



THE STATE OF NEW HAMPSHIRE INSURANCE DEPARTMENT

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March 22, 2018

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Commissioner

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The Honorable Bill Cassidy, M.D.
United States Senator
520 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Cassidy:

Thank you for the opportunity to provide feedback in the area of health care price transparency. For over a decade, the New Hampshire Insurance Department (NHID) has been a leader in this area. The Catalyst for Payment Reform and Health Care Incentives Improvement Initiative have consistently recognized the efforts by the NHID in their state comparisons, and ranked NH with top marks. We are well positioned to answer the questions you have asked.

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

A: Our NH HealthCost website provides provider and insurer specific health care prices free to the public. Anyone can look up the price of a knee surgery or a mammogram at their local hospital, and get an all inclusive price that includes the discounts negotiated by their insurance company. We also provide rates to the uninsured, based on provider charges. The website was designed for consumers, and provides information that is clear and easy to understand. Information on provider quality is available, and we have recently expanded our focus to include employers, health care providers, and insurance companies. These are all stakeholders who will benefit from better information on health care costs and quality comparisons.

The Healthcost website provides cost information using what is considered the "allowed rate" for health care services. This is the discounted rate negotiated by health insurance companies, and is the amount that cost sharing is calculated from. The charge may be \$6,000, but if the allowed amount is \$4,000, the patient will pay \$4,000 if they have a \$5,000 deductible.

Health insurance companies operating in NH provide information on out-of-pocket costs associated with the patient deductible or other cost sharing obligations. Unfortunately, many consumers do not understand their benefits very well, and insurance companies cannot always accurately tell a patient in real time what their cost sharing will be when they receive services. This is because health care may have been provided, but the claim has not been processed by the insurance company yet. Additionally, some services are covered on a first dollar basis (e.g. preventive care), but a colonoscopy can turn from preventive to diagnostic very quickly.

Through the HealthCost website, we also provide a detailed spreadsheet with discounted prices and provider charge information, designed for health care providers and insurance companies. These spreadsheets include more than 1,000 services and prices. If we expect the health care to function like a

competitive market, insurance company and providers need to know basic information about the market and where they stand.

Q: What information is not available, but should be made available to empower consumers, reduce costs, increase quality, and improve the system.

A: Easily digestible, robust, actionable information, at the time decisions are made by the patient and the doctor. Many people prefer to have their doctor make all decisions for them, including those that impact health care costs. Many doctors prefer to make medical decisions without regard to cost. The standard of care that physicians are expected to meet, defined as what their peers would do under similar circumstances, has evolved without regard to health care costs. Patients need to be informed and empowered at the time doctors and patients are making decisions about treatment. Doctors should be better prepared to make clinical decisions that balance the cost burden to their patients and the effectiveness of treatment.

Q: What role should the cash price play in greater price transparency? How should this be defined?

A: The "cash price" is often interpreted to mean something paid outside of involvement by the insurance company. It's often suggested that in some cases, the patient would be better served by working directly with a provider and paying a "cash price" for the service, prescription drug, etc. Since insurance companies and providers negotiate payment rates based on a full range of services that the insurance company expects to obtain through their members, it is possible that the cash price for one of those services could be obtained for less from an out-of-network provider (or potentially in-network without insurance involvement).

Unfortunately, the patient rarely has all the information needed to make a favorable cash price decision accurately. They would need to know how the cash price offered by a provider compares to the negotiated amount, they would need to be able to identify all of the potentially independent providers involved in their care, with the associated discounts, and they would also need to know how payments made outside of their insurance coverage would impact what they pay for all health care services throughout the year. Payments to providers that are not tracked by an insurance company are usually not credited toward the deductible or out of pocket maximum.

For example, a patient may find an advertised mammogram cash price that is very low. The advertised price might just include the hospital payment ("technical component") and not the radiologist fee. The patient may not realize that their insurance covers mammograms without cost sharing because it is a preventive care service. If the mammogram was considered diagnostic, and was subject to the deductible, the patient may also be relieved from any obligation because they have met their out-of-pocket maximum for the year.

Some policy efforts have sought to include out of network provider cash payments as credits toward deductibles due. In addition to the challenges associated with the member understanding health care pricing, providing for this opportunity would weaken an insurance company's ability to negotiate with health care providers. Hospitals recognize that the margin associated with any specific service will vary, but hospitals accept the payment terms because they see the value of a contract for all services. Ideally, patients would be well enough informed that they could choose the least expensive service among multiple providers, but we often have neither adequate provider competition for the service, nor comprehensive, complete, and accurate pricing information.

Q: Different states have used different methods to work towards price transparency... What are the pros and cons of these approaches?

A: The primary disadvantage with most of the initiatives identified is that the data come from health care providers, each with different interests, and the extensive resources necessary to create actionable information from the data. Even in a small state like New Hampshire, requiring providers to respond to a legislative requirement to develop and support price transparency efforts would require more than 2,000 providers to dedicate administrative resources to understanding and supporting a data submission or a data posting requirement that would raise several questions about the cost effectiveness and integrity of the initiative.

The Virginia approach has the advantage that it requests the data from the insurance carriers who already have the adjudicated claims information available and does not put the reporting burden on the providers.

Q: Who should be responsible for providing pricing information and who should share the information with consumers?

Ideally, the health care providers (the sellers) would tell a patient (the consumer) the price of a health care service in advance. Even better, those rates could be accessed easily in a centralized location, or from various publically accessible sources. The patient could act as an informed consumer, and make decisions accordingly, as they consider cost, access, quality, and convenience. Unfortunately, provider based price transparency requirements rarely work well. A single health care service, such as a knee surgery, may involve several independent providers. The providers may interpret "price" or "cost" or "charge" differently. The patient may need to obtain the amounts from each provider, and the amounts given often mean something different. Providers are usually prevented in their contract with insurance companies from disclosing negotiated prices. Regardless, most providers are uncomfortable reporting rates to a central location due to anti-trust concerns.

We may eventually get to a point where health care providers are able to satisfy consumer demands for price information, but there will need to be standard posting methods and aggregation used by all providers. Until then, insurance companies and state agencies are better equipped to provide pricing information for consumers.

Insurance companies have good reasons to send covered members to see the lowest cost provider, but have struggled with how to encourage patients to do so. There are several reasons for this, including how to best communicate costs to members (total price of the treatment vs. out of pocket costs due from the patient), frequent changes to provider contracts, variation in small samples of data, complexity of the reimbursement systems used, and expectations for real time information to determine cost sharing obligations. At any given point, a member may have incurred a claim that has not been processed by the insurance company and this will compromise the information a carrier can provide to a member.

At the present time, state agencies with access to an all payer claims database (APCD) are best positioned to provide pricing information to patients. In producing pricing estimates, the same methodology can be applied regardless of the health care provider(s) involved, the service, or the health insurance company. Using the claims data, a state agency has a "bird's eye" view of the different

providers involved in the particular treatment, the most robust set of data for providing an estimate, and access to the actual amounts allowed/paid (the true price), not just health care provider charges. A state agency can report on thousands of providers without each provider incurring massive administrative costs or violating anti-trust laws associated with sharing pricing information with other providers. The expectations for providing these rates are different than those obtained from an insurance company, and many of the concerns associated with specific contract provisions or cost sharing can be mitigated. State agencies are the only neutral parties without an interest other than promoting health care cost transparency.

Several years ago, the NHID asked insurance carriers whether they supported the NHID's efforts to post prices on HealthCost in the future. The answer was yes, and the reasons included: anyone can access the information and more people will understand how much prices vary, it gives carriers basic information on the market, and the NHID was doing it better than the carriers. One carrier suggested that HealthCost functioned as a benchmark, and the website encouraged carriers to build and further develop their own transparency initiatives.

Q: What role should all-payer claims databases play in increasing price and quality transparency?

A: APCDs have an important role in producing pricing information, and potentially improving publicly available information on quality. Any effort to produce information for the benefit of the public and consumers will face challenges associated with the cost of collecting, analyzing, and producing actionable information.

APCDs use information that is produced for another purpose: processing claims. Avoiding a separate data collection effort for pricing transparency purposes, allows for massive cost savings. Imagine starting from scratch and trying to collect pricing information from thousands (or hundreds of thousands) of health care providers, and disseminating that information in a publicly useful format. Every provider has the opportunity to misunderstand the requirements, miss deadlines with the submissions, include errors in the key data fields, or simply face a technical glitch in the submission process.

Instead, collecting data from a limited number of health insurance companies, using data that are already standardized by the formats associated with the two claims forms used by health care providers, the administrative costs associated with data collection can be minimized. Managing large volumes of data is a skill that insurance companies have, but many health care providers do not. New Hampshire has been producing rates on the NH HealthCost website using our APCD for more than eleven years, and at a very modest cost.

Producing reliable information on health care provider quality continues to be a substantial challenge, regardless of the data used, and will continue to be so in the future. There are some organizations that are exploring how helpful APCDs can be on this front, and the results look promising.

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

A: The first step is to better identify the indicators of quality that are the strongest indicators of high or low quality health care that matter the most to consumers. Even if that means starting with the most basic measures, such as those considered "never events," like wrong site surgery. The medical

community, insurers, and consumers are struggling with what they should focus on, and will continue to do so for some time. Part of the challenge is identifying what data are available and what measures can be calculated. A surgeon that scores high in all of the process measures may also score lowest in the outcome measures if his/her patients are the most complex. Adjusting rates for patient complexity is an imprecise science, and we don't want to penalize the best doctors and hospitals with bad scores. Consumers are also struggling with the measures that matter most, and may weigh some factors more than objective measures of health care quality. For example, things like available parking, friendliness of staff, and amenities on site, may be the things consumers feel are most important. This is in direct contrast to cost, where as long as all other things are equal, a rational consumer will choose the least expensive provider.

Q: How do we ensure that in making information available we do not place unnecessary or additional burdens on health care stakeholders?

A: As much as possible, use data and systems that are already created for another purpose. The New Hampshire APCD is created through an insurance statute, and makes use of data that are maintained by health insurance companies. Health insurance companies are already regulated by state insurance departments. So, the authority to require submission of the data to a centralized location exists, and an enforcement mechanism is in place. Release of the NH APCD is managed through an "MOU" between the NHID and the NH Department of Health and Human Services (DHHS). Because DHHS is an administrator of the state Medicaid program, they have the expertise to work with large claims databases and ensure that patient privacy protections are maintained. As discussed previously, health care claims data are a byproduct of standard health insurance business operations.

Q: What current regulatory barriers exist within the health care system that should be eliminated in order to make it less burdensome and more cost-efficient for stakeholders to provide high quality care to patients?

The US system is expensive in part because of a financial structure and incentives that are based on fee-for-service medicine, the government resources that have been provided in specific ways, and in turn, high consumer expectations that have developed over lifetimes. This system is challenged because of the high costs overall, but also because of the financial responsibility that is now owned by patients through their deductibles, coinsurance, and copays.

To the extent the US Senate is seeking market based, competitive approaches to encouraging cost effective changes, we need to reduce the barriers associated with patients acting as informed consumers. Development of better health care pricing information has great potential. One criticism of health care price transparency is that many services are not competitive, and patients are unable to "shop around" for treatment. This is true, but even for these services, public disclosure of the cost can lead to more informed decisions, and greater efficiencies.

The NHID and most stakeholders in the state are strong supporters of our APCD. One area that poses challenges for states is collecting claims data from third party administrators working for self-insured employers. The *Gobeille vs. Liberty Mutual* Supreme Court decision in favor of Liberty Mutual was an anti-consumer outcome and has undermined the ability of states to include these data in APCDs. New Hampshire is unique in the way we collect data under our insurance statute, and this is an advantage because insurance regulation is considered a safe harbor area under ERISA, the law that creates the

challenges associated with the data collection. The NHID would welcome any interest from the US Senate in providing clarification that states have the ability to collect these data.

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

A: Medicare is usually the most sophisticated payer of health care services, but does not have the flexibility to take risks that private payers have. Medicaid programs vary by state, but are a significant payer of health care services. We should not expect substantial progress with any initiative that is at odds with programs and efforts setup by Medicare. The NHID uses the information on health care quality produced with the Medicare data, and health care oversight organizations and health care delivery systems would be better served by combining the data from all payers and programs to better identify opportunities and see through random variation in the data.

The data from all payers should be available in similar formats and should be timely enough to be useful. In the past, there have been challenges with getting timely access to Medicare claims data on all providers, and an incomplete picture can undermine initiatives based on the findings.

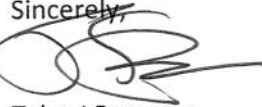
Q: What other common sense policies should be considered in order to empower patients and lower health care costs?

A: New initiatives should recognize the natural tension that exists when trying to change a health care system that has been financed the same way for a long time. It is usually not in the interest of a hospital employed doctor to tell a patient that services can be obtained from a competitor for less. Similarly, many physicians take pride in their care by indicating that their decisions are made without regard to cost. However, our expectations for an empowered patient are based on seeing changes in the way health care services are obtained.

Insurance companies compete with each other to offer the lowest premiums, but are cautious about creating friction with their members. We should be considerate of this dynamic when promoting certain policy changes.

We now have high deductible health plans and that leave the patient with more responsibility for managing their care and their expenses. We need to ensure that common sense policies exist to assist patients as they seek to act as empowered consumers. "Empowered consumers" sounds great and has strong potential to improve our health care system, but it is not a change that many patients embrace. Common sense policies are going to be those that provide an effective balance between regulation and free market. Everything from how we train physicians, make decisions about health insurance benefits, or purchase health care services, must be done with the right balance.

Thank you for the opportunity to provide feedback, and for your enthusiasm about health care price transparency. We are happy to discuss these issues further, and welcome future opportunities to improve upon our efforts in this area.

Sincerely,


Tyler J Brannen
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