CATALYST FOR PAYMENT REFORM

HEALTH CARE INCENTIVES IMPROVEMENT INSTITUTE INC

Report Card on State Price Transparency Laws

July 2015

Dear Colleagues,

In this third installment of the Catalyst for Payment Reform (CPR) - Health Care Incentives Improvement Institute (HCI^3) Report Card on State Price Transparency Laws, you will find little progress since last year and, in some cases, regression. For this reason, this year's report is concise, sharing information only on the handful of states that received new grades.

However, this bleak picture masks the recent legislative and regulatory activity that has sprung up around the country, spurred in part by our prior Report Cards. In fact, many states highlight this report when introducing bills for pricing transparency. As a reminder, when we assess each state, we base the grade on legislation passed during the prior year's legislative session; this year's report is based on legislation enacted in 2014.

Legislative sessions are still underway and some proposed bills may still pass. Many won't due to pressure from providers, payers and other suppliers to the industry who still benefit from price opacity. That pressure often rests on spurious arguments about price as a trade secret and/or the potential for a state law on price transparency to violate contracted terms between payers, providers, and suppliers—arguments legislators and the media often accept.

To outline the legal arguments raised against price transparency and how best to address them, we teamed with the University of California San Francisco and University of California Hastings Consortium on Law, Science & Health Policy. These experts host The Source on Healthcare Price & Competition. We believe it is important for the public, including the media, to understand what legal arguments are valid and question the others. A crucial point for legislators and the media is that states who take efforts to ensure price transparency seriously have successfully brushed aside the spurious arguments, and not one plan or provider has sought a challenge in the nation's highest court. Many of the arguments against price transparency -- including that it leads to higher prices and breaks laws—are toothless. We hope the legal analysis helps legislators and the media focus on the right considerations (see Appendix I).

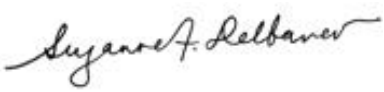
For states that enact laws on price transparency, there is much work to be done. Our report illustrates whose lead to follow. One state returned to a high score this year after a brief hiatus due to an inactive website last year: New Hampshire. Its rebound shows that even small states with few resources can develop and maintain a useful and consumer-friendly website on health care prices. Conversely, Massachusetts' grade dropped precipitously due to shutting down MyHealthCareOptions, the website that had publicly posted price information.

In this year's Report Card, as we did with the 2014 report, we review whether states had passed laws or regulations requiring health care price information be made public. In addition, we examined how well those laws were being put into action by providing residents with access to meaningful price information through public websites and the use of all-payer claims databases (APCDs) as data sources for those sites. We discuss the important role for APCDs in Appendix II. The results of our analysis show few changes since last year's report: 90% of states fail to provide adequate price information to consumers.

But it wouldn't take much to change this result. States like Connecticut and New York are still assembling their all-payer claims databases and working on consumer-facing websites. Maryland is in the process of embarking on a significant effort to publish prices on health care services, and Washington State just enacted new laws. We expect continued progress, even if at a slow pace.

Neither CPR nor HCI^3 receives funding to support the development and publication of this Report Card. We do it because we believe that markets cannot function properly without freely accessible information on price and quality. Those who oppose transparency are a shrinking minority, and we hope our efforts diminish it further.

Sincerely,



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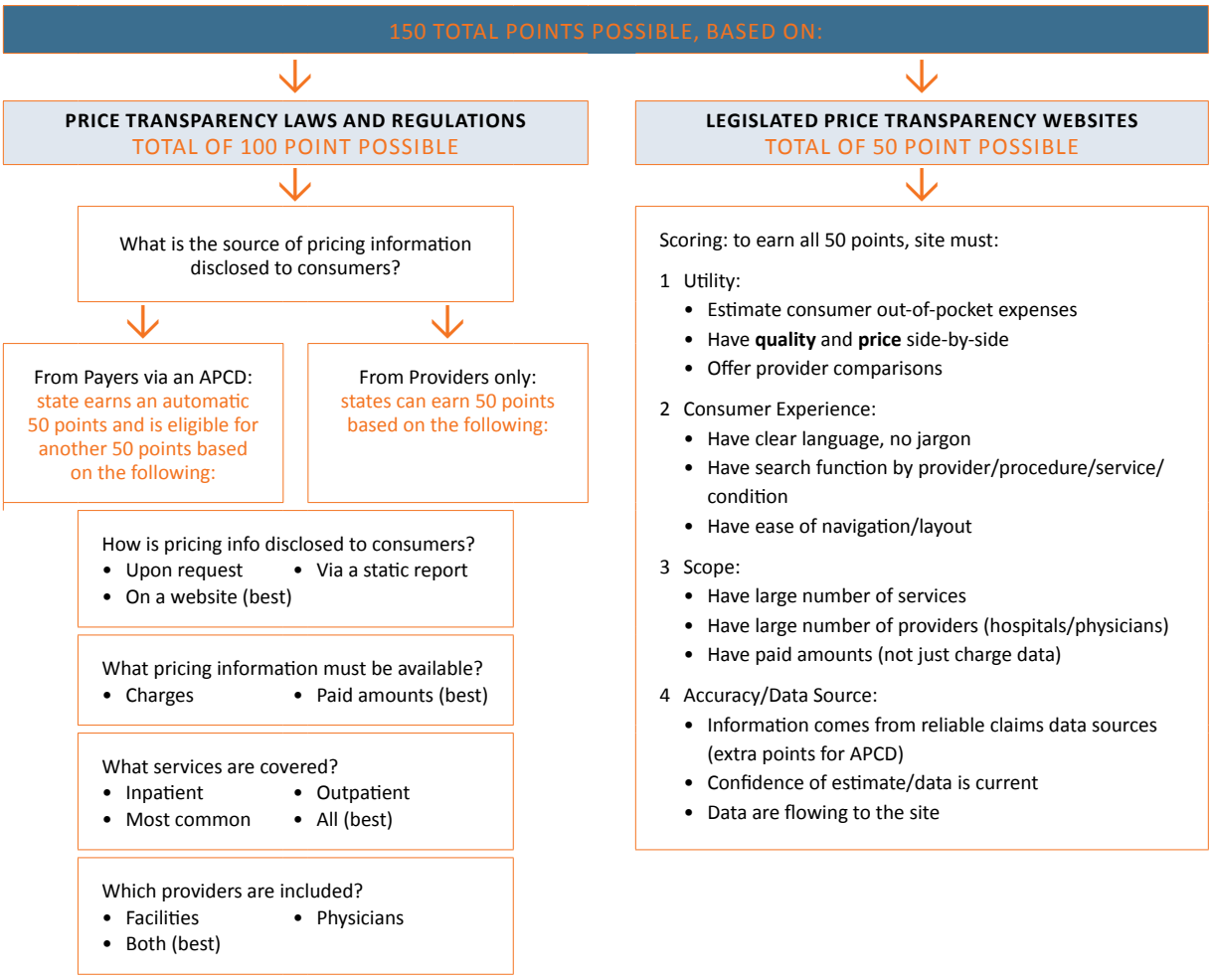
I. METHODOLOGY

For a refresher on the methodology the team uses to assess state grades please refer to our 2014 Report Card on State Price Transparency Laws. A snapshot appears below in Figure 1.

Figure 1: Scoring Methodology for Laws, Regulations, and State-Mandated Websites



II. GRADE CHANGES IN 2015

New Hampshire

In our 2014 report, we gave New Hampshire an "F" grade due to the lack of a functioning public price transparency website. However, its new website, NH HealthCost, is now a prime example of a price transparency website built with consumers in mind. The site accounts for both insured and uninsured patients and provides great details on the methodology in consumer-friendly terms. We commend New Hampshire for the effort it has put into the site and urge other states to use NH HealthCost as a model when developing price information for their residents. This year, using the same grading methodology as last year, we gave the state an "A."

Massachusetts

Massachusetts has traditionally been a leader in health care transparency. In fact, in past report cards we gave the state high honors. However, in 2014, legislation went into effect that placed the responsibility of transparency on health plans and the government

ACKNOWLEDGMENTS

Special thanks to Lauren Bennett, Communications Leader, HCI[3]; Nicole Perelman, MPP, Director of Communications and Special Projects, CPR; and CPR's legal interns, Kristin Williams and Katherine Ammirati for their research and dedication to this project.

mandated website went dark. While we believe that health plans play an important role and should assist patient members in estimating costs, the lack of a public website with price information leaves out entire populations of consumers, especially the uninsured. In addition, the health plan websites vary in the amount of information they provide. A statewide transparency tool creates uniformity. Since we awarded a possible total of 50 points to states with a mandated state website, and Massachusetts no longer has one, the state lost 50 points and dropped to an "F" in this year's Report Card.

Colorado

When we released last year's report, Colorado was on the verge of releasing a new public price transparency website. Because the site was just in the process of being launched, the state received a "C." This year we were pleased to revisit Colorado and see that the public website is indeed up and running, and consumers can look up price information for episodes of care. However, the website is still in a nascent stage, and so far consumers can only search for maternity care and "hip replacement" and "knee replacement." The site also indicates information may not be consistent across hospitals in some cases. For these reasons, this year we gave the state a "B."

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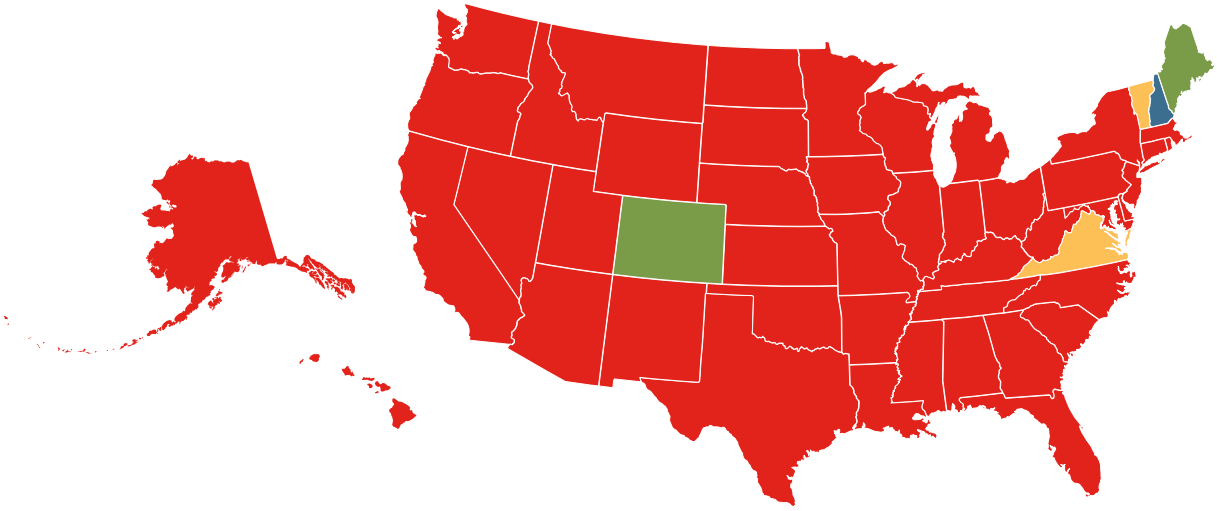

STATE	GRADE	STATE	GRADE	STATE	GRADE	STATE	GRADE
Alabama	F	Indiana	F	Nebraska	F	South Carolina	F
Alaska	F	Iowa	F	Nevada	F	South Dakota	F
Arizona	F	Kansas	F	New Hampshire	A	Tennessee	F
Arkansas	F	Kentucky	F	New Jersey	F	Texas	F
California	F	Louisiana	F	New Mexico	F	Utah	F
Colorado	B	Maine	B	New York	F	Vermont	C
Connecticut	F	Maryland	F	North Carolina	F	Virginia	C
Delaware	F	Massachusetts	F	North Dakota	F	Washington	F
Florida	F	Michigan	F	Ohio	F	West Virginia	F
Georgia	F	Minnesota	F	Oklahoma	F	Wisconsin	F
Hawaii	F	Mississippi	F	Oregon	F	Wyoming	F
Idaho	F	Missouri	F	Pennsylvania	F		
Illinois	F	Montana	F	Rhode Island	F		

We wish we had seen more progress since our last report, but are heartened that many legislatures were still in session at the time this was published, and we hope to see more change soon. Given changes to state laws and regulations were insignificant since our last published report card, we did not update our appendix of laws and regulations in this year's report card. Readers interested in reviewing specific state laws and regulations can refer to our 2014 report card starting on page 18.

APPENDIX I An Analysis of Popular Legal Arguments Against Price Transparency

INTRODUCTION

Efforts to advance price transparency in health care often run into legal obstacles that make it difficult to obtain and share the information with consumers, other health care entities, or government agencies. Health care providers and insurers often argue that pricing information may not be made public because it is (1) confidential by contract, or (2) protected as trade secret. Market dynamics exacerbate the extent to which these entities are able to keep the information out of third parties' hands—i.e., the bigger the provider or insurer, the better chance it has of holding onto its price information. In response to these legal barriers to disclosure, states have begun to prohibit the inclusion of certain contractual provisions that inhibit transparency. In addition, antitrust enforcement provides a means to promoting price transparency. This appendix details these legal barriers to price transparency and the best ways to address them.

This Appendix was prepared by the team behind The Source on Healthcare Price & Competition

CONTRACTUAL BARRIERS

In health care provider-insurer contracts, three types of clauses inhibit price transparency: (1) non-disclosure agreements, or "gag clauses;" (2) anti-tiering/anti-steering clauses; and (3) most favored nation clauses. These clauses, which typically allow a provider or insurer to mandate how pricing information is determined and/or shared, are best understood in context. Typically, the amount of market leverage a provider or insurer has is directly correlated with its ability to impose these contractual provisions on other parties.

Non-Disclosure Agreements/"Gag Clauses"

Non-disclosure agreements ("NDA") or "gag clauses" are frequently used in contracts between insurers and health care providers to require that both parties keep the negotiated provider rates confidential, i.e., any party that shared the information would breach the contract. NDAs have two main effects. First, they deny third parties, including the government and individual consumers, access to pricing information that could influence their choice of providers and insurers. Second, they facilitate the ability of "must-have" providers to negotiate above-market rates, driving up costs overall.[1] Further, NDAs between hospitals and medical device manufacturers can keep valuable price information from physicians that prescribe device use, which can lead to inefficient treatment choices.[2]

Anti-Tiering/Anti-Steering Clauses

Anti-tiering or anti-steering clauses in insurer-provider contracts also inhibit price transparency. Provider organizations often use these clauses to prevent insurers from creating incentives for their insureds to choose high value alternatives. Although anti-tiering and anti-steering clauses do not directly prohibit the disclosure of price information, they limit the overarching goal of price transparency initiatives – to enable patients to choose providers based on cost and quality.

1 Robert A. Berenson et al., *The Growing Power of Some Providers to Win Steep Payment Increases from Insurers Suggests Policy Remedies May Be Needed*, 31 Health Aff. 973, 973 (2012).

2 Government Accountability Office. GOA-12-126, Medicare: Lack of Price Transparency May Hamper Hospitals' Ability to Be Prudent Purchasers of Implantable Medical Devices 29–31 (2012).

Most-Favored Nation ("MFN") Clauses

In an insurer-provider contract, a most-favored nation clause promises that the provider will not give an equal or more favorable price to any other insurer. Insurers often request a MFN clause as part of an agreement to pay a dominant provider organization an above-market rate. Although these clauses have less to do with price transparency than with the prices themselves, they raise transparency concerns in a couple of key ways. First, MFN clauses often mandate the disclosure of rates negotiated with competing insurers, so that the insurer holding the protection can ensure it is receiving the best price. Second, they hinder rate disclosure to consumers, as neither party wants to reveal the above-market rate. Lastly, unless these clauses are eliminated from provider-insurer contracts, price transparency measures will not be able to reduce health care costs because the MFN's control over pricing will trump consumers' ability to affect prices by shifting demand.

How to Address:

Legal challenges to these contractual provisions come in two forms: (1) statutory bans on their use, and (2) antitrust enforcement that either specifically targets these clauses, or more generally addresses the market imbalances that give rise to their use by dominant firms. States have begun to outlaw these clauses in a variety of ways. For example, California banned gag clauses relating to cost information in insurer-hospital contracts in 2011, and expanded that prohibition in 2013 to cover all healthcare providers.[3] More recently, a gag clause ban[4] was introduced in Missouri, but failed to pass in February 2014. Elsewhere, including in New Mexico[5], consumer groups are advocating gag clause bans as part of a price transparency agenda. As for MFN clauses, 18 states have already enacted bans, and two have pending legislation.[6] MFN clauses have also been the subject of several successful antitrust suits brought by the Department of Justice against dominant insurers. Antitrust enforcement aimed at curbing anticompetitive mergers also must be used to prevent dominant firms from using their leverage to demand contract terms that stymie transparency and competition. The government should be especially wary of the potential for dominant providers to skirt statutory bans and specific enforcement efforts by imposing implied or outside-the-contract arrangements for best pricing guarantees.

TRADE SECRETS PROTECTION

In addition to contract-based confidentiality provisions, providers and insurers often assert that negotiated price information is a protected trade secret under the law. Whether information is a trade secret is a matter of state law; but, because forty-seven states have adopted the Uniform Trade Secrets Act, some level of consistency in legal principles exists across those states. To qualify as a trade secret, (1) the secrecy of the information must provide a competitive advantage to its owners, and (2) the owners of the information must make an effort to maintain its secrecy. Whether information qualifies under these elements is a fact-specific determination left to the courts. In other words, unilateral designations made by the owners of the information do not guarantee protection. The types of information courts often protect as trade secret include formulas, techniques, designs, and processes not generally known or easily ascertainable by others.[7] Only under very limited circumstances do courts grant trade secret protection to price information.[8] Generally, those circumstances involve courts providing trade secret protection to promote vigorous competition between rivals; not, as we see in health care, to take advantage of the consumer's lack of pricing information.

Like patent law, trade secret protection developed as a means to encourage innovation and to promote competition and economic growth. Unlike patent law, trade secret protection lasts indefinitely (until disclosure). Historically, trade secret protection furthered its policy goals by preventing employees from disclosing valuable information to the competition, protecting companies' ability to develop new and innovative products, and promoting entry into the market place by new competitors. None of these goals

3 *See* SB 751 and SB 1340, creating and amending CA Health & Safety Code § 1367.49 of and CA Ins. Code § 10133.64
4 SB 847.
5 *See* http://www.thinknewmexico.org/homepage.html.
6 "Legislative Topics: Most Favored Nations Clauses," The Source Blog, March 19, 2015 (available here).
7 *See, e.g., Minnesota Mining & Mnfg Co. v. Pribyl*, 259 F.3d 587 (7th Cir. 200
8 *See, e.g., Pepsico v. Redmond*, 54 F. 3d 1262 (7th Cir. 1995).

is served by concealing health care prices from consumers, government agencies, or preventing disclosure more generally. Indeed, concealing negotiated price information serves little purpose other than protecting dominant providers' ability to charge above-market prices and insurers' ability to avoid paying other providers those same elevated rates. Accordingly, there has been a growing recognition that trade secret protection in health care is being misused—raising health care prices without offering any upside.

How to Address:

As with contractual barriers to transparency, trade secret barriers to negotiated health care prices may be addressed through both legislation and litigation. First, states should avoid codifying confidentiality or conferring any specific trade secret protection for negotiated health care prices in provisions of health related legislation. Second, states should establish a public interest exemption to trade secret protection through legislation, which would permit the state to require disclosure of information when necessary to promote the public good. Access by states to negotiated rate information that has profound effects on their citizens' well-being would fall clearly within such an exemption. As for private litigation, plaintiffs should challenge and courts should continue to scrutinize assertions of trade secret protection with a reluctance to spread the doctrine to health care prices.

BEST PRICE TRANSPARENCY LEGISLATION

Over the last several years, numerous states have passed legislation designed to make health care prices more accessible to patients. The most effective patient-focused legislation provides price information that is directly relevant to the patient's decision. Averages, median billed prices, charge master amounts, and usual and customary charges often vary widely from what an individual patient will actually be expected to pay, which substantially lowers the utility of the information.

The most promising price transparency legislation requires that health care providers and insurance plans provide patients with:

- A good-faith estimate of the patient's out-of-pocket expenses that are specific to the patient's insurance plan, health care needs and health care provider.
  The estimate should include patient and plan specific co-pay or coinsurance and deductible information, as well as an explanation of standard prices and the potential range of variable expenses. If the patient is uninsured, the estimate should include both the average allowable reimbursement the provider accepts for the procedure from a third party, as well as the amount the particular patient will be billed.[9]
- Quality information on individual physicians and providers.
  The utility of price information increases greatly when paired with quality assessments of providers. As quality measurement improves and more information becomes available, states should collect and disseminate this information to patients to facilitate health care decision-making.
- Access to this information in real time via a website, personal electronic device, or Electronic Medical Record (EMR) system.
  Price and quality information is only useful if patients can access it easily and in real-time. States should either provide or require insurance companies to provide this information to patients through a website with personal device capability and interoperability with electronic medical record systems.

States currently offer or propose to offer this information to patients in many different ways. Some states, including Washington and Massachusetts (WA SB 6228, MA Ch 224), have passed laws that require insurance companies to provide this information directly to patients. Kansas requires insurance companies to provide all patient cost and provider reimbursement information to providers upon request in the form of a "real time Explanation of Benefits" (HB 2688). Whereas, Colorado offers this information to patients via its All Payer Claims Database.

9 (Minn. Stat. § 62J.81)

CONCLUSION

Over the last several years, states have become more aware of the problems associated with a lack of price transparency in health care. In order to be effective, price transparency initiatives must provide accessible and actionable information to decision-makers in a timely manner. While legal barriers hindered initial efforts to promote price transparency, states can address many of these barriers through legislation and litigation. Legislation can prohibit clauses in provider-insurer contracts that would obscure health care prices, as well as ensure that trade secret protection is not used in ways that harm the public interest. Patient-focused price transparency legislation can help ensure that all patients have real-time access to a good-faith estimate of the expected costs of the procedure to the patient based on his or her health care needs, insurance plan and choice of health care providers.

Litigation can be used to challenge anticompetitive practices that lead to the occlusion of health care prices. State efforts to promote price transparency must also be accompanied by efforts to reduce the market leverage and anticompetitive behaviors that enable dominant providers and insurers to drive up health care costs overall.

APPENDIX II Use of All-Payer Claims Databases (APCD) for Provider Performance Reporting and Transparency

In this year's report card we see New Hampshire regaining its "A" grade and Massachusetts falling several grades. The difference between the two is that the former has a comprehensive statewide website that uses the information in its APCD to inform consumers, while Massachusetts has shut down its statewide website and delegated to health plans the responsibility of making health care prices transparent. There are several reasons why statewide websites that leverage APCDs have an advantage when it comes to sharing information about the price and quality of health care.

1. The importance of sample sizes

   Most commercial health plans across the country have only a portion of the market for health insurance. While it is not necessary to have the totality of a market to determine, with reliability, the average price and the quality of care, larger sample sizes help significantly to differentiate performance. Figures A through F plot the average price of an episode (on the X axis of each chart) for facilities with a minimum of 30 episodes, or physicians with a minimum of 100 episodes. We set these minima to avoid the biasing effect, even after severity adjustment, of too few cases. While a health plan might have a sample size adequate to evaluate the performance of some of the physicians or hospitals in its network, it is highly unlikely to have a large enough sample to evaluate all of them. Only the combination of data from most or all the commercial plans operating in a market can provide an adequate sample size for the majority of providers in a state.

   In Figures A through F, the average market price includes an interval equal to one standard deviation above and below the average. Within that zone, it is not possible to distinguish one provider's price from another. And the smaller the sample size, the wider the distribution and the interval. When observing a single commercial plan, virtually all differences in average price are, statistically speaking, undifferentiated. In many of these figures, it is not possible to differentiate the average price per provider. In others, where the observations come from very large datasets covering multiple commercial and/or Medicaid payers in a single state, differentiation is possible.

2. The importance of multiple payers

   A key element of most APCDs is that they carry claims data from commercial payers and public payers, particularly Medicaid. Figures A through F show the differences in average costs and rates of avoidable complications, for an episode type, by payer type – commercial or Medicaid.

   Potentially avoidable complications are a construct developed by HCI[3] to help more formally link price and quality by counting, for any episode, the occurrence of these complications and their associated costs. Measures of avoidable complications have been endorsed by the National Quality Forum and are also, in a derivative form, used by Medicare for various quality reporting and value-based payment models. For example, Medicare has instituted a penalty on hospitals that have excessive readmission rates. Medicare also requires hospitals to report on patient safety errors.

   Figures A and B show the average price and rate of complications for routine vaginal deliveries. While the average price of deliveries in Medicaid varies little by provider because Medicaid fixes the prices for certain services, there is significant variability in complication rates, with some providers having rates as high as 1 in 10. Conversely, in the same state, the average cost of deliveries for the commercially insured is four times higher than Medicaid and varies quite significantly. However, rates of complications are significantly lower with almost no variability. What explains these differences,

especially after adjusting for patient severity? Why are mothers delivering babies in this Medicaid program facing far higher rates of avoidable complications than mothers in commercial plans? The point, of course, is that barring an APCD, this question could and would never be asked.

Figures C and D show results that are diametrically opposite to that of vaginal deliveries. There are significant differences in price and almost no differences in avoidable complications for colonoscopy episodes in Medicaid, but somewhat less variability in price and far more variability in avoidable complications for commercial plan members.

Figures E and F show variability in the price and rate of avoidable complications for low back pain episodes for both Medicaid and commercial plan members.

3. The importance of an independent reporting mechanism

Reporting the price and quality of health care is challenging for any organization, but particularly so for individual health plans. While a plan member can only be a member of one health plan at a time, surveys continue to indicate that consumers lack confidence in the independence of health plans when it comes to their reports on the price and quality of providers. In fact, most consumers fear the health plans are simply trying to drive them to less expensive providers rather than "the best" or highest-value.

Furthermore, there are no existing national standards for measuring the price of a medical episode of care, which can create significant heterogeneity from health plan to health plan in how they report prices. Most health plans have chosen to focus their price reporting on individual services, such as an office visit or a lab test. However, the total potential price that might be due for a specific medical episode, such as a colonoscopy or a vaginal delivery, or the treatment of low back pain, ultimately has far greater impact on patients.

Figure F shows the average price and the rates of potentially avoidable complications for the management of low back pain, a common medical episode for patients under age 65. Given that for an average health plan member the deductible is over $1,500 and the out-of-pocket maximum is over $5,000, the plan member will pay a significant percentage of the average costs of managing low-back pain. If a payer simply provides prices on individual services, it might be very difficult for a plan member to select a provider. Consider this table derived from Figure F and representing four different physicians:

	PHYSICIAN 1	PHYSICIAN 2	PHYSICIAN 3	PHYSICIAN 4
Average Price	$2,175.00	$4,173.00	$6,481.00	$8,500.00
PAC %	21.50%	37.00%	5.50%	13.15%

Some of the difference between these providers stems from the quantity of services delivered, but some from the price. Furthermore, price, without some indication of quality, could lead to different conclusions. Each episode of low-back pain consists of dozens of services, from office visits to primary and specialty care, to diagnostic imaging and even procedures. As a result, to make an informed decision, and to compare one provider to another, a consumer should know the extent to which a physician operates on patients with low-back pain, the nature and seriousness of adverse events and other complications, and the reason for the significant differences in price.

HCI[3] generated the results in Figures A through F using its ECR Analytics on an APCD, and stratifying the results by payer type. They illustrate the importance of tying together meaningful price and quality information to help consumers better gauge the relative value of providers in a state, and they also illustrate how these types of data can help policymakers and providers gain insights on the disparity in care between different types of payers. In a prior report with CPR, we delved into many of the methodological pitfalls in reporting price to health plan members, and most of those can be avoided when states take on the important leadership role of assembling data across payers in an APCD, applying a consistent set of rules to those data, and releasing the results of those consistent analyses to the general public.

Figure A: Vaginal Deliveries Medicaid

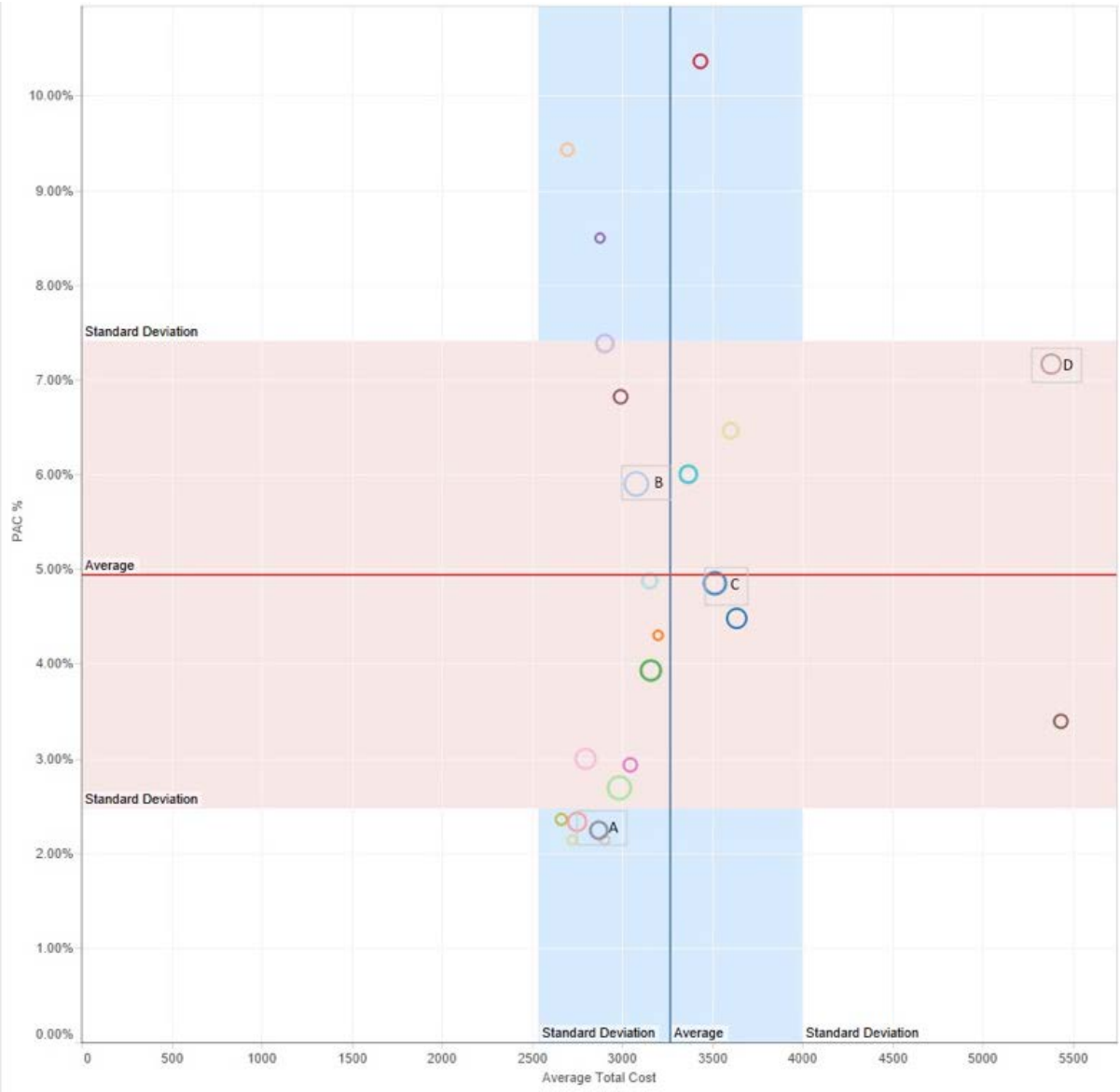

Figure B: Vaginal Deliveries Commercial

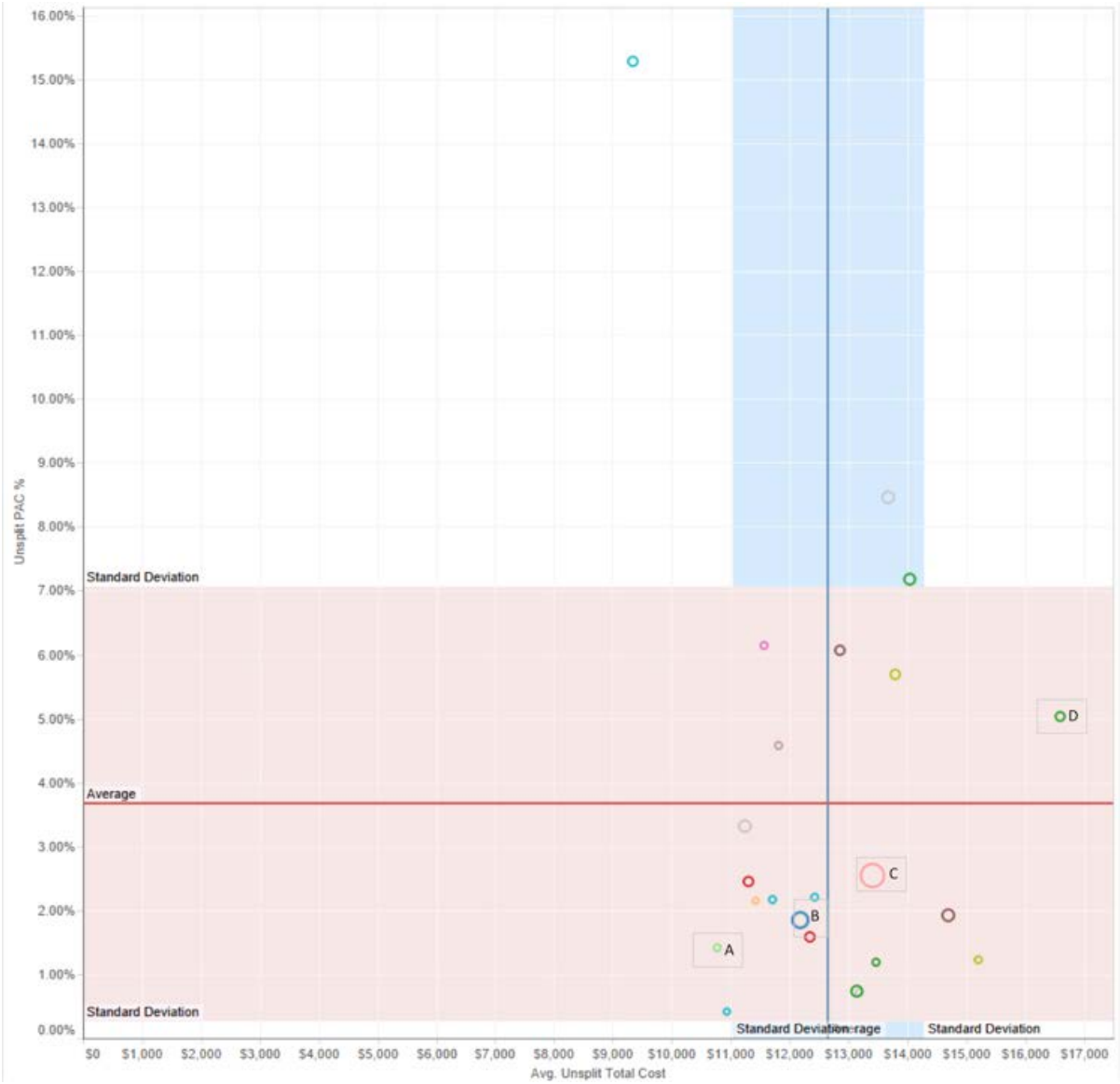

Figure C: Colonoscopy Medicaid

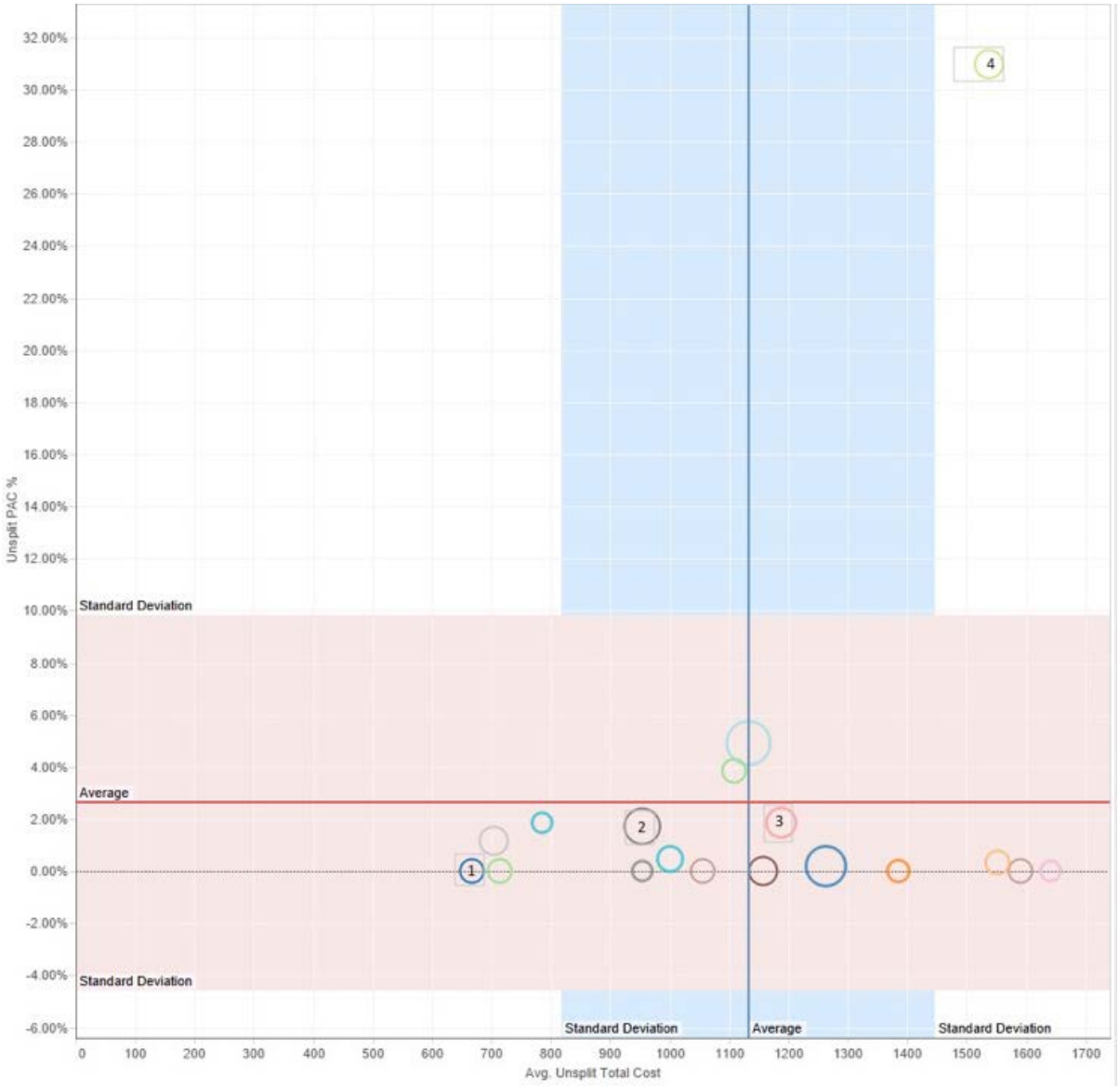

Figure D: Colonoscopy Commercial

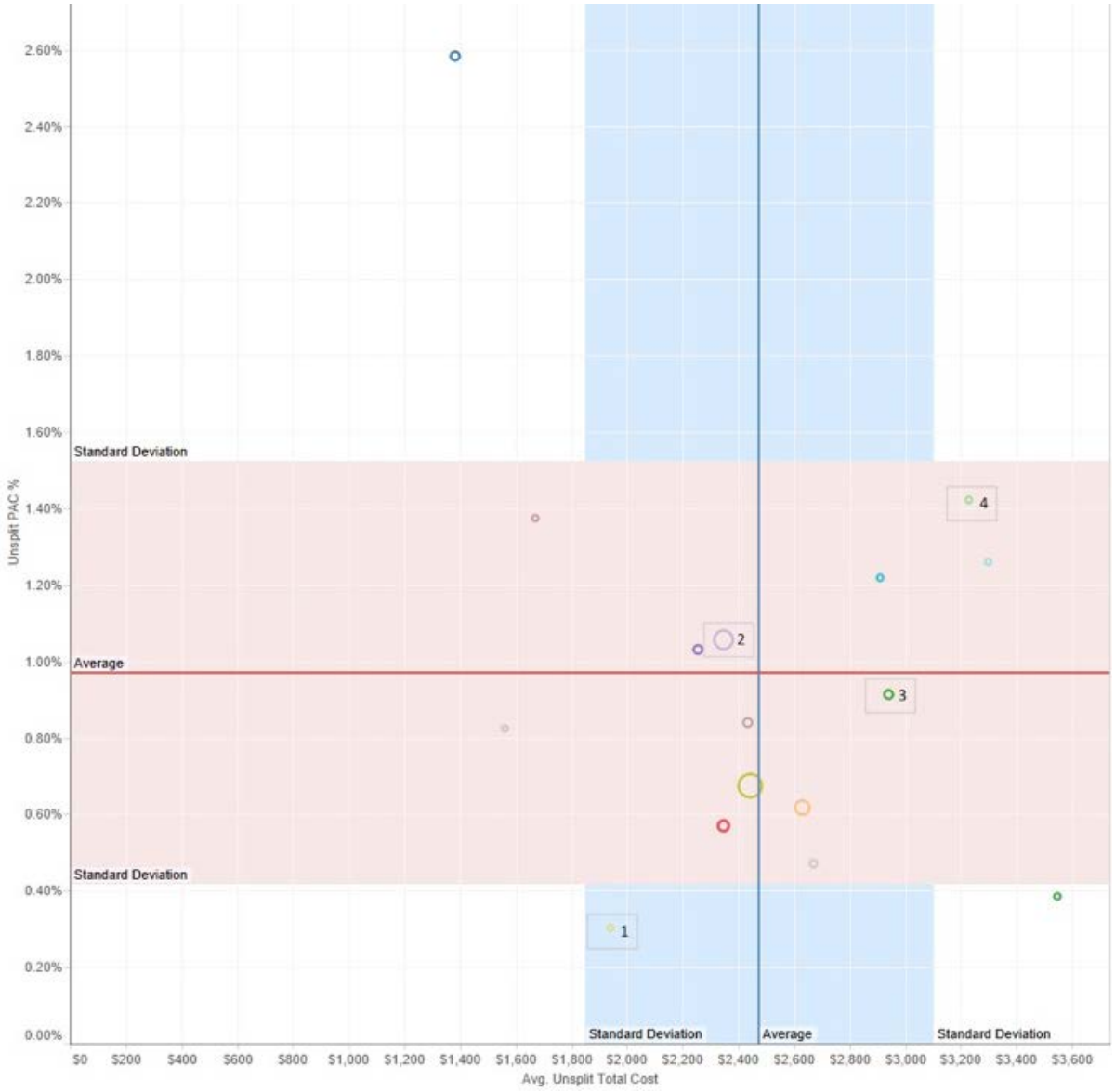

Figure E: Low Back Pain Medicaid

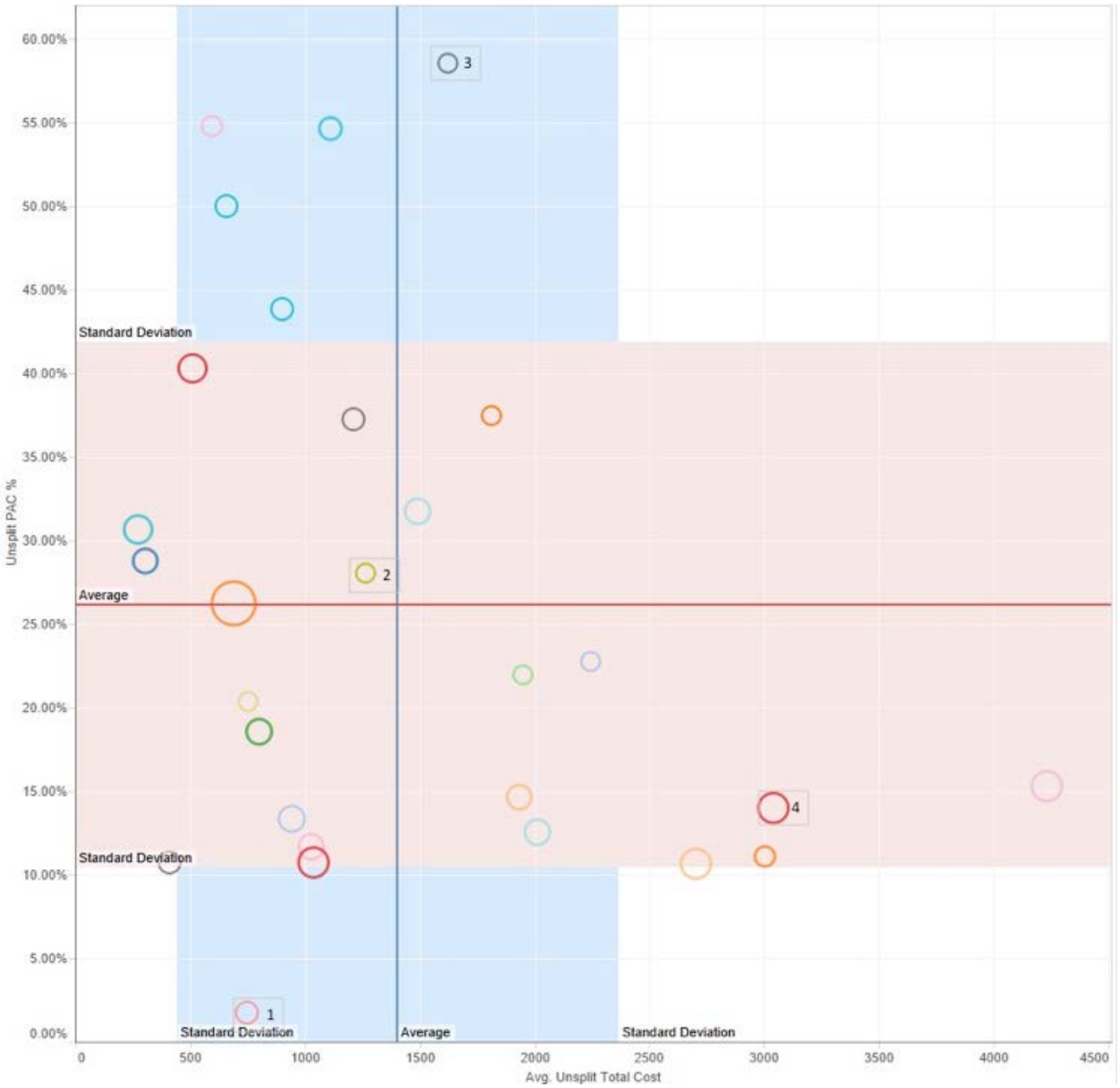

Figure F: Low Back Pain Commercial