Price Transparency's Hazy State

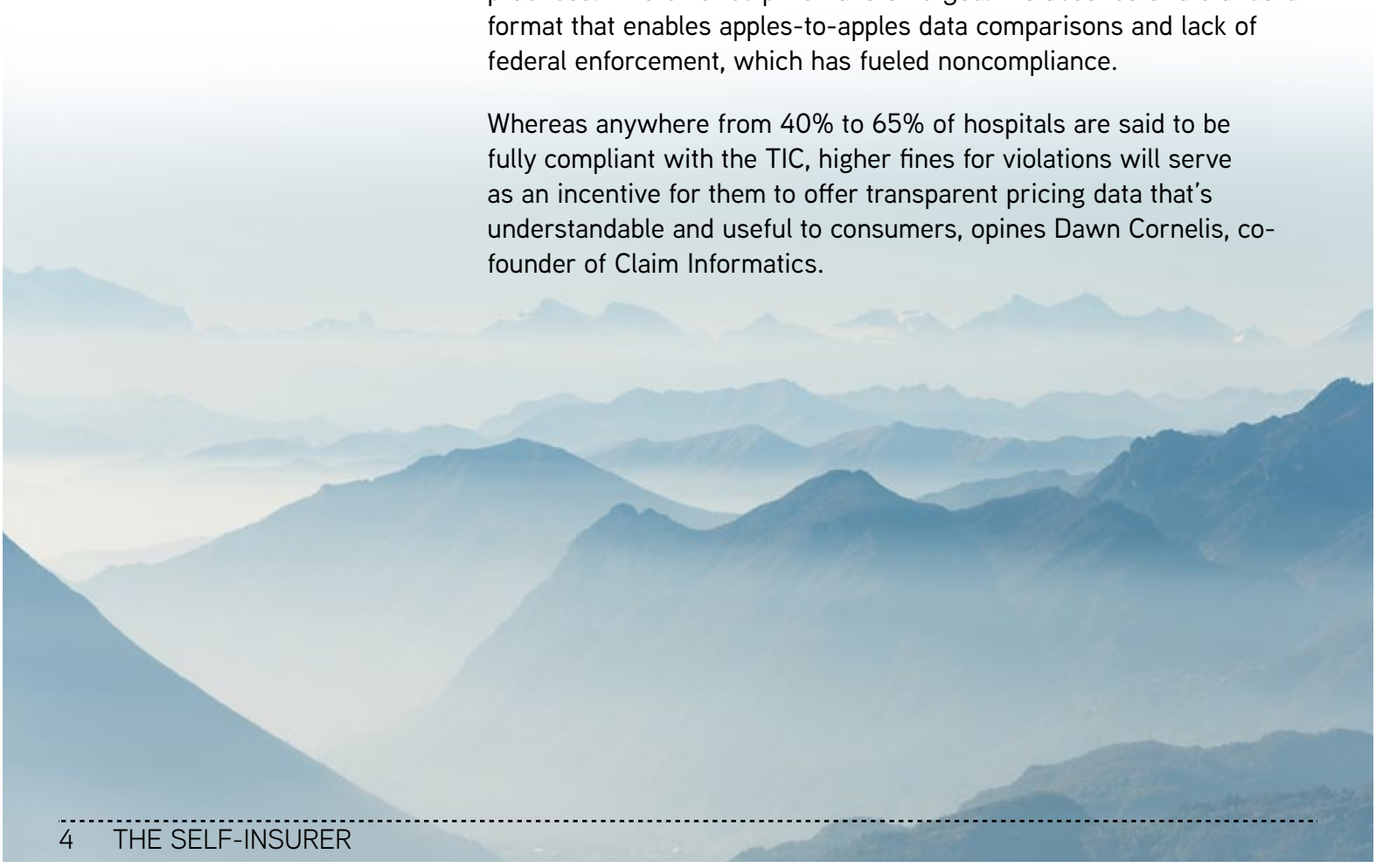
IN THE ABSENCE OF A STANDARDIZED DATA FORMAT, THE QUEST FOR USEABLE DATA IS STILL VERY MUCH A WORK IN PROGRESS

Written By Bruce Shutan

Data drives decision-making in health care, but it's not always readily available – even in the face of mandates.

More than a year after the No Surprises Act became law and seven months since the Transparency in Coverage (TIC) final rule took effect, industry observers say that while health care pricing is becoming more transparent, a seemingly bright landscape is still clouded by perverse practices. Two chief culprits have emerged: the absence of a standard format that enables apples-to-apples data comparisons and lack of federal enforcement, which has fueled noncompliance.

Whereas anywhere from 40% to 65% of hospitals are said to be fully compliant with the TIC, higher fines for violations will serve as an incentive for them to offer transparent pricing data that's understandable and useful to consumers, opines Dawn Cornelis, co-founder of Claim Informatics.




Dawn Cornelis

A Deloitte survey showed that 60% of consumers are more than likely to choose a provider that publishes local rates on their services, she noted. Yet a Harvard study indicated 75% of consumers do not know that there's even health care pricing tool available.

Therefore, Cornelis says the focus needs to be on promoting better awareness of health care price transparency and empowering consumers to use these tools to make more cost-effective choices that eventually will help drive down inflated prices across the market.

"It really is going to come down to employers that want to use price transparency in coverage to their advantage," she says. "They need to put together a team to help employees navigate the rules, as well as the CAA [Consolidated Appropriations Act] guidelines."

Despite the TIC, many hospitals continue to make a lot of information available in "a very unusable format" that the average patient struggles to understand when deciphering various medical procedures, benefit levels and out-of-pocket costs, observes Dave Cardelle, chief strategy officer of AMS.

While he believes some have done it intentionally, others have made it "super complicated for that data to be easily usable because CMS didn't provide any standard format." The result is a free for all involving confusing information floating around the marketplace with hospitals publishing machine readable files that meet certain requirements, but make meaningful comparisons an uphill battle.

Having worked with data for 35-plus years, Cornelis knew the TIC was flawed from the start. "It becomes complicated when people want to make it complicated," she quips. "I heard the single month of UnitedHealthcare's pricing transparency data is larger than three full years of hospital and physicians' claims processed within the Medicare program. They're trying to overcomplicate things with barriers and hospital systems are known for that. We need to dumb it down and say, 'it's not that complicated to put together a standard record format layout that everybody follows.'"

With access to transparent pricing on hospital websites in shoppable form and the ability to actually see price variations, facilities will find it much harder to justify higher prices for the exact same procedure, services, supplies and even doctor, Cornelis says.

But until systemic issues can be resolved, the future of price transparency will continue to hang in the balance. While the intent of this new regulatory environment was to make the marketplace more competitive, Cardelle cautions that hospitals still monopolize certain regions of the country. "I don't know that it's going to really move the needle as far as changing prices for a lot of the hospitals that are out there," he says.

THE EVOLUTION OF IMPROVEMENT

Still, the TIC is a good start that will require patience. As with any undertaking of this enormity, much can change between version 1.0 and 5.0 in the emerging health care price transparency

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Bill Kampine

marketplace, according to Bill Kampine, chief innovation officer of Healthcare Bluebook.

"The progress that occurs between these versions incorporates feedback and learnings to make it more functional over time," he says, noting that the intent was not be overly prescriptive beyond having certain elements in place to protect consumers. Rather, the thinking was that market innovators would eventually determine the clearest way of presenting shoppable information.

That starts with an ability to contextualize the volumes of data in ways that Kampine says are meaningful to patients. For example, surgeries will have multiple components that include the surgeon, anesthesia, facility and potentially other charges. In order to avoid surprise bills, he says patients need accurate and thorough estimates for the complete encounter, as well as benchmarks on key decisions that will have the greatest impact on cost such as the choice of facility.

What's critical for obtaining value is presenting consumers with a complete list of providers, prices and available alternatives, Kampine notes. One example is that the hospital transparency rules apply to a limited list of procedures, many of which include outpatient care that can be delivered in far less costly settings such as a provider's office, ambulatory surgery center and independent imaging center.

"Looking up prices one hospital at a time is time consuming, and could still lead to overpayment if the consumer cannot directly compare prices for the same service across all available settings," he adds.

Price, of course, is only one data point. "Quality is equally important and not part of the federal price transparency requirements," Kampine points out. He says risk adjusted, patient-specific outcomes based quality metrics empowers patients to make decisions that balance cost and quality in both inpatient and outpatient settings.

Having that data doesn't guarantee lower cost and better outcomes, he cautions, adding that benefit design is still "the most powerful tool plan sponsors have at their disposal for achieving improved value." A proven model for lowering his client's health care costs features intuitive, easily accessible price and quality information from high-value providers, as well as concierge level navigation support.

In terms of improving the data that's currently available, Cardelle believes it wouldn't take long to build consensus. "All basic chargemasters contain the same primary information so the government can set out a simple data

Dave Cardelle

layout – basic fields that matter," he explains.

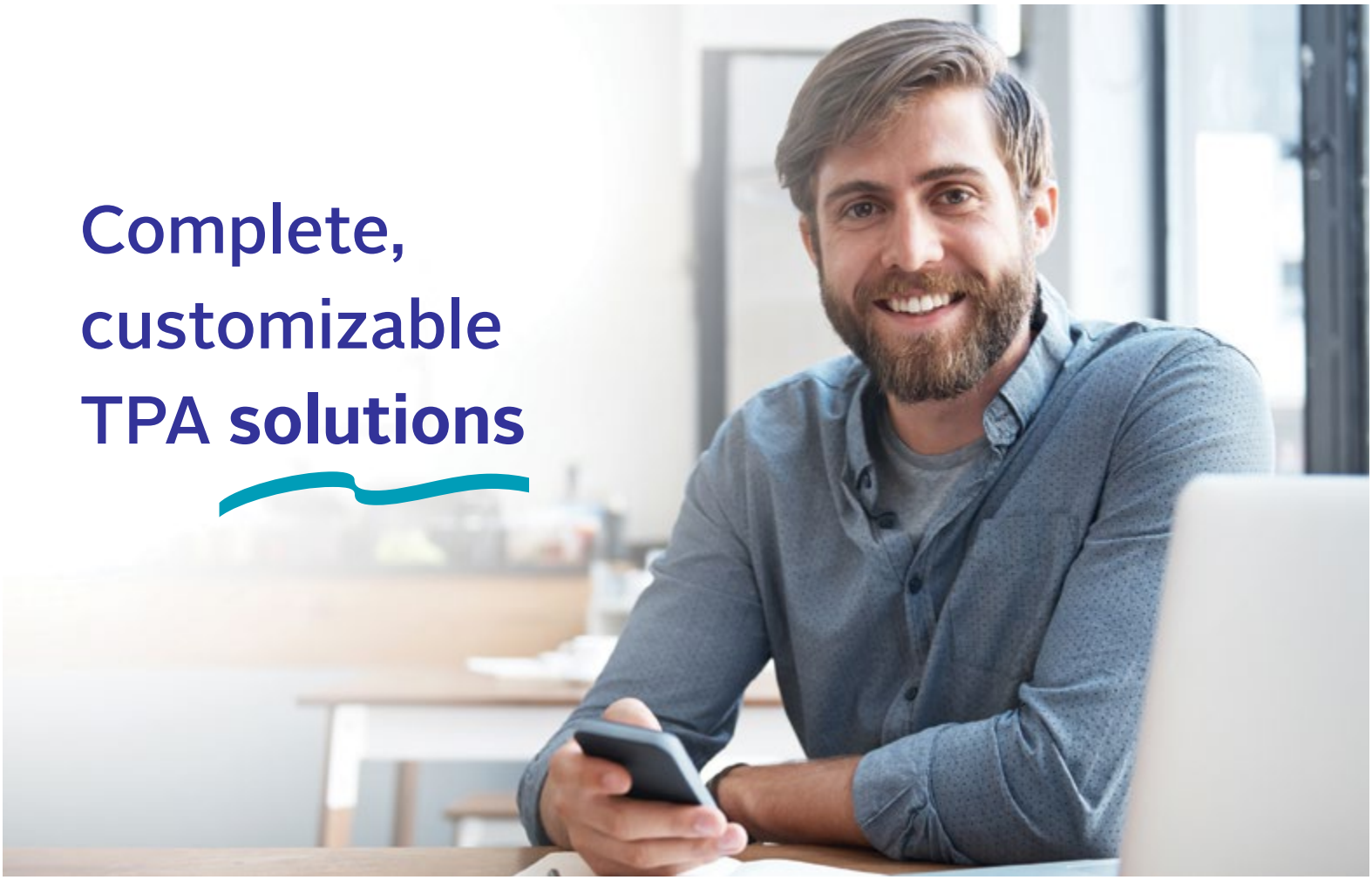
One huge benefit from the TIC is that the curtain has finally been pulled back on cash pricing, which providers have quietly accepted. Health plans can now start to see what the hospital's chargemasters are in discounted cash prices and use that information as a comparison to what they're paying, he explains.

What's most important, in his view, is that hospitals are actually willing to accept cash prices, which should be a baseline for every single service on their chargemaster, "and then from there, hospitals should be able to negotiate discounts off of that price." This is especially critical for patients who have no health insurance.

But the marketplace isn't there yet. "We have seen examples where health plans actually pay five times with the cash prices, which makes no sense whatsoever," he reports. The TIC is now shining a light on some of the discrepancies and variances, he adds.

BIRTH OF A COTTAGE INDUSTRY

Since hospital data is so massive, the information must be curated by experts for any useful comparisons, according to Cardelle. Examples include the involvement of a third-party software or data analytics vendor to download files, uncover discrepancies and aggregate the information for practical use. His firm already has downloaded more than 6,000 files from 5,600 hospitals. With over 5 million



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unique codes and approximately 5 billion line items to pore through, he says the data "becomes just unruly, but that information is super valuable."

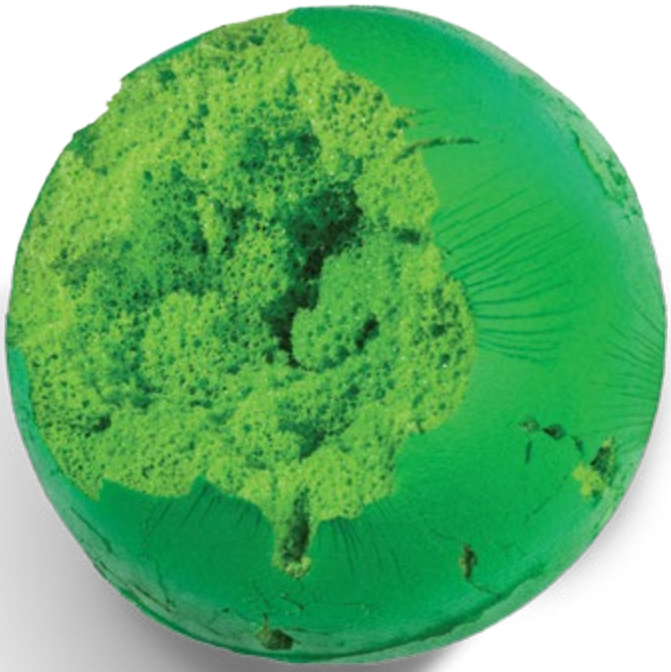
Adds Cornelis: "There is a cottage industry for taking large sets of data, but it has to be with empathy – that there's no conflict of interest or some other objective going on." Her firm has built a technology platform that allows patients to decipher the average cost of various procedures from large sets of complicated healthcare claims data.

If there's anyone who can truly relate to the level of mounting frustration among health care consumers over opaque pricing, it's Cornelis. When she recently underwent a kidney stone removal, it dramatized just how difficult it is for even a subject matter expert to navigate her way through a complex health care system.

"I called probably five different numbers and nobody could answer my question about getting a price for this procedure," she reports. "I knew the facility and who the surgeon was, and I struck out at the hospital, carrier and network. I couldn't get anywhere. That's the reality that sets in when we start looking at the price transparency rules."

But as Cornelis and others agree, there's reason to believe that the forecast for health care price transparency will likely become brighter over time. ■

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for more than 30 years.



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ARBITRATION SEEKS TO STEM NSA LAWSUITS

By Bruce Shutan


Christine Cooper

Federal regulators are forcing the health care marketplace to offer transparent pricing, but self-insured health plans will continue to encounter some landmines along this changing landscape.

Mindful of the need to reduce balance billing and litigation under the No Surprises Act (NSA), a recently issued final rule is helping implement the independent dispute resolution (IDR) process. It features "baseball-style" arbitration between payers and providers through which both sides offer a payment amount.

The IDR entity picks one of those amounts rather than split the difference, although the two parties involved still can continue to negotiate or strike a settlement. The trouble is IDR entities are "massively understaffed and not really following the rules because there's just not enough time for them to do so based on the volume of claims," cautions Christine Cooper, CEO of aqueem LLC.

"When you're an IDR entity with however many thousands of these claims streaming in, how do you have the time to sit back and look at all seven factors, then prepare a written decision and actually get through these IDR claims?"

At the center of NSA arbitration is a qualifying payment amount (QPA) that serves as the basis for determining cost sharing for items and services covered by the 13-month-old law's balance-billing protections.

Prior to the release of any IDR guidance, Cooper says providers were grumbling how it's unfair that the QPA is calculated by the TPA, health plan and insurers "because it's their information that we don't even have access to, so there is no transparency and to them it's a very arbitrary number."

While the Centers for Medicare & Medicaid Services estimates that arbiters deemed at least 22,000 disputes ineligible for IDR, all eyes are on the U.S. District Court for the Eastern District of Texas where arguments were heard in the second of three lawsuits by


Troy Sisum

the Texas Medical Association (TMA) challenging portions of the rule. TMA sought to eliminate the interim final rule provision that allows a self-insured plan to use data across their TPA for QPA calculations.

The location of this legal battle proved to be a calculated and strategic move on behalf of the provider community, according to Cooper, who points out that providers were wise to sue in the Lone Star State where the climate has been favorable for them.

Another significant factor to consider is whether the health plan employs reference-based pricing. "From an RBP standpoint, you want to be able to negotiate and go to IDR and argue that the QPA is too high," says Troy Sisum, chief legal officer at Imagine360.

His company has been able to negotiate and resolve eligible claims below the QPA by accessing enough data and supportable documentation to suggest what the plan paid is reasonable. He notes that it's important to have arbiters use the QPA as a good starting point because it's something that can be audited.

The NSA litigation impacts BUCAH plans a little more than RBP, Sisum believes, "because it potentially can allow providers to file more IDR challenges, where I think a lot of the BUCAHs were betting that if they just pay the QPA, they really wouldn't see many of these IDRs. And I think that that didn't materialize the way they had hoped."

Just as with the Affordable Care Act, Cooper sees a long road ahead for unfolding legal battles under the NSA. "We're only seeing the beginning of this litigation," she observes, advising employers to take steps in the plan design to avoid the NSA in the first place. "I think the Administrative Procedures Act is going to play a central focus in the litigation in the sense of HHS, Department of Labor and others involved in this rulemaking really overstep their bounds." ■

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for more than 30 years.