

The Need for Transparency in Health Care Markets:

Clearing the Fog to Make the Market Work

Suffering from knee problems for years, Tom Taylor of Northern California underwent knee replacement surgery for both of his knees. Taking place only months apart, the two procedures were identical, the performing doctor the same and the cost? One \$95,000 and the second, \$55,000.¹ With no substantive difference in the quality of the two procedures, Tom Taylor's story is just one of the many patient stories exposing the tremendous need for transparency in health care markets. This need spans all components of health care – health insurance, pharmacy benefit management, pharmaceutical and device manufacturing, hospital care, and other provider care. Comprehensive transparency pertains not only to price, but also to providing information relating to quality and potential conflicts of interest.

Tom Taylor's story is by no means out of the ordinary. On a broader scale, vast inconsistencies have been found to exist between pricing of identical procedures and products across states. In an investigation conducted by the Office of Attorney General Martha Coakley in Massachusetts, researchers found that “prices paid by health insurance companies to hospitals and physician groups vary significantly within the same geographic area and amongst providers offering similar levels of service.” Controlling for possible contributing factors, the study revealed that price variations are not correlated to quality of care, the sickness of the population served, the proportion of patients enrolled in Medicare or Medicaid, or whether a provider is an academic facility.²

In 1913, speaking to the merits of greater transparency, Supreme Court Justice Brandeis famously stated, “Sunlight is said to be the best of disinfectants.” While this concept is a frequent component of political discussions including the continuing debate over health care reform, it is rarely a discussion that stands alone in the health care context. Yet stories like Tom Taylor's tell us that the need for transparency, and its explicit discussion, is dire.

The new health care reform bill marks progress in responding to this need. Shedding light on a market previously blanketed with a layer of fog, the Patient Protection and Affordable Care Act (PPACA) is an important step in transforming the health care marketplace. While its various disclosure provisions aimed at better educating payors and regulators mark tremendous progress, proper implementation and further reform are still needed for comprehensive transparency and functioning market principles to be realized.

¹Helfand, Duke. "Healthcare Providers Experiment with Lump-sum Pricing." *The Los Angeles Times*. 24 Apr. 2010. <<http://articles.latimes.com/2010/apr/24/business/la-fi-healthcare-costs-20100424>>.

²*Investigation of Health Care Cost Trends and Cost Driver*. Rep. Office of Attorney General Martha Coakley, 29 Jan. 2010. <http://www.mass.gov/Cago/docs/healthcare/Investigation_HCCT&CD.pdf>.

Inconsistencies that persist due to a lack of transparency create tremendous challenges for consumers, regulators, and almost every participant in the health care system. Without transparent pricing information, it is virtually impossible for individuals and employers to compare insurance costs and for patients to grasp the true price of health services. Transparency in other areas such as quality and potential conflicts of interest moreover allow for the comprehensive comparison of services that is essential to a functioning market. Regulators, unarmed with transparent information on insurer market practices, face significant roadblocks in their efforts to effectively understand health care markets, foster competition, and protect consumers. The potential benefits of increased transparency in health care reach all stakeholders and components of the market. Understanding the principles and practical implications of transparency helps illuminate why we should value communication, openness and accountability in health care markets.

This paper will examine what all health care market participants stand to gain from increased transparency as well as the importance of standardization, data reporting to regulators, and disclosure to consumers in achieving the potential benefits of cost control, quality effects and access impact. With respect to the recent health care reform bill, I will outline the transparency provisions achieved under PPACA and will evaluate them in terms of the necessary preconditions of transparency. Using the hospital systems in Wisconsin and Colorado, detailed hospital reports published by New Hampshire and Maine, and the savings resulting from transparent contracts with pharmacy benefit managers, I will lay out examples of the potential success of transparency reform. Finally, I will address the anticompetitive concerns surrounding price sharing and present recommendations for effective implementation of transparency under PPACA as well as for any future efforts at transparency reform.

Benefits of Transparency

Increased transparency may be utilized differently across participants in the health care market, but Regina Herzlinger, Nancy R. McPherson Professor of Business Administration at the Harvard Business School, identifies three uniform benefits: cost control, quality effects and access impact.³

Cost Control: Perhaps transparency's most compelling benefit for the current political climate, is its ability to help contain cost. When a market's transparency increases, useful pricing information enables consumers to become more discerning and comparative in their consumption decisions. As a result, consumers can obtain a higher value for their health products and services, receiving better quality care at a lower cost. Additionally, price awareness by physicians and patients can help bring attention to issues such as excessive utilization and furthermore, help to drive down costs for individuals, employers and group plan sponsors. Oftentimes, simply obtaining price data can prompt positive changes among suppliers. This behavior, known as the "audit effect," occurs when providers improve their behavior simply as result of a review or reporting

³ Herzlinger, Regina E. *The Missing Health Care Reform: Transparency*, U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health. 111th Congress. May 4, 2010. <http://energycommerce.house.gov/Press_111/20100506/Herzlinger.Testimony.05.06.2010.pdf>.

process. To this effect, the U.S. Congressional Budget Office estimated that sharing peer profile scorecards with physicians would save Medicare \$350 million from 2010-2014.⁴

Quality Effects: Publishing information on the outcomes and effectiveness of hospitals, providers and products also has the benefit of improving quality within the health care market. A report on quality reporting by Judith Hibbard, Jean Stockard and Martin Tusler concluded that publicizing hospital performance data encourages hospitals to respond across broad measures to improve the quality of care and their relative ranking.⁵ In studies on quality reporting in New York and Pennsylvania, patients exhibited similar quality effects by responding to the quality “report cards” and making comparative decisions to increase the market share of high quality providers.^{6,7}

Access Impact: Price disparities affect all participants in the health market, but uninsured patients usually bear a disproportionately high share of the financial burden. Prices for care received by the uninsured vary widely, show little stability, and can be very difficult to pin down prior to treatment. One study revealed that for one procedure, uninsured patients pay 75% over Medicare prices.⁸ Publishing price data would enable uninsured patients to compare prices and make competitive decisions. For both insured and uninsured individuals, transparent pricing would assist patients in realistically grasping which services and procedures are financially accessible to them.

Necessary Preconditions of Transparency: Standardization, Data Reporting, and Disclosure

In order to achieve the benefits of improved transparency, reform efforts must include certain essential components. Karen Pollitz, former Research Professor at Georgetown University Health Policy Institute, testified during a Senate hearing on health reform and suggested that the underlying principles of transparency include: standardization of terms and coverage minimums, data reporting to regulators, and disclosure to consumers.⁹

Standardization of Terms and Coverage Minimums: Standardization of health care terms and definitions is the foundation of transparency reform. Navigating the many components of the health care market is already very complex, but the use of inconsistent meanings between health care terms poses further challenges. For example, the definition

⁴ Churchill, N.C., Govindarajan V, Cooper WW. Effects of audits on the behavior of medical professionals under the Bennett Amendment. *Auditing: A Journal of Practice and Theory*. 1982:69-90.

⁵ Hibbard JH, Stockard J, Tusler M. Does publicizing hospital performance stimulate quality improvement efforts? *Health Affairs*. 2003;22(2):84-94.

⁶ Kolstad, Jonathan T. and Michael E. Chernerw. Quality and Consumer Decision Making in the Market for Health Insurance and Health Care Services *Med Care Res Rev* 2009 66: 28S-52S

⁷ David, Dravone and Andrew Sfekas. Start spreading the news: A structural estimate of the effects of New York hospital report cards. *Journal of Health Economics*. Sept. 2008. Vol. 27 Issue 5. Pp1201-1207.

⁸ Kolstad.

⁹ Pollitz, Karen. Testimony before Hearing on Health Insurance, Transparency and Accountability. U.S. Senate Committee on Commerce, Science, and Transportation. 111th Congress. June 24, 2009. <http://commerce.senate.gov/public/?a=Files.Serve&File_id=27023dc6-ef58-48e7-a25b-8ea97d089618>.

of “out-of-pocket” limit used by all insurers should include all patient cost sharing. When an insurer uses a definition of “out-of-pocket” limit that only caps some of a patient’s costs, it is very difficult for consumers to make health plan comparisons and purchasing decisions. Standardization of health care terms enables consumers and regulators to make more accurate market comparisons and assessments. In addition to terms and definitions, insurers should develop a “minimal benefit standard” or a basic level of coverage that is always delivered to consumers. Coverage minimums allow consumers to be confident in a basic level of benefits when facing insurance decisions and comparisons.

Data Reporting to Regulators: Insurance commissioners and other state regulators are charged with monitoring health care markets, but are often thinly staffed, operate with limited resources, and erratically bring enforcement actions. As a result, the level of consumer protection and antitrust compliance in health care markets varies widely across states. A Center for American Progress study of 33 states found that over one-third brought no significant consumer protection actions in the last five years.¹⁰

A contributing factor to this pattern of irregular consumer protection action is the scarcity of useful data provided to regulators. In 2009, the U.S. House of Representatives Oversight and Government Reform Committee requested all 50 state insurance departments to provide the Committee with data on health insurance rescissions. In response to that request:

- Only 4 states could provide data on the number of rescissions that occurred
- Only 10 states could provide the number individual health insurance policies in force, and
- More than one-third of states could not supply a complete list of companies that offer insurance within their states.¹¹

In order to effectively assess and regulate health care markets, regulators need to obtain specific and comprehensive data from insurers and providers. Currently, most enforcement actions result from information gathered from complaints filed with local insurance commissioners. A complaint-driven understanding of health care does not provide regulators with an accurate or a market-wide view of compliance with consumer protections. For example, a nationwide survey revealed that over half of insurance policyholders experienced some kind of problem with their plan in the past year, but only 2% contacted their state regulator to file a complaint.¹² Responding to this kind of limited information, regulators must take enforcement actions with only a partial understanding of the consumer’s experience.

For a more effective view of the health insurance market, regulators need insurance companies to provide a standardized and detailed “regulatory scorecard” that reveals an accurate view of an insurance company’s operations in the state. This

¹⁰ Balto, David; Gross, Stephanie. “Don’t Leave It to the States.” *Center for American Progress*. October 29, 2009. < http://www.americanprogress.org/issues/2009/10/health_oversight.html>.

¹¹ Staff memo to Members of the Energy and Commerce Committee Subcommittee on Oversight and Investigations, June 16, 2009.

¹² National Survey of Consumer Experiences with Health Plans, Kaiser Family Foundation, June 2000.

“regulatory scorecard” should include data on an insurer’s marketing practices (number of applications new enrollments, retention, renewals, cancellations, and rescissions), coverage practices (coverage effectiveness, what policies are sold, what they cover, and who is covered), provider practices (participation rates, insurer reimbursement levels), and policy loss ratios (the share of premiums that is allocated to claims versus administrative costs). Similarly, regulators must collect additional data from hospitals, physician groups, and other providers that includes: price information based on severity of condition, data on typical bundling of services depending on treatment cycles, information on pricing and financial assistance for insured and uninsured patients, and data on quality measurements and patient outcomes.

Disclosure to Consumers and Employers: In addition to providing regulators with an overview of company’s operations, insurers and providers need to equip consumers and other purchasers with accessible and useful pricing information. Although types of purchasers vary widely, including individual consumers, small and large employers, and state or federal benefit programs, all purchasers require standard cost and quality data to make accurate buying comparisons. A 2008 study on insured consumers showed that only half of respondents knew the cost of their monthly premiums and less than a quarter understood the terminology in their insurance policy.¹³

Without access to useful data on health insurance policies, it is very difficult for consumers to accurately assess their own plans and compare health plans in the market. For example, in her report on the adequacy and transparency of health insurance in Massachusetts, Pollitz found that under two “bronze” labeled policies that boasted the same actuarial value and same benefit coverage, a breast cancer patient might pay \$7,600 in out-of-pocket expenses under one policy, but \$13,000 fees for the same treatment under the other policy.¹⁴ These policy differences are very difficult for consumers to detect and hinder their ability to choose plans with the highest value.

To remedy this lack of transparency, insurance companies should publicly share contract language, network directories, and prescription formularies on websites and other resources. In addition, a standard “summary of coverage” or “explanation of benefits” should be provided for every insurance policy. This summary should include definitions and specific values for premiums, deductibles, out of pocket limits, and other coverage limits. Pollitz, in the same report on Massachusetts’ health insurance, suggests that a “Coverage Facts” label (see below) provides an example of how insurers may present coverage information in a standard form designed for consumers. She explains that this label could break down patient cost liability by type of service (with information on the impact of non-covered or limited benefits) and by type of cost sharing. For example, a series of “Coverage Facts” labels may be needed to demonstrate how co-pays

¹³ eHealth, Inc., “New Survey Shows Americans Lack Understanding of Their Health Coverage and Basic Health Insurance Terminology.” January 3, 2008.

<http://www.insurancenewsnet.com/article.asp?a=top_news&id=89712>

¹⁴ Pollitz, Karen, et al. “Coverage When It Counts: What Does Health Insurance in Massachusetts Cover and How Can Consumers Know?” Robert Wood Johnson Foundation and Georgetown University. May 2009. <<http://www.rwjf.org/pr/product.jsp?id=42248>>.

add up during the treatment of a chronic condition. In addition to general benefit data, every coverage summary should model simulated claims for expensive medical circumstances, such as heart attack, breast cancer, diabetes or pregnancy. This enhanced and standardized reporting enables individual consumers, employers, and programs to line up “Coverage Facts” labels and simply evaluate the coverage and costs associated with each policy.¹⁵

Figure 8. Sample “Coverage Facts” Label for Health Insurance

Coverage Facts				
Individually Purchased Health Insurance, 2008				
Plan C (Bronze)				
Monthly Premium (age 55)	\$596			
Annual deductible	\$2,000, \$100 for Rx			
Annual OOP limit	\$5,000			
Cost sharing not subject to annual OOP	Medical, prescription, mental health co-pays			
Significant exclusions, benefit limits	none			
Breast Cancer Scenario*				
(May 1 diagnosis, 87 weeks active treatment)				
Estimated allowed charges for all treatment	\$143,180			
Estimated paid by patient	\$12,907 (9%)			
Care type	# billed	Total allowed charges (\$)	\$ paid by patient	% paid by patient
Office Visit	48	4,357	1,200	38%
Office Procedure	47	466	202	43%
Radiology	12	5,789	898	6%
Laboratory	40	2,924	472	10%
Surgery	1	3,386	1,883	34%
Hospital	1	3,293	659	0
Inpat Med Care	1	174	35	0
Rx Drugs	36	5,473	1,185	19%
Prostheses	1	360	72	0
Chemotherapy	36	98,124	3,967	*
Mental Health	36	2,894	900	33%
Radiation Therapy	35	15,911	1,835	10%
* signifies less than 1/2 of 1%				
Source of patient expense	Number encountered	Amount		
Annual deductibles	3	\$4,300		
Co-pays	120	\$3,160		
Co-insurance	-	\$5,447		
Non-covered care	n/a	\$0		

Accompanying individual benefit summaries, each state’s Office of Health Insurance Commissioner should publish regular reports that detail useful, user-friendly information relating to cost, coverage and national ranking of their commercial insurance companies. The “Rhode Island Health Plans’ Performance Report” provides an excellent template for statewide insurance reports to be used by consumers. Rhode Island’s annual

¹⁵ Pollitz, Karen, et al. “Coverage When It Counts: What Does Health Insurance in Massachusetts Cover and How Can Consumers Know?” Robert Wood Johnson Foundation and Georgetown University. May 2009. <<http://www.rwjf.org/pr/product.jsp?id=42248>>.

report is divided into sections containing similar dimensions of performance. These sections examine enrollment and market share, cost information, utilization comparisons, screening information, treatment statistics, and access measures. The report also includes results of member satisfaction surveys and comparisons with regional (New England) and national averages. By explaining what consumers should look out for and where they can make meaningful comparisons, the report aims to educate consumers about their existing plans as well as offer aid for insurance decisions in the future.¹⁶

This kind of transparent data reporting is extremely useful for employers and sponsors selecting health insurance plans and networks for their benefit programs. By gaining a full perspective on an insurer's costs, operations, and performance, employers and sponsors can select plans with the highest possible value for their company or organization. It is very important to employers to offer the most competitive benefits packages as well as maintain employee health and productivity. Employers can more easily meet these goals and choose high value plans when equipped with data on enrollee satisfaction, coverage, and provider practices. Employers and plan sponsors also significantly benefit from understanding policy ratios and the exact proportion of their premiums that are dedicated to health improvements among their employees.

Hospitals and providers must also improve transparency for consumers by presenting pricing information that is bundled by condition or treatment in order to demonstrate the full cost of care. Because transparency will do no good for consumers if the disclosed data is incomprehensible to them, information needs to be presented in a manner that is useful to the average consumer. Hiding the complex reality of health insurance pricing with concrete examples that people can relate to will help consumers to better understand the total cost of varying health scenarios. Further, this information should be presented with tiers of severity and pricing options for possible additional services or procedures. Currently, some hospitals publish pricing information, but the information is usually only offered for individual services. Even with this information, it is very difficult for consumers to determine and anticipate all of the services associated with a procedure or treatment and the resulting total cost. Finally, hospitals and providers must present pricing data with financial assistance information for uninsured patients or coverage information based on individual insurance policies.

These shortcomings of current hospital pricing data highlight a fundamental tension in transparency reform. Transparent information that is too specific does not help consumers understand total costs of medical care, yet information that is too general does not reasonably apply to every consumer. Efforts to increase transparency must strike a balance between these types of reporting and should focus on publishing information that is actionable for consumers. Furthermore, disclosure must be tailored to specific audiences and organized for usability. In order to benefit consumers, pricing information must be clearly expressed and easily accessed, enable comparisons, cover all costs associated with a treatment, and link to quality information.

¹⁶ Gifford, David R., Donald L. Carcieri, and Christopher F. Koller. *RI Health Plans' Performance Report*. (2008). Rep. Rhode Island Department of Health and the Office of the Health Insurance Commissioner, Nov. 2009. Web. <<http://www.health.ri.gov/publications/reports/HealthPlanPerformanceReport.pdf>>.

Transparency Reform in PPACA

The principles of transparency indeed circulated throughout the legislative debate on PPACA and in its final version, numerous provisions requiring significant increases in transparency were included. PPACA's transparency provisions impact health insurers, pharmacy benefit managers, pharmaceutical and device manufacturers, and hospitals, although some of the provisions have limited reach by only applying to Medicare contractors or insurers participating in the Exchanges.

Insurance Companies: Currently, health insurers operate with little oversight, public reporting, or accountability. Insurance purchasers and regulators are lacking the data necessary to make competitive market decisions and enforce consumer protection regulations. PPACA offers a number of disclosure provisions aimed at remedying these competitive and enforcement issues.

PPACA amends the Public Health Service Act to require individual and group health insurers to submit annual reports to the Secretary on the percentages of premiums spent on reimbursement for medical services or quality initiatives. If the reported reimbursement level, also known as a medical loss ratio, does not meet guidelines of 80% for individual and small group insurers and 85% for large group insurers, beginning in early 2011 with its implementation, insurers must offer the difference to enrollees in the form of rebates. This reporting will require detailed data relating to the cost, kind, and quality outcomes tied to all expenditures.¹⁷

While many fear that medical loss ratio requirements will only lead to increasing premiums, PPACA aims to control "unreasonable" premium increases by requiring insurers to provide a justification for such increases prior to the implementation of the increase. Exchanges must require plans to publicly post justifications for rate increases on their websites (not just unreasonable) as a condition of certification. The justification must also be made to the Department of Health and Human Services (HHS) and simultaneously posted to the insurers' website in a prominent manner that the public can see.¹⁸

PPACA aims to improve transparency for consumers by requiring all private health plans to provide a health insurance disclosure form, called the Summary of Benefits and Coverage.¹⁹ Utilizing a fixed layout and standard terms, these forms are intended to improve consumer understanding of their coverage options, allowing them to meaningfully compare health plans. This form will include a version of the coverage facts

¹⁷ Public Health Service Act. Section 2718. Amended March 23, 2010 by PPACA. 111th Congress. <http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf>.

¹⁸ Recall also that in 2014, the Affordable Care Act empowers States to exclude health plans that show a pattern of excessive or unjustified premium increases from the new health insurance Exchanges.

¹⁹ PPACA. Title I, Subtitle A, Section 1001.

label described above. All plans will be required to use these forms beginning in January of 2012.

Also intended for consumer benefit, beginning in 2014, PPACA requires that coverage meet a standard coverage minimum so consumers can rely on a basic benefit level when choosing a health insurance plan. Plans will have to cover a specified set of “essential benefits” including emergency services, prescription drugs, preventative health services, rehabilitation care and more.²⁰ These minimum standards of coverage will provide consumers comparing health plans with the confidence that, in all cases, their basic health care needs will be covered, HHS is also to create new rating measures to inform users to the basis of the relative quality and price of each plan offered.²¹ Now given new rating tools to assist with plan comparison and with the knowledge that all plans have a standard of coverage, consumers should be better equipped to meaningfully make coverage decisions.

Additional disclosure requirements are intended to not only equip consumers with useful coverage and cost information but also to provide standardized data to regulators. All plans must supply data on enrollment, denied claims and rating practices as well as provide rate filings and submit review forms for rate increases. Information concerning cost sharing and payments with respect to out-of-network coverage as well as details on enrollee and participation rights are also areas of required disclosure. The National Association of Insurance Commissioners (NAIC) is currently drafting guidelines for reporting forms and eligibility in the Exchanges to be finalized by early 2013. State Exchanges will be open for individual and small group plans in January 2014.

Other aspects of PPACA’s transparency requirements focus on regulating insurance plans offered in the individual and small group insurance exchanges to be opened in January 2014. Plans seeking certification in the insurance Exchanges must of course submit to regulators and publish information on claims payment policies and practices as well as periodic financial disclosures. Particular to the Exchanges, however, is the requirement of disclosure for information on enrollee rights and information on quality measures for health plan performance.²²

Pharmacy Benefit Managers (PBMs): PBMs administer drug benefits for health plans and plan sponsors by processing pharmacy claims and negotiating drug prices with manufacturers. Private contract negotiations and unknown reimbursement rates and rebates create an environment with little transparency and opportunity for anticompetitive pricing. PBMs conceal the spread between outgoing claims payments and premium earnings, resulting in enormous profits for PBMs and huge costs for plans and consumers. PPACA works to shine light on this component of the health care market by requiring additional data reporting from PBMs that manage contracts under Medicare Part D or the Exchanges. These PBMs must provide regulators with data on the percentage of all prescriptions that are provided through retail pharmacies compared to

²⁰ PPACA, Title I, Subtitle D, Section 1302.

²¹ PPACA, Title III, Subtitle C, Section 1311.

²² PPACA, Title I, Subtitle D, Section 1311.

mail-order facilities and the generic dispensing rates for each type. PBMs must also submit the aggregate amounts and types of rebates and discounts or price concessions that the PBM negotiates on behalf of a plan. Importantly, PBMs must disclose how much of these rebates and discounts are “passed through” to the plan versus kept as company profits. In addition to this information, PBMs must also supply regulators with the aggregate difference between the amount paid by the plan and the amount the PBM pays the retail and mail-order pharmacy and number of prescriptions dispensed.²³

Pharmaceutical and Medical Device Manufacturers: Pharmaceutical, medical device, biological, and medical supply manufacturers sometimes offer gifts and payments to providers, offering a troubling incentive for providers to favor certain manufacturers’ products. These practices are often done with little reporting and can have significant effects on competition and consumer protection. PPACA aims to bring more transparency to transfers and gifts given by manufactures to health care providers and eliminate conflicts of interest. PPACA includes the “Sunshine Act” which requires these drug, medical device, biological or medical supply manufacturers to report direct payments to physicians and teaching hospitals that exceed \$10. The scope of payments is broad and includes consulting fees, honoraria, gifts, entertainment, food, travel, education, charitable contributions, and more. In September 2013, this information will be published on a searchable public website with details about the gifts and payments.²⁴ Additionally, this provision requires manufacturers to submit information on any non-public ownership or financial interest in the manufacturer held by physicians and their immediate family.²⁵

Hospitals, including Tax-Exempt and Physician-Owned: When facing treatment at a hospital facility, many consumers are very price insensitive and inquire little about costs until after receiving expensive tests and treatments. Price information is often difficult for consumers to obtain and, if prices are published, they are usually not usefully organized or represent the total cost. PPACA works to bring more transparency to hospital operations by requiring hospitals to annually publish a list of charges for items and services and report on diagnosis-related groups, bundling these costs by practical medical conditions and the usual associated care. PPACA mandates that standard methods and reporting mechanisms be established by the end of 2010.

In 2014, hospital readmission rates for additional conditions will be added to the current conditions publicly released on Hospital Compare. Beginning in October 2014, HHS will report on its Hospital Compare website each hospital’s record for medical errors and infections covered by Medicare’s policy of nonpayment for hospital-acquired conditions.²⁶ This limited reporting will cover only Medicare patients with certain errors or infections for which the hospital was not paid.²⁷

²³ PPACA. Title VI, Subtitle A, Section 6005.

²⁴ PPACA. Title VI, Subtitle A, Section 6002.

²⁵ PPACA. Title VI, Subtitle A, Section 6002.

²⁶ Note: The federal government already restricts Medicare payments to hospitals for the extra care required to treat Medicare patients harmed by certain preventable infections and medical errors, known as “hospital-acquired conditions” (for example, serious bed sores, catheter associated urinary tract infections and certain types of falls and trauma). The new law expands this policy to Medicaid so critical public funds

Tax-exempt hospitals provide the important service of offering care to uninsured individuals and connecting them with financial assistance. However, financial assistance policies and processes are not always publicized or made clear to patients. To improve financial assistance programs, PPACA requires tax-exempt hospitals to submit to the Department of Treasury a detailed financial assistance policy that explains the criteria and method for financial assistance eligibility and includes the reasoning for calculating amounts charged to patients. These reports must also outline the process and steps taken after nonpayment by patients.

Physician-owned health care operations pose transparency challenges because of possible financial incentives for physicians to provide unnecessary and excessive treatments to patients. PPACA works to illuminate these potential conflicts of interest by requiring these facilities to fully disclose to regulators the existence of such financial relationships and any patient referrals to these providers.²⁸ The referring physician must inform the individual at the time of the referral that:

- The individual may obtain the services from a person other than the referring physician; a physician who is a member of the same group practice as the referring physician; or an individual who is directly supervised by the physician or by another physician in the group practice.
- The individual must be provided with a written list of suppliers who furnish services in the area in which the individual resides.

Building on PPACA's Transparency Provisions

While PPACA offers many significant improvements for transparency, further reform is needed in order to establish a sufficiently transparent medical marketplace where buyers have all the tools necessary to make competition work. As demonstrated by a recent Consumers Union study, in order for buyers to make informed purchasing decisions, lawmakers need to be sure that the transparency mechanisms included under PPACA are designed to be useful for the average consumer.²⁹ This study, authored by Lynn Quincy, sought to gain consumer feedback on the PPACA required insurance disclosure forms-- forms intended to help consumers understand and compare coverage options when purchasing insurance. While the forms did mark an improvement for transparency, testing revealed that profound consumer confusion persisted with respect to health plan cost-sharing. This study highlights the importance of consumer testing in the implementation of health care reform. Transparency efforts will surely not realize their intended goals, unless testing and robust feedback mechanisms are used to reliably demonstrate that the disclosure is understood and trusted by a wide-range of consumers.

will no longer pay hospitals when patients covered by Medicaid are harmed during their hospital stay. [HR3590, Title II, Subtitle I, Sec 2702, p. 200]

²⁷ PPACA, Title III, Subtitle A, Sec 3008,

²⁸ PPACA, Title VI, Subtitle A, Section 6001.

²⁹ Quincy, Lynn. "Making Health Insurance Cost-Sharing Clear to Consumers: Challenges in Implementing Health Reform's Insurance Disclosure Requirements." *The Commonwealth Fund*. Feb. 2011.

During the regulatory process and implementation of PPACA, it is crucial to promote the broadest interpretations of the transparency provisions. The National Association of Insurance Commissioners (NAIC) and the Department of Health and Human Services (HHS), as is generally required in the creation of federal regulation, will draft the provisions of PPACA in a very open fashion. Draft regulations will be made publicly available and open for evaluation and comment. This opportunity to comment provides an important avenue for advocating effective transparency reform through PPACA. After considering comments and revisions, proposed regulations move on to obtain certification by the HHS Secretary. In addition to the implementation of PPACA more legislation at the state and federal levels that would advance transparency should be proposed and supported. Examples of federal legislative efforts to improve transparency include the Transparency in All Health Care Pricing Act of 2010 (H.R. 4700), the Health Care Price Transparency Promotion Act of 2009 (H.R. 2249), and the Patients' Right to Know Act (H.R. 4803).

The Transparency in All Health Care Pricing Act of 2010, introduced by Representative Steve Kagen (D-WI), requires for hospitals, physicians, nurses, pharmacies, pharmaceutical manufacturers, dentists, and the insurance entities to "publicly disclose, on a continuous basis, all prices for such items, products, services, or procedures." The bill would require price reporting "at the point of purchase, in print, and on the Internet" and would give power to the Secretary of Health and Human Services to investigate and penalize noncompliant entities.³⁰ The Health Care Price Transparency Promotion Act of 2009, introduced by Representative Michael Burgess (R-TX), follows similar transparency goals, but would require states to develop disclosure requirements without input from the HHS Secretary. The bill would require states to develop rules related to price reporting on hospital charges and out-of-pocket costs and call for the Agency for Healthcare Research and quality to develop a report on these costs.³¹

The broadest of the three bills, Representative Joe Barton's (R-TX) Patients' Right to Know Act, would allow HHS to define some of the specifics of reporting, but would also rely on states to enact disclosure requirements. It would require health insurers to report information on the limitations and restrictions of health plans, the process for appealing coverage decisions, cost-sharing, and the number of participating providers. Additionally, it would specifically include ambulatory surgical centers as an entity required to report on pricing information.³²

Cases of Successful Transparency

³⁰ United States Congress. House of Representatives. *Transparency in All Health Care Pricing Act of 2010*. 111th Congress. HR 4700. <http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h4700ih.txt.pdf>.

³¹ United States Congress. House of Representatives. *Health Care Price Transparency Promotion Act of 2009*. 111th Congress. HR 2249. <http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h2249ih.txt.pdf>

³² United States Congress. House of Representatives. *Patients' Right to Know Act*. 111th Congress. HR 4803. <http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h4803ih.txt.pdf>.

While legislation is a vital avenue for achieving transparency reform, some components of the health care market have voluntarily grasped the principles of transparency and put them into action. One example is ThedaCare, a four-hospital, community-owned health system in Wisconsin. In his testimony before the House Committee on Energy and Commerce in May 2010, Walter Rugland, ThedaCare's Chairman of the Board, presented the health system's efforts to improve transparency and the resulting achievements. Rugland explained that, since 2003, ThedaCare's hospitals have voluntarily reported public information on the cost and quality of care delivered. This data is published on a user-friendly website and organized by retrospective prices for "fully loaded" or "all in" cost of care and then linked to information on patient outcomes and best practices. Rugland remarked that disclosing transparent information "meant people inside and outside our organization knew how well we were doing and where we needed improvement" and that "sharing our data held us accountable." As a result, ThedaCare has been able to identify areas for quality improvement and cost savings, enabling achievements such as eliminating errors during admission medication reconciliation, reducing average hospital stay, and reducing costs per case by more than \$2,000.³³

During the same congressional hearing, Steven Summer, President and Chief Executive Officer of the Colorado Hospital Association (CHA), offered his testimony on Colorado's transparency efforts and implementation of a "Hospital Report Card." In 1988, CHA began publishing reports on hospital charges and average length of stay for the 35 most common medical conditions and procedures. These reports have evolved over time to take into account different factors such as complicating illnesses patients may have and the general severity of the medical condition. CHA's report on hospital stays shows historical data on the full range of possible stay lengths with probability information for the patient. In 2007, CHA began publishing the Hospital Report Card through an interactive website that expands on pricing information and provides information on patient outcomes at specific hospitals. On this report card, the outcomes for each hospital are compared to all other health facilities in Colorado. This readily-grasped information helps consumers make informed decisions about both the price and quality of their care options.³⁴

New Hampshire and Maine offer another approach to price transparency by making the costs of routine and hospital health care services available to consumers on state-sponsored websites called NH Health Cost (www.nhhealthcost.org) and Main HealthCost (www.healthweb.maine.gov). For insured consumers, patients can access these websites and retrieve cost data organized by service, demographic, geographic location, insurance plan type, and deductible and co-payment information. For example, a person living in Concord, New Hampshire with a health maintenance organization (HMO) plan from CIGNA with a \$500 deductible, and 20% coinsurance (paid by enrollee) would pay \$2682 for gall bladder surgery at Concord Hospital. Similarly,

³³ Rugland, Walter. Testimony before the U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health. 111th Congress. May 8, 2010. <http://energycommerce.house.gov/Press_111/20100506/Rugland.Testimony.05.06.2010.pdf>.

uninsured Maine and New Hampshire residents can access basic out-of-pocket pricing information organized by service, demographic, and location. These websites generally lack detailed quality measurements, but offer some information by ranking doctors by typical patient complexity. New Hampshire also presents cost information for employers, offering an overview of the state insurance market, member liabilities, and loss ratio comparison. Additionally, employers can utilize a “Benefit Index Tool” that helps them make geographic and carrier comparisons. New Hampshire and Maine’s cost initiatives work to provide consumers and employers with details and individualized price data in order to improve informed comparisons and competitive behavior in their state health care markets. As more consumers access these websites and become more educated on health care costs, Maine and New Hampshire aim to use these tools in promoting consumer driven market.^{35,36}

Hospital pricing and cost information are crucial steps in transparency reform, however one of the areas of health care with the least transparency is pharmacy benefit management. Health plans and plan sponsors agree to a negotiated fee and contract with pharmacy benefit managers (PBMs) to administer drug claims and serve as an honest third-party broker with pharmaceutical manufacturers. However, the role of the PBM has evolved over time and PBMs now earn windfall profits by concealing negotiated rates with pharmacies, health plans, and drug manufacturers. PBMs negotiate contracts with pharmacies to determine how much the pharmacists will be paid for dispensing medication and providing services. By paying a lower reimbursement rate to pharmacies, PBMs can generate more revenue from the health plan and collect these profits. Additionally, PBMs earn enormous profits by negotiating rebates and discounts with drug manufacturers in exchange for promoting certain drugs on their preferred formulary. As a result of these practices, two of the largest PBMs, Express Scripts and Medco Health Solutions, have experienced a five-fold profit increase in the past decade.³⁷ These profits yield high reward for PBMs, but correspondingly result in high costs for consumers, health plans, employers, and other plan sponsors.

Large plan sponsors, such as universities, states, and federal programs have recently learned that they can achieve substantial cost savings by opting for contracts with transparent PBMs that disclose negotiations with manufacturers or simply managing their own pharmacy benefit. For example, TRICARE, the federal health plan for military personnel and their families, anticipates savings of \$1.67 billion by negotiating its own drug prices, including rebates, rather than going through a PBM. The University of Michigan has saved nearly \$55 million by administering its own plan for the past six years. Similarly, New Jersey projects savings of \$558.9 million over six years and Texas

³⁵ Summer, Steven J. Testimony before the U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health. 111th Congress. May 8, 2010. <http://energycommerce.house.gov/Press_111/20100506/Summer.Testimony.05.06.2010.pdf>.

³⁵ *NH Health Cost*. New Hampshire Insurance Department, New Hampshire Health Information Center, and the NH Institute for Health Policy and Practice. <<http://www.nhhealthcost.org/default.aspx>>.

³⁶ *Maine HealthCost*. Maine Health Data Organization. <http://www.healthweb.maine.gov/claims/healthcost/procedure_pricing_insured.aspx>.

³⁷ Britt, Russ. “Health care’s healthy decade.” MarketWatch.com. November 19, 2009. <<http://www.marketwatch.com/story/health-care-ends-bonanza-decade-on-bright-note-2009-11-19>>.

expects savings of \$265 million by switching to a transparent PBM contract. Instead of managing drug benefits through a traditional PBM, TRICARE, University of Michigan, New Jersey and Texas are be able to engage in a fully transparent negotiation process and experience significant cost control.

The Overstated Risks of Transparency

Discussions of transparency reform sometimes raise the concern that sharing pricing information among competitors may actually lead to price increases. From an antitrust perspective there is a concern that in industries where pricing terms are known among competitors, collusion among competitors to raise prices is more likely. The concern is that transparent price data may make it easier for companies to tacitly agree on higher prices and undercut market competition. This worry is particularly relevant in markets that are highly concentrated which applies to many components of the health care market.³⁸ While these are valid concerns, it is important to note that these risks are typically overstated. In my testimony before the U.S. House of Representatives Small Business Committee in September 2008, I argue that, while the FTC has brought many enforcement actions against health providers that have exchanged price information, none of these proceedings have resulted in lower rates for insurers or lower premiums for consumers. Additionally, there is no evidence on whether these provider groups continued to exist or were disbanded. While antitrust theory may raise concerns of collusion, experience and evidence does not suggest that price increases will result from transparency.³⁹ Additionally, the type of transparent data reporting that is most useful in health care markets is aggregate disclosures of full treatment costs. By representing prices as bundles, this data will be less useful for collusive behavior by competitors and more actionable for consumers driving market decisions.

While antitrust enforcement agencies like the Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ) put forth legitimate arguments for the risks associated with transparent pricing, both of these agencies also acknowledge the potential benefits of greater transparency. In 1996, the FTC and DOJ established the current antitrust “safety zone” for exchanges of price and cost information that will not be challenged under antitrust laws. The “safety zone” allows for collection of current or historical fees or other aspects of reimbursement without raising significant antitrust concerns. In order to qualify for this exemption and effectively avoid anticompetitive behavior, the FTC and DOJ explain that firms must follow three guidelines: 1) data collection must be managed by a third party, 2) information that is available to competing providers must be three months old (current price data may be provided only to

³⁸ Cowie, Michael G. Testimony before the U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health. 111th Congress. May 6, 2010. <http://energycommerce.house.gov/Press_111/20100506/Cowie.Testimony.05.06.2010.pdf>.

³⁹ Balto, David. “A Progressive Vision for Antitrust Enforcement to Protect the Opportunities for Small Businesses and to Protect Consumers.” Testimony before the U.S. House of Representatives Small Business Committee hearing on “Small Business Competition Policy: Are there Markets Open for Entrepreneurs?” September 25, 2008.

purchasers), and 3) five providers must contribute to the data collection and no individual provider's data may represent more than 25 percent of information.⁴⁰

We observe this “safety zone” in action in the DOJ's response to several large California health purchasing organizations' request for a Business Review Letter on their proposed information exchange. The California purchasing organizations, the Pacific Business Group on Health (“PBGH”), the California Public Employees' Retirement System (“CalPERS”), and the California Health Care Coalition (“CHCC”), proposed the creation of a data exchange program for hospital services called the Hospital Value Initiative (HVI). HVI seeks to improve transparency by measuring cost, efficiency, and quality of hospital services and issuing two types of index scores: Buyer Cost Index (BCI) and Resource-Use Efficiency (RUE). The BCI will allow payors, group purchasers, and hospitals to identify how a given hospital charges for a specific service compared to the average charges for the same service across all California hospitals. The RUE will calculate scores to determine a hospital's resource utilization levels on a per “bed-day” basis for specific procedures. The DOJ Antitrust Division found that the HVI would not likely reduce competition because the proposed survey will be managed by a third party that will collect information at least three months old; no hospital, payor, or group will have access to disaggregated data; the HVI will not reveal prices for services; and it is unlikely for entities to ‘reverse engineer’ statistics to determine individual rates.⁴¹

The Next Frontier of Transparency Reform

Transparency reform has progressed with the passage of PPACA and other legislative efforts on the horizon, but we must consistently reconnect the debate on transparency with an understanding of the organization, presentation, and ultimate application of disclosed information. The effectiveness of transparency reform rests on whether consumers can utilize price, quality and conflict-of-interest information to make informed purchasing decisions and similarly, whether regulators can utilize similar information, paired with information about market conduct, to make appropriate market interventions. New developments such as Accountable Care Organizations (ACOs) present interesting opportunities for an integrated perspective of health care that may translate price information into a more actionable tool based on treatment bundles, care continuums, and coverage coordination.

As we move forward with PPACA's implementation as well as continued debate, it is important to both acknowledge the strides it has made towards greater transparency, as well as to note the areas of sunlight yet to be shed. To be commended are PPACA's provisions that:

⁴⁰ "Statements of Health Care Antitrust Enforcement Policy." *Competition in the Health Care Marketplace*, Federal Trade Commission. Federal Trade Commission and U.S. Department of Justice, Aug. 1996. Web. 07 Sept. 2010. <<http://www.ftc.gov/bc/healthcare/industryguide/policy/statement5.pdf>>.

⁴¹ Varney, Christine A. "Response to Pacific Business Group on Health's Request for Business Review Letter." Letter to Mit Spears. 26 Apr. 2010. *Antitrust Division*. United States Department of Justice. <<http://www.justice.gov/atr/public/busreview/258013.htm>>.

- Standardize health care terms and definitions so regulators and consumers can make direct and accurate comparisons.
- Set a standard coverage minimum so consumers can rely on a basic benefit level when choosing a health insurance plan.
- Require insurers to provide regulators with information on marketing practices, coverage practices, provider practices, and policy ratios.
- Equip consumers with insurance information in a standardized “summary of benefits” that details coverage and exclusions as well as models typical patient costs for common and expensive conditions such as heart attack or diabetes.

To further promote transparency and foster a functioning health care marketplace, future efforts at reform should seek to most comprehensively:

- Require hospitals and providers to report to regulators on pricing based on severity of condition and typical treatment bundles, pricing differences based on insurance and financial assistance, and quality measurements.
- Require hospitals and providers to publish pricing information for consumers based on full cycles of care and individualized co-payments. Hospital financial assistance programs must publish eligibility and pricing information that can be easily accessed by uninsured consumers.
- All transparent information must enable comparisons and offer an actionable tool for regulators and consumers. Consumer willingness to use the information must be demonstrated through consumer testing and robust feedback mechanisms.