

**Statement of James P. Highland, Ph.D., President
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Before the Maine Commission to Study Transparency, Costs, and
Accountability of Health Care Systems Financing
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Senator Gratwick, Representative Gattine, and members of the Commission, thank you for the invitation to participate in the investigation of transparency, costs, and accountability in the healthcare system. My name is Jim Highland, and I am a health economist and president of Compass Health Analytics, Inc. of Portland, Maine. Compass has provided support in past years to the Maine Bureau of Insurance in assessing cost savings estimates submitted by the Dirigo Health Agency, in reviewing insurance premium increase requests, and in designing and producing a public price transparency tool for commercial small group and individual health insurance premiums that can be found on the Bureau's website ([http://www.maine.gov/pfr/insurance/consumer/Medical Trend Survey Report %20Individual.html](http://www.maine.gov/pfr/insurance/consumer/Medical_Trend_Survey_Report_%20Individual.html) and [http://www.maine.gov/pfr/insurance/consumer/Medical Trend Survey Report %20Small Group.html](http://www.maine.gov/pfr/insurance/consumer/Medical_Trend_Survey_Report_%20Small_Group.html)). We have also worked extensively with the New Hampshire Insurance Department and the Massachusetts Department of Human Services.

I'll make three points about improving health care costs, transparency and accountability in my comments today:

- 1.) Improving provider price transparency is worthwhile but its limited reach should make it only one of many cost control tools
- 2.) Additional steps to limit charges to self-pay patients should be considered
- 3.) Under evolving ACO global payment schemes for providers, the focus of transparency efforts and the availability of information is likely to shift in ways that the Commission should consider

Provider price transparency and its limitations

Effective use of pricing information not only saves one patient money for a particular procedure, it can exert downward pressure on prices in the market when many patients behave this way. However, there are limits to how much of the spending pie this behavior can affect:

- Early evidence obtained from price transparency tools in New Hampshire and California did not show evidence of improved price shopping; there are a number of reasons why the impact may be limited;

- Price transparency works better for the screening colonoscopy I am about to have than for the emergency appendectomy I had two years ago; large amounts of healthcare spending are not amenable to shopping in advance;
- Since 70% of health care costs are expended for 10% of the population in a given year, most spending occurs after individuals have hit their out-of-pocket maximums for the year (capped at \$6,350 per person in 2014), so for a very large percentage of care there is no additional cost sharing by the patient and so no price incentive to shop;
- It can be difficult to capture many complex services in online price tools
- Quality of care and other non-financial considerations are often bigger considerations than cost; cost is sometimes interpreted by consumers as an indicator of quality
- In concentrated markets (few competitors), it has been shown that price information can lead to price increases (lower price participants raise prices)

Beneficial effects of provider pricing transparency are likely, particularly in more populated areas of the state, but limitations suggest this should be one tool of many in the cost control tool belt. Care should be taken to make sure that additional administrative requirements related to transparency, and their associated costs, are not introduced without carefully considering the added benefit, particularly given voluntary initiatives under way.

Provider Prices Paid by Self-Pay Patients

I have the distinct displeasure of having a colonoscopy scheduled in the near future, and I have taken this opportunity to do some research on pricing with available tools, including the MHDO's health cost site and my insurer's cost estimate tool. The attached table contains some numbers I have put together about this procedure:

- The first line contains an approximate cost (\$426) of delivering a service based on Medicare practice cost and physician work data;
- For uncompensated care the hospital will receive zero for this service;
- For Medicaid, I do not have data but have used approximate ratios of payment to cost for Medicaid to estimate a Medicaid reimbursement of \$250;
- The Medicare reimbursement for this procedure in Maine is approximately \$400 or 94% of cost (based on average payment to cost for Medicare);
- The charges obtained from the MHDO website for three example hospitals range from \$1,500 to \$3,375, with charges generally increasing away from the Portland area;
- The allowed charges, or the amount allowed as the valid charge based on the insurer's contract with the provider range from \$1,000 to \$2,700;
- My insurer estimates my out of pocket costs to be from \$150 to \$400;
- A self-pay patient would be liable for the full "list" charge amounts of \$1,500 to \$3,375

This information illustrates a number of important points:

- Charges for private patients are high at least in part to make up for losses related to care provided for uncompensated care and Medicaid patients; high/distorted list prices are a legacy of insurer pressure for discounts in “percent of charge” contracts which incentivize hospitals to increase charges in general and for particular less visible items;
- Cost sharing in a traditional policy dampens the price incentive effect;
- Prices as one moves away from Portland get much higher; possible causes are higher concentrations of uninsured and Medicaid patients and/or inefficiencies of scale (small hospitals in small towns), facilitated by market power; the tradeoff in price shopping is geographic proximity and access for those living in these more rural locations;
- Finally, the self-pay patient pays not the \$400 cost, nor the \$1,000 charge allowed by the lowest-charge provider, but the full list price, which is \$1,500 at even the least expensive facility, and as high as \$3,375 (or even higher at other facilities not shown); self-pay patients are in one sense victims of the back and forth between insurers and providers about discounts and charge levels, and price shopping cannot remove this fundamental lack of fairness.
- The Commission may want to consider legislation similar (in intent if not content) to California’s Fair Pricing Act, which requires hospitals to charge self-pay patients amounts consistent with payments from government payers (Medicare).

ACOs and Provider Payment Reform Increase the Importance of Insurance Price and Quality Transparency

The point of “purchasing” a service is only one of several key buying decisions made in the chain of healthcare cost decisions. The initial decision to buy insurance by employers and/or individuals, and the preceding decisions by insurers to contract with providers are key decisions about which better information can be made available. Indeed, the point of insurance purchase has the potential to answer many of the questions individuals would want answered at the time of requiring a service.

- Insurers have the data, expertise, and resources to analyze complex information and contract with better performers, and can provide general scoring information about providers in their network;
- Insurers can and have (in some cases) provided information about out-of-pocket cost exposure for specific services; this could be expanded to non-network providers;
- It is important for the Commission to consider how evolution away from fee-for-service payment will affect pricing transparency requirements;
- “Global budgets” are a form of provider payment that in effect pays a provider delivery system a fixed rate per month to provide all required

services for a population; combined with quality measures these are intended to incentivize more efficient and effective delivery of care;

- Massachusetts passed a law in 2012 that over five years aims to replace fee-for-service payment with global budgets, supporting the formation of provider Accountable Care Organizations (ACOs) to accept these budgets for payment, as well as promoting patient-centered medical homes and expanded public reporting of cost and quality data;
- Maine's \$33 million CMMI grant supports the stated goal of moving gradually to ACOs for both private and public payers, global budgets, patient-centered medical homes, and cost and quality transparency.
- If in fact provider charges are no longer a basis for provider payment, these changes are likely to shift the focus for cost and quality transparency to the level of the delivery system and the insurance purchase decision, and to information that ACOs are required to make available. The Commission's work should consider these developments in focusing its efforts for ongoing improvement of transparency and accountability.

Conclusion

Our health care delivery and financing system is complicated and evolving. Efforts at improving transparency, accountability, and costs will work best if they carefully consider available evidence about what is likely to work, and plan for changes that are underway in provider payment.

Thank you again for including me in today's agenda.