



March 23, 2018

Dear Senators Cassidy, Bennet, Grassley, Carper, Young and McCaskill:

The Health Care Cost Institute (HCCI) appreciates your request to provide comments on the type and quality of price transparency information available to U.S. health care consumers as they navigate an increasingly complex and expensive system. HCCI is an independent, non-profit organization that aggregates data from Aetna, Humana, Kaiser Permanente, and United Health Group. HCCI uses this data to conduct and facilitate research that seeks to better understand the drivers of health care costs and to promote transparency solutions at the national and state levels. HCCI has also been certified by the Centers for Medicare and Medicaid Services (CMS) as a national “Qualified Entity,” giving us access to 100% of national Medicare fee-for-service claims, which enables us to conduct public reporting on both price and quality and work directly with providers to improve care. Combined, HCCI possesses data on approximately 100 million Americans in any given year.

In response to your questions, our main points include:

- There is a need for improved national standards in how price and quality information is collected, calculated and presented to consumers. This includes agreed upon definitions of concepts such as price, out-of-pocket price and cash price.
- National and state APCDs can play a key role in promoting price and quality transparency, but they require additional federal funding and support to do so.
- The Federal Government should relax restrictions on the use of already available data and work to make additional data more available.

“What information is currently available to consumers on prices, out-of-pocket costs, and quality?”

There are a variety of consumer-facing tools that provide health care cost and quality information, typically sponsored by health insurers, government entities, and employers. No two such tools are alike, as each is dependent on its underlying data source, and there exists no common standard for health care cost reporting. Though many of these tools provide meaningful components of the value of health care services, the vast majority, if not all, do not integrate price, out-of-pocket costs and quality in a way that consumers can easily absorb. For example, some tools provide the average cost of certain procedures for certain geographies but not the actual cost of a particular facility or provider. Some insurer-sponsored tools incorporate provider/facility-specific and out-of-pocket cost but omit corresponding quality information. Only a very savvy consumer can cobble together the disparate sources of health care cost and quality information in order to inform their health care decision-making.

Quality information is perhaps the most widely available and well-established source of information for consumers with the federal government and other organizations maintaining multiple quality reporting websites that provide consumers with information on the quality of care for hospitals, physicians, home health agencies, skilled nursing facilities, hospice care companies and more. However, despite the efforts of organizations such as the National Quality Forum, differing interpretation and calculation of quality measures mean different sources may score providers differently. While this information is primarily accessed via websites, other organizations have aggregated and presented government calculated quality data in different formats such as smartphone apps, which may be easier for consumers to use.

Several existing price transparency tools aim to help consumers better understand the cost of their care. National and regional health insurers frequently offer pricing tools to their members. A variety of third-party organizations such as HCCI, Amino, Healthcare Bluebook, and ClearHealthCosts provide web-based cost estimating tools to help consumers understand variations in health care pricing. For example, HCCI's price transparency tool, Guroo.com, reports average prices and the range of prices for the 295 most frequently used "care bundles" – common groups of health services such as knee replacements or childbirth. This allows consumers to more fully assess the total cost of care associated with health care events. In addition to providing consumers with information on price, Guroo.com also includes limited geographic quality information related to care for the treatment of diabetes, asthma, and hypertension, as well as hospital readmission rates, which are considered an indicator of quality for hospitals in an area.

It should be noted that a drawback of Guroo.com and many other price transparency sites is that the prices presented are the aggregated prices of the service or care bundle across multiple payers; they do not have access to information regarding individuals' specific health insurance coverage benefit design structure (e.g. what is the co-insurance percentage or co-pay amount associated with the use of a set of services?). Individual health plans sometimes make this information available to already-enrolled consumers, but the information usually sits behind a password-protected portal. Without the critical overlay of an individual's own insurance benefits, currently available price information can't be fully informative for consumers.

“What information is not currently available, but should be made available to empower consumers, reduce costs, increase quality, and improve the system?”

Ideally, consumers should be able to easily determine their total and out-of-pocket cost for “shoppable”, or planned procedures and services. This information would be standardized, available for any provider or facility of interest, and would clearly articulate all charges, including facility fees, professional services, insurance benefits, and out-of-pocket costs. The utility and richness of this information could be increased with the addition of meaningful quality measures, patient-reported outcomes and experience metrics, and other decision-making aids. A robust transparency tool could also allow the user the flexibility to weight these factors based on their own preferences. Armed with this information, consumers could choose providers based on quality and cost inputs and better budget for the care they would receive. It is important to note that this ideal scenario relies on an understanding of the content

provided; purveyors of cost and quality information should make every effort to build a tool that gives clear and concise explanations of the content and its limitations.

Today, some elements of this scenario exist, but there are a few key gaps. A general lack of consensus regarding the meaning of “price” of health care leads to a lack of national standards in how data is captured and reported, which in turn makes comparisons problematic. This understanding is further hindered by the complexity of the health care system, which is such that even when information is publicly presented, consumers can find the information difficult to absorb and understand. Educating consumers on the content and tools available to them related to costs and quality will not only empower consumers, but also help them make more informed decisions.

“What role should the cash price play in greater price transparency? How should this be defined?”

As with many aspects of health care transparency, there is a general lack of understanding as to what constitutes the “cash” price for a health care service. Because providers have traditionally negotiated prices with payers and not individual consumers, the cash price is often thought of as the price that is listed on the hospital or other provider’s internal charge master (which consumers are rarely privy to). It is not clear to what extent uninsured patients are paying more than insurers for the same services, but conventional wisdom holds that uninsured patients pay more because they do not benefit from the insurer’s ability to negotiate. In fact, a recent study by HCCI found that insurers typically paid between 50% and 55% of billed charges.¹

However, billing consumers the full amount of the charge master can be a futile and costly administrative effort for providers as uninsured consumers frequently struggle to pay these increasingly large bills. Likely in relation to this phenomenon, there are some emerging examples of providers offering consumers a cash price that in some cases has been lower than the amount paid on behalf of a consumer with health insurance. In 2016, the Wall Street Journal documented cash-based payment approaches and examples, and several recent stories feature GoodRx, a company that offers cash prices for select drugs that can be less than the amount paid by a consumer under their health insurance coverage.^{2,3}

¹ Barrette, Eric, and Niall Brennan. “The Value of Health Insurance Through Price Discounts.” *Catalyst*, New England Journal of Medicine, 20 Nov. 2017, <https://catalyst.nejm.org/value-health-insurance-price-discounts/>.

² Ornstein, Charles, and Katie Thomas. “Prescription Drugs May Cost More With Insurance Than Without It.” *The New York Times*, 9 Dec. 2017, <https://www.nytimes.com/2017/12/09/health/drug-prices-generics-insurance.html>.

³ Beck, Melinda. “How to Cut Your Health-Care Bill: Pay Cash.” *The Wall Street Journal*, 15 Feb. 2016, www.wsj.com/articles/how-to-cut-your-health-care-bill-pay-cash-1455592277.

“Different states have used different methods to work towards price transparency. What are the pros and cons of listed state approaches? What is the best quality and price information to collect for consumers and businesses?”

As you note in your letter, there are a multitude of state initiatives around price transparency. Rather than attempt to evaluate each individual state, we would point to the good work currently being done by the Catalyst for Payment Reform, which as you note, gave 43 states a failing grade in its most recent report. HCCI would also like to note recent price transparency efforts in Florida, where the Florida Legislature enacted House Bill 1175, which intends to promote health care price and quality transparency and improve competition in the health care market. HCCI is working on behalf of the state of Florida to leverage our existing Guroo.com platform to develop a price estimating tool with care bundle prices to be reported in an easily accessible on-line tool – FloridaHealthPriceFinder.gov – at the state, county, and facility level.

“Who should be responsible for providing pricing information and who should share the information with consumers?”

While the cooperation of providers, insurers, and other payers is essential to the creation of strong consumer-facing pricing resources, HCCI believes that trusted, independent third parties are best positioned to develop and maintain these tools. Third parties can work on behalf of the government entities, employers, and payers looking to empower consumers without conflicts of interest and with a sole focus on creating the most accessible and useful health care information resources. Moreover, third parties can act as conveners to bring together key stakeholders in order to establish a common vision, define priorities, settle disputes, and ensure that the consumer perspective is incorporated throughout.

“What role should all-payer claims databases play in increasing price and quality transparency? What barriers currently exist to utilizing the tools?”

All Payer Claims Databases (APCDs) can be a powerful tool to collect and disseminate data to increase price and quality transparency. APCDs are frequently thought of as state based organizations, but HCCI, with 100 million covered lives from major national payers and Medicare, functions as a de facto national APCD. There are currently 19 states with APCDs. APCDs currently face two main challenges that hamper their effectiveness. One is the 2016 Supreme Court decision prohibiting APCDs from mandating self-insured health plans to contribute data to APCDs, and the other is a general lack of funding for APCDs.

In *Gobeille v. Liberty Mutual Insurance Company* (2016), the U.S. Supreme Court held that the Employee Retirement Income Security Act (ERISA) barred Vermont from requiring self-insured health plans to report data to the state’s all-payer claims database (APCD). It is estimated that data from self-insured

health plans represents more than 60% of the population with employer-sponsored coverage. This ruling will significantly affect the ability of APCDs to produce meaningful price transparency estimates.⁴

State APCDs also tend to be expensive to establish, implement, and maintain. There is an inherent inefficiency in developing each individual state APCD from scratch when state APCDs could benefit from the experience and economies of scale that national entities, such as HCCI, could provide. APCDs also suffer from the same lack of standardization that bedevils price transparency efforts. APCDs should develop and adhere to national standards regarding data submission and validation in order to reduce the burden on national payers who have to contribute data to multiple APCDs using different data submission guidelines.

In some cases, states have struggled to obtain adequate funding and legislative support, making APCD efforts challenging and underwhelming. In 2016, the state of Washington issued a bid for their price transparency effort but initially received no bids, because vendors felt that the available funding was not sufficient for the task.⁵ Greater government funding and support for state and national APCDs is needed to maximize the potential of these data sources to contribute to broader price transparency efforts.

“How do we advance greater awareness and usage of quality information paired with appropriate pricing information?”

Awareness and usage is a product of the availability, timeliness, and usefulness of the data provided. In order to advance awareness and usage, data must be easily accessible, understandable, and valuable to consumers and the health care arena. If the information is readily available, accurate, and deemed meaningful to the user, people will be more aware of it and use it – if consumers see value in it, they will use it. That said, a large-scale campaign to raise awareness of such tools and educate consumers on their benefits is a critical first step, but thereafter, only the utility of the tools and underlying information itself will beget more awareness and increased use.

“How can our health care system better utilize big data, including information from the Medicare, Medicaid, and other public programs, to drive better quality outcomes at lower costs?”

Big data and advanced analytics continue to hold great potential to drive better quality outcomes at lower costs. While big data techniques are promising, they can only be applied to data that is available and are dependent on the integrity of the data. In this regard, there are a number of steps the government should take to promote greater availability of robust public data. There are three specific steps CMS could take to promote the use of big data to drive innovation and better quality.

⁴ Brown, Erin Fuse, and Jaime King. “The Consequences Of Gobeille v. Liberty Mutual For Health Care Cost Control.” *Health Affairs*, 10 Mar. 2016, www.healthaffairs.org/doi/10.1377/hblog20160310.053837/full/.

⁵ Martinell, T.J. “State’s All-Payer Claims Database Still Far Short Of Lift-Off.” *The Lens*, 22 Mar. 2016, thelens.news/2016/03/22/states-all-payer-claims-database-still-far-short-of-lift-off/.

1. Remove restrictions on how Qualified Entities (QEs) can use CMS data for research purposes. Currently, approved QEs are only permitted to use the Medicare data they receive for public and non-public reporting under the regulations established by CMS. QEs can apply to CMS to “reuse” the data they already maintain for broader research purposes. However, CMS data use policies restrict QEs to only using a 20% sample of the data they already physically possess for research purposes. This limitation on use of CMS data by already authorized users is not a requirement under any regulation, including HIPAA, and the policy could be easily and quickly reversed to permit QEs to conduct large scale research into a multiplicity of critical health care reform issues that could drive innovation, higher quality, and lower costs.
2. CMS should immediately authorize the release of Medicare Advantage Encounter data to QEs and researchers, and create aggregated provider-level public use files that can give a broader audience a window into how providers practice care in the Medicare Advantage program. The Medicare Advantage program currently covers one-third of Medicare beneficiaries and is projected by some to grow to as many as half of all Medicare beneficiaries by 2025. A lack of available data for this program significantly hampers overall health system transparency.⁶
3. CMS should immediately authorize the release of Medicaid data to QEs and researchers, and create aggregated provider-level public use files that can give a broader audience a window into how providers practice care in the Medicaid program.

In addition to CMS-related data, the growth of electronic medical record (EMR) systems used by providers include a wealth of information that will greatly enhance the understanding of health care delivery beyond what claim history databases provide today. A nationally-based EMR extract database that can be used for research to drive improved health outcomes should be considered for the future.

“What other common-sense policies should be considered in order to empower patients and lower health care costs?”

“Surprise billing” or “balance billing” a patient – a practice that occurs in many states – is widespread and should be addressed at a state and federal level.⁷ An unplanned ER visit, which can require the involvement of multiple doctors, should not result in an unexpected bill for treatment received by an out-of-network doctor. With no explicit federal protections against balance billing, some states have stepped in to protect consumers from this costly and confusing practice. As of July 1, 2017, California and 20 other states will no longer allow “balance billing” to occur.⁸ For example, all health care providers in California must accept what a patient’s insurance company pays for care delivered in an in-network setting, regardless of whether they have agreed to an in-network contract with the insurer.

⁶ Brennan N, Ornstein C, and Frakt AB. Time to Release Medicare Advantage Claims Data. *JAMA*. 2018;319(10):975–976.

⁷ Adler L, Hall M, Brandt C, Ginsburg PB, Lieberman S. “Stopping Surprise Medical Bills: Federal Action Is Needed.” *Health Affairs*, 1 Feb. 2017, www.healthaffairs.org/doi/10.1377/hblog20170201.058570/full/.

⁸ Brenoff, Ann. “No More Surprise Bills From Out-Of-Network Doctors In California.” *The Huffington Post*, 30 June 2017, www.huffingtonpost.com/entry/surprise-no-more-balance-billing-from-docs-in-california_us_59567da0e4b0da2c73232bd7.

In conclusion, HCCI would like to note that it is critical that any price transparency efforts engage all kinds of health care stakeholders and include continuous evaluation efforts to understand and address the impacts on patients and providers. As with most health care reforms, price transparency efforts could have unintended consequences that should be identified and monitored. By definition, greater price transparency for consumers means more transparency for providers and insurers related to their competitors' negotiated rates. The impact of transparency on what is currently and typically trade secret information could have unintended consequences on prices and consumers' health care choices.

Thank you for the opportunity to comment on this issue of critical importance to every American. The role of Congress and the federal government will be key in identifying a path forward towards greater price and quality transparency across the U.S. health care system. HCCI stands ready to assist in any way it can.

Respectfully,

A handwritten signature in black ink, appearing to read "Niall Brennan". The signature is fluid and cursive, with a long horizontal stroke at the end.

Niall Brennan
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