NBCH action brief

MAY 2012

Price Transparency: *Now More than Ever*

In February 2012, the National Business Coalition on Health (NBCH) held a meeting of the National Health Leadership Council (NHLC) in San Francisco, CA. The meeting focused on the need for business coalitions, employers, and health plans to promote health care price transparency to employees and others as part of a comprehensive strategy to control costs and improve quality. Based on the presentations and discussions at the meeting, this NBCH Action Brief reviews factors that drive the need for greater price transparency and outlines actions employers can take in this area.

WHAT'S THE ISSUE?

INFORMATION ABOUT THE VARIATION IN HEALTH CARE PRICES (AND HOW IT DOES NOT RELATE TO QUALITY) DOES NOT EXIST, NEGATIVELY AFFECTING PATIENT CARE AND ADDING TO THE HEALTH CARE COST CRISIS

Even though employees have become more responsible for health care costs, they are unaware of the huge variations in price and quality between providers. Employees don't have an incentive or adequate information to consider price and quality when choosing providers and sites. Instead, they make decisions based on other factors, such as convenience, reputation, and/or the recommendation of a friend or physician. So they often end up choosing high-price providers who offer no better quality than lower-priced peers. This lack of transparency contributes to the current health care cost crisis, which threatens the nation, employers, and families.

SIGNIFICANT VARIATIONS IN PRICES AND QUALITY

- An analysis in the Bay Area found that prices for a CT scan of the abdomen differed by a factor of 16, with large variations in prices for an MRI of the spine (4.1 times), diagnostic colonoscopy (8 times), and knee arthroscopy (10 times) as well.
- In 2008, a review of 45 California hospitals uncovered widely varying fees for a total knee replacement, ranging from $7,668 to $24,476. Quality varied greatly as well (with complication rates ranging from under 1 percent to 12 percent), but not in a manner that correlated with price.

HEALTH CARE AFFORDABILITY PROBLEM

Employees and their families, companies, state governments, and the nation as a whole simply cannot afford continued cost increases.

- **EMPLOYEES AND FAMILIES–**The average health insurance policy premium for a family costs more than the annual income of someone making the minimum wage—in 2009, that premium represented 115 percent of the person's income, up from only 15 percent in 1970.
- **BUSINESS–**Many companies spend more on health care benefits than they earn in profits. In the mid-2000s, Safeway spent roughly $1 billion on health care benefits (well above the company's after-tax profit of $600 million), with spending having gone up by roughly 10 percent in each of the previous five years. If those trends had continued, the company would likely have gone out of business within five years, causing 200,000 people to lose their jobs (and health insurance).
- **GOVERNMENT–**In 2008, the U.S. spent 16 percent of gross domestic product on health services, at least 50 percent more than most other developed nations. At both the state and federal level, government budgets are increasingly being consumed by entitlement programs, primarily Medicare and Medicaid, leading to unsustainable levels of accumulated debt, ever-increasing interest payments on that debt, and less money available for other pressing priorities, including education and transportation.

> "No other industry would tolerate such variations, yet the health care industry does so on a daily basis."
>
> — Ken Shachmut,
> Senior Vice President at Safeway, Inc.

TAKE ACTION

ACTION ITEM #1: Make the case for transparency to your employees

You need to help employees become aware of price and quality variations and understand how changing their decision-making process will benefit them (not just you or your health plan) by improving the quality of care and reducing their out-of-pocket (OOP) costs. Making this case effectively requires strong leadership and clear communication on an ongoing basis (not just during open enrollment).

ACTION ITEM #2: Target initiatives to areas where price transparency can be most effective

Price transparency should not be held out as a "magic bullet" that can solve all the nation's health care-related problems. If expectations become too high (as occurred with other so-called "solutions," such as capitation), disappointment and disillusionment will inevitably follow. Instead, price transparency should be used where it can have the biggest impact.

- **HIGH-COST, COMMODITY-LIKE SERVICES WITH WIDE PRICE (BUT NOT QUALITY) VARIATIONS–**Start by focusing on high-cost acute services where prices vary greatly but quality does not. Potential targets include screening colonoscopies, routine imaging procedures and laboratory tests, and brand-name drugs where generic alternatives exist. Over time, you can expand your approach to other areas where both price and quality vary significantly, such as total knee replacement surgery.
- **NON-URGENT, NON-EMERGENCY SERVICES–**Focus on services where there is time for employees to consider alternatives and make informed decisions, not urgent situations where they do not have the time to "shop" for providers.
- **CHOICE OF PROVIDER AND SITE–**Not all decisions will be improved by greater price transparency. For example, choices about the type of test or treatment provided may not lend themselves to price transparency initiatives (although there may be other ways to assist employees in making these important decisions). Instead, focus price transparency initiatives on assisting employees in choosing providers that offer high quality at a reasonable price for a specific test or treatment.

ACTION ITEM #3: Promote data acquisition

Once the appropriate targets have been chosen, you must gather the requisite data, a process that often proves challenging. Key lessons are outlined below:

- **SEEK ALL-PAYER DATA–**Employers should require health plans to share price information with other vendors that work with them on health care issues. The goal is to gather data from as many payers as possible, since data from a single source (e.g., one health plan) may not be representative of the entire marketplace. The All-Payer Claims Database (APCD) Council may be a useful resource in this area. (Go to http://apcdcouncil.org/ for more information.) The National Association of Health Data Organizations (www.nahdo.org) also has information on how various states, such as Oregon, have created all-payer databases.
- **SEEK LONGITUDINAL DATA–**A hospital that charges 10-percent more than average for a particular procedure or inpatient stay may still save employers and employees money and offer higher quality than its competitors if it can manage chronic conditions over time to prevent exacerbations and/or readmissions. Data, therefore, needs to provide information on the total price for the relevant unit or "bundle" of services. Depending on the condition being targeted, the appropriate unit might be a one-time procedure (e.g., a routine imaging procedure), an episode of care (e.g., a surgical procedure, combined with follow-up services to promote recovery), or continuous management of a chronic disease over time.
- **TO EXTENT POSSIBLE, HAVE DATA COME FROM INDEPENDENT SOURCE–**Employees may not trust information from their health plan, employer, or the government, feeling they care primarily about cost control. To the extent possible, independent data sources should be used, such as the Consumers Union, voluntary collaboratives, or independent third parties. For example, the St. Louis Area Business Health Coalition created an independent, non-profit organization (the Midwest Health Initiative) with a multi-stakeholder board to oversee a shared data warehouse. Oregon used a neutral party overseen by an "all-stakeholder" board to create an all-payer, all-claims database, development of which had been mandated by elected officials.
- **WORK TO ELIMINATE NON-DISCLOSURE AGREEMENTS–** These clauses, often found in contracts between plans and providers, can prohibit the release of information on provider pricing and quality.

ACTION ITEM #4 Provide your employees with usable information

Your employees need more than data to make informed decisions. Rather, they need information they can understand and use. Key strategies and lessons include the following:

- **PERSONALIZE THE INFORMATION**–Employees and their dependents do not care about the costs to you or their health plan. Rather, they want to know the OOP costs they face based on their specific coverage and situation. To that end, CIGNA offers a tool that provides personalized, OOP cost information to members at every key decision point, including information on how much money is left in the individual's health savings account to cover OOP expenses. The tool provides expected costs at the procedure, physician, and facility-level for 200 common

Continued on page 3

procedures, based on claims data. Other plans and vendors offer similar tools.

- **PRESENT QUALITY AND PRICE DATA (NOT PRICE DATA ALONE)–**In the absence of information on quality, employees will equate high price with high quality (as they do with goods and services in virtually all other industries). They will also resist efforts to use low-price providers, fearing that you or their health plan is only interested in saving money. Focus groups suggest that adding information on quality to pricing data greatly enhances employee acceptance of the information. In some cases, it makes sense to begin with information on quality, and then add price information after the initiative gains acceptance. The state of Oregon successfully used this approach.
- **CONSIDER PRESENTING SPENDING AS A QUALITY ISSUE–**In focus groups, consumers readily attached to the notion that health care spending can be divided into two "buckets"—the costs of recommended/needed care and the costs of care required due to avoidable complications. This framing fits into consumers' mental model, as it highlights the fact that spending more on recommended care leads to better quality, while also making clear that a high proportion of spending goes to dealing with avoidable problems that are a sign of lower (not higher) quality.
- **MAKE INFORMATION EASY TO UNDERSTAND–**Employees often do not fully understand how their benefits plan works. For example, focus groups found that many individuals with high deductibles (particularly older individuals) did not understand that choosing a high-cost provider would result in greater OOP expenses, or that the "waiving" of the deductible for low-priced providers meant that they would have lower OOP costs if they chose one of these providers. Consequently, every effort must be made to communicate to your employees in clear language about how the plan works and to use visual cues to help them understand the information presented. Useful advice on this topic can be found at www.talkingquality.ahrq.gov.
- **BEWARE OF PUBLIC RELEASE OF PRICING DATA, WHICH CAN LEAD TO HIGHER PRICES–**In several states (including California), the broad, public release of pricing information led to higher prices, as consumers did not find the information useful (and hence ignored it), and low-price providers used it to justify rate increases.
- **LIMIT "PUBLIC" RELEASES TO EASILY UNDERSTANDABLE PROBLEMS–**Stakeholders should consider focusing public releases on easily understandable problems, such as commonly overused services. For example, Consumers Reports published a list of the 10 most overused services, encouraging consumers to speak with their physicians about them. (Go to http://www.consumerreports.org/health/doctors-hospitals/medical-ripoffs/10-overused-tests-and-treatments/medical-ripoffs-ten-over_1.htm for more details.) In partnership with Consumer Reports and nine specialty societies, the ABIM Foundation launched the Choosing Wisely Campaign; each society recently released a list of five frequently performed tests and procedures that lack clinical evidence for their effectiveness. (More information is available at: http://www.abimfoundation.org/Initiatives/Choosing-Wisely.aspx.) The American College of Physicians recently identified 37 tests and procedures that provide little or no value to an identifiable group of patients (available at: http://annals.org/content/156/2/147.full.pdf+html).

ACTION ITEM #5: Encourage *your employees* to use and act on the information

Your employees will not use price and quality information unless they have a meaningful incentive and adequate support.

- **CREATE FINANCIAL INCENTIVES, SUCH AS THROUGH REFERENCE PRICING–**Under most benefit designs, employees see little variation in what they pay, regardless of which provider or site they choose. Reference pricing can address this issue by setting your (or your health plan's) payment for a particular service at a price consistent with those of high quality, low-price, easily accessible providers in the market. If an employee wants to go elsewhere, he or she pays some or all of the difference, with the additional payment typically not counting toward the deductible. Reference pricing is most commonly used with commodity-like services with wide variations in costs but little variation in quality. Safeway anticipates that the strategy will reduce the costs of targeted services by 10 percent. Castlight, a vendor specializing in price transparency, estimates that reference pricing can cut costs 15 to 30 percent, with no impact on access or quality.
- **INTEGRATE WITH OTHER RELEVANT INFORMATION AND TOOLS–**Employees do not make health care decisions in a vacuum, and want all relevant information to be in one place. For example, Cigna integrates its quality and price information with its provider directory.
- **PROVIDE DECISION SUPPORT (NOT JUST INFORMATION)–**Information and incentives may not be enough for your employees to act. They may need additional tools and in some cases personal guidance. Several health plans and employers have introduced such support. For example, Aetna has a web-based "payment estimator" that helps members understand the quality and costs (to the member) of various providers for 40 bundled hospital and 460 bundled physician services. Some plans and employers also offer telephone-based support from a clinical support team that helps consumers understand their options. For example, several members of the St.

Continued on page 4

TAKE ACTION CONTINUED FROM PAGE 3

Louis Area Business Health Coalition contracted with Compass Health, a Dallas-based company, to provide telephone-based support to consumers. Early results are promising; one employer where only 7 percent of employees have used the service generated hard savings of $3 for every dollar spent.

- **USE MULTIPLE CHANNELS**–Many of your employees may not regularly use computers or have time to read paper documents. Most rely heavily on mobile devices and phones in their daily lives. Consequently, price and quality information should be available whenever and wherever they want it, typically through multiple channels, including smart phones and other devices.
- **ENGAGE THE MEDIA**–Stories that highlight wide variations in prices, provider market power, and high provider profit margins can capture the attention of employees, legislators, and other policymakers.

ACTION ITEM #6: Join your local business health care coalition

The coalition movement is a proven vehicle for stimulating meaningful change at the local level. Coalitions are well-suited to supporting you in executing several of the Action Items outlined above, particularly raising awareness and making the case for price transparency, promoting data acquisition, providing employees with usable information, and encouraging them to act on that information. Coalitions can also help in bringing together and promoting collaboration among the multiple stakeholders who are critical to the success of price transparency initiatives, including physicians, hospitals, and health plans.

WHAT'S THE IMPACT?

SUCCESFUL IMPLEMENTATION OF THESE STRATEGIES IS LIKELY TO LEAD TO SIGNIFICANT COST SAVINGS

Both you and your employees can benefit significantly from the successful execution of some or all of these strategies. At Safeway, a combination of these transparency-related initiatives helped keep health care costs flat for the last several years, saving the company and its employees significant money as compared to the prior trend of 10-percent annual increases. Based on their experience, Safeway leaders estimate that a 50,000-employee, self-funded employer could conservatively save $525 million over five years by pursuing similar initiatives, adding $1.375 billion to its market capitalization. Castlight has also seen significant savings with the companies it supports. For example, a large retailer saved an estimated $5.3 million versus expected costs (assuming continuation of historic trends), a return of roughly $8 for every dollar spent on the program. Even if costs had remained flat in the absence of the program (an unrealistic assumption), savings would have totaled $1.8 million, or $3 for every dollar spent.

A NOTE OF THANKS

NBCH would like to thank the faculty of the February 2012 NHLC meeting for being so generous with their time and expertise. As noted, their presentations and insights serve as the basis for this Action Brief. Faculty members are listed below in alphabetical order:

Naomi Allen, Vice President of Sales and Professional Services, Castlight Health

Carmella Bocchino, Executive Vice President of Clinical Affairs and Strategic Planning, America's Health Insurance Plans

Dustin Corcoran, Chief Executive Officer, California Medical Association

Nancy Foster, Vice President of Quality and Patient Safety Policy, American Hospital Association

David Hopkins, PhD, Senior Advisor, Pacific Business Group on Health

Jennifer Eames Huff, Director of the Consumer-Purchaser Disclosure Project, Pacific Business Group on Health

David Lansky, PhD, President and Chief Executive Officer, Pacific Business Group on Health

Louise Probst, Executive Director, St. Louis Area Business Health Coalition

James Robinson, PhD, MPH, Leonard D. Schaeffer Professor of Health Economics and Director of the Berkeley Center for Health Technology, University of California, Berkeley

Ken Shachmut, Executive Vice President and Chief Financial Officer, Safeway Health, Inc.

Mark Smith, MD, Chief Executive Officer, California HealthCare Foundation

Shoshanna Sofaer, DrPH, Robert P. Luciano Professor of Health Care Policy at the School of Public Affairs, Bruch College/CUNY

John Young, Senior Vice President of Consumerism, Cigna Healthcare

Anyone with questions about NHLC or the February 2012 meeting should contact Susan Dorsey, Vice President of Education at NBCH, at 202-775-9300.