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Opportunity Solutions Project (OSP) strongly supports the U.S. Department of Health and Human Services' (HHS) efforts to increase transparency in health care and lower health care costs. The status quo harms individuals with chronic conditions trying to afford care, raises premiums, and creates barriers to entry for health care innovators. OSP has worked in nearly two dozen states across the political spectrum to actively increase transparency in health care and lower health care costs. These state-led efforts provide HHS with key lessons on what works, potential challenges, and major milestones on the path to success.

Five lessons from recent state-led transparency reforms

Not all transparency reforms are created equal. Lessons learned from state-led reform efforts, including policy changes that have been *unanimously* approved by state legislatures, can provide important context as HHS considers transparency reforms.

1. Patients in the small group and individual markets need the most help

Unlike self-insured companies that can access their claims data, small businesses and individuals frequently have no access to past claims or cost estimates ahead of time. Insurers are closest to the right information for patients and should provide this information to their enrollees. That is why transparency must not stop at the hospital or facility level. Using electronic health records to access price information may work in some circumstances, and may be most helpful for providers, but for patients getting tailored information from their insurer would be the simplest and least complex way to accomplish this goal.

2. Patients need to know what their health plan pays ahead of time

In order to compare options, patients need to know what their specific health plan pays for a given service. Without information on estimated out-of-pocket costs, what the plan will pay a specific provider, and the average real price paid for other providers (or some other form of pricing anchor, such as a median in-network rate), patients cannot compare rates and decide if they are getting the best value. In short, patients need more than just out-of-pocket estimates.

While many states have required provider-level transparency on charge rates, the information required is often not actionable for patients, and providers are often not best positioned to provide contracted real price rates quickly given unique insurer plan designs. Transparency of cash-pay prices is important, but these prices are often not the same as the final paid amounts, a fact that is often overlooked in transparency efforts. Patient need to know more than the undiscounted charge rates.

While many insurance companies offer some kind of cost information or transparency tool, many of the tools are hard to find, rarely publicized, not user-friendly, limited in nature, and do not display enough information for patients to make fully informed decisions.

3. Patients need to see a direct benefit from shopping

Transparency alone is not enough. Even some of the better transparency tools often disclose only the estimated out-of-pocket costs for a handful of services or procedures. Estimated out-of-pocket cost estimates are not enough information for patients to select high-value providers, as patients have little or no incentive to shop for better value options in many cases, wasting money on higher-cost care and driving insurance premiums higher in the future.

Patients need to be engaged every time they interact with the health system, even if they do not have out-of-pocket costs for a particular service. There is no cost-sharing for patients seeking preventative services in most cases and no cost-sharing for individuals with chronic conditions once he or she has reached the out-of-pocket limit. Out-of-pocket estimates do not help these patients find their way to a procedure or service that may cost ten times less for the same—or better—quality.

Patients must directly benefit from shopping for the best value, including by sharing any savings generated by shopping for better deals. According to transparency companies that offer shared savings incentives to patients, patient engagement increases up to elevenfold when shared savings are included in a pricing transparency program. Patients empowered with this information and incentives to shop can dramatically reduce health care spending without sacrificing quality of the care they receive. These shared savings can work not only in fee-for-service arrangements, but also when care is bundled and in value-based care contracts.

4. Patients need access to high-value providers, regardless of network status

Independent providers are becoming increasingly rare. In many markets, they are being pushed out of insurer networks altogether, even when they provide high-quality care at lower costs. Significant provider consolidation has taken place and many insurers have narrowed their networks. Better-priced options often exist out-of-network, but patients are effectively penalized for seeking those options, as they pay up to 100 percent of the costs, and that out-of-pocket spending does not count against their deductible or out-of-pocket limit.

5. The public supports greater transparency

National surveys show that 82 percent of voters want the right to know the cost of non-emergency procedures ahead of time. Likewise, 72 percent support the ability to pick out-of-network providers if they are a better deal, and 68 percent support rewarding patients directly when they shop for better-value care. Nearly 60 percent of consumers said they personally would consider switching to another provider for sharing savings as little as $50.

Learning from missed opportunities

State experiences in this area also offer valuable lessons on potential challenges to transparency reform efforts as HHS moves forward.

1. Avoid limited value transparency

Requirements to disclose only average prices paid, only initial charge rates, or only a handful of the most common procedures undermine meaningful patient engagement to shop for the highest value care.

2. Avoid putting too much faith in public websites and all-payer claims databases

Some individuals have advocated for all states or the federal government to adopt all-payer claims databases or set up public websites for claims data. While there is some value to these efforts, the experience at the state level should be instructive. The benefits can include better-informed research and increased public awareness of price transparency. However, very often

these databases have been expensive to operate, difficult and at times expensive to obtain information from, and the quality of the data is often mixed and outdated.

Data collection efforts should focus on releasing as much information as possible as quickly as possible, so the data is timely, with a limited role for government to serve as a gatekeeper for the data.

3. Avoid overregulating quality

Quality is critically important for understanding the value of care received. However, cementing one standard of quality in law may not account for rapid quality improvements in the market. Additionally, it is difficult to set a uniform policy for such a broad array of services and areas. The best protection of quality is stronger transparency. If patients know actual prices and have incentives to share savings for obtaining high-value care, providers will have a natural incentive to market their services to patients based on both cost and quality. But patients cannot make those decisions about value without transparency.

4. Avoid overcomplicating disclosure and delays

In some states, debates over transparency have dragged on for years as policymakers strive for the perfect level of transparency and disclosure. But while this process of perfection is underway, patients lose out on receiving any important, actionable cost information. Taking a first step, even if imperfect, provides immediate help and refocuses the discussion on how to improve it further. Delaying longer than absolutely necessary will only leave in place a status quo that is already unsustainable and actively hurting patients.

Additional considerations for future action on transparency

Opponents of health care transparency efforts have often created confusion about reforms by claiming that pricing information is proprietary information, designated as confidential through contracts, or even protected as a trade secret. Some opponents have even raised antitrust implications that could result from pricing clarity. These false claims should not deter HHS from taking future action on transparency.

1. Policymakers set the standard for health care transparency

Several states have recently enacted laws requiring robust disclosure of contracted rates in the fully insured market, applying to all or most individual and small-group plans. These disclosure requirements are most often reflective of the enrollee's individual plan design. Some have required transparency for all services and procedures, while others are more limited in scope. Casting an even broader definition of transparency, numerous states have passed laws on transparency that require some version of posting prices and estimates to patients ahead of time. In these states, policymakers are making it explicit that price transparency is the law and signaling that anti-disclosure loopholes being used in contracts are no longer permitted.

New Hampshire, for example, puts contracted rate pricing data online for the public to see for their individual insurance carriers. The New Hampshire Insurance Department's transparency website uses paid claims data collected from New Hampshire's health insurers to show insured and uninsured patients' estimated costs on more than 100 medical services and dozens of dental procedures. The website offers side-by-side comparisons of health care costs and quality, and consumers can use side-by-side provider comparisons for dozens of common medical

procedures such as MRIs, CT scans, and surgeries. Results include costs for physicians and other staff, hospital or outpatient facility fees, and additional costs associated with tests or treatments. While the disclosure is somewhat limited in New Hampshire, the website shows that insurer-specific transparency is possible.

Massachusetts also recently launched a public website, which currently relies more heavily on averages of claims paid. However, the state plans to expand and release far more detailed data in the future.

But while public websites provide somewhat limited data and require taxpayer funds to support them, the private sector is starting to fill the gaps. Companies such as Healthcare Bluebook, MyMedicalShopper, and Vitals Smartshopper already have national databases of claims for millions of Americans. Some of that data is free to the public.

2. There is little basis for health care prices to be considered trade secrets

Trade secret protections have historically been used to help spur innovation and promote competition in the marketplace. There is growing economic and legal recognition that trade secret protections do not apply in the health care prices, because pricing data does not meet common standards used to justify such protection. As the Catalyst for Payment Reform—an employer member-based non-profit working to reform the health care system—has observed, trade secret protection is normally applied to information like "formulas, techniques, designs and processes not generally known or easily ascertainable by others," and that courts protect trade secrets "to promote vigorous competition between rivals." The secrecy of health care prices is not designed to promote competition, but instead "to take advantage of the consumer's lack of pricing information." Accordingly, keeping negotiated price information from consumers has no meaningful public benefit and even allows some providers to charge above-market prices, arguably harming consumers with higher out-of-pocket costs and making care more difficult to access.

3. There is little basis for health care prices to be considered confidential

Some price transparency opponents have attempted to thwart public disclosure of pricing information—including disclosure through all-payers claims databases—by inappropriately citing confidentiality agreements and anti-trust concerns. But these attempts should not prevail.

In a 2016 presentation, the Maine Office of Attorney General explained that providers and insurers attempting to claim that their pricing data were trade secrets, confidential information, or proprietary data have the burden of proving that this data meets the legal definition for proprietary data. To meet this burden, providers or insurers would need to prove that the pricing data has not been made available to the public and would directly result in that provider or insurer being placed in a competitive economic disadvantage if it were released. No provider or insurer has ever successfully met this burden in Maine.

4. Insurers already disclose contracted rates—but only after treatment

Insurers already disclose contracted pricing information in every state. Unfortunately, this disclosure frequently only happens after treatment, through an explanation of benefits mailed to the

enrollee. This illustrates that insurers do release this information, just not in a manner or at a time that consumers could use it to find the best value. This practice debunks the false claim that pricing data is proprietary data that cannot and should not be released to enrollees.

5. Many carriers disclose prices in advance in the form of estimated out-of-pocket costs

Access to cost-estimator tools offered by insurers has become increasingly common. When an enrollee has a deductible, the estimated out-of-pocket cost will be the same as the contracted price when the services they are seeking cost less than the total remaining deductible owed. In these cases, the out-of-pocket estimates—obtained through an insurer's online cost estimator tool or by calling the insurer—would simply reflect the contracted allowed amount prices. The availability of this information further undercuts any false claims that the underlying data is confidential or proprietary.

HHS should continue to pursue health care transparency reforms

OSP strongly supports HHS's efforts to increase transparency in health care and lower health care costs. The status quo harms individuals with chronic conditions trying to afford care, raises premiums, and creates barriers to entry for health care innovators. As HHS moves forward with future reforms, it should incorporate lessons learned from state-led efforts.