Transparency in Health Care

David Balto
Senior Fellow
Center for American Progress
David.balto@yahoo.com - (202) 789-5424

“Sunlight is the best disinfectant.”

-Justice Louis Brandeis

Transparency in Health Insurance

- **Three key elements**:
  1. Data reporting to regulators on health insurance products and practices
  2. Greater disclosure to consumers of how their coverage works and what it will pay
  3. Standardization of health insurance terms, definitions, and practices

1. Data Reporting

- Insurers should report information to regulators on an ongoing basis about their:
  - **Marketing practices** (number of applications, new enrollments, retention, renewals, cancellations, and rescissions)
  - **Coverage practices** (coverage effectiveness, what polices are sold, what they cover, and who is covered)
  - **Provider practices** (participation rates, fees, insurer reimbursement levels)
  - **Policy loss ratios** (share of premium that pays claims vs. administrative costs)

2. Disclosure

- Adequate disclosure requires complete information about coverage and health plan choices to be readily available
- Contract language, network directories, and prescription formularies should be available on websites and open to public examination at all times

2. Disclosure

- Need a standardized “Coverage Facts” label or “Explanation of Coverage” (included in PPACA) for every policy offered by a health insurer
- These coverage summaries must include definitions and specific values for premiums, deductibles, out of pocket limits, and other coverage limits
- Summaries should also include simulated claims for expensive medical conditions, such as breast cancer, heart attack, diabetes, or pregnancy

2. Disclosure

Figure 2. Sample "Coverage Facts" Label for Health Insurance

Coverage Facts

Individually Purchased Health Insurance, 2008

Plan C (Bronze)	
Monthly Premium (age 55)	$596
Annual deductible	$2,000, $100 for Rx
Annual OOP limit	$5,000
Cost sharing not subject to annual OOP	Medical, prescription, mental health co-pays
Significant exclusions, benefit limits	none

Breast Cancer Scenario ‡ (May 1 diagnosis, 87 weeks active treatment)	
Estimated allowed charges for all treatment	$143,180
Estimated paid by patient	$12,907 (9%)

Care type	# billed	Total allowed charges ($)	$ paid by patient	% paid by patient
Office Visit	48	4,387	1,200	38%
Office Procedure	47	466	202	43%
Radiology	12	5,789	898	6%
Laboratory	40	2,924	472	10%
Surgery	1	3,386	1,683	34%
Hospital	1	3,293	659	0
Inpat Med Care	1	174	35	0
Rx Drugs	36	5,473	1,185	19%
Prostheses	1	360	72	0
Chemotherapy	36	98,124	3,967	*
Mental Health	36	2,894	900	33%
Radiation Therapy	35	15,911	1,635	10%

* signifies less than 1/2 of 1%

Source of expense	Number encountered	Amount
Annual deductibles	3	$4,300
Co-pays	120	$3,160
Co-insurance	-	$5,447
Non-covered care	n/a	$0

‡ Breast Cancer Scenario includes outpatient lumpectomy, 4 two-week cycles each of two chemotherapy regimens, 7 weeks of daily radiation therapy, one year of Herceptin therapy, short term mental health counseling, various diagnostic lab and imaging services and prescription drugs. Scenario based on treatment guidelines published by NCCN. ***Individual patient care needs may vary.***

All care assumed to be received from in-network providers following all plan rules for prior authorization. Receipt of care by non-plan providers or without required authorizations can result in substantially higher out-of-pocket costs.

Active treatment over 87 weeks beginning in May assumes patient faces annual deductibles and other cost sharing in three plan years. Diagnosis at different time during calendar year could produce different cost sharing results.

Example of "Coverage Facts" label from Karen Pollitz

2. Disclosure

Example of "Explanation of Coverage" from NAIC Working Group

Do Good Insurer
Plan Name

Health Insurance Summary and Cost Information

- This form outlines your health insurance's cost, coverage, and benefits.
- Please read your policy carefully, because it explains the exact scope of this plan's coverage.

Frequently Asked Questions	Explanation of Commonly Used Health Plan Terms	This Plan's Coverage
What is the premium?	The premium is the amount of money that must be paid for health insurance.	Your Premium/time period [Optional employer premium contribution/time period]
What is the deductible?	The deductible is the amount of money you must pay for health care covered by your health insurance before your health insurance begins to pay. This amount does not include your premium payments. You may have separate deductibles for different health care products and services.	Medical deductible $2,000 Prescription drug deductible $500 Mental health deductible $1,000
Is there a limit on my total expenses each year?	The out–of-pocket limit is the most you will pay each year for services covered by health insurance. This limit includes your deductible, co-payments, and co-insurance. It does not include your premium.	$4,000
Are there caps on how much this insurance will pay for my claims?	Health insurance may limit the amount of money it will pay on a lifetime or illness basis, even if your own medical expenses are greater than this limit. These limits are called maximums.	No maximum
Do I need to choose a primary care doctor from the plan's list?	You may be required to choose a primary care doctor from a list of doctors in their network. These doctors are referred to as preferred providers. If you do not use a preferred provider, you will pay higher costs when you receive services.	Yes, see webpage with network doctors. No, you can choose any doctor.
Do I need a referral from my primary care doctor to see a specialist?	You may be required to get permission from your primary care doctor to see a specialist. This permission is called a referral or pre-authorization.	Yes, you need a referral No, you do not need a referral

Questions: Call 1-800-xxx-xxxx or visit us at www.dogoodinsurer.com

3. Standardization

- Coverage varies in so many ways that consumer choices can become very overwhelming
- Insurers should adopt a benefit minimum standard so consumers can be confident that their health plan choices deliver a basic level of protection
- Key insurance terms and definitions should be standardized

Wisconsin Hospitals

- In 2003, hospitals voluntarily began telling the public the cost and quality of care delivered
- Information is organized by procedure, price, and a checklist of best practices
- Published on a use-friendly website
- **Results:**

  Found that high cost did not necessarily correlate with high quality, so expensive hospitals worked to **cut costs** and poorly rated facilities followed feedback for **performance improvements**

Transparency Provisions in PPACA

- **Transparency in Coverage**: Plans seeking certification in the Exchange must submit to regulators and make public the following information:
  - Claims payment policies and practices
  - Periodic financial disclosures
  - Data on enrollment
  - Data on number of denied claims
  - Data on rating practices
  - Information on cost-sharing and payments with respect to any out-of-network coverage
  - Information on enrollee and participation rights

Transparency Provisions in PPACA

- **Use of Plain Language:** All information submitted by insurers must be in plain language, meaning that the audience, including individuals with limited English proficiency, can readily understand it

Transparency Provisions in PPACA

- **Cost Sharing Transparency**: Plans seeking certification in the Exchange must permit individuals to learn the amount of cost-sharing (deductibles, copayments, and coinsurance) under the individuals' plan. At a minimum, this information should be available through a website and other means for those without Internet access.

HR 4700: Transparency in All Health Care Pricing Act

- Introduced by Rep. Kagen (WI) in Feb. 2010
- Requires public reporting on price information for almost every participant in health care sector
  - Hospitals
  - Physicians
  - Nursing services
  - Pharmacies
  - Drug manufacturers
  - Dentists
  - Health insurers
  - Any related provider

HR 4700: Transparency in All Health Care Pricing Act

- House Energy and Commerce Subcommittee held hearing on May 10, 2010
- Rep. Kagen testified that published prices would foster competition between providers and begin to eliminate variability in pricing and discounting
- Rests on theory of consumer choice in a market based system

HR 4700: Transparency in All Health Care Pricing Act

- Increased transparency raises some antitrust concerns
- Competitors in health care markets may use published prices to engage in anticompetitive pricing through collusion

Transparency to Empower Employers

- California groups proposed the creation of a data exchange program for hospital services called the Hospital Value Initiative (HVI)
- HVI seeks to improve transparency by measuring cost, efficiency, and quality of hospital services and issuing two types of index scores:
  - Buyer Cost Index (BCI)
  - Resource-Use Efficiency (RUE)

Transparency to Empower Employers

- DOJ Antitrust Division found that the HVI would not likely reduce competition because:
  - Survey is managed by a third party and produces information at least 3 months old
  - No hospital, payor, or group will have access to disaggregated data
  - HVI does not reveal prices for services
  - Unlikely for entities to ‘reverse engineer’ statistics to determine individual rates

Concluding thoughts…

- Transparency is central to a working market
- Transparency will enhance competition and market efficiencies
- Further legislation and regulation is necessary to increase transparency