Lessons from Beyond the Empire: State Government Efforts to Promote Healthcare Price Transparency

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Overview of Presentation

- Milbank Memorial Fund
- Defining the Public Interest in the Issue
- Examples of Price Transparency Efforts in RI and elsewhere
- Lessons Learned
What do we mean by “Price”

- What the purchaser pays.
- Can be charges unrelated to cost or discounted.
## Stakeholders’ interests in price transparency

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Interest</th>
</tr>
</thead>
</table>
| Uninsured and Out of Network Consumer           | - Avoid sticker price shock  
- Protection from bankruptcy                     |
| Insured Consumer                                 | - Information for rational choices.  
- Protection from price variation not based on quality |
| Insurer and purchaser                            | - Protection from market power (failure of private negotiations)         |
| Provider                                         | - Information for rational choices                                      |
### Common State Actions

| Uninsured Consumer | - Mandated charge master disclosure  
|                    | - Mandated discounts |
| Insured Consumer   | - Maintenance of fee schedule databases with public access  
|                    | - Charge master analysis |
| Insurer and purchaser | - Fee schedule collection and analysis |
| Provider           | - Mandated access to insurer information |
1. Maintenance of Price Databases for Public Access

Examples: Massachusetts, Minnesota, New Hampshire, Florida...among others

Challenges:
- User accessibility (Patient language vs CPT language)
- Companion Quality Info
- Updates
- Resources and Competencies required

Experience to date:
- No evidence of effectiveness – not a typical state skill
- Better done by carriers?
2. Charge Master Analysis

• Examples:
  – (CMS), New York State, Fairhealth.org

• Policy Goals:
  – Motivate outrage (Steven Brill)
  – Public Shaming

• Outcomes:
  – (Useful, but part of a bigger strategy)
3. Fee Schedule Analysis

• **Goals:**
  – Document and understand price variation in local markets: *by hospital and payer*
  – Evidence for subsequent policy

• **Process**
  – State collection of data
  – Internal analysis
  – Stakeholder engagement
  – Publication

• **Examples:** Massachusetts, RI, New Hampshire among others.
3. Fee Schedule Analysis

Challenges:
• Collecting Data
• Risk adjustment
• Naming names and dealing with blowback
• Fear of unintended effects
  – Variation can also be reduced by raising lowest
Fee Schedule Analysis in RI

- Focus on hospitals
  - Previous anecdotal evidence of variation
  - Cross subsidies of public payers?
- Paid for by ACA Rate Review Funds
- Collect all payer data
- Third party contractor
- Relative pricing, not insurer specific
- Intense stakeholder process
Results – Inpatient Services
Ratio of average risk adjusted per day rate to overall average

<table>
<thead>
<tr>
<th>Payer</th>
<th>Lifespan</th>
<th>Mirm</th>
<th>Nwprt</th>
<th>Care New England</th>
<th>CharterCARE</th>
<th>Unaffiliated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RIH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare FFS</td>
<td>0.99</td>
<td>0.75</td>
<td>0.64</td>
<td>1.06</td>
<td>0.82</td>
<td>0.94</td>
</tr>
<tr>
<td>MCR mgd care</td>
<td>0.94</td>
<td>0.89</td>
<td>0.85</td>
<td>0.89</td>
<td>0.82</td>
<td>0.83</td>
</tr>
<tr>
<td>Medicaid FFS</td>
<td>1.03</td>
<td>0.9</td>
<td>1.17</td>
<td>1.57</td>
<td>2.15</td>
<td>1.57</td>
</tr>
<tr>
<td>MCD mgd care</td>
<td>1.15</td>
<td>0.94</td>
<td>0.85</td>
<td>1.14</td>
<td>1.02</td>
<td>1.12</td>
</tr>
<tr>
<td>Commercial</td>
<td>1.36</td>
<td>1.21</td>
<td>1.14</td>
<td>1.57</td>
<td>1.05</td>
<td>1.23</td>
</tr>
<tr>
<td>All</td>
<td>1.07</td>
<td>0.89</td>
<td>0.76</td>
<td>1.61</td>
<td>0.92</td>
<td>1.05</td>
</tr>
<tr>
<td>Ratio–highest payer to lowest</td>
<td>1.45</td>
<td>1.61</td>
<td>1.81</td>
<td>2.46</td>
<td>2.02</td>
<td>1.66</td>
</tr>
</tbody>
</table>

Notes:
1) This table shows relative payment levels, where 1.00 equals the average payment for all stays in the analytical dataset. For example, 0.99 in the top cell for Rhode Island Hospital means that Medicare FFS paid RIH 1 percent less than the statewide average. Numbers in each cell are comparable to each other because all data have been adjusted for differences in casemix using APR-DRGs.
2) Data are shown only for services where the hospital performed at least 50 services for a specific payer in 2010. Other cells are shown as blank.

Fee Schedule Results in RI

1. Hospital outpatient is half the revenue and harder to analyze.
2. Public Scrutiny reduced monopoly pricing
   – Greater public accountability by hospitals
3. No comprehensive legislative action
   – What is a fair price?
   – Hospitals – public utility or private asset?
4. Some executive action
   – OHIC followed up with limits on rates of increase and contracting conditions
   – Similar actions by Medicaid
Lessons Learned

1. Have funds to do it right
   - Risk adjustment and all payer
2. Conduct public process to address concerns.
3. Relative price is fine
4. Be ready to deal with consequences
   - Leads to health services planning and policy questions on rate oversight
   - Rate oversight reduces inflationary concerns
4. Provider Access to Fees

• Conflict
  – Incented providers who want access to fee information
  – Insurers who want fee information private; fear of price escalation.

• Why the insurers will lose this battle
  – “Really?”: Indefensible position to the providers who they want to control costs
  – Medicaid and Medicare are publicly accessible
  – They are making more info available to consumers.
4. RI Provider Price Disclosure Bulletin

- In response to concerns of PCMH’s and at risk provider groups.
- OHIC issued q2 2013 (new) as bulletin
- Directs Health Insurers to disclose provider rates for requested services to primary care providers upon request of PCP
  - Public interest to trump private contract
  - Only for purposes of care coordination
  - Limits on disclosure.
4. Provider Disclosure

• Status in RI
  – Enforcement is key: insurers can stonewall.

• Lessons
  – Setting culture for insurers
  – Sophisticated providers will get claims and reverse engineer a price.
  – Information is not conclusive
Final reflections on state role in price transparency

• Winning policy politically
• Stay out of consumer disclosure
  – Ample evidence that consumer facing transactions are not core public skill
• Do not oversell: necessary but not sufficient for delivery system transformation
• Be prepared for consequences…
Be Prepared for What Happens
When You Lift The Rock…
Be Prepared for Policy Discussion:
How provider rates are determined is fundamentally conflicted.

But That is the Place for Public Leadership

(Public rate setting) (Negotiated rates)