



CATALYST
FOR
PAYMENT
REFORM

PRICE TRANSPARENCY REPORT

FOR THE COMMONWEALTH OF PENNSYLVANIA

CATALYST FOR PAYMENT REFORM

JULY 14, 2016

Table of Contents

Introduction	2
Section I: Understanding the Price Transparency	
Legal and Regulatory Landscape in the Commonwealth	4
• Current and Existing State Laws and Regulations	
• Past Proposed State Laws and Regulations and Lessons Learned	
• The Availability and Variation of Price and Quality Data	
Section II: Leveraging Best Practices from Other States	10
• Understanding CPR’s Report Card Methodology	
• Spotlights on State Best Practices	
Section III: Evaluation of Health Plan Transparency Tools	16
• Health Plan Participation	
• Data Collection & Assessment Methodology	
• Aggregate Summary of Health Plan Responses	
• Assessment of Strengths, Gaps, and Differentiators	
Section IV: Opportunities and Gaps	24
• Transparency Movement Not Clearly Articulated	
• Political and Legal Environment	
• Budgetary Concerns	
Section V: Recommendations	28

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Introduction

The Landscape

Today we live in the information age. Modern technology is abundant, providing individuals access to a wealth of knowledge and resources. With so much information at our fingertips, we can compare the price and quality of just about any good or service we want with a few clicks.

It is no surprise that, for millions of Americans, health care is increasingly a retail market as well. With high expectations regarding the availability of information, consumers find it baffling that it is such a challenge to compare individual physicians or facilities on price and quality. According to a [recent survey](#) by Public Agenda, 56 percent of consumers reported trying to figure out their out-of-pocket expense, or how much their insurers pay a provider, prior to receiving care. Furthermore, when seeking price information, 21 percent of consumers tried to compare prices across multiple providers. The majority (69 percent) of consumers believe a website showing how much different providers charge for care would help them to manage their health care spending.

Americans need this information more than ever due to changes in health care benefits. Approximately one in five Americans with private insurance is enrolled in a high deductible health plan.¹ According to the [2015 Kaiser Family Foundation survey](#) of health care benefits, 63 percent of employees in small firms and 46 percent of workers overall have a deductible over \$1,000.² On average, the deductible for single coverage is slightly over \$1,300.³ Beyond the base deductible, many insured workers also have to pay co-insurance until they reach their out-of-pocket maximum, which can be in excess of \$20,000 per year.⁴ The ever-increasing financial responsibility of consumers for health care services makes the need for price and quality information even more necessary. Without it, consumers will continue to struggle to manage their health care costs.

Definitions

We should acknowledge that transparency – specifically price transparency – has different meanings to different stakeholders, as we describe in this report. Two helpful and complementary definitions come from the U.S. Government Accountability Office (GAO) and the Healthcare Financial Management Association (HFMA). The GAO defines price transparency as “the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties.”⁵ GAO further defines price as “an estimate of a consumer’s complete health care cost on a health care service or set of services that (1) reflects negotiated discounts; (2) is inclusive of all costs to the consumer associated with a service or services, including hospital, physician and lab fees; and, (3) identifies the consumer’s out-of-pocket costs (such as co-pays, co-insurance and deductibles).”⁶ The multi-stakeholder HFMA Price Transparency Task Force adds to the GAO definition with “readily available information on the price of health care services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers

¹ <http://kff.org/report-section/ehbs-2015-summary-of-findings/>

² *ibid*

³ *ibid*

⁴ <http://www.catalyzepaymentreform.org/images/documents/accuracy.pdf>

⁵ View the complete GAO report at: www.gao.gov/products/GAO-11-791

⁶ *ibid*

that offer the desired level of value.”⁷ Catalyst for Payment Reform (CPR) uses these concepts and definitions in this report.

This Report

On behalf of the Department of Health and working closely with the Department of Insurance, CPR created this report to evaluate the level and robustness of health care price transparency in the Commonwealth of Pennsylvania today and the opportunities to enhance it going forward. The report reviews and assesses the legal and regulatory landscape related to price transparency; identifies and compares the best practices of other states that are leading the country in enhancing price transparency; summarizes results from a CPR-conducted evaluation of consumer-facing transparency tools offered by health insurance plans; identifies gaps in price and quality transparency in the state; and lastly, provides actionable recommendations for furthering price transparency to the Commonwealth based on our research, as well as CPR’s expertise in this area.

⁷ 2014. Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force. www.hfma.org/transparency.

Section I: Understanding the Price Transparency Legal and Regulatory Landscape in the Commonwealth

This section will provide an overview of the most significant current and past proposed legislation related to health care price transparency in the Commonwealth. This section also reviews information on the availability of price and quality data and the variation of price and quality of care. This section does not seek to address legislation related to all payer claims databases (APCDs), as we understand that another party is actively addressing this topic.

Current and Existing State Laws and Regulations

The Health Care Cost Containment Act

Context

A notable aspect of the Health Care Cost Containment Act (Act 89 of 1986, as amended by Act 3 of 2009) is its creation of the Pennsylvania Health Care Cost Containment Council (PHC4) and establishment of the Council's duties. PHC4 is an independent state agency representing a variety of stakeholder groups in the Commonwealth. The main duties of the Council include collecting and analyzing health care data and issuing public reports about the cost and quality of care in the Commonwealth.⁸

Opportunities

Section 6, entitled Data submission and collection, is a PHC4-specific provision that is a foundational element to furthering price and quality transparency in the Commonwealth. This section is particularly significant as subsection (a) (1) authorizes the Council to collect health care facility data as listed in subsection (c) including:

- Principal diagnoses by standard code;
- Principal procedure by Council-specified standard code;
- Uniform identifiers for health care facilities and admitting physicians;
- Total charges and actual payments to the health care facility, segregated into major categories such as laboratory, operating room, drugs, medical supplies, etc. according to guidelines specified by the Council;
- Charges and actual payments to each physician or professional rendering service relating to an incident of hospitalization or treatment in an ambulatory service facility; and
- Uniform identifier of primary payer.⁹

Limitations

However, section 7, entitled Data dissemination and publication, may place limitations on the way in which these data can be distributed and in what forms. Subsection (b) authorizes PHC4 to create special reports derived from the raw data collected, and allows for the Council to grant computer-to-computer access to raw data to any purchaser¹⁰; however, subsection (b) is subject to restrictions under section 10.¹¹

⁸ <http://www.phc4.org/council/mission.htm>

⁹ <http://www.phc4.org/council/docs/act3.pdf>

¹⁰ A "purchaser" is defined by this Act as "all corporations, labor organizations and other entities that purchase benefits which provide covered services for their employees or members, either through a health care insurer or by means of a self-funded program of benefits, and a certified bargaining representative that represents a group or groups of employees for whom employers purchase a program of benefits which provide covered services," excluding health care insurers.

¹¹ <http://www.phc4.org/council/docs/act3.pdf>

Section 7 subsection (a) mandates that the Council issue public reports on provider quality and service effectiveness for conditions and procedures representing the best opportunity to improve overall quality, patient safety, and cost reduction when ranked by volume, cost, payment, and high variation in outcomes.¹² However, the reports emphasize broader quality and cost trends and statistics, as opposed to facilitating direct price and quality comparisons for specific health care services.

Moreover, section 10, entitled Right-to-Know Law and access to council data, outlines specific limitations on the use of PHC4 data and references the state's Right-to-Know Law. This section recognizes that information received by PHC4 should be used for the benefit of the public and as such, all determinations on requests for information should be made in favor of providing access.¹³ However, the following notable restrictions apply:

- Raw data that does not simultaneously disclose payment, provider quality, and provider service effectiveness shall not be released. This provision is intended to ensure that those who view the data gain a sense of the overall value being offered by the provider.
- Raw data relating to actual payments to any identified provider made by any purchaser, excluding access by a purchaser (or entitled entity) requesting data for its own population, shall not be released. This provision is intended to keep intact anti-trust and collusion protections.
- Raw data disclosing discounts or allowances between identified payers and providers shall not be released, unless the data is in a statewide aggregate format that does not identify any individual payer or class of payers. Such information is considered confidential proprietary information and not subject to disclosure under the Right-to-Know Law.¹⁴ This provision is intended to preserve the individual market leverage of both payers and providers by protecting their negotiated rates.

Key Takeaways

Because provisions in section 6, Data submission and collection, already grant PHC4 the authority to collect the types of data important to price and quality transparency, the Commonwealth is in a position to expand upon both the level and types of data collected and which organizations can participate in collection and analysis, rather than having to develop novel legislation creating entirely new mechanisms for collection.

While the language in section 6 seems promising, provisions in section 7, Data dissemination and publication, limit Council reports to high level, aggregate information on provider quality and cost indicators, rather than providing direct price and quality comparisons for services rendered by individual providers that enable consumers to shop for care. Furthermore, both subsection (a) and (b) are subject to restrictions outlined under section 10.¹⁵

The passage of the Health Care Cost Containment Act and its creation of PHC4 was a key precedent for creating greater levels of transparency on health care prices in the state. However, the law poses limitations as it is currently written. As such, there are a number of additional ways both PHC4 and the legislation that created it can further foster transparency in the Commonwealth.

¹² *ibid*

¹³ *ibid*

¹⁴ *ibid*

¹⁵ <http://www.phc4.org/council/docs/act3.pdf>

The Right-to-Know Law

Context

The Right-to-Know Law (Act 2 of 2008) establishes rules and procedures regarding the request and provision of information to the public.

Opportunities

The law applies to any local, legislative, and judicial agencies within Pennsylvania and stipulates that public records from these agencies shall be made available to the public, unless otherwise protected by law.¹⁶

Limitations

As referenced in the Health Care Cost Containment Act, payer discounts and allowances are considered confidential proprietary information and are not subject to disclosure. Specifically, section 708 of the Right-to-Know Law, entitled Exceptions for public records, subsection (b) part (11), exempts records that constitute or reveal a trade secret or confidential proprietary information from being accessible to those who request the information.¹⁷

Key Takeaways

The provisions of the Right-to-Know Law, in conjunction with the limitations set forth in the Health Care Cost Containment Act, create a significant barrier to public access to payer data.

Pharmaceutical Cost Transparency (Section 635.7)

Context

This is a proposed amendment to The Insurance Company Law of 1921 (Act of May 17, 1921) put forth by the General Assembly as House Bill 1042. This bill remains active and was referred to the Insurance Committee on April 21st 2015.

Opportunities

If enacted, subsection (b) of the amendment would require a prescription drug manufacturer of a drug with an average wholesale price (AWP) of \$5,000.00 or more, annually or per course of treatment, to file a report with the Insurance Department containing:

- Drug production costs, such as internal and external research and development costs;
- A cumulative annual history of AWP increases (percentages);
- A description of patient prescription assistance programs; and
- Any payments to hospitals and providers in excess of actual acquisition costs of the drugs.¹⁸

Limitations

While HB 1042 releases both health plans and government programs from the requirement to provide benefits for expensive prescription drugs for which the manufacturer has failed to file a report, it does not specify how else such a report can be leveraged.¹⁹

Key Takeaways

¹⁶ http://www.openrecords.pa.gov/Additional-Resources/Documents/pa_righttoknowlaw.pdf

¹⁷ *ibid*

¹⁸ <https://legiscan.com/PA/text/HB1042/2015>

¹⁹ *ibid*

These annual reports from drug manufacturers will undoubtedly be useful internal tools for containing drug spending, but more could be done with the cost and price information contained in them to help consumers gain access to the price information they need.

The Patient Medical Access and Affordability Act

Context

The Patient Medical Access and Affordability Act, put forth by the General Assembly as House Bill 774, would, among other things, establish pricing disclosures for certain health care providers.²⁰ This bill remains active and was referred to Health Committee on March 10th 2015.

Opportunities

Section 3, Pricing disclosures, subsection (a) would require individual health care providers to establish a set price (charges) for all services and supplies, as well as report these prices using the Healthcare Common Procedure Coding System and the diagnosis-related grouping system.²¹ Most importantly, HB 774 would require that these set prices be posted on a publicly accessible website.²²

Other notable provisions within HB 774 include the requirement in section 3, subsection (b) that third-party payers establish a fee schedule applicable to all covered individuals and post this fee schedule on a publicly accessible website.²³ As was the case with previously mentioned legislation, the Patient Medical Access and Affordability Act, if passed, would be a significant step towards greater price transparency in Pennsylvania.

Limitations

The requirements set forth under HB 774 do not apply to programs administered, regulated, or paid for by government entities including, among others, Medicare and Medicaid.²⁴ However, it is important to note that the Pennsylvania Employees Benefit Trust Fund (PEBTF), which administers health care benefits to eligible Commonwealth employees, retirees, and dependents, is not exempt from this Act.

Key Takeaways

The Patient Medical Access and Affordability Act provides an important foundational element to allow for greater transparency on health care prices. However, to be more effective at fostering price transparency in the state, HB 774 would have to apply to government-sponsored entities, such as Medicare and Medicaid.

Past Proposed State Laws and Regulations and Lessons Learned

The Fair Health Care Provider Contracting Act

Some of the legislation mentioned in interviews with key stakeholders focused on creating fair contracting practices between payers and providers. The perception among some stakeholders is that fostering price transparency between providers and payers, a component of fair contracting practices, will result in greater transparency for consumers. Essentially, if providers have access to accurate price information, they can encourage their patients to choose high-value care based on their insurance coverage. Thus, fair contracting practices can form a basis for consumer transparency.

²⁰ <https://legiscan.com/PA/text/HB774/2015>

²¹ *ibid*

²² *ibid*

²³ *ibid*

²⁴ *ibid*

Summary

House Bill 1763, the Fair Health Care Provider Contracting Act, was introduced in 2011 and sought to address perceived gaps in contracting practices.²⁵ Among other provisions, section 3 of the Act, entitled Availability of fee schedules and scheduled payment dates, sought to require payers to implement a plan to permit physicians to view, on a confidential basis, complete fee schedule information pursuant to their contract with the payer.²⁶ Section 18 of HB 1763, entitled Gag clauses, mandated that no payer could include provisions in its contracts with providers that limit:

- The free, open and unrestricted exchange of information between its physicians and its plan members regarding the nature of a member's medical conditions, treatment and provider options, and the relative risks and benefits and costs to the plan member of the options; or
- Whether or not the treatment is covered under the plan member's plan.²⁷

Although the House Insurance Committee held a public hearing on the bill in late 2011, HB 1763 never made it through the legislative process.²⁸ In a joint statement from the Department of Health (DOH) and the Pennsylvania Insurance Department (PID), both stated that while the provisions of HB 1763 “seek to address some of these technical issues surrounding contracting and reimbursement...the DOH and PID have a number of concerns with seeking a legislative remedy to business process issues between private parties...the Commonwealth should not seek to codify specific business operations or practices as this will limit innovation of the private sector in advancing new approaches to improve quality and control costs.”²⁹

Lessons Learned

According to key stakeholders interviewed, a key lesson learned from the failure of HB 1763 includes recognition of the power of politics and the role it plays in the Commonwealth. Powerful stakeholder groups with competing interests can form special interest lobbies that create strong barriers to the passage of consumer-friendly transparency legislation, such as HB 1763. However, this perception must be juxtaposed with the concerns expressed in the joint statement from the DOH and PID.

The Availability and Variation of Price and Quality Data

In the Commonwealth today, there are not enough available data on health care prices to make price transparency a reality. Similarly, quality data at the individual provider level are also lacking. Since we will explore the availability of price and quality data throughout this report, the focus here will be on the variation of price and quality of care in the Commonwealth.

A December 2015 study led by Yale University analyzed insurance claims data for individuals with private employer-sponsored insurance, as well as Medicare data, to determine the variation in health care spending and hospital prices throughout the U.S., within and across geographic areas.³⁰

²⁵ <http://berkscms.org/legislative-update-2/>

²⁶ <http://www.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=PDF&sessYr=2011&sessInd=0&billBody=H&billTyp=B&billNbr=1763&pn=2257>

²⁷ *ibid*

²⁸ http://www.insurance.pa.gov/Documents/112911_JOINT_STATEMENT_HB1763.pdf

²⁹ *ibid*

³⁰ http://www.healthcarepricingproject.org/sites/default/files/pricing_variation_manuscript_0.pdf?version=meter+at+null&module=meter-Links&pgtype=Multimedia&contentId=&mediaId=&referrer=https%3A%2F%2Fwww.google.com%2F&priority=true&action=click&contentCollection=meter-links-click

The study also sought to examine how these hospital prices influence variation in health spending on the privately insured, and to analyze various factors associated with hospital price variation.³¹

The study produced four main findings, one of which was that there is low correlation between total spending per privately insured beneficiary and total spending per Medicare beneficiary across geographic areas (hospital referral regions). Second, there is large variation in both overall inpatient hospital prices and prices for seven relatively common and standardized procedures including hip replacements, knee replacements, cesarean sections, vaginal deliveries, percutaneous transluminal coronary angioplasties (PTCAs), diagnostic colonoscopies, and magnetic resonance imaging (MRI) of lower-limb joints without contrast.³²

While the study did not examine Pennsylvania at the state level, it did a close examination of prices in Philadelphia. Health care price data for Philadelphia from the study shows that spending on Medicare patients is very high in this area (41st highest spending for Medicare out of 306 places), but spending on private insurance is relatively low (117th lowest spending for private insurance).³³

Furthermore, researchers found that wide variation in prices for care can occur within the same community, as well as between broader geographic areas. The study looked at prices for a knee replacement surgery at twenty-three hospitals in the Philadelphia area and found that in this area alone, the procedure can cost anywhere between \$12,400 and \$36,600, depending on which hospital is chosen.³⁴

In addition to huge variation in prices for certain health care services, quality of care is also variable in the Commonwealth. For instance, drawing from PHC4's 2014 Hospital Performance Report, in general the hospitals in Western Pennsylvania had significantly higher in-hospital mortality rates than the rest of the state for eight conditions, including pneumonia - aspiration, while Southeastern Pennsylvania had significantly lower in-hospital mortality rates than the rest of the state for ten conditions, including pneumonia - aspiration.³⁵ Results were similar for 30-day readmission rates, with hospitals in Western, Central and Northeastern, and Southeastern Pennsylvania having significantly higher or lower 30-day readmission rates than the rest of the state, depending on the health condition.³⁶

In summary, we know that there is uneven value across Pennsylvania that only greater transparency on quality and prices can reveal.

Conclusion

In reviewing the legal and regulatory landscape in the Commonwealth it is clear how certain laws and regulations lend themselves more readily as foundational elements to furthering price transparency than others. In the next section, the report will expand the lens and explore some of the bigger picture, best practices for price transparency from other states, as well as at a national level.

³¹ *ibid*

³² *ibid*

³³ http://www.nytimes.com/interactive/2015/12/15/upshot/the-best-places-for-better-cheaper-health-care-arent-what-experts-thought.html?_r=0

³⁴ *ibid*

³⁵ <http://www.phc4.org/reports/hpr/14/docs/hpr2014keyfindings.pdf>

³⁶ <http://www.phc4.org/reports/hpr/14/docs/hpr2014keyfindings.pdf>

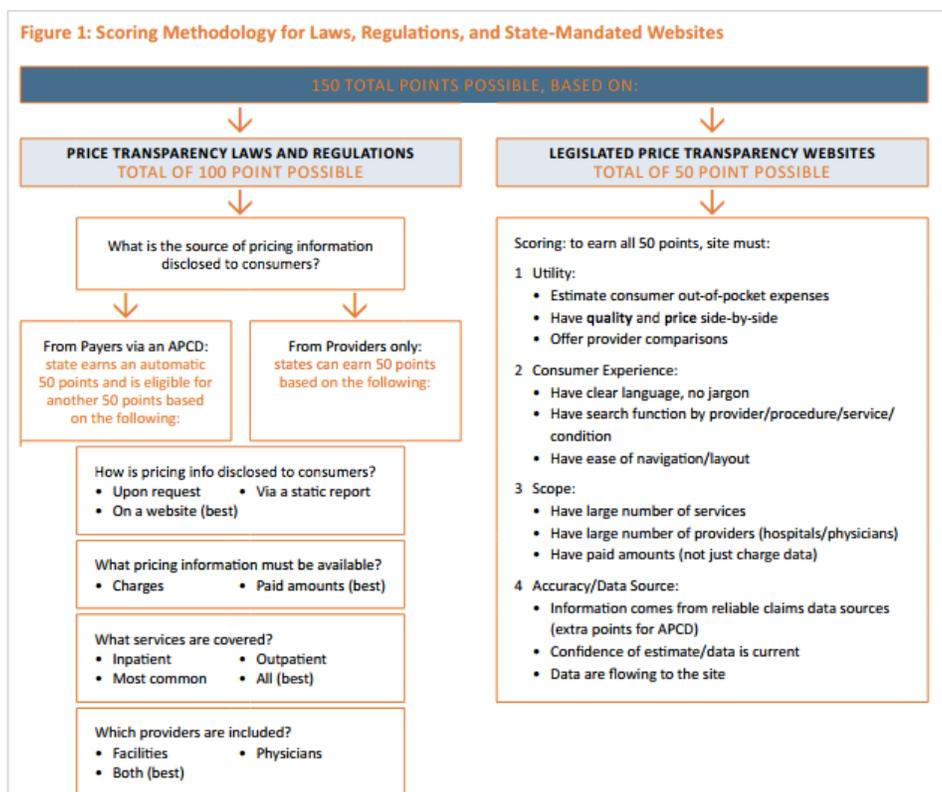
Section II: Leveraging Best Practices from Other States

Introduction

In its effort to make tangible progress toward advancing price transparency, the Commonwealth of Pennsylvania can benefit from understanding what practices other states have implemented and what they learned in the process. Beginning in 2013, Catalyst for Payment Reform (CPR) and the Health Care Incentives Improvement Institute (HCI3) have partnered to produce the Report Card on State Price Transparency Laws (Report Card), which applies a thorough evaluation framework and scoring criteria to determine which states have taken effective action to increase consumers’ access to meaningful price and quality data. Using this methodology, CPR identified states that are leading the country in enhancing price transparency.

Understanding CPR’s Report Card Methodology

A review of CPR’s Report Card methodology elucidates which actions and initiatives CPR deems to be “best practices.” The criteria and the relative weights assigned will continue to evolve over time to reflect the changing regulatory environment and overall landscape facing states. CPR and HCI3 grade each state on a letter scale; we base the state “grade” on an evaluation of both the price transparency laws and regulations and the state-mandated website, if one exists. CPR developed a standardized, rigorous framework to delineate the qualities in a law, regulation, or website that may best promote transparency in a state.



State Legislation & Regulations: Our Methodology

CPR and HCI3 examined and scored the statutes, enacted bills, and regulations in each state. We used WestLawNext database, the National Conference on State Legislature’s website, and websites from various state legislatures, among other sources, to research these laws. We used a search

string of terms including: hospital; health care; prices; charges; payments; reports; website; request; all-payer claims database, and others in the WestLawNext tool to identify relevant information.

State Legislation & Regulations: Rationale for Scoring & Best Practices

We have outlined the key rationale behind the decisions contributing to scoring and the determination of best practices below.

Source of pricing data: APCD vs. Other sources of data

CPR and HCI3 assessed the source of pricing data outlined by the law or regulation. CPR's methodology identifies all-payer claims databases (APCD) as a superior source of price information. Most APCDs contain data on what was actually paid for all services and procedures by commercial and public payers, including Medicaid. By collecting a broad range of claims data, states with APCDs benefit both from estimates reflecting large sample sizes and the ability to compare price and quality using multiple dimensions (e.g., provider, payer). Additionally, APCD's provide an independent, objective reporting mechanism based on a standard methodology for assessing cost, quality, and value.³⁷

In states without an APCD, price information typically comes from individual health plans or providers. Generally speaking, data supplied by individual health plans alone inherently reflects that single payer and access to the data is limited to its member population. Additionally, provider-supplied information is limited in that the data typically reflects what the provider "charges" for a service or procedure or the data only reflects a portion of the overall episode of care.

Method of delivering data to the consumer: Website vs. report vs. upon request

Almost equally important as the source and quality of the data is the mechanism for distributing it to consumers. In 2014, CPR and HCI3 automatically gave states the highest score if they require that pricing information be made available on a public website. CPR believes that websites make information searchable and easily accessible to consumers in real-time, and consumers may not be aware that pricing information is available through a report or upon request.

Types of prices made available: Paid amounts vs. charges

The type of price data made available has a significant impact on its usefulness. "Charges" are the amount that the provider bills for providing care. "Paid amounts" are the actual dollars paid to the provider for care received. There can be a wide discrepancy in the amount providers charge and the amount they are paid across Medicare, Medicaid, and private insurers. The release of Medicare charge data and paid amounts in 2013 illustrated the huge variation in what hospitals charge. A joint-replacement charge ranged from \$5,300 to \$223,000 depending on the hospital.³⁸ However, there was much less variation in what hospitals are actually paid, which is the relevant figure for consumers, as the paid amounts are set by statute.

Types of services made available: Outpatient vs. inpatient vs. both

It is important to assess the scope of services available for consumers. Depending on the service or procedure, patients may need care that is both inpatient and outpatient. Providing access to both allows consumers to understand the full cost of care and assess price and quality differences at different service sites, which can also be a significant source of variation. We gave the highest score to states that mandate that both outpatient and inpatient price data be made available.

³⁷ Appendix II, 2015 Report Card on State Price Transparency Laws, Catalyst for Payment Reform and HCI3

³⁸ <http://www.modernhealthcare.com/article/20130508/NEWS/305089960>

Types of providers made available: Facilities vs. physicians vs. both

Lastly, states that mandate that price information be made available for different levels of health care providers, such as facilities and individual physicians, demonstrate a commitment to providing comprehensive and actionable information to consumers. Like the previous section, by only mandating facilities, physicians or a subset of both, consumers are less equipped to understand the real scope of their health care options (e.g., sites of service) and what they will pay for each.

State-Mandated Websites: Our Methodology

We did a thorough review of state-mandated public websites to assess if the execution of the law was truly living up to the “spirit and letter of the law.” We learned that in some cases, states have robust laws or regulations regarding price transparency, but their implementation lags behind. North Carolina is an example of a state whose legislation mandated that price and quality information be made available “in a manner that is easily understood by the public,” but this has yet to translate to a meaningful, consumer-friendly site.

State-Mandated Websites: Key Rationale for Scoring & Best Practices

We used four categories to assess the effectiveness of each state-mandated website. We derived these criteria from the [CPR Specifications for the Evaluation of Price Transparency Tools](#).

Scope: The website should list a large number of services, provide information for physicians and hospitals, and have price information based on paid amounts so consumers can assess options available to them in the market.

Ease of Use: Consumers should be able to easily navigate the price transparency website. It should use clear language, without health care or legal jargon and offer easy, intuitive design, a straightforward layout, and a robust search function for providers, procedures, and conditions.

Utility: We assessed whether a website helps consumers understand value in health care and educates them on how to use the price information to make decisions. Sites that provided ranges or estimates of what the consumer will likely pay, price and quality information in combination, a value-rating, and provider prices side-by-side for comparison shopping were rewarded. Even the best existing websites have room for improvement; few if any have all of these features.

Accuracy / Data Source: Lastly, we assessed websites based on their ability to provide price information that was both accurate and from a reliable source. Therefore, the website’s data should be current (most recent 12 months) and prices should be based on a reliable source, such as APCDs, that provides data from multiple sources and allows for comparison.

Combining Scores for Laws, Regulations, and State-Mandated Websites

We gave each state a score specific to its laws and regulations and a corresponding letter grade, as well as a website score and a corresponding letter grade if they had a state-mandated website. We then combined these into an overall score and corresponding letter grade, placing greater relative weight on the underlying legislation than the website.

Spotlights on State Best Practices

When CPR and HCI3 first began assessing the level of price transparency across the country in 2013, almost all states received a failing grade. Year over year, there have been several states whose efforts to further transparency continuously stand out, and some that show new commitment to addressing their gaps. In 2015, New Hampshire, Maine, and Colorado each demonstrated the best practices we outlined above and can serve as valuable models for the Commonwealth of

Pennsylvania. CPR has also included additional insights and best practices from Colorado that contributed to its success.

New Hampshire

As the only state to receive an “A” in recent Report Cards on State Price Transparency, New Hampshire leads the charge among states for price transparency. New Hampshire has mandated the creation of both an APCD and a public, consumer-facing website.

- ✓ **In 2005, New Hampshire was one of the first states to pass legislation creating its APCD, the New Hampshire Comprehensive Health Care Information System (NH CHIS).**

The NH Insurance Department and the NH Department of Health and Human Services partnered to create and maintain the NH CHIS, which first began collecting data on paid amounts in 2005. The goals of the NH CHIS include facilitating continuous review of health care prices and utilization and empowering consumers and purchasers to make more informed decisions. The database includes data provided by insurers, purchasers, employers, providers, and state agencies.

- ✓ **New Hampshire mandates that data be collected from a wide scope of providers, including physicians and facilities across the state.**

New Hampshire is one of only a few states that mandates that price information for all physicians and facilities be made available on its website, which makes it much more likely that consumers will find information relevant to them as they consider their health care options in the state.

- ✓ **New Hampshire’s mandated website, [NH HealthCost](#), is one of the most consumer-friendly websites evaluated, increasing ease of use.**

NH HealthCost proved to be one of the most usable transparency websites provided by any state. The website features intuitive navigation and consumer-friendly language and provides great detail on its methodology for calculating cost estimates and also accounts for both insured and uninsured patients.

However, the site still has room for improvement. It only offers price information on a limited number of services and does not yet include quality information paired with price information for a particular service, which is one of our key criteria. Yet by creating demand for and access to price transparency data, New Hampshire has helped tilt its health care market in favor of the consumer.

Maine

In both 2014 and 2015, CPR and HCI3 gave Maine a letter grade of “B.” Beginning in 2003, Maine was the first state to collect data through its APCD, the Maine Health Data Organization. However, the state only made data publicly available through its first website in 2014. Since our most recent evaluation, Maine has launched the new user-friendly website [CompareMaine](#), which demonstrates significant progress in providing access to price information to consumers.

- ✓ **By mandating the reporting of paid amounts by a large number of commercial payers, Maine delivers accurate prices to its consumers.**

Maine has always prioritized the accuracy of price estimates by mandating the collection of paid amounts from over 89 sources of commercial claims data. In addition, CompareMaine provides the average cost of a service by facility and the overall state average. Additionally, the consumer is able

to obtain the average amount paid by his or her specific insurance company to the provider, which increases the relevance of the data for the consumer.

- ✓ **CompareMaine was designed to deliver complex price and quality information in a simple, usable fashion to consumers, increasing both ease of use and utility.**

In CPR's current, informal review of CompareMaine, it is clear that the state prioritized creating an easy-to-use website that provides consumers with access to side-by-side comparisons to facilitate informed decision-making. Users can search for procedures and services in plain language, and the site provides explanations of key terms. In addition to average cost, the site allows users to compare facilities by quality ratings and overall patient experience.

Colorado

Colorado was one of the only states to improve its grade between the 2014 and 2015 Report Cards, moving from a "C" to a "B" due to the launch of its new public website, [CO Medical Price Compare](#). Beyond its adherence to specific criteria from our methodology, Colorado provides a useful model for relying on stakeholder collaboration to pave the way for passing legislation and building an APCD. The Commonwealth can learn from Colorado's procedural experience as it approaches similar challenges.

- ✓ **Colorado established a clear business case articulating the need for transparency in price and quality data and set a vision for how the data would be used.**

Colorado succeeded in advancing price transparency in large part because they were able to create state-wide consensus around the need. Legislative leadership came forward to articulate that understanding costs in their state was paramount to improvement. In the process, the state was able to neutralize the politics of the topic by appealing to both sides of the aisle including conservatives, interested in creating a fair marketplace, and liberals, interested in understanding price and quality variation. Additionally, Colorado identified tangible benefits for stakeholder groups who may otherwise have been opposed, such as hospitals and providers, by offering the APCD as a principal way for hospitals to gain access to their own readmissions data.³⁹ The state created a clear vision that outlined why Colorado was prioritizing transparency and how the data would ultimately be used.

- ✓ **The multi-stakeholder APCD Advisory Committee provided the infrastructure for progress and accountability across a range of diverse interests in the state.**

Colorado's Center for Improving Value in Health Care (CIVHC), a non-profit organization, worked to coalesce support for the creation of an APCD from key stakeholders within the state. In 2010, Colorado passed legislation appointing CIVHC as the administrator of the APCD and allowed for the creation of an Advisory Committee to provide guidance on the implementation plan for Colorado's APCD. From 2010 to 2012, CIVHC and the Advisory Committee worked with stakeholders across the state, including commercial payers, to draft requirements and identify a technical solution. The Advisory Committee set specific milestones so the group was accountable for the timeline. The state also empowered Advisory Committee members to make collective decisions about specific components of the effort, such as reporting requirements across all relevant stakeholders.⁴⁰

³⁹ CPR stakeholder interview with Linda Greene, Vice President of Freedman Healthcare

⁴⁰ CPR stakeholder interview with Tracey Campbell, Vice President of Strategy & Business Development of CIVHC

- ✓ **Colorado incorporated sustainable revenue generation into the creation of the APCD, allowing for some degree of financial independence for the long-term.**

Due to the timing of Colorado's efforts, it faced challenges securing funding for the creation of the APCD. The legislation did not provide any state appropriation and there were no State Innovation Model (SIM) grants available. Colorado used private foundation funding to cover the start-up costs, but prompted the state to consider how its APCD could generate revenue to sustain itself. No APCD in the country is entirely self-sustaining, but Colorado's model is the furthest along in using the data collected to generate income by selling it to health care stakeholders (e.g., hospitals, vendors, etc.).⁴¹ This may be of interest to states facing budgetary challenges.

Key Takeaways

The central goal of reviewing the best practices of other states is to provide an understanding of the methodology used for assessing progress and how the Commonwealth of Pennsylvania may learn from other successful models. There are several high level takeaways we would like to call out that may help the Commonwealth in applying best practices to its own efforts.

- ✓ **Identifying a relevant business case for price transparency in the state is an important step to gaining widespread stakeholder buy-in and removing political barriers.** Examples of narratives used by other states include: "waving the flag" on behalf of consumers, exposing variation in price, and linking price transparency to achieving the "triple aim" (price, quality, access) in health care.
- ✓ **Legislation calling for the creation of an APCD should be specific and lay a strong foundation for multiple uses of APCD data, including a public facing, consumer website.** The ultimate goal in price transparency efforts is to make the quality and price data available in a useful fashion to a range of audiences with various needs.
- ✓ **A law is likely necessary, but not sufficient on its own.** Some states have made legislative advancements, but then fail to make tangible progress in state-wide transparency. Passing legislation is a helpful impetus, but does not guarantee an end result. Conversely, states could bypass the legal step and create a website based on voluntary participation, but this is unlikely to produce the breadth of data required to benefit consumers.
- ✓ **There are multiple characteristics of a database or a website that can significantly enhance or diminish its effectiveness.** For example, paid amounts, not charges, are the most useful for consumers. Offering a breadth of services and providers is also key.
- ✓ **Even the "best" have room for improvement.** Both the landscape and the supporting technologies underlying this area of health care will continue to evolve quickly. We have identified relevant best practices that help serve as a model, but even the best states demonstrate areas that can be improved upon in coming years and are continuously making advancements.

⁴¹ CPR stakeholder interview with Linda Greene, Vice President of Freedman Healthcare

Section III: Evaluation of Health Plan Transparency Tools

Introduction

In CPR's experience, most health plan and vendor transparency tools are primarily available to health plans' insured members in the commercial market. The six health plans included in this report represent roughly 92 percent of commercially insured lives in the Commonwealth⁴². It is important to note that while consumers in the commercial market appear to have access to transparency tools, not all citizens in the Commonwealth have access to these tools. In fact, 18 percent of Pennsylvanians are covered either by Medicaid or some other public coverage and 8 percent are uninsured.⁴³

CPR worked with willing health plans to review the current state of their health plan transparency tools available to their insured members in Pennsylvania. While the scope of their impact on the consumer landscape is inherently limited (i.e., tools are only available to members and based on plan-specific data sets), these tools are still an important asset for many consumers making decisions about where and how they receive care based on price and quality data.

Health Plan Participation

With the support of the Governor's office, the Department of Health (DOH), and the Pennsylvania Insurance Department (PID), CPR distributed a request for information to seven prominent health plans in Pennsylvania, as identified by the DOH and PID, inquiring about their willingness to participate in our assessment of health plan transparency tools for the Commonwealth. CPR informed prospective participants that it would not distribute plan-specific information in any public forum, nor compare the plans' tools or any strengths or weaknesses side-by-side in the final report.

All seven health plans in Pennsylvania expressed a willingness to participate in our project. However, some plans were not able to participate fully in various parts of the project due to lack of resources and bandwidth or because they had tools that were not yet live and/or still in the procurement phase. Ultimately, CPR was able to secure full participation from six plans.

Some health plans included their vendor partners in the process. For instance, in some cases, health plans and their vendors both participated in a live demo of their transparency tool. This allowed the vendor to demonstrate the full range of capabilities available to the plans they work with, as well as the specific features in the health plan's current tool and in the future roadmap.

Data Collection & Assessment Methodology

CPR worked with health plans to collect data using two different methods.

Transparency Questionnaire & Health Plan Submissions

CPR created a custom Transparency Questionnaire for health plans that built off of prior work by CPR to evaluate transparency tools. The questionnaire assesses five categories that impact tool effectiveness. These categories include:

- ✓ **Scope:** Criteria that help assess whether a given tool possesses an adequate breadth of information and features.
- ✓ **Quality:** An assessment of the quality measures used to generate quality scores against CPR's Priority Measure set and the education available for users about the quality and

⁴² Based on approximate covered lives data from the Pennsylvania Insurance Department.

⁴³ <http://kff.org/health-reform/fact-sheet/the-pennsylvania-health-care-landscape/>

- appropriateness of services and the relationship to cost.
- ✓ **Price Accuracy:** Criteria to gauge the accuracy and breadth of the price information provided to users.
 - ✓ **Usability:** An assessment of the tool based on its usability, including search functionality, user-friendly design, and accessibility of customer service.
 - ✓ **Engagement:** An assessment of the methodology for measuring consumer use of the tool, consequent changes in consumer behavior, and the level of support provided.

Health plans submitted the completed Transparency Questionnaire with supporting documentation as needed, including screenshots or supplementary data. CPR worked with health plans throughout the process to answer any questions and streamline the submission process where possible.

Live Demonstrations of Health Plan Tools

Health plans also provided live demonstrations of their tools for CPR, which helped us substantially in our assessment of the Usability category and provided a hands-on understanding of the supporting features built into the tools. Finally, the demonstrations also helped see how tool designs vary, creating user experiences that emphasize different components of the “shopping” experience.

Assessment Methodology

Following submission of the completed Questionnaires, CPR conducted a thorough assessment of each health plan tool by reviewing their responses to the Questionnaire, validating answers provided with screenshots and other supporting documentation, and cross-referencing information obtained from the live demonstrations. We provided a summary of how tools compared to CPR’s price transparency criteria so the Commonwealth can understand how tools performed at a high-level, along with a more detailed write up of specific strengths, gaps, and differentiators identified in the evaluation process.

Aggregate Summary of Health Plan Responses

The table below provides a high-level summary of the criteria CPR used to assess each health plan tool, broken down by category, along with indicators of how health plans performed. The color coded indicators denote whether a criterion was met by all health plans (i.e., green), only some health plans (i.e., yellow), or no health plans (i.e., red). Please note, “yellow” indicates that anywhere from one to five health plans may have met the criterion, but that there are still gaps somewhere in the market.

Table 1: Summary of CPR Assessment Criteria and Proportion of Tools Meeting the Requirement

SCOPE	
Reported percentage of shoppable services (those that are non-emergent).	●
Reported access to the tool by product type and geography.	●
Tool includes provider directory and related information.	●
Tool includes information on select services.	●
Tool includes detailed, provider information.	●
Tool displays user's financial liability in real time (refreshed every 30 days) including deductible, copay, rewards or cash bonus, OOP maximums, savings and account balances.	●
Tool accommodates a variety of benefit and network designs.	●
Tool provides for all levels of data security including encryption and compliance with all applicable state and federal laws and regulations.	●
QUALITY	
Tool displays measures from CPR's Priority Measure Set (either displays or incorporates into provider's quality rating).	●
Provided additional measures that the tool displays.	●
Shows user-generated reviews (e.g. reviews posted on the site as comments or stars, etc.).	●
Provides an average rating for individual providers on the tool.	●
Identifies providers with special recognition by health plans or whether they are part of a particular tier, such as a tiered network.	●
Tool shows quality information on the same display as price estimates.	●
Tool combines quality and price into an overall value rating.	●
Tool helps users identify potentially unneeded care (e.g. Choosing Wisely campaign).	●
Tool educates the user about what care is recommended based on their health status and conditions (e.g. recommended diabetes care).	●
Tool identifies care that is underused by users and inform them that this care may be necessary to maintain good health.	●
Tool displays the average wait time between scheduling an appointment for care to having the appointment.	●
PRICE ACCURACY	
<i>User Education</i>	
Tool shows the user's share of the cost (the deductible, copay, coinsurance).	●
Tool shows the total amount paid to the provider, through a combination of the amount paid by the user and the insurer.	●
Tool educates the user about the fact that higher prices may not indicate that the care is higher quality or that lower prices may not indicate lack of quality.	●

<i>Episodes</i>	
Tool shows prices for episodes of care.	●
Episodes of care for which the principal site of service is the hospital use ICD10 procedure codes.	●
Users alerted to potential additional costs that may be associated with the episode.	●
<i>Data</i>	
Has a minimum number of data points required to display price estimates.	●
Tool includes a "confidence interval" with the price estimate, explaining the range of possible prices in user friendly terms.	●
Tool discloses to users which providers' price information cannot be displayed due to contractual restrictions known as "gag clauses."	●
Tool shows prices that reflect the most recent negotiated fees.	●
Provided the percentage of price estimates provided to users accurately predict the actual cost for entire episodes of care.	●
USABILITY	
Tool has a search function.	●
Users can search by categories such as services, procedures, physicians, facilities, other.	●
Users can input preferences, such as location, price, quality, gender of physician, language, etc.	●
Tool comes with access to online or telephonic customer service.	●
Tool offers users the option to provide feedback about the tool.	●
Tool is at middle school reading level.	●
ENGAGEMENT	
<i>Communication and Support to Encourage Engagement</i>	
Plan/vendor offers communication support to employers or other purchasers to encourage their members to use the tool.	●
The communication support is included in the price of the tool.	●
Plan/vendor supports various ways provide to encourage member use of the tool.	●
Health plan/vendor encourages health care providers to use the tool with their patients.	●
<i>Tool Accessibility</i>	
Tool can be accessed both through the web and mobile devices	●
Tool can be accessed from the employer's website or intranet home-page.	●
<i>Tracking Utilization and Performance Guarantees</i>	
Plan provided a methodology that is used to measure utilization of the tool (e.g. tracking registration, repeat users, compare against claims).	●
Health plan/vendor tracks changes in where users seek care, or what services they are seeking or receiving, as a validation of its engagement strategy.	●
Health plan/vendor has results to share about changes in user behavior resulting from use of the tool.	●
Plan provided the most current information on eligible users, registered users, registered users who have conducted more than one search, and users with medical claims who used the search function.	●
Health plan/vendor agrees to performance guarantees on the percent of users that will use the tool.	●
Plan provided promised utilization rates.	●
Plan provided the percent of customers that have met the promised engagement goals.	●

Assessment of Strengths, Gaps, and Differentiators

CPR observed meaningful strengths, gaps, and differentiators in our assessment that are worth sharing. We classify a “strength” as a requirement that the majority of tools are successfully addressing today and a “gap” as an area where there is consistent room for improvement across all tools. Note that even if some tools partially addressed the requirement, CPR may still have classified the area as a gap. “Differentiators” represent areas where a specific tool demonstrated a meaningful capability that sets it apart from the market.

Strengths across health plan tools

Over the last several years, both health plans and vendors have made significant progress in advancing the quality and features of their tools for consumers, so we were not surprised to find that the transparency tools available today are meeting many of the most critical, foundational criteria.

Scope of information included in the tools

Each tool CPR reviewed performed well in regards to scope. Each provide sufficient access and breadth of information to meet a consumer’s need when shopping for care. Health plans are making progress in increasing the percentage of shoppable (non-emergent) services included, along with specific providers, facilities, select services, and a host of detailed provider information. None of the tools yet offer information related to the average time between seeking appointment and when appointments are scheduled, which signals an area needing improvement.

Note: there was significant variation among the six plans in the percentage of shoppable services they claimed that their tools contained. However, with the exception of two tools, one of which displays only 5.3% of shoppable services, the other health plans reported that their price transparency tools included at least 50% in one case, up to 100%. We feel there is an opportunity to clarify the definition of a “shoppable service” to create greater consistency across health plan tools’ reporting.

Accommodation of narrow networks or tiered benefit designs

Most tools currently accommodate narrow networks or tiered networks of providers. As health plans and payers increasingly use these benefit and provider network designs, transparency tools will be a vital resource for helping the consumer understand which providers are in-network and the cost and quality trade-offs associated with their choices. Five of the tools denoted specific tiers of providers, or displayed which providers were designated as in-network for the consumer, and all six identified providers with special recognition by health plans. Five out of six tools provided some link to quality information about specific providers. Note that the breadth, depth, and user-friendliness of the data varied tool by tool.

Display of relevant price data and financial liability

For price transparency tools to be valuable to a consumer in decision-making, the tool needs to display accurate and up-to-date information about the price of services and a user’s personal financial liability as it relates to their benefit plan. CPR was pleased to see that each plan has invested in displaying a real-time breakdown of a user’s cost (including deductible, copay, coinsurance, and out-of-pocket max), as well as what is paid for by the plan in a clear fashion. Additionally, most tools provide information on the range of prices in the market or an average market price for procedures or episode of care.

Usability and intuitive design for the consumer

All health plan tools performed well in the Usability assessment. Health plans and vendors have designed tools that are user-friendly and consumer-oriented and offer advanced search functionality, a foundational criterion in the Usability category. Users are able to search based on numerous inputs (e.g., providers, services, or procedures) and filter based on a range of preferences (e.g., location, price, gender of physician), helping consumers narrow down options based on shopping preferences. Lastly, all tools are at an appropriate reading level (middle school level) to help ensure consumers understand the information presented.

Gaps across health plan tools

Lag in integration of specific quality data across tools

Quality is an early and emerging area in price transparency tools in the Commonwealth, and all health plans expressed a desire and willingness to improve this component of their tools. Today, each health plan tool links to general quality data from various sources (e.g., internal quality data, Leapfrog Hospital Grades, HCAHPS, NCQA, WebMD), but there is little success thus far at making specific quality metrics about the procedure, service, or provider available to consumers, along with their price estimate.

When comparing the general quality data provided by current tools to CPR's Priority Measure Set⁴⁴, health plan tools proved to be lacking across the board with an average of 5 priority measures addressed in any capacity out of 30 priority measures.

Given the challenges associated with this data, it is no surprise that tools are not yet combining cost and quality into a value rating for consumers, which CPR deems a critical feature. Some health plans attempt to address this gap by offering "Distinction" or "Special Recognition" to providers who meet high quality and cost standards. However, health plans do not always explain their designations in a way that consumers understand, and there is no consistency across health plans regarding which providers they recognize. For example, one tool notes that providers with Distinction either have demonstrated cost efficiency along with high quality *or* in the absence of quality data, just cost efficiency. In addition, consumers may not understand the difference between Tier One, Distinction, or Special Recognition.

All drug estimates provided outside of cost estimator tool

All of the health plans are committed to providing estimates of pharmacy costs, but today, they are only offered through separate tools or separate vendors. During the live demonstrations, CPR observed how a user could navigate from the price transparency tool to the pharmacy estimation tool and assess general usability. Many of these pharmacy tools demonstrate some of the same advanced capabilities CPR identified in its questionnaire (e.g., facilitating easy searches, alerting users to lower cost generics, allowing side-by-side price comparison). However, the fact that drug pricing is not incorporated into the tool providing prices for health care services makes it difficult for the consumer to assess how pharmacy drugs impact their total cost of care for a particular episode. Additionally, because the tools are separate, health plans are likely to experience incomplete searches as consumers try to navigate multiple tools. It is worth noting that at least one health plan indicated that incorporating drug prices is on its roadmap for 2016.

Minimal effort to educate consumers about how to shop for care

CPR found that while tools have demonstrated the ability to offer consumers an increasing amount of provider and price information, there is a gap when it comes to decision support and user

⁴⁴ CPR's Priority Measure Set is based on measures identified as areas of highest spend for purchasers where there is also significant variation in cost and/or quality.

education about value and appropriateness of care. One of the key criteria CPR evaluated when viewing the live demonstrations was “How easy is it for the consumer to identify the best care option for his or her condition?” All of the tools can find ways to better help consumers make an educated decision about the best care option based on the price data provided.

Limitations to accommodating innovative benefit designs

CPR observed that most of the tools have built in features to accommodate narrow or tiered network benefit designs and some plans are beginning to accommodate other benefit designs, including centers of excellence and reference pricing. However, no health plan tool demonstrated the ability to accommodate all of the benefit designs in our Questionnaire (i.e., tiered/narrow networks, centers of excellence, reference-based pricing, and value-based insurance design). This is not necessarily a “ding” on the current state of health plan tools today, as we expect tool capabilities to evolve with the benefit designs that are most prevalent for each population of users.

Lack of performance guarantees for utilization of the tools

We felt it was noteworthy that none of the vendors serving health plans yet provide performance guarantees related to rates of consumer use of the tools; there is little accountability for consumer engagement making it difficult to assess whether these tools produce the intended outcomes, much less the cost savings or return on investment, that health plans or vendors promise.

Differentiators between health plan tools:

One of the most important outputs from CPR’s assessment was an understanding of how specific tools incorporate features that differentiate them from the other tools. These are areas where we observed a meaningful difference among the tools and identified how specific plans are leading the pack regarding transparency. These differentiated features may signal how transparency tools will evolve and can help the Commonwealth identify what features together would create a leading model.

Differentiators that enhance a consumer’s understanding of price accuracy

Most of the tools currently provide users with price estimates for care based on the range of prices in the market or the overall market average price. However, there is variation among tools in how much additional information they provide to help users understand that estimate in context.

- Two tools track whether their price estimates accurately predict the cost of care through various methodologies including auditing and data analysis, while the other tools have not yet developed a methodology for evaluation.
- Two tools provide the user with the range of potential prices in user friendly terms, while the other tools provided a disclaimer alerting users that there may be additional costs associated with the estimate. CPR feels that displaying a range is more effective because users can quantify potential variance.
- One tool currently discloses to users which providers prohibit the health plan from displaying their price information due to contractual restrictions known as “gag clauses.” Having this information enables consumers to understand the true barriers preventing price transparency, to put pressure on their providers to display their prices, and/or to seek care from providers who make their costs known beforehand.

Differentiators in explaining an episode of care to the user

Some tools did an outstanding job at breaking down for the user what is included in an episode of care, which helps the consumer understand the complete set of services they will get for a given price.

- One tool offers a very clear visual breakdown of the expected timeline associated with each phase of the episode (e.g., evaluation, surgery, follow-up) and the average price for each service that a patient is likely to receive during each phase.
- One tool provided a clear grouping of services by episode and a detailed breakdown of specific costs, but the user had to navigate further to locate it.
- Two tools currently use ICD10 procedure codes for episodes of care for which the principal site of service is the hospital. Using ICD10 codes can create more accurate definitions of an episode of care than Diagnosis Related Groupers (DRGs).

Differentiators that impact overall engagement

All health plans demonstrated commitment to driving increased utilization through various engagement methods, including targeted communications, online classes, and onsite trainings. Having only reviewed samples of content, CPR is not in the position to determine any best practices or meaningful differentiators here. However, we did take note of several features and strategies that set health plans apart when it comes to engagement strategy.

- Two health plans have implemented robust methods of measuring utilization and engagement, along with cost savings associated with the use of the tool.
- One health plan encourages providers to use a version of their tool with patients, which could not only have material influence on utilization of the tool, but could also enhance shared decision making and the doctor-patient relationship.
- One health plan encourages member use of their tool through social media driven annual engagement campaigns supplemented with rewards, such as prize drawings.

Differentiators that add meaning for consumers

Some tools included features that add meaning and insights for consumers when they are shopping for care.

- Three tools show user-generated reporting on their sites in the form of qualitative, written reviews and/or aggregated star ratings. Familiar and trusted, user-generated reviews, which many consumers are accustomed to from websites like Yelp, offer consumers first-hand accounts of provider experiences to complement health plan designations and allow the user to quickly compare numerous providers based on a rating, in addition to diving deeper into the qualitative experience.

Conclusion

By evaluating some of the most prominent health plan transparency tools available to consumers in the Commonwealth, strengths, gaps, and specific differentiators were identified across these tools. In the following section, the report will explore both gaps and opportunities for improving transparency in the Commonwealth, drawing on key findings from the previous sections, as well as insights from key stakeholders.

Section IV: Opportunities and Gaps

Thus far, this report has provided an overview of the legal and regulatory landscape in Pennsylvania, reviewed the price transparency best practices of other states, and assessed the capabilities and features of health plan/vendor transparency tools available in the Commonwealth. This section summarizes the takeaways and identifies gaps and opportunities in price and quality transparency in the Commonwealth.

Transparency Movement Not Clearly Articulated

Gap: No Clear Vision for Transparency in the State

The key stakeholders we interviewed could not recall elected leaders in the Commonwealth offering a clear vision for how they hope to enhance price transparency for consumers in the Commonwealth or what that would mean. For instance, some health providers might see greater price transparency as having fair contracting laws and/or empowering providers to help consumers manage costs. Others, such as payers, may prefer a consumer self-driven, value-oriented approach to transparency. Based on the lessons other states learned, the Commonwealth would do well to create and put forth a vision for transparency that also defines what data it needs, how it and others will use the data, and how those who provide the data gain value in return.

- ✓ **Opportunity:** The Commonwealth has a unique opportunity to lead the development of the vision for price transparency. By defining transparency, what is needed to achieve it, and how it can be used to improve health care in the state, the state can work with stakeholders to set goals for price transparency and take steps to achieve them.

Gap: Consumer Demand is Not Yet There

There is a perceived mismatch between the desire for transparency at the state level and the demand for transparency coming from consumers. While this is not unusual or unique to the Commonwealth, many stakeholders noted that consumers have not yet created sufficient demand in the marketplace for transparency; others felt that consumers cannot demand something if they are unaware it exists. Furthermore, this lack of consumer demand contributes to an underwhelming legislative push to pass price transparency related bills. However, some stakeholders noted that this might change now that consumers are selecting health insurance products with higher deductibles that require them to shop for care. Others expressed that high deductible health plans (HDHPs) have pervaded the market enough and there is a “quiet desperation” on the part of consumers, rather than an active appetite for price transparency. Supporting these opinions is the fact that health plans and vendors offering transparency tools in the Commonwealth are not seeing high levels of engagement with their products.

- ✓ **Opportunity:** This presents an opportunity for all stakeholder groups to renew and reinforce their efforts to engage consumers, help them understand why price transparency is an issue that directly affects them, and why more transparency is needed for a robust health care market. For instance, some hospitals have taken the initiative to build out their own transparency tools; if their efforts are successful, a provider-based tool could hold legitimacy in the eyes of the consumer and be seamlessly integrated into a search for care. However, a critical mass of data is required to make the tools effective and accurate, as consumers need to be able to access price and quality data from multiple hospitals in order to compare their options. In addition, there are opportunities for increased communication between health plans and members to help people understand the financial components of coverage and that some price information is available via transparency tools. High member utilization of available tools

can better arm consumers with the information they need to shop effectively for care; however, it is important to note that these tools are generally restricted to member populations. Moreover, if consumers using plan provided tools feel their need has been met, and these consumers represent a significant portion of the population in the Commonwealth, then widespread consumer demand for public-facing transparency tools may not materialize.

Political and Legal Environment

Throughout our review of the Commonwealth's legislative history and during interviews with key stakeholders, we consistently heard how the political environment in the state serves as a barrier to progress on price transparency. We identified the following gaps and opportunities related to this challenging, but essential, area.

Gap: Political Stalemate Can End Up Preserving the Status Quo

Pennsylvania is currently divided between powerful stakeholder groups including payers, providers, consumer advocacy groups, the legislature and the state government generally. Each stakeholder group seems to envision a different path forward and timeline for the advancement of price transparency in the state. Because of continuing divergent views, there has been little alignment of interests around what next steps should be taken by the Commonwealth.

- ✓ **Opportunity:** The striking differences across stakeholders' interests present a unique opportunity for the Commonwealth to lead transparency efforts and bring stakeholders together, a process that the Commonwealth has notably already initiated. The Commonwealth should draw on the experience of other states, which faced similar divergent interests and managed to build consensus by highlighting shared goals across the healthcare industry (e.g., the Triple Aim). One factor contributing to the success in Colorado, for example, was convening an Advisory Committee and setting specific, public milestones and goals for transparency. This encouraged a problem-solving attitude and stronger accountability for all parties to contribute to a solution, as opposed to blocking progress.

Gap: Appetite for Risk is Low Given the Perceived Precarious Political Climate

Due to the strength of all of the various stakeholders in the Commonwealth, influential lobbies can exert strong pressure on the legislative process, which affects the path of certain pieces of legislation. As a result, many stakeholders expressed hesitancy to trying to create sweeping changes to price transparency via legislation. However, many stakeholders are not willing to participate in voluntary transparency efforts either, as they perceive participation as too risky.

- ✓ **Opportunity:** Addressing this gap fundamentally ties back to whether or not the Commonwealth can shift the political dialogue in the state to be more collaborative and forward-thinking. Many of the stakeholders we interviewed expressed an interest in and willingness to further price transparency and came to the table with tangible ideas for how to make progress, but felt limited by the larger political circumstances and the risk aversion such an environment creates.

Gap: Opposition to Additional Regulations

There is a general wariness about increasing legislative and regulatory burdens on various industries in the Commonwealth. These sentiments are magnified by uncertainty around the value proposition for the collection and use of price transparency data. Until the potential impact is clarified with a larger vision for the state's path forward, there will likely continue to be opposition to additional regulations. Some feel that the legislative and regulatory burden can be lessened through a more equal distribution of responsibilities. For instance, while health plans tend to be the

source of the most data (because most information is claims based), there may be data that health care providers can provide. However, even if responsibilities are more evenly shared across stakeholders, there isn't a clear path to or evidence of better value for any of them.

- ✓ **Opportunity:** The previously mentioned opportunity for the Commonwealth to provide leadership on the vision for price transparency would help to resolve many of the gaps identified here. A shared understanding of the roadmap for transparency can help to condition stakeholder expectations regarding future initiatives, and lessen the perception of burdens. In addition, demonstrating the value proposition for price transparency can make efforts to further it more palatable among many stakeholders.

Gap: Existing Transparency Laws Are Not Sufficient

Three of the most prominent laws regarding transparency in the state (the Health Care Cost Containment Act, the Right to Know Law, and the Patient Medical Access and Affordability Act) are strong foundational pieces of legislation, but do not alone pave the way for furthering price transparency in the Commonwealth. For instance, there are limitations to the PHC4 charter as it is currently written, and the perception by stakeholders is that discussions focused on expanding the charter quickly become politicized and polarizing. In addition, the Right-to-Know Law is not entirely relevant to health care price transparency and considers some key elements of transparency data to be protected from disclosure requirements. Lastly, the Patient Medical and Affordability Act does not apply to large state programs like Medicare and Medicaid, cutting out significant portions of the market.

- ✓ **Opportunity:** Although they are not sufficient as written, current laws provide an excellent legal foundation from which to build; the Commonwealth has the opportunity to fill the legal gap by introducing new transparency legislation that complements them. For instance, PHC4 could be granted the authority to use the data it already collects in more dynamic ways, such as producing direct price and quality comparisons for health care services and providers, rather than aggregate reports. Another example would be to rescind the status of payer discounts and allowances as exempt, confidential proprietary information under the Right-to-Know Law.

Budgetary Concerns

Gap: Politically Charged Budget Discussions Present Continual Challenges for Renewing the PHC4 Charter and Stifle Progress

Politically charged budget discussions as described by stakeholders create a large gap for price transparency efforts in the state. Specifically, renewal of the PHC4 charter tends to turn political, as various stakeholders seek to use the renewal of the charter to enact new legislation and leverage the organization in different ways.

As mentioned previously, perceptions that the political climate is precarious have resulted in the traditional operational strategy of PHC4 stakeholders going into charter reauthorizations to be to maintain the status-quo and to not seek any sweeping changes to the bill. In other words, it may be that PHC4 is reluctant to take a direct stance on policy matters, including transparency, or seek expanded responsibilities or changes to its charter because the entity has repeatedly had difficulty securing budget reauthorization.

For instance, PHC4 was late to be reauthorized in 2003, and then again in June 2008, due to unrelated political disagreements in which PHC4's legislation became entangled. At a high-level, late in the legislative process, the Senate added an amendment that would reinstate the Medical Care

Availability and Reduction of Error Act (Mcare). Mcare is the Commonwealth's medical malpractice insurance abatement program. Although some stakeholders and politicians were pleased with the addition, others were highly dissatisfied and pushed back strongly against passage of the bill as it stood at the time. Administrative and political complexities ensued and the bill was held indefinitely in the House without a vote. PHC4 was finally reauthorized in November 2008 via an executive order issued by the Governor. The final reauthorization bill excluded the Mcare amendment.

Although PHC4 has been described as the "jewel of the state," continued difficulties in passage of the PHC4 charter may be a reflection of differences in how each stakeholder values and seeks to leverage the organization regarding its role in fostering price transparency. Furthermore, because the organization and its endurance are valued by so many, it is at risk of becoming a centerpiece in political conflicts, as occurred in 2008.

- ✓ **Opportunity:** There is strong consensus that PHC4 should play a central role in the state regarding transparency, even though various stakeholders may not agree on how to leverage the organization to this end. The opportunity presented here is that the Commonwealth has the opportunity to justify the expansion of PHC4's charter, to keep the organization up to date with consumers' needs. For instance, given the data it currently collects via its mandate, many stakeholders expressed a desire for PHC4 to house an APCD. However, it is important to note how the reauthorization of the organization can become highly politicized.

Gap: Limited Budget Can Restrict PHC4 Activities

In addition to the legislative challenges facing PHC4, particularly with charter renewal, the organization is also constrained financially, due both to uncertainty around renewal of funding as well as funding levels that are only sufficient. This allows the organization to fulfill its mission to collect data and produce reports, but does not leave room for any additional activities. For instance, if the Commonwealth envisions PHC4 as the entity responsible for directly housing an APCD, then organizational funding would need to be raised to match increased expectations. However, as previously noted, discussion on the budget and reauthorization of PHC4 has been highly political in nature, presenting a real barrier to meaningful changes to the organization.

- ✓ **Opportunity:** If the Commonwealth decides to expand the responsibilities of PHC4 to include additional price transparency initiatives, then this also presents an opportunity (or a need) to increase the amount of funding and resources devoted to the organization, to increase its capacity and bandwidth for future endeavors.

Conclusion

Having reviewed the big picture opportunities and gaps in price and quality transparency, supplemented with information from key stakeholders, the last section of the report will provide recommendations for furthering price transparency in the Commonwealth.

Section V: Recommendations

Throughout this report, we highlight key takeaways, potential legislative solutions, best practices from other states, and opportunities based on existing gaps. This section distills these items into a set of long-term, mid-term, and short-term recommendations. The recommendations are ordered this way to help the reader understand the end points up front and move to tactical starting points.

CPR recognizes that there may be political, budgetary, and/or regulatory issues that may interfere with implementation of certain recommendations. Other recommendations may have fewer constraints and a more direct impact on the citizens of the Commonwealth. We defer to the Department of Health, the Pennsylvania Insurance Department, and stakeholders to determine the feasibility of these recommendations and identify the best path forward for the Commonwealth.

Long-Term Recommendations

The first four recommendations below relate to the creation of an APCD. CPR provides high-level recommendations and defers to the APCD Council, which has been retained by the Pennsylvania Department of Insurance, for specific legislative language and recommendations of other uses of APCD data. The final recommendation suggests an amendment to the state's Right-to-Know law.

- ✓ Introduce and pass legislation calling for the creation of an APCD. While the Commonwealth could consider the creation of a voluntary APCD, in other states these have failed to produce price and quality transparency. Therefore, legislation is usually required.
- ✓ Develop stakeholder-specific business cases. To garner support from stakeholders for the creation of an APCD, we recommend that relevant business cases be developed so individual stakeholders understand the specific value of an APCD to them.
- ✓ Write specific legislation. The legislation should be specific and lay a strong foundation for multiple uses of APCD data, including a public-facing, consumer website. There are many states with APCDs that limit the use of the data. If the APCD is prohibited from using the data it has collected to power a public-facing website, the Commonwealth would miss an opportunity to support its citizens with consistent, reliable and relevant data.
- ✓ Permit display of specific data. Legislation should explicitly permit the display in a public-facing website of the following:
 - Paid amounts, not charges
 - Inpatient and outpatient services and prices
 - Price and quality information on facilities and individual physicians

Mid-Term Recommendations

The following recommendations focus on PHC4, which is a unique resource in the Commonwealth. This existing resource can be leveraged in new ways to help advance price transparency without creating a new entity.

- ✓ Insulate PHC4 from political pressures. The Commonwealth should seek to protect the state agency from political actions that are unrelated to the direct function and mission of the agency. As long as PHC4 is put in the middle of legislative debates that are not directly related to its mission, it is not able to function at its highest capacity on behalf of the citizens of Pennsylvania.
- ✓ Grant additional authority to PHC4. Through the appropriate legislative and/or regulatory channels, CPR recommends the expansion of PHC4's authority to use the data it already collects in more dynamic ways. Such an expansion includes producing direct price and quality comparisons for health care services and providers, rather than only aggregate reports.

Short-Term Recommendations

CPR recommends the following items because they are practical, non-legislative solutions to improve price transparency in the Commonwealth.

- ✓ Rally around a vision for price transparency in the state. Even if the vision is known by executive, regulatory, and legislative leaders in the Commonwealth, most stakeholders are not able to recite or describe it in a common way. A critical first step is to articulate the vision and disseminate it in a campaign-style way to stakeholders in order to gain widespread support for solutions that help carry out the vision.
- ✓ Educate consumers. Continue efforts to educate consumers on the importance of shopping for care. Consumer advocacy groups, health plans, transparency vendors, and state government, etc. can all help to educate consumers.
- ✓ Ensure continuous evolution of transparency tools. Consumers, regulators and other stakeholders can encourage the continued investment in and evolution of health plan/vendor websites and tools. Health plans can make this investment voluntarily and regulatory leaders can encourage ongoing improvements through regular, possibly annual, interactive demonstrations of the tools.

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