



Improving Health Care Efficacy and Efficiency Through Increased Transparency

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A Position Paper of the
American College of Physicians

This position paper, written by Hilary Daniel, BS, was developed for the Health and Public Policy Committee of the American College of Physicians: Sue S. Bornstein, MD (Chair); Gregory C. Kane, MD (Vice Chair); Jan K. Carney, MD; Heather E. Gantzer, MD; Tracey L. Henry, MD; Joshua D. Lenchus, DO; Joseph M. Li, MD; Bridget M. McCandless, MD; Beth R. Nalitt, MD; Lavanya Viswanathan, MD, MS; Caleb J. Murphy; Ayteetin Azah, MD; and Lianne Marks, MD. Approved by the ACP Board of Regents on 22 July 2017.

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For questions about the content of this Policy Paper, please contact ACP, Division of Governmental Affairs and Public Policy, Suite 700, 25 Massachusetts Avenue NW, Washington, DC 20001-7401; telephone 202-261-4500. To order copies of this Policy Paper, contact ACP Customer Service at 800-523-1546, extension 2600, or 215-351-2600.

Executive Summary

In 2014, the United States spent \$3.0 trillion on health care, a 5.3% increase over the previous year (1). Part of this growth is due to newly insured individuals entering the marketplace as a result of the Patient Protection and Affordable Care Act. With an influx of new consumers and health care costs rising in general, policymakers have looked to health care transparency, and specifically health care price transparency, as a way to empower consumers to become savvy health care shoppers, lower out-of-pocket costs for patients and for health care services generally, and add efficiency to a traditionally opaque pricing and payment system.

Health care transparency generally denotes access to price, cost, and quality data as they relate to health care services. As the health care system moves toward emphasizing high-quality, high-value, and cost-conscious care, transparency has emerged as a central component of the transformation through claims and quality data aggregation and analysis.

Although there are various challenges to proper utilization and understanding of health care data through increased transparency, analysts believe that it is reasonable to conclude that greater transparency can reduce spending, contribute to better health outcomes, and have a positive impact on the health care market. This hypothesis is reflected in evidence and assessments of price transparency initiatives at the state and federal level. One analysis of such transparency in health care found that use of price transparency information was associated with lower total claims payments for common medical procedures (2).

Increased health care price transparency can potentially save billions for consumers. For example, a study of the Consumer Reports Best Buy Drug Program, an educational program that combines prescription drug cost-effectiveness data with prices to identify “best buy drugs” in several therapeutic classes, showed that increased use of the recommended “best buy drugs” could save an estimated \$2.76 billion (3). When considering potential cost savings associated with prescription drugs, it is important to keep access to affordable alternatives and the best interests of the patient at the center of any decision to modify a drug regimen. Care should be taken to ensure that changing a prescription drug does not jeopardize patient safety or increase adverse events, including hospitalization, that may preclude cost savings. Creating databases that provide reliable and complete information on the prices and out-of-pocket costs of services, such as all-payer claims databases in addition to quality information, can help optimize the potential benefits of transparency in the health care system.

Addressing issues of price-, cost-, and quality-level transparency can support a more efficient and effective health care marketplace with potential for reduced costs and improved outcomes (4). In addition to increased transparency in all sectors of the health care system, action should be taken to increase protection for consumers who face unexpected or surprise bills through no fault of their own. Network adequacy should also be examined and addressed to ensure that enough in-network care providers are available in a given network in both the ambulatory and acute care settings. In this position paper, the American College of Physicians looks at the current environment and challenges to achieving greater health care transparency, identifies key principles regarding health care price transparency, proposes state-level action to improve the availability of quality claims data, and addresses the issue of unexpected billing. Together, these efforts can help to improve the efficiency and efficacy of the health care system.

Recommendations

- 1. ACP supports transparency of reliable and valid price information, expected out-of-pocket costs, and quality data that allows consumers, physicians, payers, and other stakeholders to compare and assess medical services and products in a meaningful way. ACP reaffirms the position that “price should never be used as the sole criterion for choosing a physician, other health care professional, or health care service” (5).**
- 2. Health plans and health care facilities should clearly communicate to a consumer whether a provider or clinician is in-network or out-of-network and the estimated out-of-pocket payment responsibilities of the consumer.**
- 3. ACP recommends that payers, plans, and other health care organizations develop patient-targeted health care value decision-making tools that are written for patients at all levels of health literacy that make price, estimated out-of-pocket cost, and quality data available to consumers. This information should be communicated in an easy-to-understand way. Tools should aggregate price, cost, and quality information on health care services and treatments, including prescription drugs. Health care comparison tools should include the following components:**
 - Total estimated price of the medical service or treatment both in-network and out-of-network;**
 - A personalized estimate of the patient’s potential out-of-pocket cost for the medical service both in-network and out-of-network;**
 - All services provided within the estimate;**
 - Availability to search or compare by CPT code;**
 - Assistance to consumers in identifying potentially unnecessary or avoidable procedures or medical services;**
 - Quality or outcomes data for the medical service or treatment alongside price information;**
 - Data updated in a timely manner.**
- 4. ACP supports legislative action at the state level to require private and public health plans to submit data in a standardized manner to an all payer claims database (APCD).**
- 5. APCDs should be set up for future expansion to other relevant sources of information, such as sources of vital statistics, data contained in regional health information exchanges, or data compiled in quality clinical data repositories (QCDRs).**
- 6. ACP supports legislation at the state level to prohibit “gag clauses” and similar contractual arrangements that interfere in the transparency of relevant health care data.**
- 7. ACP supports federal grants or similar incentives to states for the development of APCDs.**
- 8. ACP supports efforts to provide greater protections for patients from unexpected out-of-network health care costs, particularly for costs incurred during an emergency situation or medical situation in which additional services are provided by out-of-network clinicians without the patient’s prior knowledge. While the College reaffirms the right of physicians to establish their own fees and to choose whether to participate as an in-network provider, ACP supports establishing processes to reduce the risk for “surprise” bills for out-of-network services for which a patient was unable to obtain estimates for services prior to receipt of care or was not given the option to select an in-network clinician. Health plans also have an affirmative obligation to pay fairly and appropriately for services provided in- and out-of-network, and regulators should ensure network adequacy in all fields, including emergency care.**

- 9. Efforts to reduce the negative impact of surprise billing should be at the state and federal levels. Legislation aiming to limit surprise billing should, at a minimum, include one or more of the following components:**
- **Support for increased pricing and out-of-pocket cost transparency;**
 - **Dispute resolution process;**
 - **Assessment of economic impact on patients, providers, and payers.**

Background

Understanding Cost Savings and Outcomes Associated With Health Care Price Transparency

The health care market is different from other markets and should be looked at in a way that takes into account its unique qualities. There can be significant variation in the price of health care services based on a number of factors—individual patients will have different out-of-pocket costs based on their health care plan, geographic location, the physician or health care professional caring for them, and the facility where health care services are rendered. Trends in health insurance coverage require patients to become increasingly engaged with their health care. The degree to which a patient is involved with and understands health care price, cost, and quality that may have an impact on their bottom line relies heavily on consumer behavior, the extent and type of information that stakeholders in the health care system are allowed to disclose, and the inflexibility of health care in general.

Savings associated with health care price transparency can be broken down into two areas: out-of-pocket cost savings for patients, and savings for the health care system overall (state or federal). Patient out-of-pocket cost savings tend to have the greatest impact on the public's perception of the success of transparency tools or initiatives. Research shows that patients who have high-quality cost information for multiple physicians are more likely to get the best care at the best price (6). Cost savings potential for patients from health care price transparency are most likely when patients can plan ahead and access the necessary information about pricing and cost prior to the procedure or intervention. An analysis of health care spending on "shoppable" services (the ability to compare medical services before obtaining the service) found that less than half (43%) of the amount spent on health care services for commercially insured individuals was considered shoppable; 15% (almost \$81 billion) of the total spent on health care was spent out-of-pocket by insured consumers; and of this, 44% of out-of-pocket expenditures were spent on shoppable ambulatory physician services (7). However, there are a number of services, including prescription drugs and medical devices, that are not included in what are considered shoppable services.

Savings related to transparency may also come from reduced expenditures in the health care system. One analysis of health care price transparency shows that various interventions to increase price transparency have the potential to save \$100 billion over 10 years, including \$18 billion from mandating price comparison tools on insurer websites and \$61 billion using all payer claims databases (8). A JAMA study showed that consumers who used an online pricing platform saw a 14% drop in lab costs and 13% drop in imaging costs (9).

State health care price transparency programs have shown the extent to which price transparency proposals may affect savings at the local level. The California Public Retirement System (CalPERS) implemented a reference pricing model that capped the cost of knee and hip replacements to steer patients to lower-price hospitals. Prices were clear to patients, and a level of patient choice was maintained. As a result, several hospitals lowered prices in order to keep patients. After the implementation of the model, CalPERS saved \$2.8 million for joint replacement surgery and \$7 million for colonoscopy, and the number of hospitals charging prices below the CalPERS reference limit for orthopedic procedures rose from 46 to 72 (10).

State initiatives have also identified weaknesses of some price transparency efforts and show where it may not add value in the marketplace. In 2007, New Hampshire implemented a tool called HealthCost, a website that reported the cost of 30 common health care services for both physicians and facilities in the state. Analysis of the program and cost savings showed that price variation did not decrease in light of the effort. Researchers attributed this outcome to weak provider competition, low hospital competition, and little incentive to shop based on price due to low enrollment in high-deductible health plans at the time (11). However, since then the shift to paying for value-based care has spurred increased collaboration among payers in the state and increased levels of transparency. Two of the state's private payers, Granite Health Care Network and Cigna, formed a collaborative care partnership to improve health and increase affordability through data sharing. In the first year of the collaboration, medical costs trended 1.2% lower, emergency department use was down 4%, and advanced imaging costs were down 7%. In addition, their quality performance scores and reduction in costs were higher than the New Hampshire state average (12).

Impact of Health Insurance Coverage on Patients

Patients are increasingly responsible for a greater portion of their health care costs through higher deductibles, co-insurance, and cost sharing, making the need for health care transparency even more important. Between 2003 and 2013, out-of-pocket costs for premiums and deductibles have doubled and now amount to 9.6% of household income (13). Enrollment in high-deductible health plans has increased over the past decade, and now over 30% of adults with private health insurance are enrolled in high-deductible plans (14). The 2015 Kaiser Family Foundation Employer Health Benefits Survey found that between 2005 and 2015, worker contributions for family health plans increased 83%. In 2010, 13% of covered employers were covered in high-deductible health plans with a savings option; this has increased to 24% in 2015. The Commonwealth Fund reports that 11% of adults enrolled in a private health plan with a deductible of \$3,000 or more, compared with 1% of adults in 2003 (15). Additionally, the average deductible for covered workers has increased 67% since 2010 (16).

An analysis by the health consulting firm Avalere found that increases in health insurance premiums in 2016 are in line with the distribution of spending in health insurance markets (17). This not only suggests a correlation between overall increases in health care spending and insurance premiums, but could support the argument that transparency may reduce spending for the health care system and lower out-of-pocket costs for consumers, especially those in high-deductible health plans, if they are able to find the best-priced service.

State Health Care Transparency Legislation and Regulation

At least 28 states have some degree of health care transparency legislation or regulations primarily aimed at health care providers and plans that impact the disclosure, transparency, reporting, or publication of health care prices, costs, and fees. Additional states have proposed or are pursuing price transparency legislation. These laws and regulations can differ greatly in scope and impact. For example, California has a number of transparency laws and regulations, including a requirement that "hospitals disclose prices for the top 25 most common outpatient services or procedures and requires, upon request, a person to be provided with a written estimate of charges for the health care services that are reasonably expected to be provided billed to the person if the person does not have health coverage" (18). On the other hand, Delaware only requires the Division of Public Health to "periodically compile and disseminate reports on the data collected such as, but not limited to: charge levels, age-specific utilization patterns, morbidity patterns, patient origin and trends in health care charges" (19).

For the past 4 years, the Catalyst for Payment Reform, an independent nonprofit organization, and the Health Care Incentives Improvement Initiative have issued report cards on state health price transparency laws. The grading methodology takes into consideration laws and regulations on health care price transparency and whether they provide residents with access to meaningful price information through public websites or all payer claims databases. In 2016, 43 states received an "F" rating, indicating that considerable work needs to be done at the state level to improve health care price transparency, despite increased interest by policymakers and other stakeholders (20).

Health Care Price Transparency Efforts at the Federal Level

There have been ongoing efforts at the federal level to increase price transparency over the past decade. Medicare operates several comparison websites, including Hospital Compare, Physician Compare, and Nursing Home Compare, that allow Medicare beneficiaries to review quality ranking of facilities and health care providers (21). Separate from the comparison efforts, in 2013 the Centers for Medicare & Medicaid Services released charge data for the 100 most common inpatient hospital services and 30 common outpatient hospital services (22). The agency releases information about the amount it pays to individual physicians on a case-by-case basis upon request (23).

The Affordable Care Act (ACA) included price transparency elements, such as the requirement for hospitals to annually publish and update a list of standard charges. Health plans participating in health insurance exchanges are to create tools that allow consumers to look up their estimated out-of-pocket cost sharing responsibilities for in-network services covered by the plan. Additionally, the ACA's Medicare Data Sharing for Performance Measurement Program allows the disclosure of Medicare claims to qualified public or private organizations approved by the Secretary of Health and Human Services to use claims data to evaluate physician performance. The information gathered by these organizations may be evaluated and released in public reports on cost, quality, and physician performance (24).

The implementation of the Medicare and CHIP Reauthorization Act (MACRA), which establishes a new way to care for patients and pay physicians, will bring additional transparency and data to the public. Physicians will choose one of two reimbursement pathways—alternative payment models or merit-based incentive programs—and be reimbursed for high-value care as defined by measures of quality and efficiency. MACRA requires CMS to expand the information available on the Physician Compare website to further the goal of empowering beneficiary choices through continued access to information on physician services.

MACRA also expands the use of Medicare data by Qualified Entities. The original qualified entity program created under the Affordable Care Act authorized CMS to provide Medicare Part A and B claims data and Part D drug data to defined "qualifying entities" (QEs) covering one or more geographic regions. Under the original program, the QEs were required to combine the Medicare claims data with those from other sources and could only use them to produce, and make available to the public, comparative reports summarizing the performance of "providers and suppliers". Information provided through these public reports needed CMS's approval to ensure that beneficiary privacy and data security standards were met, and that the data were valid, reliable, and accurate. Under MACRA, the program has been expanded to allow QEs to provide or sell these analyses to authorized users for nonpublic use to assist quality improvement activities. Authorized users include providers/suppliers, issuers, employers, medical societies/hospital associations, and any other entity approved by the Secretary. The legislation also authorizes the Secretary to release data from the Medicaid and CHIP programs. It is anticipated that this expansion will encourage innovation in how the data are utilized to improve health care. It will also result in increased data about patient outcomes, resource use, and provider performance.

Ongoing Challenges to Achieving Meaningful Health Care Price Transparency

Logistic and legal challenges continue to impede to health care price transparency. The cost for services are not consistent for every patient across the health care system; insurance carrier, patient cost-sharing arrangements, and location all factor into how much each individual pays for the same service. A 2011 Government Accountability Office (GAO) report outlined factors that may make it difficult for consumers to obtain cost estimates or prices for the health care services they receive. These factors included difficulty predicting health care services in advance, billing from multiple providers, and the variety of insurance benefit structures (25). Another issue the GAO uncovered during interviews for the report was that contractual obligations with providers may prohibit sharing negotiated rates with the insurer's members on their price transparency websites. Additionally, some noted that disclosing such information is prohibited by the proprietary nature of negotiations and antitrust laws (26). Finally, the accuracy of claims and quality data may be limited.

Consumer behavior may be one of the most challenging components to realizing the benefit of health care price transparency. With high-deductible health plans, patients are encouraged to shop around for the best prices on products and services; however, some data suggest that individuals with those plans are not comparing prices as expected. A study of 75,000 employees switched to a high-deductible plan showed a reduction in spending between 12% and 14% (27). However, this reduction was not the result of consumers making more cost-effective choices but because they were forgoing care, which may lead to higher-cost care, such as hospitalization, at a later date. Other research confirms that persons enrolled in high-deductible health plans use less health care when faced with higher cost sharing (28). They may also be reluctant to use shopping or comparison tools even if they are available. A 2015 study showed that more than half (56%) of Americans have sought information on the price of health care before obtaining services, but only 21% compared the information across multiple care providers (29). Younger consumers have signaled that they place more emphasis on value and long-term considerations of quality than previous generations, but it is unclear whether those views will be reflected in action (30).

Not only are consumers not using tools, many lack the health care literacy that would enable them to completely understand the information provided to them. Consumers with limited health literacy are more likely to skip preventive measures, have less knowledge about illness and management, and have an increased number of preventable hospital visits. As a result, limited health care literacy is associated with higher health care costs (31). Disparities in access to technology, such as computers or the internet, can also be a factor in health care literacy (32).

While the significance of price transparency is great as patients are asked to bear a larger cost burden for health care, there is some concern that this increased focus on consumerism may pose a challenge to a value-based reimbursement and the Patient-Centered Medical Home (PCMH) model. The joint principles of the PCMH model, strongly supported by the American College of Physicians, emphasize a holistic approach to a patient's care over time through care coordination. The consumerism model in which patients shop around for the best price for medical services—regardless of where the service is rendered or who treats the patient—can appear to be counter to the concept of the PCMH. A greater understanding of how these concepts intersect would be beneficial for all stakeholders. Efforts are being made to increase the understanding of this dynamic. An analysis of three consumerism-driven primary care trends (retail health clinics, direct and concierge care, and home-based diagnostics and care) identified that key components of incorporating consumerism into value-based primary care are connectivity and payment structures (33). The Commonwealth Fund also notes the Healthcare Blue Book has developed a subscription service specifically for PCMHs to enable physicians to work with patients and make referrals to high-quality, low-cost providers (34). Further consideration must be given to how an increased focus on price transparency fits into the evolving primary care landscape.

There is some uncertainty regarding President Trump's pledge to increase health care price transparency as well as concerns about transparency provisions in the ACA in light of his support for repealing a majority of ACA provisions. During the 2016 election, the president made price transparency a key part of his health care platform, stating that he would "Require price transparency from all health care providers, especially doctors and health care organizations like clinics and hospitals. Individuals should be able to shop to find the best prices for procedures, exams or any other medical-related procedure" (35). However, since the campaign neither the president nor his administration has made specific proposals to increase transparency or indicate whether the proposed increase in transparency will come through federal regulations or a market-based approach.

The potential repeal of the ACA could pose challenges to supporting and maintaining the health care price transparency policies already in place. Provisions that are intended to make information available to the public and help consumers understand how their health coverage works, such as uniform summary of coverage, transparency in coverage disclosures, and quality reporting for private health insurance, would be at risk (36). Rolling back these provisions would undercut transparency efforts and slow the flow of timely, reliable data.

Finally, there continues to be a loose connection between patient perception of the relationship between cost and quality in the health care system despite changing attitudes. Although most Americans do not associate price with quality, a large section (21% to 24%) either believe that there is an association or is uncertain whether there is an association (37). While the price/quality connection may be true in other areas of commerce, it is not always true in health care.

Surprise or Unexpected Billing and Medical Debt

Surprise billing, or unexpected bills patients receive as the result of receiving care from an out-of-network physician or facility or unexpected in-network service charges, can be a financial burden on patients that can contribute to medical/consumer debt. Medical debt is a growing concern, even for those who are insured. The Kaiser Family Foundation found more than 25% of adults reported that they or someone in their household have challenges created by medical debt, including 20% of insured individuals under the age of 65. Of insured individuals, 51% reported owing sums of \$5,000 or more. Those who experience medical debt may also feel residual consequences stemming from such debt—they are nearly three times more likely than those without debt to delay other care and have reported having housing problems as a result (38).

Unexpected billing may come as the result of several situations in which the patient receives out-of-network care or services that they are unaware of, such as additional imaging. For emergency services, such as emergency transport to an out-of-network hospital after a heart attack or being transported to an in-network hospital but receiving care from an out-of-network physician, the patient has no option but to be treated by the out-of-network physician. Surprise bills may also result from an in-network physician or facility using out-of-network services, such as a physician using an out-of-network laboratory to analyze samples or an out-of-network physician assisting an in-network physician without the patient's knowledge. In a real-life case, a patient who had neck surgery was billed \$117,000 by an out-of-network assistant surgeon while the in-network primary surgeon's fee was \$6,200 (39). Additionally, there is growing concern about recent policies put in place by some health plans that would deny claims for patients who went to the emergency room for symptoms that were later determined to be nonemergent and may potentially leave patients with unexpected out-of-pocket costs (40).

The rate of surprise billing is high. A survey of privately insured Americans found that one quarter received a bill from a doctor that they did not expect and a third received a bill where their health plan paid less than expected (41). For insured patients, a surprise bill may come from the difference in cost sharing between in-network and out-of-network care or from "balanced billing." This is the practice of billing the patient the balance of a bill the patient's health plan

does not pay, even after the patient has met all deductibles and coinsurance because the fee for services exceed what the plan considers “usual, customary, and reasonable” rates (42). Balanced billing is prohibited in several cases, but there are no protections against the practice for out-of-network care (43).

Recommendations and Rationale

1. ACP supports transparency of reliable and valid price information, expected out-of-pocket costs, and quality data that allows consumers, physicians, payers, and other stakeholders to compare and assess medical services and products in a meaningful way. ACP reaffirms the position that “price should never be used as the sole criterion for choosing a physician, other health care professional, or health care service” (44).

Access to reliable pricing and quality information is essential to realizing the cost savings and potential as well as the improved outcomes associated with health care price transparency. If information is out of date, not applicable, or not of value to the consumer or physician, its scope may be diminished. For example, the release of charge and claims data by Medicare was intended to increase transparency by providing pricing and costs aggregated to individual physicians or groups; however, the information was ultimately of little benefit since few people actually pay charge prices (45). Additionally, when health plans publish quality and cost data about physicians, they should also explain how the data were calculated and allow physicians to view the data prior to publication, as in the Medicare system.

As the cost of care becomes more integrated into clinical visits, access to data can inform shared decision making and may better equip physicians and patients to discuss costs at the point of care. Schiavoni and coworkers supplied 46 primary care physicians with the median price paid for common tests and surveyed their reaction to having such information, when they used the information in decision making, whose responsibility it was to address cost, and suggestions for improvement. The survey showed that having the information helped physicians engage patients when out-of-pocket spending concerns were brought up. It also shows the benefit of multiple stakeholders having access to information that supports price transparency (46).

It is also important that policy proposals addressing such issues as health care price transparency do not consider price or reduction in cost as the only component of success. Although some consumers only use available transparency tools to compare price, assessing price alone may not result in an effective and efficient health care system that rewards both cost-conscious and quality care. In the 2010 paper *Health Care Transparency—Focus on Price and Clinical Performance Information*, ACP asserted, “...price alone is a poor indicator of the potential value of a health care service or product. The price information must be evaluated with consideration of the quality/effectiveness of that service or product to be meaningful in making an informed health care decision” (47). In light of increased attention on the cost of health care, ACP reaffirms this position and supports comprehensive efforts to improve the health care system through increased transparency. Moreover, transparency efforts made by health plans should emphasize the importance of considering not just the cost of the health care service but also the quality and value of the services provided.

2. Health plans and health care facilities should clearly communicate to a consumer whether a provider or clinician is in-network or out-of-network and the estimated out-of-pocket payment responsibilities of the consumer.

The opacity of the health care system’s pricing of goods and services and what exactly patients will pay out-of-pocket for those goods and services does little to benefit the patients and consumers who drive it. Pricing transparency

should start at the point-of-enrollment in health plans and continue through all stages of care. Disclosure of the best available estimated out-of-pocket cost sets the foundation for a greater level of informed decision making. Patients should have access to information on estimated negotiated price, estimated total price for care, and the consumer's share of costs (48).

Providing supplemental information about the cost of a patient's care should not put additional burden on the physician; it should be the primary responsibility of health plans to provide this information, including whether patients might encounter additional out-of-pocket costs outside a cost estimate. For example, if a patient seeks an estimate for the cost of a radiologist visit, the estimate should indicate whether that estimate includes imaging tests and, if not, the potential cost of those tests.

Patients who lack insurance are likely to end up paying higher costs. According to the Institute of Medicine, while the uninsured pay less out-of-pocket for health care services than insured patients, they pay a higher proportion of total health care costs out-of-pocket than insured patients (49). A contributing factor to this variation is that the uninsured tend to use fewer and less expensive procedures than those who are insured; however, they are more likely to delay care, ultimately leading to more expensive care. Some efforts have attempted to help uninsured patients determine potential costs of health care services. An analysis of California legislation that requires hospitals to provide a cost estimate to a requesting uninsured patient and prevents hospitals from billing uninsured patients for amounts greater than the reimbursement they would receive from a government payer found that only 28% of hospitals responded to the request (15% did not provide a quote but asked for more information), 57% provided an estimate for hospital services only, and 18% did not specify what was covered. Additionally, the estimated discounted price estimate was higher than Medicare reimbursement for all procedures (50). The analysis shows the need for multiple layers of disclosure and communication between representatives of the health care system and patients.

3. ACP recommends that payers, plans, and other health care organizations develop patient-targeted health care value decision-making tools that are written for patients at all levels of health literacy that make price, estimated out-of-pocket cost, and quality data available to consumers. This information should be communicated in an easy-to-understand way. Tools should aggregate price, cost, and quality information on health care services and treatments, including prescription drugs. Health care comparison tools should include the following components:

- **Total estimated price of the medical service or treatment both in-network and out-of-network;**
- **A personalized estimate of the patient's potential out-of-pocket cost for the medical service both in-network and out-of-network;**
- **All services provided within the estimate;**
- **Availability to search or compare by CPT code;**
- **Assistance to consumers in identifying potentially unnecessary or avoidable procedures or medical services;**
- **Quality or outcomes data for the medical service or treatment alongside price information;**
- **Data updated in a timely manner.**

Patient-targeted decision making tools, also known as comparison tools, can be a valuable asset for patients to gain a better understanding of how much certain health care services will cost and how much they can expect to pay out-of-pocket. These tools can be useful for patients, particularly those who have high deductibles and will be paying out-of-pocket for services until their deductible is met. Health plan price comparison tools display a number of specific elements primarily for in-network providers, and plan members have the ability to compare prices for specific health care services across individual providers. The

number of health plans that offer comparison tools with multiple comparison or price estimation components is promising. Seventy-one percent of plans include price estimates for treatments at the individual provider level. Potential out-of-pocket costs that a member may incur are displayed by 90% of plans; such out-of-pocket costs could include co-pays, coinsurance, and the deductible for which the member is responsible. Fewer plans display information on reference-based pricing for services (13%), health savings account balances (29%), and links to an outside HSA administrator (10%) (51).

Information on consumer behavior and how consumers understand or use the available data are also essential. Patient-targeted health care tools should encourage their use by offering a variety of elements, not just price data, that complement each other and support a patient in their decision-making, such as quality data in conjunction with price data. In addition to providing practical information, these components support a larger goal of promoting high-quality, low-cost care. If a patient is mindful of the difference of the price of a knee replacement at two different facilities but does not consider comparative quality or effectiveness data, the usefulness of the information is superficial. Additionally, access to price and quality data can help patients choose which services show positive cost-benefit ratios and potentially reduce unnecessary medical procedures.

Finally, a lingering question is whether and if so to what degree patients will use information made available through health care price transparency tools. Patients may feel overwhelmed by the amount of information they are presented, or they may lack an understanding of how the information factors into the historically opaque health care system. Patients may also simply not use the tools that are made available. Desai and colleagues examined the use of a health care price transparency tool offered to employees by two large employers and the association between the tool and outpatient spending. The authors found low rates of utilization for the transparency tool and no association between use of the tool and lower health care spending (52). There are hundreds of websites that purport to provide reliable and accurate information on the price of health care products and services but may use different information and metrics to make their estimates. A patient may find it difficult to understand across platforms which procedures or services are unnecessary or avoidable, and which services could lead to lower costs to the patient and health care sector in long-term. Moreover, data on health care quality are not always easy to obtain, optimize, or understand and may be of little use to consumers. Therefore, it is important that the health care sector support transparency efforts that make the information easy to understand and accessible to an array of patients.

4. ACP supports legislative action at the state level to require private and public health plans to submit data in a standardized manner to an all payer claims database (APCD).

There has been significant interest at the state level to increase the transparency of health care price and quality data despite the lack of comprehensive legislation. This information can be of value to all stakeholders, including consumers, policymakers, researchers, employers, providers, and commercial and public payers. One approach of increasing transparency of health care information is through the establishment of All Payer Claims Data Bases (APCD). APCDs are defined as databases “created by state mandate that typically include data derived from medical claims, pharmacy claims, eligibility files, provider files, and dental claims from private and public payers” (53). APCDs directly address the current problem of silos of health care information—information is available from some, but not all, relevant public and private sources and is not reported in a standard manner that would facilitate use by multiple stakeholders.

The APCD approach aggregates claims data from all relevant sources within the state, and this larger degree of transparency in health care information can be used for such purposes as creating tools for consumers and purchasers to compare prices and quality across payers as they make health care decisions or to provide statewide information on costs, quality, utilization patterns, and both access and barriers to care to inform health care policy decisions. As of January 2016, at least 18 states had enacted APCDs (54) and many more are considering legislation. Issues currently being addressed by states through the use of APCD information include the effects of care delivery initiatives, such as Medicaid medical homes; inappropriate wide variations in utilization and costs of health care services throughout the state; and the development of state policies to increase competition in the delivery of high-quality services by health care providers.

Recently, the APCD model was dealt a setback when the Supreme Court ruled that the federal Employee Retirement Income Security Act (ERISA) pre-empts state law and does not require self-insured employers to submit claims data to APCDs (55). In *Gobeille v. Liberty Mutual*, defendants Liberty Mutual argued that the Vermont state APCD law was in conflict with ERISA law. Although the case was considered damaging for the APCD model, it is unlikely that the ruling will end the operation of APCDs or prevent their establishment unless ERISA claims data are shown to differ fundamentally from non-ERISA data. An assessment of ERISA versus non-ERISA claims data found that while there are differences in plan types and demographics between the two groups, the overall average prices are similar (within 5%) (56). Although there is still work to be done to ensure that APCDs are operating at the highest level for patients, physicians, and payers, the model serves to support the intent of health care transparency to deliver high-quality care while being mindful of cost considerations.

5. APCDs should be set up for future expansion to other relevant sources of information, such as sources of vital statistics, data contained in regional health information exchanges, or data compiled in quality clinical data repositories (QCDRs).

APCDs provide the opportunity to analyze health care quality, cost, and outcome. However, the type of data they collect varies. For example, all APCDs collect enrollment, medical, and pharmacy claims, but others may collect dental claims or vary on what/how much Medicare data they collect (57). It is expected that the Federal Employee Health Benefit Plan and TRICARE will also be explored as data sources for APCDs (58). In order to expand the use, function, and benefit of APCDs, policymakers and systems architects should structure APCDs to ensure the ability to link the system to additional sources of information like vital statistics databases and health information exchanges. The requirement to standardize data submitted to APCDs from Position 5 of this paper supports potential expansion. Primarily, certain elements should be identical in all databases, such as name and Social Security Number (59).

From this perspective, APCDs have the potential to serve a public health function in addition to increasing health care price and quality transparency. Since they rely on population-based data to monitor and assess health outcomes and trends, linking an APCD to a vital statistics database can improve the understanding of the prevalence of certain diseases in specific areas, such as cancer (60). States may have common interests in understanding how certain health care services are used from a regional perspective and can use the information collaboratively. States may build on the knowledge and experience of others to improve on their own APCD. This is beneficial to supporting the overall function and sustainability of APCDs. Qualified clinical data repositories (QCDR) could also be beneficial as APCDs evolve. QCDRs “collect medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients” (61). Creating the opportunity to incorporate QCDRs into APCDs will help to build a link between payment and quality databases.

6. ACP supports legislation at the state level to prohibit “gag clauses” and similar contractual arrangements that interfere in the transparency of relevant health care data.

Confidentiality clauses, also known as “gag clauses” and “nondisclosure agreements,” continue to block full transparency of health care prices. These contractual practices prohibit the public disclosure of negotiated prices between specific health care providers (e.g., hospitals, physician practices) and health insurers or payers. This information can be very useful to consumers, who would benefit from knowing what prices a health plan has negotiated with local physicians and hospitals, both when choosing a plan and choosing providers within a plan. It could also be helpful to employers to ensure that the plan they choose for their employees has negotiated effectively with the local providers, as well as to inform strategies by employers to encourage employees to avoid high-priced physician practices and hospitals. The importance of this information is elevated by the increase in health care coverage through high-deductible plans. These clauses also limit the availability of important information to various state-wide APCDs, used both to assist consumers in making health care decisions, as well as policymakers in ensuring the accessibility of effective health care throughout their region.

Various advocates and others have urged the elimination of these confidentiality clauses through state legislation or litigation in service of the public good (62,63,64). California banned gag clauses relating to cost information in insurer-hospital contracts in 2011, and expanded that prohibition in 2013 to cover all health care providers (65). There has been some concern based on limited data that public release of these negotiated prices might have the effect of raising health care costs, particularly in markets where health care services are highly concentrated (66). While more research is necessary to evaluate the potential adverse effects accompanying full public disclosure of negotiated price data, several solutions have been proposed that may help achieve the intended results of lowering health care costs, including releasing data with a delay, limiting the data reported to a select group of service categories, reporting data in ranges, and reporting data in terms of out-of-pocket costs under various insurers rather than full negotiated price transparency (67,68,69).

A related legal barrier to full health care price transparency are Most Favored Nation (MFN) clauses that, when used, are typically paired with clauses that prohibit the public disclosure of negotiated prices between the provider and insurer/payer but also commits the contracted provider (most often a hospital setting) to not provide an equal or more favorable price to any other insurer/payer (70). These clauses have been linked with anticompetitive practices within a marketplace (because they make it more difficult for a new insurer to enter the marketplace) and raising consumer health care prices (71). Michigan and North Carolina have passed legislation banning these clauses, and many other states have similar pending legislation (72).

7. ACP supports federal grants or similar incentives to states for the development of APCDs.

The cost of establishing and maintaining an APCD may be prohibitive to some states and prevent the creation of an APCD despite the potential benefit. As the benefit of health care price transparency initiatives, such as APCD, are recognized, federal agencies are opening up funding opportunities for states operating or wishing to establish an APCD. The Center for Consumer Information and Insurance Oversight Rate Review Cycle III funding opportunities will consider grant applications from states to support health insurance rate review and increase transparency in health care pricing. The grant opportunities allow all 50 states and DC to enhance rate review programs and/or establish Data Centers. For the purposes of the grant cycle, grant funds can also be used to work with an existing APCD to expand pricing transparency as part of rate review activities as long as certain conditions are met.

The cost associated with APCDs was cited by New Jersey as the reason it chose not to apply for federal grant funding despite a bill that would require it to create an APCD (73). The Rutgers Center for State Health Policy estimates the overall cost of an APCD to vary widely among the states—anywhere between \$200,000 to \$1.5 million annually. These costs arise from data collection, management, and analysis; vendor management; hardware and software purchases; and staff (74). Typically, APCDs attempt to utilize diverse funding pools, including state and nonprofit funding sources, to reduce the risks associated with having a majority of their funding from one source (75). Opening up more grant opportunities to support the creation or maintenance of an APCD can allow for stability and growth of this endeavor.

8. ACP supports efforts to provide greater protections for patients from unexpected out-of-network health care costs, particularly for costs incurred during an emergency situation or medical situation in which additional services are provided by out-of-network clinicians without the patient’s prior knowledge. While the College reaffirms the right of physicians to establish their own fees and to choose whether or not to participate as an in-network provider, ACP supports establishing processes to reduce the risk for “surprise” bills for out-of-network services for which a patient was unable to obtain estimates for services prior to receipt of care or was not given the option to select an in-network clinician. Health plans also have an affirmative obligation to pay fairly and appropriately for services provided in- and out-of-network, and regulators should ensure network adequacy in all fields, including emergency care.

In an ideal situation, patients would be armed with enough information to have a realistic understanding of potential out-of-pocket costs for various health care scenarios and be able to direct themselves toward in-network providers and facilities. However, an examination of the experiences of patients who received out-of-network physician charges found that education alone might not reduce the prevalence or burden of those types of surprise bills (76). Seventy percent of patients who received a surprise bill and had difficulty paying it were unaware that the care was out-of-network, and the problem is likely to grow (77). The concern about high out-of-pocket costs incurred by patients through no fault of their own is shared by patients, physicians, and policymakers alike. In a recent paper released by the Schaeffer Initiative for Innovation in Health Policy at the Brookings Institution on surprise billing, the authors noted, “The consensus for meaningful reform is reflected by the absence of any serious opposition to taking well-considered action” (78).

Despite the need for reform, stakeholders disagree about what steps should be taken to reduce the costs associated with surprise billing and the factors that contribute to the increase in out-of-network care, including physician reimbursement. For example, narrow networks have been cited as contributing to the out-of-network costs. In Texas, 56% of health insurer Humana’s in-network hospitals have no in-network emergency room physicians (79). Patients with Humana coverage who must visit an emergency department have no choice but to risk incurring out-of-network charges. Additionally, a study by researchers at the Federal Trade Commission found that one in five in-network emergency department visits involved out-of-network physicians (80).

How network adequacy and the fair payment of services for physicians may contribute to the increase in patients receiving out-of-network care should also be examined to ensure an appropriate number of available in-network physicians, especially in the emergency setting. In an effort to address the issue of network adequacy, the National Association of Insurance Commissioners included changes to its draft network adequacy model act with regard to surprise bills. The updated act would be applicable to in-network facilities and nonparticipating facility-based providers. The draft model act would require state-regulated plans to apply in-network cost sharing rates for surprise medical bills for emergency

services; notify enrollees that surprise medical bills could arise for facility-based care; and require out-of-network facilities to offer patients who receive a balance bill to pay the bill, submit a claim for mediation on bills greater than \$500, or rely on other rights or remedies in the state (81). Additionally, the Department of Health and Human Services Notice of Benefit and Payment Parameters for 2017 included a provision related to network adequacy and cost sharing. The rule requires issuers to “count the cost sharing charged to the enrollee for certain out-of-network services at an in-network facility by an ancillary provider toward the enrollee’s annual limitation on cost sharing,” effective starting in 2018 (82). ACP’s 2016 paper Addressing the Increasing Burden of Health Insurance Cost Sharing noted, “(f)urther research is needed to determine what solutions protect patients while also establishing predictable reimbursement schedules for physicians and health care professionals” (83). Further consideration of proposals to ensure levels of network adequacy is needed.

9. Efforts to reduce the negative impact of surprise billing should be made at the state and federal levels. Legislation aiming to limit surprise billing should, at a minimum, include one or more of the following components:

- **Support for increased pricing and out-of-pocket cost transparency;**
- **Dispute resolution process;**
- **Assessment of economic impact on patients, providers, and payers.**

State legislatures are primarily leading the charge against surprise charges. Two bills with the strongest protections for patients who experience high out-of-network costs came from New York and Florida. In 2015, New York passed what is considered the most comprehensive surprise billing law, which limited medical bills from out-of-network providers in emergency and nonemergency situations when patients receive treatment at an in-network hospital or facility. The law contains provisions applicable to insured and uninsured patients, dispute resolution processes, and the inclusion of bills in emergency and nonemergency situations. The law also contains a requirement that physicians and hospitals clearly communicate their health plan affiliations to patients via website or in writing before the patient arrives (nonemergency services) or to make such information available on the hospital’s website or during the admission process (emergency services) (84).

Florida’s law applies to patients with certain health plans who inadvertently receive services from out-of-network providers at in-network facilities. In these cases, patients would only be responsible for in-network cost sharing. Additionally, the law contains a voluntary dispute resolution process. In conjunction with this bill, Florida passed a law that will increase health care price transparency (85).

It is too early to tell whether either bill will achieve the desired result of reducing out-of-pocket costs for patients who receive unexpected out-of-network care.

No federal regulations shield patients from unexpected medical bills, and state laws may not provide adequate protection from surprise bills. Analysts have argued that federal action is needed to protect the millions of patients who receive health insurance benefits through private employer self-funded plans that are exempt from state regulation under ERISA. As a result, people who live in states like New York and Florida may still be susceptible to surprise bills (86). A mix of federal protections and state laws is likely to provide the comprehensive approach needed to shield patients from surprise bills. Generally, proposals to mitigate or eliminate surprise billing at the state level take multiple approaches, including holding patients harmless, requiring hospitals to take steps to prevent patients from receiving care from out-of-network physicians, limiting what clinicians can charge, and dispute resolution (87). Variations in existing state laws on surprise billing range from highly prescriptive or strong to offering only minimum protection (88). ACP recommends focusing legislation to address issues related to surprise billing on providing necessary relief for patients while ensuring that clinicians receive appropriate

and fair payment for services. Legislation should also support and encourage additional health care transparency efforts. Finally, while the potential benefit and effects on patients may seem clear, legislation should take into consideration the overall economic impact on patients, physicians, payers, and the state.

Conclusion

As the health care system undergoes multiple transitions—an increase of insured consumers, a shift to paying for quality of service over quantity, and an influx of data from multiple sources—health care price transparency has emerged as an important component to address costs for patients and maintaining a health care system accountable to those it serves. By tailoring tools and data to individuals, health care price transparency can work to mend the fragmentation of health care through access to meaningful information for consumers, physicians, and payers. From a broader perspective, health care price transparency can support collaborative efforts at the state and federal level to optimize the potential of data sharing and potentially reduce costs to the health care system. While also acknowledging the limitations of health care transparency, it is vital to support policies that improve health care price transparency tools; protect patients from high, unexpected out-of-pocket costs in cases where they had little or no control over their care situation; and streamline access to reliable data on price, cost, and quality.

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