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Price transparency gives health plans and self-insured employers a financial win

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Excerpt for HCL

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The Situation: Healthcare costs are notoriously secretive; however, change is in the air. Beginning in July 2022, three phases of US health plan price transparency regulations will become effective, extending existing rules for hospitals that were implemented January 1, 2021. The intent of price transparency rules is to make consumers aware of the cost of covered item(s) or service(s) before receiving care, so they are empowered to shop for the healthcare that best meet their needs. The concept of price transparency has broad support, but its implications across hospitals and health systems (providers), health plans, self-insured employers, and consumers require some reflection.

The evolution of price transparency requirements will drive industry changes as healthcare enterprises change how they operate

Centers for Medicare and Medicaid Services (CMS) indicated that "health plan price transparency helps consumers know the cost of a covered item or service before receiving care" and that the requirements will provide "pricing information and enhance consumers' ability to shop for the healthcare that best meets their needs."

These requirements for health plans go into effect in three phases starting July 1, 2022.

Additional requirements will start on January 1, 2023, and January 1, 2024. These requirements update the January 1, 2021, hospital price transparency rule requiring each hospital operating in the US to provide clear, accessible pricing information online about the items and services they provide in a comprehensive machine-readable file with all items and services and display of 300 shoppable services in a consumer-friendly format. Exhibit 1 outlines the impact and timeline for each phase.

The rules will expand by January 1, 2023, requiring health plans and health systems to publish costs for 500 common items and services, and by January 1, 2024, to publish costs on all covered items and services.

Exhibit 1: Price transparency rules will evolve as CMS solicits feedback and the market better understands the implications across the stakeholder ecosystem

	Health plan transparency requirements	Healthcare provider transparency requirements
Jan 1, 2021	Not applicable	Healthcare providers will provide a consumer-friendly display of at least 300 shoppable services or as many as the hospital provides if less than 300, that a health care consumer can schedule in advance. The display must contain plain-language descriptions of the services, group them with ancillary services, and provide the discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges.
Phase 1 **Jul 1, 2022**	Health plans will provide machine-readable digital files containing the following sets of costs for items and services: • **In-network rate file:** Rates for all covered items and services between the plan or issuer and in-network providers. • **Allowed amount file:** Allowed amounts for, and billed charges from, out-of-network providers.	Not applicable
Phase 2 **Jan 1, 2023**	Health plans will provide an internet-based price comparison tool (or disclosure on paper, upon request), providing an individual with an estimate of their cost-sharing responsibility for a specific item or service from a specific provider or providers **for 500 items and services.**	Not applicable
Phase 3 **Jan 1, 2024**	Health plans must provide an internet-based price comparison tool (or disclosure on paper, upon request), allowing an individual to receive an estimate of their cost-sharing responsibility for a specific item or service from a specific provider or providers **for all items and services.**	Not applicable

Source: Centers for Medicare and Medicaid Services

We will explain the requirements and discuss their implications across multiple stakeholders in the short term (about three years), medium term (about five years), and long term (about 10 years).

Price transparency across health plans and providers will drive rationalization of pricing in the public domain

Health plans and health systems are incented to keep prices secret to better negotiate contracts between them. Unlike other industries, healthcare pricing is more complex than pricing in other industries because disease conditions are connected to severity, underlying conditions, therapy allergies, and other factors. Transaction volume is another critical element of rate setting; for example, Medicare sets a lower rate than an employer group plan because of its higher volume and larger membership.

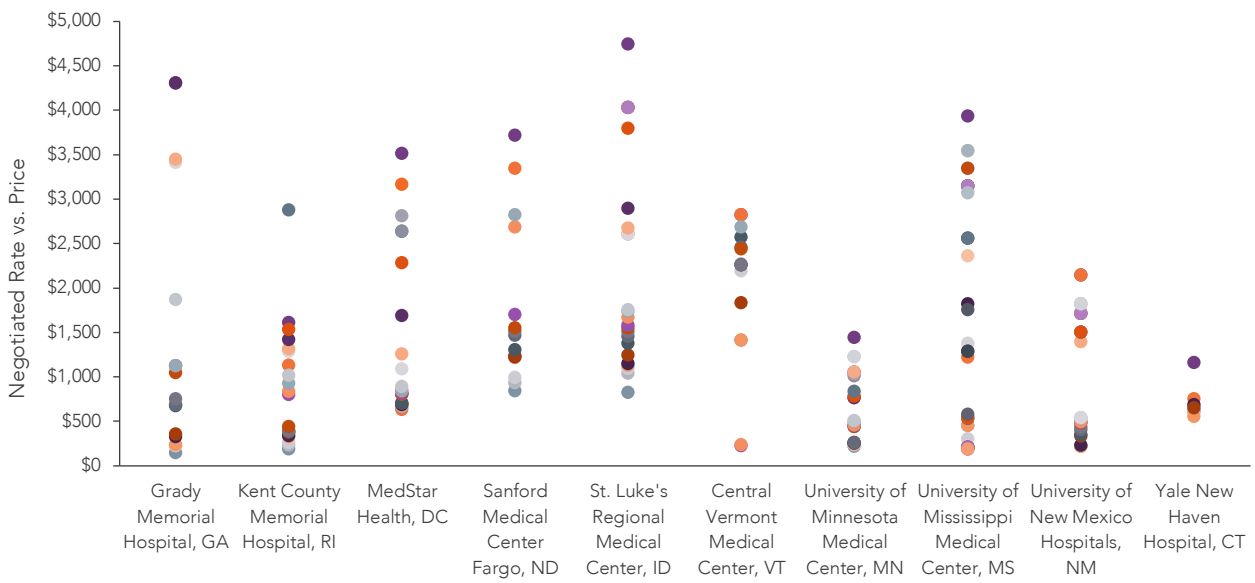
Pricing must factor in multiple variables; it's a uniquely complex endeavor where the same procedure could have a range of price points in the same hospital depending upon the health plans' negotiated rates. Exhibit 2 shows the range of payer-negotiated price points at 10 different hospitals for the same service, an MRI of the lower spine.

In the short term, there will be no shock and awe over the next three years

Health systems and hospitals will face inconsistent impacts. Larger health systems might be relatively immune in the early years, but rural and safety-net hospitals already operate on thin margins and will experience significant strain. We expect to see an acceleration in consolidation, mergers, and acquisitions, as well as changing operating dynamics, where higher-margin outpatient services will expand over lower-margin in-patient care. Additionally, the administrative burden will have an effect; PatientRightsAdvocate.org that only 14.3% of the 1000 hospitals they reviewed as part of their February 2022 report were compliant with the transparency rule.

National and regional plans are licking their chops as they will find price negotiations particularly biased towards them. There could be an argument that price transparency could de-incentivize the transition to the value-based care (VBC) paradigm given health plans will see leverage it to negotiate favorable fee-for-service (FFS) contracts.

Exhibit 2: Health plan negotiated rates for MRI of the lower spine across 10 hospitals



Data: Kaiser Family Foundation
Source: HFS Research, 2022

Self-insured employers have generally leaned on health plans to manage their benefits pricing, provider networks, and claims. Price transparency will inform them of the actual prices, potentially incenting them to explore direct-to-provider contracts.

A Kaiser Family Foundation poll indicates that only 9% of American **consumers** know that hospitals are required to disclose the prices of treatments and procedures on their websites. Given the anemic levels of awareness and that healthcare purchasing decisions are emotional, price transparency is unlikely to impact consumers in the early years.

In the medium term, expect to see chargemaster on Google within the next five to seven years

At a policy level, we should expect an enhanced level of connectivity between prices and health outcomes. CMS could likely link quality and performance measures alongside pricing, for example, star ratings for health plans and HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) scores for hospitals.

There will be a transformative change for **health systems and hospitals** contracting to pivot to VBC and away from transactional (FFS) pricing to combat severe price negotiation challenges. Given the trend of increased enrollment with self-insured employers, we expect direct-to-provider contracts to become material. While VBC will elevate financial pressures on health systems, it will not eliminate them. That could lead to further consolidation, particularly in urban areas, while services shift to outpatient settings. We also expect increased efforts to integrate revenue cycle management, pre-authorization, and claims processing systems to improve provider life cycle management.

We expect pressure on **health plans** to continue as their risk-based business declines and self-insured employers gain traction. Consequently, health plans will resort to reducing premiums and crafting attractive VBC to remain relevant. Provider-sponsored health plans (payviders) will face similar challenges as health plans. They will likely disband operations to focus on their core capabilities in care delivery.

Self-insured employers emboldened by increasing enrollment, cost clarity, and direct-to-provider contracts will also experiment with other models. These experiments could lean toward holistic health by incorporating social determinants of health through primary care and partnering with health systems on centers of excellence for specific procedure types such as cardio-vascular, hip replacement, or even cancer treatment.

We expect health **consumers** to get more care choices, access to better information (such as clinical and admin information), and improved quality of care, empowering their decision making. We expect the adoption of pricing transparency tools to slowly increase with personalized price comparison and estimation availability, potentially leading to better care choices–clinically and financially. On the downside, conflicts such as physician referrals vs. price comparison tool recommendations could strain a physician-patient relationship.

For the long term, a decade of more gray hair and value-based care

Health systems and hospitals will continue to battle financial challenges, but we expect them to lean far more toward VBC and for FFS to be the exception. This change will set a better context for improved collaboration and information exchange among health systems and hospitals. On the downside, if not managed and calibrated properly, health systems might become uber-competitive regionally, defeating the purpose of closer collaboration and joint responsibility for the population's wellbeing.

Health plans will pivot toward becoming services businesses managing government programs (CHIP, Medicare, Medicaid) as their risk-based business declines further. Some health plans may explore dynamic pricing contracts with health systems to embed flexibility and loyalty and create win-win situations while still sharing accountability for utilization and consumer value as they seek relevance.

Self-insured employers will craft new models focusing on productivity, driven by social determinants of health. They will double down on prevention, creating avenues to keep their employees healthy while leveraging price transparency to structure strong direct-to-provider VBC agreements.

Assuming the current glide path continues, **consumers** will be further empowered for matters surrounding their health as envisioned by the transparency rules. Usage of price transparency tools may improve and referring physicians will increasingly leverage patients' personalized price transparency solutions for more informed and better referrals, thus reducing friction. The construct will support greater choice for health consumers; however, given clinician burnout, provider consolidation, and estimates of clinician shortages, the choice may not be what it seems.

Technology enablement will be critical to complying with price transparency rules while realizing its benefits

Service providers must invest in understanding the business implications of price transparency and develop solutions to help health plans and providers adhere to the rules. We should expect to experience various challenges and benefits associated with price transparency rules (see Exhibit 3). By understanding the impacts service provides can tailor their services to health systems, health plans, or self-insured employers needs and to those they cover.

Early adopters of price transparency will likely adopt blockchain to manage multiple pricing models and artificial intelligence (AI) to service efficient financial operations as primary enablers for a more sophisticated price transparency mechanism. It will lead to a more integrated technology stack across revenue cycle management, pre-authorization, claims processing systems, provider life cycle management, and even consumer experience.

Price transparency tools will be mainstream and embedded into patient and member portals for better personalization and usage over time. Blockchain, AI, deep analytics, and visualizations will play a central role in the mainstream adoption of tools and technologies enabling transparency-led choices. API-led integrations and interoperability will potentially establish significantly seamless data flow between all healthcare constituents as it relates to healthcare financial management.

Exhibit 3: Price transparency is a good thing in healthcare, even though it has been slow getting there

Tailwinds

- Price transparency incentivizes providers to move to VBC to offset revenue declines by managing margins while providing value to patients.
- Consumers can control their out-of-pocket costs through personalized choices that price transparency tools can enable. This will be a win-win-win for the payer-provider-consumer nexus.
- Health systems will be primed to offer direct-to-consumer services without the overheads of managing third-party contracts supporting most primary care non-urgent needs.
- Data from the price transparency initiative can help better policymaking.
- Price transparency has greater potential for success incenting healthy behavior and dynamic health plan contracts, which in the long run could reduce overall disease burden and healthcare expenses.

Headwinds

- A lack of quality-of-care metrics could lead to the wrong choice of care, driven purely by costs.
- Price transparency could force health plans to offer services aligned purely on financial outcomes, potentially impacting access to care.
- Higher prices in underserved areas could nullify savings elsewhere, or worse, rural and safety-net hospitals could suffer further due to increased losses where local market conditions cause bargaining power to shift to health plans.
- Limited capabilities in real-time estimates and comparisons can lead to wrong care choices, impacting life and limb.
- Payvider models may distract health plans from their core business as they attempt to diversify enterprise revenues.

Source: HFS Research, 2022

The Bottom Line: The impacts of price transparency will show up gradually across the healthcare ecosystem and affect stakeholders differently empowering health consumers, disrupting health plans, pressuring health systems, and giving self-insured employers a license to experiment.

Overall price transparency is a step in the right direction, but it will not have any material impact on the triple aim attributes of cost of care, health outcomes, and the experience of care in the near term.

Authors

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Rohan Kulkarni leads the Healthcare and Life Sciences practice at HFS, bringing to bear his vast experience across the healthcare ecosystem. His experience includes being the Head of Healthcare Strategy at multiple Fortune 500 companies such as Xerox, Conduent, and Concentrix; Product Management executive at Highmark Health; and CIO at Versant Health. He is passionate about the Triple Aim (improving health outcomes, reducing the cost of care, and enhancing the care experience) and believes that health and healthcare is a polymathic opportunity that intersects with every industry and facet of our lives. His well-rounded experience and passion bring a practical approach to his analyst role at HFS.

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Dr. Prabhu leads the Practices and Solutions strategy for HCL Technologies' Life sciences and Healthcare business. He is a physician executive on the leadership team responsible for designing solutions to address industry and clients' pain points leveraging digital and foundational technologies. He is also responsible for HCL technologies' thought leadership, partner strategy and investments in the life sciences and healthcare space.

Dr. Prabhu has nearly two decades of experience in healthcare business & IT consulting industries. Remote patient monitoring, blockchain, cyber security, clinical data aggregation, data science and automation are some of the key focus areas for him.

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