocket costs before insurance coverage kicks in. If a consumer with an HDHP has little or no cost-sharing responsibility after meeting the deductible, there is less incentive to consider price. For insured consumers with plans that require minimal cost sharing, there is even less incentive to shop around for care.

Prices are not specific enough

The majority of published prices in existing transparency tools are an average price for the standard consumer. Such prices generally do not account for confidential, negotiated rates between insurers and providers. Likewise, published prices do not reflect total costs and/or out-of-pocket costs that are specific to a consumer's particular situation; there is no accounting for plan design, deductibles, spending to date, cost-sharing requirements or a

consumer's unique course of care. This makes it difficult for the consumer to estimate and/or compare the total price of care before undergoing treatment. While published average prices provide a good reference point, they are generally not specific enough to have real impact on spending.

Market competition limits impact

Consumers' ability to shop for healthcare services based on price is limited for those living in areas with a non-competitive provider market. This is particularly true in rural areas where a consumer's ability to shop for care is limited by the small number of providers. Similarly, the trend toward narrow provider networks impacts the power of transparent price data by limiting the consumer's options of providers. In competitive markets, greater price transparency could lead to less price variation, but higher prices overall.

Consumer understanding and behavior are limited and hard to change

Consumers often have limited understanding of how to access or use price data or are unaware that such data is publicly available. Nearly two-thirds of insured consumers say that finding healthcare price data is difficult. Among the uninsured, this rate increases to three quarters.¹⁷

Consumers who do access data often find that it is difficult to understand and use. Problems range from formats that are not user-friendly and measures that are not clearly defined to inadequate search functions. In addition, when price information is not coupled with reliable quality data, some consumers assume incorrectly that higher cost equates to better care, so they choose the higher-price provider.

Even with pricing data available, research shows that patients tend to rely more on their physician's advice about where and from whom to seek medical care or on a provider's reputation rather than on the price differential among providers. One study found that 97 percent of the time, consumers will select a hospital with a higher safety score over a hospital with lower costs.¹⁶ While 98 percent of major health insurers offer cost calculator tools to their members, only two percent of members actually use them.¹⁷ Among marketplace plan enrollees, 63 percent said they were likely to use an online tool to look up how much their insurer would pay for certain services, but only 19 percent had actually done so.¹⁸

"'Skin in the game' is not working," Quincy said at the HPIO forum in December. "Yes, consumers cut spending, but they are indiscriminant in how they cut it... And in the absence of usable quality data, consumers default to higher prices."

Measuring consumer response to healthcare price information: What a recent study tells us about consumer-directed health care

In 2013, a large, self-insured firm shifted tens of thousands of employees from a no-deductible health plan into a high-deductible plan. Each employee was given a health savings account (HSA) fully funded by the employer up to the deductible amount. The company also provided workers with online tools to compare prices for doctor visits, clinical tests and other services.

In one year, health spending dropped 15 percent. Between 2012 and 2014, emergency room spending declined 25 percent and spending for physician office visits declined 18 percent. Mental health service spending declined 6 percent.

The study found, however, that "spending reductions are entirely due to outright reductions in quantity," not due to shopping for lower prices. In fact, the average price per doctor visit did not change. While employees reduced spending on potentially unnecessary services such as imaging, they also cut back on "potentially valuable care," like preventive care visits or filling prescriptions.

Interestingly, it was the sickest employees – those most likely to meet their deductible quickly – that cut back on care the most. According to one of the study's authors, "They respond to the spot pricing [the price of receiving care right then], and that leads to a very large reduction in care. We don't find any evidence they look for a lower cost. They just don't go." Even with a fully-funded HSA, these employees cut back on services early in the plan year, perhaps in the hopes that their health spending might go down enough to allow for an HSA fund rollover.

The authors note that reducing care, particularly necessary or preventive care, may worsen health conditions in the long run, and potentially lead to costly medical treatment in future years that wipes out any early year savings. This, coupled with lost worker productivity, calls into question the long-run value of high-deductible health plans. Longer-term studies will be needed to fully understand the impacts on spending and health outcomes.¹⁹

High healthcare spending: What's not working?*

- 1. Tensions between “mega-insurers” and “must-have health systems”:** Both have varying degrees of leverage in a marketplace
- 2. Employers spread thin:** Employers do not always have the resources necessary to effectively manage their employee's health benefits and utilization
- 3. High patient expectations, no medical expertise:** Patients often have inadequate information to make evidence-based and well-informed decisions about their healthcare needs
- 4. Price is not the panacea:** Price without quality means little, and quality is difficult to measure
- 5. Unhealthy chicken and expensive egg:** We have bad health outcomes so we invest more in healthcare; we invest more in healthcare, rather than prevention, so we have bad health outcomes

*Information adapted from a list shared by Chapin White at HPIO forum on Dec. 10, 2015.

State price transparency legislation

Twenty-eight states have enacted health price transparency legislation. The legislation ranges from provider-price reporting to state agencies and publishing prices on public websites, to requiring insurers and/or providers to make available prices for common procedures.

Fourteen states maintain all-payer claims databases (APCDs), with varying degrees of access, release and usage of the data. APCDs can contain data derived from medical claims, pharmacy claims, eligibility files, provider (physician and facility) files and dental claims from both private and public payers. Data usually includes patient demographics, provider demographics, as well as clinical, financial and utilization information. While typically created by state mandate, a couple of states have established APCDs through voluntary reporting. The benefits of an APCD can include:

- Encouraging consumer engagement and informed decision-making
- Allowing for data-driven policymaking and

legislative efforts

- Driving quality improvement efforts, allowing for performance assessments across systems and payers
- Supporting data-driven management of healthcare cost and utilization
- Improving population health by illuminating disease and vaccination patterns
- Informing private and public sector contracting decisions (e.g. allowing exchanges to use performance data to determine if an insurer should be allowed to participate)
- Assisting with state regulation of insurers (e.g. allowing states to determine if proposed rate increases are reasonable)

“APCDs are not a red state/blue state issue,” said Denise Love, Executive Director, National Association of Health Data Organizations and Co-Chair, APCD Council, speaking at HPIO's forum in December. “States may come at it from different perspectives, but all states have an interest in getting a handle on health spending.”

In December 2015, the U.S. Supreme Court heard arguments in *Gobeille v. Liberty Mutual Insurance Company*, a case to determine whether the Employee Retirement Income Security Act of 1973 (ERISA) preempts state statutes that require payers to submit data to state-run APCDs. At issue is a Vermont law requiring providers submit to that state's APCD. If the court rules that ERISA invalidates state requirements to participate in APCDs, it would have a significant impact on APCDs in all states that maintain them.

Two states have emerged as leaders in healthcare price transparency: Colorado and New Hampshire. Both states have built upon their state APCD platforms to implement consumer-facing public price transparency websites that allow comparisons of provider price information at an episode-of-care level (the only other state to offer a consumer-facing price transparency site is [Maine](#)).

New Hampshire's website, [NH HealthCost](#), arguably the most advanced price transparency tool, is useful for both insured and uninsured patients. For consumers with insurance, the website reports the cost to the consumer for covered services based on the contracted “allowed rate” between the provider and the insurance company for that consumer's specific health plan. For an uninsured consumer, the website reports charges less any discounts

typically offered by the provider to those who are uninsured. Using NH HealthCost, consumers can compare prices across healthcare providers for more than 24 medical procedures, including MRIs, CT scans, ultrasounds and X-rays. There are plans to add dozens more procedures, including rates for laboratory services, dental care and prescription drugs.

Colorado's website, [CO Medical Price Compare](#), has been called "a veritable beacon of best practices" containing "a world class interactive map and report generator."²⁰ CO Medical Price Compare shows the median price insurers and consumers pay for specific services at specific facilities; provides a cost calculator to help consumers estimate their own out-of-pocket costs; and includes information on the quality of services by facility. Still in the early stage of development, the website offers price and quality information for three episodes-of-care: maternity care, hip replacement and knee replacement. There are plans to add ambulatory surgery centers, additional outpatient services and about 30 procedures (e.g. MRI, CT scans, etc.) across a variety of facility types. Eventually, prices at the provider group level will allow consumers to compare cost and quality for office-based services such as annual physicals and other preventive care.

Price transparency legislation in Ohio

Ohio's first significant legislation to address healthcare data transparency, House Bill 197, was enacted into law in 2006. The law requires most hospitals to submit information to the Ohio Department of Health (ODH) on various inpatient and outpatient performance measures.²¹ Information that must be reported to ODH is outlined under [Ohio Administrative Code 3701-14](#) and also includes both hospital utilization and charge data. ODH is required, under Ohio Revised Code 3727.39, to make the hospital reporting information available to the public on a website at no charge. The hospital reporting information was provided on the [Ohio Hospital Compare](#) website for a period of time, however it appears the website has not been updated now for several years.

More recently, under Ohio House Bill 52, signed into law on June 30, 2015, health-service providers and health-plan issuers may have to comply with new price transparency rules. HB 52 calls for the establishment of a Health Services Price Disclosure Study Committee to evaluate the impact and feasibility of a medical-services provider submitting

in writing to a consumer a reasonable, good-faith estimate of expected medical charges prior to a consumer receiving a product, service or procedure. Such charges include:

- The amount a provider will charge a consumer or consumer's health plan issuer
- The amount the health plan issuer will pay for the product, service or procedure
- The difference in amount, if any, the consumer or other responsible party would be required to pay

The committee is to provide recommendations on health-plan issuer price and cost information disclosures to consumers. The Governor's Office of Health Transformation is drafting recommendations from the committee. Based on these recommendations, the Ohio Medicaid director is required to adopt rules regarding pre-service price disclosures by July 1, 2016. As of Jan 1, 2017, health services providers will be required to comply with adopted rules regarding price transparency. For HB 52 text, [click here](#).

Implementation of HB 52 faces some operational challenges. It can be very difficult for a provider to predict the cost for a patient's medical care prior to treatment. Costs of care vary widely based on differences in individual treatment course, response and unforeseen complications. This is complicated by potential billings from multiple providers, all of whom have unique, undisclosed fee schedules that are negotiated with each insurer. In addition, within the current system, it is difficult for a provider to account for each patient's specific health-plan design and out-of-pocket expenditures profile to provide actual, real-time dollar estimates.

In Massachusetts, where a similar law took effect in January 2014, the impact has been mixed. Healthcare providers must, upon request and within two business days, provide prospective patients with the amount they are paid by an insurance carrier or, in self-pay or even some out-of-network situations, the charge for a procedure. If providers are unable to quote a specific price, they must give an estimated maximum charge. In a recent study by the Pioneer Institute, only 13 of 25 practices were able to provide price information for physician, facility and anesthesia fees within two business days. Many practices had no knowledge of the state law.²²

Consumer-friendly price tools

FAIR Health

FAIR Health, a national, independent, not-for-profit corporation makes charge data for healthcare procedures available to consumers through free, web-based consumer cost-lookup tools at www.fairhealthconsumer.org. The tools allow consumers to estimate out-of-network expenses for specific medical and dental services in their geographic area.

Guroo

Guroo is a website created by the Health Care Cost Institute (HCCI), a price transparency initiative jointly created by insurers Aetna, Assurant Health, Humana and UnitedHealth. The site provides information about healthcare utilization and cost through data provided by the four companies. Guroo provides cost and quality data, free and accessible to the public. Data includes national, state and local cost and quality information for 78 care bundles, a grouping of a health condition and the services typically provided for that condition. Later in 2015, HCCI plans to create a separate website for consumers with health plans of participating insurers that will provide personal information on consumers' out-of-pocket costs.

Healthcare Bluebook

Healthcare Bluebook allows consumers to search any procedure to find "fair price" information – the reasonable amount a consumer should be paying in their particular geographic area based on a nationwide database of medical payment data.

Consumer-friendly quality tools

Best Hospitals

Best Hospitals is a hospital ranking report by U.S. News and World Report. The interactive online report ranks over 5,000 U.S. medical centers in 16 specialty areas. The report includes an Honor Roll for hospitals scoring very high in at least six specialties. Common Care, a Best Hospitals tool released in May 2015, provides data on how hospitals perform on select chronic health conditions and common elective surgeries.

Consumer Reports Health Ratings Center

The Consumer Reports Health Ratings Center creates, promotes and publishes independent evaluations of healthcare products and services. Through Consumer Reports magazine and ConsumerReports.org, the Ratings Center publishes:

- Best Buy Drugs ratings on prescription medications for more than 35 medical conditions
- Ratings of more than 3,000 U.S. hospitals
- Ratings of more than 300 groups of heart surgeons
- Ratings of nine common heart disease screening tests
- Rankings of health insurance plans, from the National Committee for Quality Assurance

The website also includes guides on how to use the ratings and pick a provider.

Home Health Compare

An online tool, created by the Centers for Medicare and Medicaid Services (CMS), for comparing the quality of care that home health agencies provide. It provides a list of U.S. home health agencies, services provided and quality measures. The information comes from home health agencies that have voluntarily agreed to submit quality information.

Hospital Compare

A CMS online tool for comparing the quality of care that hospitals provide. It also includes data on some Department of Veterans Affairs medical centers. The quality measures are developed by the Hospital Quality Alliance, a public-private partnership established in 2002. Quarterly reporting is mandatory for all acute care hospitals in order to receive the annual Medicare inflationary payment update.

Nursing Home Compare

A CMS online tool for comparing the quality of care provided by Medicaid or Medicare-certified nursing homes. Ratings are based on health inspection reports, staffing data and quality measures.

Conclusion

As HPIO reported in its 2014 *Health Value Dashboard*, Ohio ranks near the bottom in state rankings for health outcomes, despite spending more on healthcare than most other states.

As Ohio policymakers continue to explore ways to improve health outcomes while reducing costs, they will need to look for innovative ways to transform the healthcare system.

The federal State Innovation Model (SIM) project provides an unprecedented opportunity to address some of these challenges. In December 2014, the federal Center for Medicare and Medicaid Innovation (CMMI)

awarded Ohio a four-year \$75 million SIM test grant for implementation of episode-based payments and roll out of a state-wide patient-centered medical home (PCMH) model over a four-year period.

The efforts underway as part of the SIM process can both be enhanced by greater healthcare cost transparency and encourage the spread of transparency.

While transparency is not a panacea, as Ohio policymakers explore ways to reduce cost and increase quality, encouraging greater healthcare cost transparency is one area worth exploring.

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