

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-A-15

Subject: Price Transparency
(Resolution 819-I-14)

Presented by: Jack McIntyre, MD, Chair

Referred to: Reference Committee G
(Courtland G. Lewis, MD, Chair)

1 At the 2014 Annual Meeting, the House of Delegates adopted Policy D-155.989, which directs the
2 American Medical Association (AMA) to “study appropriate mechanisms through which patients
3 and physicians will be able to obtain price data from providers, facilities, insurers and other health
4 care entities prior to the provision of non-emergent services, and that our AMA study the barriers
5 to this goal and serve as a leading voice in this discussion.”
6

7 Subsequently, at the 2014 Interim Meeting, the House referred Resolution 819, “Price
8 Transparency,” submitted by the Iowa Delegation. Resolution 819-I-14 asked “that the AMA: 1)
9 develop an educational program by early 2015 for physicians that would make health care price
10 and reimbursement site differences clear; and 2) work with the Center for Healthcare Transparency
11 (CHT), the Health Care Cost Institute (HCCI), and the Centers for Medicare & Medicaid Services
12 (CMS) to make their websites easier to access and use, and make their data for hospital and
13 physician prices and payments more accurate and useful for physicians, purchasers, and patients.”
14

15 Using Policy D-155.989 and referred Resolution 819-I-14 as a guide, the scope of this report is
16 limited to identifying ways to expand the availability of health care pricing information that will
17 allow patients (insured or uninsured) and their physicians to make value-based decisions when
18 patients have a choice of provider or facility. The Council notes that increased transparency is
19 needed throughout the health care system in order to help increase the value of health care
20 spending by individuals, public and private insurers, and society at large. Board of Trustees Report
21 6, “Medical Information and Its Uses,” also before the House at this meeting, establishes principles
22 for data transparency that will help ensure that physicians in particular have access to timely and
23 actionable data that will help them improve care and manage costs.
24

25 BACKGROUND

26
27 For many years policymakers and others have emphasized the need for increased transparency to
28 help control rising health care costs. Many believe that the lack of timely, standardized
29 information about the cost of health care services prevents health care markets from operating
30 efficiently. Recent developments in the health care system have created a more immediate need for
31 price transparency. Many health plan benefit designs and network strategies require patients to
32 assume greater financial responsibility for their care choices. As deductible levels increase for
33 standard plans, and more patients opt for high deductible health plans paired with a health savings
34 account, the demand for better information about anticipated out-of-pocket costs will increase.
35 Similarly, benefit design strategies such as reference pricing depend on transparent pricing

1 information both to set fair benefit levels and to enable patients to make decisions about where to
 2 seek care and understand how that choice may affect their out-of-pocket costs.

3
 4 Patients enrolled in narrow network plans may face several layers of opacity that affect their ability
 5 to effectively manage their out-of-pocket spending. Determining a provider's network status may
 6 be difficult because of outdated provider directories or confusion associated with multiple plan
 7 contracts. Furthermore, the more services a patient needs, the more difficult it becomes to ensure
 8 that every provider involved in the care will be covered at in-network rates. Although some plans
 9 may offer an out-of-network benefit, patients who receive care from out-of-network providers face
 10 the potential of significant out-of-pocket costs, including higher cost-sharing requirements and a
 11 separate bill from the provider reflecting the difference between the provider's charges and the
 12 amount covered by the health plan. The increasing use of narrow networks requires that patients be
 13 fully informed not only about the network status of a physician or provider, but also the exact
 14 financial obligations associated with receiving in network or out-of-network services.¹

15
 16 The AMA has long-standing policy encouraging physicians to consider the relative cost of the
 17 treatment of services they are recommending for their patients (e.g., Policy H-450.938). Under
 18 alternative payment models such as shared savings arrangements, physicians are expected to be
 19 more actively engaged in helping patients make health care decisions that balance cost and quality.
 20 Price transparency, including pricing information from other providers, is necessary to allow
 21 physicians to assess cost of care implications of their treatment and referral recommendations.

22
 23 **BARRIERS TO PRICE TRANSPARENCY**

24
 25 The lack of transparency in health care pricing and costs is primarily the result of a health care
 26 financing system that depends largely on complex arrangements between and among employers,
 27 third-party payers, providers and patients. The health care system's reliance on third-party payers
 28 to negotiate prices for patients and pay providers makes it difficult to identify accurate and relevant
 29 information regarding costs associated with specific medical services and procedures. Individually
 30 contracted payment rates represent proprietary information, and insurer payment policies, coverage
 31 rules, and cost-sharing requirements are difficult to communicate in a standardized manner, and the
 32 cumulative effects of each of these factors often make it difficult to provide accurate pricing
 33 information for an individual patient in the absence of an actual service claim.

34
 35 Because the vast majority of health care is compensated through third-party payers at individually
 36 contracted rates, many practices or facilities do not maintain standard fee schedules that reflect the
 37 amounts that patients would be reasonably expected to pay if directly billed by the provider. In
 38 some cases, providers may be concerned that developing and publicizing a cash-pay fee schedule
 39 could negatively affect contract negotiations with third-party payers. The lack of price information
 40 becomes a significant problem for patients who seek care from providers outside of their insurance
 41 network, and for patients who are uninsured or otherwise choose to pay for medical care directly.

42
 43 Providers and insurers may be reluctant to make certain pricing information available because of
 44 concerns about antitrust laws.² Federal and state antitrust laws are intended to promote competition
 45 by discouraging entities from working together to set prices, and there is a risk that some
 46 transparency efforts that involve reporting rates negotiated between providers and payers could
 47 give the appearance of or result in collusion by either party in future price negotiations. The
 48 Department of Justice and the Federal Trade Commission, the primary enforcers of antitrust law,
 49 are aware of the potential competitive benefits associated with health care price transparency, and
 50 have issued guidance regarding situations that involve the release of health care price information

1 that are unlikely to raise antitrust concerns.³ Nevertheless, the complexity of antitrust law and the
 2 fear of increased scrutiny often serve as deterrents to the release of detailed pricing information.

3
 4 Even if basic pricing information were widely available, there are additional barriers to achieving
 5 meaningful price transparency in health care. For example, an ideal price transparency system
 6 would allow patients to access relevant and accurate information prior to receiving care. This
 7 would enable patients to anticipate their potential costs in advance, and to choose among providers
 8 to seek the best value care. Yet, anticipating the need for health care services is often difficult. The
 9 urgent nature of some medical care, the inability to predict the particular course of treatment that
 10 might be indicated or identified subsequent to the initial complaint, and the intensity and scope of
 11 services required often leave patients without time to evaluate their options prior to receiving care.

12
 13 Even for health care services that are more predictable, such as routine office visits or scheduled
 14 elective surgeries, developing and implementing a consumer-friendly health care cost tool that
 15 patients will actually use is another challenging task. According to a recent study by the Catalyst
 16 for Payment Reform, 98 percent of health plans surveyed offer some kind of cost estimator tool,
 17 but only two percent of plan members use the tools, which have varying levels of sophistication
 18 and functionality.⁴ Even if comprehensive pricing and quality information were available, more
 19 work needs to be done to find ways to increase the relevance of the information and to encourage
 20 patients to use it to inform their health care decisions.

21
 22 Finally, successfully integrating cost and quality information in health care transparency initiatives
 23 is challenging. In addition to the fact that many health care services still lack relevant quality
 24 metrics, designing tools that help patients interpret and balance quality and cost information is
 25 difficult. Studies indicate that patients are willing and able to make choices based on value (e.g.,
 26 the best quality at the lowest price) as long as the information is presented clearly and effectively.
 27 Conversely, in the absence of quality information, or when information is difficult for patients to
 28 interpret, many patients believe that there is a direct correlation between cost and quality, and are
 29 likely to choose a higher cost provider if their priority is high quality care.⁵

30
 31 **PRICE TRANSPARENCY RESOURCES AND INITIATIVES**

32
 33 As noted, almost all major health insurers offer some kind of cost estimator tool to help enrollees
 34 research and predict their out-of-pocket costs for certain health care services. In addition, a 2013
 35 survey by Towers Watson found that almost one-third of large employers have a cost and quality
 36 tool available for their employees, and more than 40 percent plan to add one within the next few
 37 years.⁶ In the public sector, many states are exploring or pursuing various price transparency
 38 initiatives, including legislation that requires providers to disclose certain fees prior to the
 39 provision of care, health insurers to provide cost estimates to their enrollees, and state agencies to
 40 produce annual reports on the prices of common medical procedures.⁷

41
 42 At the time this report was written, 12 states had established an all payer claims database (APCD),
 43 and another six states are pursuing APCD implementation.⁸ APCDs serve as a centralized resource
 44 for data related to health care costs and charges, and in most cases payers are legally mandated to
 45 report claims information. APCDs typically include data derived from medical, pharmacy and
 46 dental claims from private and public payers. APCDs are potentially valuable sources of data for
 47 policymakers, physicians, patients, payers and purchasers of health care if the claims data is
 48 accurate and reported in a usable format. Although APCDs do not typically provide information
 49 directly to consumers, Maine and New Hampshire have created public-facing tools that allow
 50 patients to research health care prices and identify variations in prices of common services.
 51 Resolution 819-I-14 identifies two organizations that are working to advance price transparency

1 initiatives for patients and physicians, the Health Care Cost Institute (HCCI) and the Center for
 2 Healthcare Transparency (CHT). HCCI was established in 2011 to promote independent, non-
 3 partisan research and analysis related to health care costs in the United States. HCCI's goal is to
 4 create and maintain a database of information about public and private sector health care costs and
 5 utilization, including private claims data from several major health insurers.⁹

6
 7 In February 2015, HCCI launched guroo.com, a free online transparency tool that provides national
 8 and local cost averages for common health care treatments and services based on claims
 9 information provided by Aetna, Humana, UnitedHealthcare, and Assurant Health. At the time of
 10 the site launch, information was searchable by health care condition, medical test, or "care bundle,"
 11 which includes costs commonly associated with a particular course of treatment. HCCI envisions
 12 expanding the tool's capabilities to include more detailed price information, information about
 13 prescription drug prices, and quality information, which will be developed in partnership with the
 14 National Committee for Quality Assurance (NCQA).

15
 16 CHT was established in 2014 and is leading an 18-month planning process to provide meaningful
 17 and actionable health care cost and quality information to health plans, employers or other health
 18 care purchasers, and consumers. CHT's executive committee includes representatives from the
 19 Centers for Medicare & Medicaid Services and the Office of the National Coordinator, as well as
 20 representatives of health plans, purchasers and providers. CHT is a partnership between the
 21 Network for Regional Healthcare Improvement and the Pacific Business Group on Health.¹⁰

22
 23 For-profit price transparency services are emerging. Health Care Bluebook, Castlight, and
 24 HealthSparQ are examples of private vendors that use claims data and other information from
 25 insurers and employers to generate "fair price" cost estimates for various medical services. Basic
 26 consumer tools may be offered for free, but companies often offer additional paid services that
 27 provide quality and cost information about providers. Such for-profit tools are generally marketed
 28 to large employers or health insurers, who make the tools available to employees or plan members.

29
 30 **PRICE VARIATIONS ACROSS SITES OF SERVICE**

31
 32 Resolution 819-I-14 asked that the AMA develop an educational program that would help explain
 33 site of service price and reimbursement differences. The Medicare program and private insurers
 34 frequently pay different rates and impose different patient cost-sharing amounts for the same
 35 service, depending on where it is performed. These site of service differentials primarily result
 36 from separate Medicare payment methodologies that are used for physician offices, ambulatory
 37 surgical centers (ASCs) and hospital outpatient departments (HOPDs). Medicare generally pays
 38 lower rates for services performed in a physician's office, and patient cost-sharing is also lower.
 39 Payment rates and cost-sharing are greater for services delivered in ASCs, and are generally
 40 highest for services delivered in HOPDs. Most private insurers mirror Medicare's fee schedule.

41
 42 CMS Report 3-A-13, "Payment Variations across Outpatient Sites of Service," and CMS Report
 43 3-A-14, "Medicare Update Formulas Across Outpatient Sites of Service," provide detailed
 44 information about the disparity in payments and patient cost-sharing for procedures performed
 45 across outpatient sites of service. The AMA also developed a concise briefing document, "Payment
 46 Variations across Outpatient Sites of Service," that discusses price and payment disparities across
 47 sites of service, and highlights policies that promote equitable payments across sites of service and
 48 enable patients to seek care in the most appropriate and cost-effective care setting. Reference
 49 Committee testimony on Resolution 819-I-14 highlighted these resources and suggested that they
 50 effectively achieve the intent of an educational program related to site of service price differences.
 51 In addition, Council on Medical Service Report 2, "Physician Payment by Medicare," also before

1 the House at this meeting, addresses the impact of hospital acquisition of physician practices on
2 health care costs, patient access to health care and physician practice. The report includes a
3 discussion of the impact of hospital acquisition of physician practices on health care costs.

4
5 DISCUSSION

6
7 Policy D-155.989 and referred Resolution 819-I-14 specifically address the need for increased
8 price transparency, which is widely seen as essential for controlling health care costs. According to
9 analyses by the Catalyst for Payment Reform, the overall functionality and utility of price
10 transparency tools is improving. Patients generally have access to pricing estimates for a broader
11 range of services and procedures, and many tools include options that can estimate costs for a full
12 episode of care. Some health plans and vendors are introducing tools that provide provider-specific
13 cost estimates for some common, elective procedures and services, although antitrust concerns or
14 contractual restrictions can present barriers to comparative cost estimates for specific providers.

15
16 Successful implementation of any price transparency program will require cooperation and
17 collaboration by all stakeholders. With approximately 87 percent of Americans covered by private
18 or public health insurance, third-party payers control most of the information necessary to help
19 patients understand the costs associated with the health care services they receive. Nevertheless, the
20 Council believes physicians can provide leadership by demonstrating a willingness to communicate
21 information about the cost of their professional services, which is particularly important in cases
22 where physicians are not part of a patient's insurance network. As narrow networks gain market
23 share, increasing numbers of patients may find themselves intentionally or inadvertently receiving
24 out-of-network care. In such cases, patients need to know directly from their physicians what their
25 total bill will be in order to determine total out-of-pocket obligations.

26
27 Our AMA should continue to advocate that health plans provide enrollees with complete
28 information regarding plan benefits and cost-sharing information, such as the amount paid toward
29 the deductible and annual out-of-pocket maximum, patient cost-sharing responsibilities associated
30 with specific in-network providers or services, and specific amounts the insurance company would
31 pay for out-of-network providers or services. Likewise, the Council recommends reaffirming
32 Policy H-373.998, which supports empowering patients with understandable fee/price information,
33 and challenges physicians, hospitals, pharmacies, durable medical equipment suppliers, and other
34 health care providers to make this information available to patients.

35
36 The Council was encouraged to learn about the progress that has been made to advance price
37 transparency in health care. It is critical that our AMA engage actively and positively with health
38 plans, public and private entities and other stakeholders in their work promoting better, more
39 actionable price and quality transparency. Physicians should find ways to facilitate price
40 transparency efforts, and help ensure that entities promoting price transparency tools and services
41 have processes in place to ensure the accuracy and relevance of the information they provide. Our
42 AMA is already engaged in helping states advance the development and use of APCDs, and should
43 continue supporting the growth of these valuable sources of information related to health care
44 costs. The Council also believes that electronic health records (EHR) have the potential to facilitate
45 price transparency, and recommends that our AMA encourage EHR vendors to include these
46 capabilities as EHR products continue to evolve.

47
48 Efforts to promote price transparency and help patients better prepare for their out-of-pocket costs
49 are highly dependent on a patient's willingness and ability to become a more engaged purchaser of
50 health care. Patients need to be better educated about the complexity of health care pricing,
51 including the implications of in-network and out-of-network coverage rules and out-of-pocket

1 spending obligations. Our AMA should encourage efforts to promote health care economics
2 literacy that give patients tools and information to allow them to be more proactive in researching
3 the cost of health care services they receive or anticipate receiving.

4
5 The Council recommends rescinding Policy D-155.989, which was accomplished with this report.

6
7 **RECOMMENDATIONS**

8
9 The Council recommends that the following be adopted in lieu of Resolution 819-I-14, and that the
10 remainder of the report be filed:

- 11
12 1. That our American Medical Association (AMA) reaffirm Policy H-373.998, which
13 supports the principle that all health care providers and entities should be required to make
14 information about prices for common procedures or services readily available to
15 consumers. (Reaffirm HOD Policy)
- 16
17 2. That our AMA encourage physicians to communicate information about the cost of their
18 professional services to individual patients, taking into consideration the insurance status
19 (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant
20 information where possible. (New HOD Policy)
- 21
22 3. That our AMA advocate that health plans provide plan enrollees or their designees with
23 complete information regarding plan benefits and real time cost-sharing information
24 associated with both in-network and out-of-network provider services or other plan designs
25 that may affect patient out-of-pocket costs. (Directive to Take Action)
- 26
27 4. That our AMA actively engage with health plans, public and private entities, and other
28 stakeholder groups in their efforts to facilitate price and quality transparency for patients
29 and physicians, and help ensure that entities promoting price transparency tools have
30 processes in place to ensure the accuracy and relevance of the information they provide.
31 (New HOD Policy)
- 32
33 5. That our AMA work with states to support and strengthen the development of all-payer
34 claims databases. (Directive to Take Action)
- 35
36 6. That our AMA encourage electronic health records vendors to include features that assist
37 in facilitating price transparency for physicians and patients. (Directive to Take Action)
- 38
39 7. That our AMA encourage efforts to educate patients in health economics literacy,
40 including the development of resources that help patients understand the complexities of
41 health care pricing and encourage them to seek information regarding the cost of health
42 care services they receive or anticipate receiving. (Directive to Take Action)
- 43
44 8. That our AMA request that the Centers for Medicare and Medicaid Services expand its
45 Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.
46 (Directive to Take Action)
- 47
48 9. That our AMA rescind Policy D-155.989, which requested this report. (Rescind HOD
49 Policy)

Fiscal Note: Less than \$500.

REFERENCES

- ¹ Council on Medical Service Report 4-I-14, "Network Adequacy," is available on line at download.ama-assn.org/resources/doc/cms/x-pub/i14-cms-report4.pdf AMA advocacy resources related to network adequacy are available at www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/private-payer-reform/insurance-fairness-transparency.page Accessed March 24, 2015.
- ² Health Care Price Transparency: Meaningful Price Information is Difficult for Consumers to Obtain Prior to Receiving Care. U.S. Government Accountability Office September 2011. www.gao.gov/products/GAO-11-791 Accessed March 24, 2015.
- ³ Statements of Antitrust Enforcement Policy in Health Care, Statement 6. U.S. Department of Justice and Federal Trade Commission. www.justice.gov/atr/public/guidelines/0000.htm#CONTNUM_49 Accessed March 24, 2015.
- ⁴ The State of the Art of Price Transparency Tools and Solutions. Catalyst for Payment Reform November 2013.
- ⁵ Hibbard J et al. An Experiment Shows That A Well-Designed Report On Costs And Quality Can Help Consumers Choose High-Value Health Care. Health Affairs 31, no.3 (2012):560-568. content.healthaffairs.org/content/31/3/560.full.html Accessed March 24, 2015.
- ⁶ Catalyst for Payment Reform November 2013.
- ⁷ See Transparency and Disclosure of Health Costs and Provider Payments: State Actions. National Conference of State Legislatures. January 2015. www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx Accessed March 24, 2015.
- ⁸ www.apcdouncil.org/state/map Accessed March 24, 2015.
- ⁹ www.healthcostinstitute.org/ Accessed March 24, 2015.
- ¹⁰ www.pbgh.org/cht Accessed March 24, 2015.