

# MA Health Insurers Have Improved Their Consumer Price Transparency Efforts, But Significant Work Remains

After six years on the books, the market is waking up to the benefits of consumer price transparency. Carriers' systems far exceed provider efforts.

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## Pioneer's Mission

Pioneer Institute is an independent, non-partisan, privately funded research organization that seeks to improve the quality of life in Massachusetts through civic discourse and intellectually rigorous, data-driven public policy solutions based on free market principles, individual liberty and responsibility, and the ideal of effective, limited and accountable government.



**This paper is a publication of Pioneer Health,** which seeks to refocus the Massachusetts conversation about health care costs away from government-imposed interventions, toward market-based reforms. Current initiatives include driving public discourse on Medicaid; presenting a strong consumer perspective as the state considers a dramatic overhaul of the health care payment process; and supporting thoughtful tort reforms.



**Pioneer Public** seeks limited, accountable government by promoting competitive delivery of public services, elimination of unnecessary regulation, and a focus on core government functions. Current initiatives promote reform of how the state builds, manages, repairs and finances its transportation assets as well as public employee benefit reform.



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**Pioneer Opportunity** seeks to keep Massachusetts competitive by promoting a healthy business climate, transparent regulation, small business creation in urban areas and sound environmental and development policy. Current initiatives promote market reforms to increase the supply of affordable housing, reduce the cost of doing business, and revitalize urban areas.

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## Introduction

In 2012, the Massachusetts Legislature enacted what was intended to be comprehensive health care cost containment legislation: “An Act Improving the Quality of Health Care And Reducing Costs Through Increased Transparency, Efficiency and Innovation (Ch. 224).” Some of the more touted features of Ch. 224 were innovative provisions dealing with healthcare price transparency that require both insurance companies and providers of all types to make price information available to consumers seeking such information.<sup>1</sup> The goal of these provisions was that transparency in pricing would help reduce healthcare costs as market forces would drive patients toward lower-cost, higher-value providers.

By 2012, the Massachusetts healthcare insurance market had started seeing a growth in high-deductible health insurance plans. In 2014, almost 20 percent of Massachusetts families spent at least \$3,000 on out of pocket health costs.<sup>2</sup> Another indicator of the magnitude of family healthcare costs is reflected in the 2015 average statewide premium *and* cost-sharing of about \$20,000.<sup>3</sup> These trends underscore the need for price transparency.

Ch. 224 required insurers and providers to establish a toll-free number by January 1, 2014 through which patients/consumers could obtain cost estimates for services and procedures within two business days. By October 2014, insurers were required to develop online cost estimator tools to allow members to compare information such as co-pays, deductibles and other costs associated with a particular procedure or service among competing providers.<sup>4</sup> State government at the time provided guidance to insurers and providers, stressing that they should make their transparency systems consumer friendly and easy to use. The state also added that consumers should not be required to provide technical medical codes for their procedures, but that insurers and providers should be ready to assist consumers in obtaining the information needed to get an estimate.<sup>5,6</sup>

In 2014, the Commonwealth developed a public website, [www.getthedealonline.org](http://www.getthedealonline.org), that promoted transparency through transit, web and print advertisements, and linked to the cost estimator tools of every carrier in the state. This campaign kicked off that fall at a State House event that featured healthcare leaders from government, business, and consumer groups, and featured demonstrations of cost estimator tools by most of the Commonwealth’s carriers. The Massachusetts Center for Health Information and Analysis (CHIA) intends to launch a website that seeks to provide actual average costs of numerous procedures for various Massachusetts providers. Most importantly, the CHIA website expects to link to the cost transparency tools of each Massachusetts carrier.

The architects of and public policy advocates behind Ch. 224’s transparency provisions hoped the new law would spur

innovation and competition among providers and carriers to promote transparency as an added benefit to businesses, consumers, members and patients. In particular, the state Office of Consumer Affairs and Business Regulation, which is located within the Economic Development secretariat and oversees the Division of Insurance, believed the issue of price transparency was one where consumers and insurance companies shared a mutual interest in reducing healthcare costs. However, as events unfolded, that shared interest was not sufficient to make healthcare price transparency a top priority for either carriers or providers.

When Ch. 224 became effective in 2014, three major carriers controlled almost 79 percent of the Massachusetts insurance market: Blue Cross Blue Shield (BCBS); Harvard Pilgrim Healthcare (HPHC) and Tufts Health Plan (THP).<sup>7</sup> In 2015, the advocacy group Health Care For All (HCFA) undertook a project to test and assess these carriers’ online consumer cost estimator tools. The results of that research, *Consumer Cost Transparency Report Card*, issued in 2015, assigned each carrier an overall “C” grade and identified specific areas for improvement with respect to each.<sup>8</sup>

To ascertain **providers’** performance under Ch. 224, Pioneer Institute (Pioneer) conducted several surveys from 2015-2017 to determine the ease or difficulty consumers may experience in trying to obtain price information from hospitals, doctors and dentists. With the exception of dentists, the Pioneer surveys found that *it is difficult, time consuming and frustrating for an average consumer to obtain such legally required information from Massachusetts hospitals or doctors.*<sup>9,10,11</sup> Recommendations were made in each of three surveys to help hospitals and doctors to improve patient/consumer access to healthcare prices. Those recommendations and subsequent adoption of same are discussed later in this paper, see pages 22-23, *infra*.

This survey of **insurance company** price transparency tools was conducted at the end of 2017 and is a follow up to the 2015 HCFA *Report Card on Insurers’ Consumer Costs Web Sites*. Pioneer examined the same three companies: BCBS, HPHC and THP. Although carriers did not give us unfettered access to their tools, they did provide demonstrations, screen shots and we were able to gain access to HPHC’s tools through permission of HPHC members. (Unless you are a member of a particular health plan, you cannot access the parts of their websites containing members’ confidential information and the cost estimator tools contain such information.)

In addition, each company provided responses to the 20-question survey, found here in Appendix A. Representatives of each carrier submitted to in-person interviews with Pioneer staff, and the Institute wishes to acknowledge the cooperation of and information provided by the carriers. Although not

all our questions were completely answered by every carrier, we believe sufficient information and data were obtained to describe and assess the performance of Massachusetts' major carriers regarding state transparency laws. Before describing the survey results, it is important to understand how price transparency influences healthcare choices.

## Background: the Issue of Price Transparency

Surprisingly, healthcare price transparency is not without controversy. While legislators, policy makers, providers and carriers claim to support price transparency in theory, many such stakeholders are quick to point out myriad complexities in the healthcare system that make price transparency a dubious endeavor. Some providers claim that until a service is actually completed, it is impossible to know the price. Others argue that if consumers know the price ahead of time, they will always choose the highest price as a proxy for quality, the so-called "Neiman Marcus" effect. Still others explain that the healthcare market is unlike other markets in that a third party, the insurer, pays for most costs and consumers therefore have little incentive to choose a high-value, lower-cost provider. Even the respected legislative Special Commission on Provider Price Variation, which issued its report in 2017, did not broadly embrace price transparency. Instead, it explained how intricacies in healthcare make transparency difficult to achieve, but that we should continue working on the issue.<sup>12</sup>

None of the stakeholder observations above are entirely without merit, and some present significant behavioral and cultural challenges that need to be addressed through education and appropriate financial incentives. However, while parts of our healthcare system are indeed complex, especially from a technological standpoint, there are a number of fairly straightforward non-emergent services, including radiological scans, laboratory tests, routine office visits and procedures such as colonoscopies, dental cleanings, non-complicated childbirth, and hundreds more, that are accurately priced ahead of time. Moreover, under existing law, good faith estimates can be modified to reflect actual costs resulting from complications or procedures that were not anticipated.

Consumers may not be aware that the contracts between carriers and providers actually specify charges (known as the allowed amount) for thousands of services, surgical procedures and any ancillary charges that may materialize during the delivery of medical services or procedures. The contracts between carriers and employers spell out the deductibles, co-pays and any other costs consumers or employees are expected to bear. In other words, the price of healthcare services across providers and

within a particular plan is known to everyone but the consumers who pay the premiums and other out-of-pocket costs. The first time consumers get cost information is usually after they receive a bill for the services or procedures rendered. So-called "surprise" medical bills are a common occurrence.

For a long time many healthcare policy makers, including in Massachusetts, argued that to reduce healthcare costs, consumers had to have "skin in the game" to incent them to avoid unnecessary services and expensive providers. For approximately the past 10 to 15 years, consumers have seen increased deductibles, co-pays, and even more widespread use of co-insurance. Under the Affordable Care Act (ACA), a single person's deductible can reach over \$7,000, while a family can see a deductible of over \$14,000. (Before the ACA, there were no limits on deductibles.) As noted above, in 2015, the average statewide family premium and cost-sharing for healthcare was \$20,000, against a statewide median household income of approximately \$70,000.<sup>13</sup>

Over the years, our healthcare system has been restructuring to give consumers more "skin in the game" in an effort to slow

cost growth. The conclusion reached by some researchers is that consumers are reacting to high-deductible plans by deferring or forgoing care. What is not known is whether the deferred care is necessary.<sup>14</sup> (It should be noted that many consumer advocates are critical of the trend toward higher deductible plans and claim it is an effort to shift risk away from insurers to employers and ultimately toward consumers).

There is no question that changing consumer behavior when it comes to value shopping for healthcare services is challenging. It requires

ongoing educational efforts and appropriate incentives to prompt behavioral and cultural changes. The fact that some consumers with high-deductible plans choose to defer care shows that consumers can be incentivized to be more selective with healthcare services overall. What we have not done is devise programs and incentives that will help consumers be more selective in terms of spending their out-of-pocket limits without deferring necessary healthcare services.

However, the adoption of employer financial rewards and incentive programs by self-funded employers is beginning to accelerate across a range of industries. Indeed, some large employers are taking bold steps by combining forces, such as Amazon and Berkshire Hathaway Industries, to create more leverage over healthcare costs for their employees with carriers and providers.<sup>15</sup> Other large groups, such as Gillette in Massachusetts and the California Public Employee Retirement System, are embracing reference pricing, under which an employee pays extra to have procedures done by a provider

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whose prices are above the budget selected by the employer, or at a facility other than the employer's preferred provider.<sup>16</sup>

It is no secret in the Massachusetts healthcare marketplace that higher-priced providers are generally not enthusiastic proponents of price transparency. Until very recently, the Massachusetts Health and Hospital Association was publicly skeptical of efforts to promote transparency, although that seems to be changing somewhat.<sup>17</sup> At the same time, smaller and less expensive community hospitals are not very vocal about promoting their favorable price differentials, instead devoting their efforts to persuading policy makers to regulate contract prices by bringing up the bottom levels paid by carriers to community hospitals.<sup>18</sup>

While in some medical specialties wide price differentials among provider hospitals may be justified for reasons such as differences in quality outcomes, studies by the Massachusetts Attorney General's office in 2011 and 2013 showed that there was no statistical relationship between quality and price among most Massachusetts hospitals.<sup>19, 20</sup> Hence, state policy makers now frequently use the term "unwarranted price variation." It simply means that price differences between or among hospitals cannot be explained by patient acuity, teaching responsibilities or underlying costs.<sup>21</sup> The conclusion policy makers draw is that such differences most likely exist because of lopsided market power and influence among higher-priced academic medical centers which, for the most part, are located in downtown Boston.

Another factor that dissuades consumers from even thinking about finding lower priced providers for simple tests is the referral patterns of many physician practices. Generally, providers will direct their patients to specialists and facilities that are within their organization and patients simply follow "doctor's orders." For example, a physician practice employed by a high-cost hospital is going to refer its patients to that hospital's imaging or radiology centers for MRIs, CAT-scans or x-rays. These hospitals charge significantly more for such tests than do community hospitals or standalone imaging centers, yet the patient is not given the option of a lower priced service even when s/he is paying for the service.

If the patient is in a so-called network plan, s/he needs the doctor's authorization to go elsewhere for a less expensive test.<sup>22</sup> Even when the patient is in a "Preferred Provider Organization" (PPO) plan, where the rules for out-of-network referrals are more relaxed, patients are rarely aware that they have the option to go elsewhere for less money. Thus, what seems like a mutually beneficial interest among insurers and their members in choosing lower priced providers faces administrative and practical barriers to implementation. The health plan has to support both the member and the provider and these situations may pose a conflict.

There are, however, some promising programs, such as HPHC's "SaveOn" and "Flex Benefit" and BCBS's SmartShopper Plan, which help employees find lower-cost providers and give financial rewards to employees for choosing high-value, lower-cost providers. THP also has a financial rewards program but to date no employers have purchased it. These programs, described in further detail later in this paper, recognize that incentives are needed to prompt consumers to switch to lower-cost options. It should be noted that while not part of this survey, in 2016, the Commonwealth's Group Insurance Commission (GIC), initiated a SmartShopper program for the 90,000 members of its indemnity plan, which is administered by UniCare, a subsidiary of Anthem.

If a consumer's out-of-pocket costs are only a few hundred dollars before services are, for the most part, fully covered, the use of rewards programs to change behavior seems a necessity. Paying a cash incentive to drive employees toward lower-cost providers creates measureable cost savings for insurers and employers as the incentives given to consumers usually represent only a fraction of the total savings for the insurer or self-funded employer whose plan is managed by a third-party administrator.

There is some concrete proof that healthcare price transparency can help slow the rate of cost growth and save money for consumers, employers and health plans. Transparency can also benefit lower-cost providers that struggle for market share against their larger competitors. National studies by Public Agenda, a non-profit based in New York City and funded by the Robert Wood Johnson Foundation, continue to show that consumers would use price to make choices if they had the information available. Not surprisingly, the higher the deductible, the more likely a consumer is to want to know the price of healthcare before obtaining services.<sup>23, 24</sup>

Back in Massachusetts, the Pioneer surveys of providers and HCFA's survey of carriers show we still have a long way to go on healthcare price transparency. In hindsight, it does appear that provider and carrier stakeholders could have benefitted from more state government leadership and compliance programs. In fairness, industry stakeholders have also been experiencing turbulent times from the first days of implementation of the ACA to current developments in both Massachusetts and Washington. State government leadership on transparency could have helped to direct greater compliance, generate more innovation in this area, and further engage the public. Incentives to bring employers, carriers and providers together to develop programs and spur educational efforts could have made a difference. It appears, however, that no branch of state government has chosen to lead in this area. At the meeting of the Price Variation Commission, a high-ranking legislator explained that these transparency provisions in state law were

considered more aspirational than mandatory and that time was needed for compliance.<sup>25</sup> It is important to note, however, that the legislative language in Ch. 224 directed at providers and carriers uses the word “shall” and is mandatory rather than permissive.

## Results of Pioneer’s Carrier Survey

When HCFA performed its assessment of carrier tools in 2015 such tools had been operational for about a year. (While the law was passed in 2012, the transparency provisions did not become effective until 2014.) The HCFA survey was focused on various attributes of the web tools and their consumer friendliness, such as the ease with which tools could be navigated, whether multiple providers’ prices could be compared on one screen, the display of consumer cost information, availability of languages other than English, clearly labeled links and other technical components. As stated earlier, HCFA gave each carrier an overall grade of “C.”

State government leadership on transparency could have helped to direct greater compliance, generate more innovation in this area, and further engage the public.

In conducting the survey, not only was Pioneer guided by the major recommendations of the 2015 HCFA report, but Pioneer also had the advantage of three years of performance by each carrier with respect to its transparency tool. This allowed the Institute not only to measure the use of each tool by carrier members, but also to obtain a more complete picture of the total number of procedures

available to members and carriers’ efforts to promote, educate, and innovate in this area. It allowed Pioneer to assess whether transparency was viewed as a legal obligation that had to be fulfilled, or carriers saw the law as an opportunity to gain a competitive edge and reduce healthcare costs.

Unfortunately, however, Pioneer’s survey spanned a period during which both HPHC and THP were in the midst of replacing their old cost estimator tools’ with redesigned models. This was necessitated by the fact that sometime in 2016 both carriers were informed by their previous tool’s vendor, Castlight Health Inc. (Castlight), that it was no longer going to provide this service to insurers. It appears that since that time, no further investments or upgrades were made by either HPHC or THP to their original tools. These two carriers set about to hire new vendors to redesign and relaunch their cost estimator tools. One consequence of the Castlight pullout was that HPHC’s tool was down for almost half of 2016, during which time members were directed to a toll-free number. Both HPHC and THP launched their new tools in early 2018, and

except for minor operational details, they are fully functional. In both cases, the new tools provide much more information than was in the previous versions.

Since both carriers’ original tools were designed and built by the same vendor, both HPHC’s “Now iKnow” and THP’s “EmpowerMe” had similar positive and negative features as detailed in the 2015 HCFA report. While the report found that both met some key criteria with respect to clear presentation of total cost and member out-of-pocket costs, both were criticized for the limited number of services available with cost estimation and the need for quality information.

## The Major Recommendations of the HCFA 2015 Report and Overview of Carriers’ Response

Pioneer began by looking at the major recommendations made by HCFA in 2015 to determine the degree of progress made since then with respect to technical components of the cost estimator tools.

The major HCFA recommendations included<sup>26</sup>:

1. ***Make the cost estimator tool easily accessible on the home page.***

Results: The three major carriers vary in terms of ease of locating the tools from their home pages. In response to a HCFA recommendation and one that had been made earlier to BCBS by the state Office of Consumer Affairs and Business Regulation, BCBS revised the title of its tool from “Find a Doc” to “Find a Doctor and Estimate Costs.” The earlier title made it difficult for members to know that cost information was part of the “Find a Doc” tool. The simple change of adding “and Estimate Costs” as well as repositioning the location of the tool to a more prominent place on the carrier’s landing page are noticeable improvements. It should be noted that the improved BCBS tool has been awarded a Healthcare Monitor Gold Award by Corporate Insight for the second year in a row.<sup>27</sup>

The THP tool is accessible from the main member page with a link that reads “Use Our Treatment Cost Estimator,” which is the fifth item down in a row of links under the heading “What would you like to do?” While relatively easy to see, a move to a more prominent position on the list of possible options would be desirable.

Our criticism of HPHC is that finding the cost estimator tool from the carrier’s home page is not as easy as it could be. There is nothing on the homepage about finding “cost estimates.” The member has to know to click on “Tools and other features” in the main menu bar across the page and then scroll down to midway on the page to find the “estimate my cost” link. There is a link on the member

dashboard page, but no link on the first page a member sees upon signing in. Easy consumer access is a prerequisite to encouraging the use of transparency tools. We also could not find links on other pages to “estimate costs” and would suggest that these issues be addressed. Both HPHC and THP should make their estimator tool links more prominent and use language such as “find a price” or “estimate costs” to make the location of those tools crystal clear to consumers.

**2. Include inpatient services, behavioral health, and prescription drug cost information in tools.**

Results: In the process of examining progress on this recommendation, Pioneer also looked at the number of total services each of the three carriers makes available or plans to make available to their members for comparison price shopping. Each includes some in-patient services, although the majority of services available are for outpatient needs.

We found that BCBS had the largest number of total services online, with 1,568. BCBS started out with 128 procedures six years ago, grew that list to 500, and increased to nearly 1,600 in 2015. Of its 1,568 services online, 65 are in-patient and the rest are out-patient.

HPHC expects to increase its display prices from 500 to 800 procedures over time (110 in-patient and 690 out-patient); and THP has increased its original EmpowerMe tool from 300 inpatient procedures to about 700 inpatient and outpatient services with its new tool, with plans to continue adding new services and procedures. See Table 1 below.

**Table 1. Number of Procedures Available on Online Tool**

	BCBS	HPHC	THP
<b>Inpatient Procedures</b>	65	110	226
<b>Outpatient Procedures</b>	1,503	690	458
<b>Total Procedures</b>	1,568	800	684

In addition, THP’s new tool includes pricing by thirty-nine surgical episodes of care together with timelines for the care required. For example, a knee replacement would include most pre-and post-operative care and services in one estimate. This is a positive development in helping members make better informed healthcare decisions.

As far as Pioneer can determine, BCBS includes 14 outpatient behavioral health procedures and services online and plans to add two new inpatient categories to support behavioral health and substance abuse. HPHC does not appear to provide pricing information for any appreciable number of behavioral or mental health services. THP does

include pricing information for about a dozen common behavioral health services. All carriers have a dedicated line that members can call for additional information regarding behavioral health services. These results show some improvement over the 2015 HCFA findings.

Each of the three carriers reports that it has a separate tool for prescription drug prices. The ease of finding the drug price tools varies among the carriers but each shows patient-out-of-pocket costs and co-pays.<sup>28</sup>

**3. Present cost data alongside easy-to-interpret quality information and highlight value options. Use presentations of data that include interpretations instead of only comparative numbers.**

The BCBS tool has easy-to-understand quality information for provider hospitals taken largely from the national Centers for Medicare and Medicaid Services (CMS). This data covers seven variables all hospitals are encouraged to report to CMS and include such services as Emergency Department, Radiology Outpatient, Surgical Complications, Patient Mortality, and Readmission rates. In addition, BCBS shows the HCAHPS quality ratings (Hospital Consumer Assessment of Healthcare Providers and Systems), which are a patient satisfaction survey required by CMS for all U.S. hospitals. What is not clear is the five-star system BCBS uses on its comparison among providers page. While the page is generally helpful in comparing price and attributes of up to 10 providers at a time, it is not clear what the star “ratings” encompass.

HPHC reports that it provides “Harvard Pilgrim Honor Roll” designations as well as links to the previously described CMS Hospital Compare Tool. It is not clear, however, what the “Honor Roll” designation signifies.

Tufts Health Plan provides a blue ribbon “Top Quality Recognition” symbol to hospital and provider groups ranked in the top 25 percent. According to its website, “quality information includes awards, certifications and similar designations from accredited independent or third parties.” These third parties include CMS, the Massachusetts Health Quality Partners’ Patient Experience Survey, and others. See Table 2 below.

**Table 2. Type of Quality Information Provided on Online Tools**

BCBS	HPHC	THP
<b>Rates providers on various criteria based on CMS quality data. Patient reviews are also available</b>	<b>Awards HP Honor Roll designations based on CMS data (links to underlying data available)</b>	<b>Awards Blue Ribbon certifications to top 25% in quality based on CMS and internal data</b>



It appears that BCBS has made the greatest improvement with respect to quality information on its cost estimator tool. While HPHC and THP generally report that they use the same criteria from the CMS system, at this time the specific CMS information is not as easily accessible on their tools, as it is with the BCBS tool. While interpreting the data for consumers is laudable, carriers should also permit easy access to the underlying data. Hence, it appears that both HPHC and THP need further work with respect to explaining quality information per the 2015 HCFA report.

**4. Run usability testing and modify tools to be more intuitive for consumers.**

Results: The carriers were circumspect with respect to internal research on their respective tools. BCBS reports that it has increased its commitment to usability testing and capabilities over the past year, which it believes will show dividends in future iterations of its cost estimator tool. Unfortunately, because of Castlight’s pulling out, neither HPHC or THP made improvements in their old tools to improve consumer usability, although in discussions concerning their new tools, it appears that each carrier is very conscious of the importance of usability and ease of online consumer navigation. Because HPHC and THP are in effect starting over with brand new cost estimator tools, they have an opportunity to test, modify, and improve their tools on an ongoing basis from new starting points.

**5. Ensure tools are accessible to members who speak languages other than English.**

Results: According to BCBS, its website is compatible with online translation tools and BCBS, HPHC and THP make interpreter services for phone calls available in Spanish and numerous other languages. HPHC and THP plan to make their tools available in Spanish after the launch of their new sites, but this has not yet occurred. It does not appear that significant progress has been made regarding direct accessibility to members who speak languages other than English. See Table 3 below.

**Table 3. Alternative Languages Available on Online Tool**

BCBS	HPHC	THP
None, but website is compatible with online translation tools	None	None

\* All carriers are able to assist speakers of other languages over the phone.

**6. In addition to the five recommendations above, HCFA made “specific key recommendations” to each of the specific carriers<sup>29</sup>:**

**Blue Cross Blue Shield:** Provide an estimated cost to the member of the procedure/service level that is more specific than the member’s out-of-pocket maximum.

Results: The BCBS tool, Find a Doctor and Estimate Costs, shows the expected cost to the member – not just the out-of-pocket maximum – and the estimated cost to BCBS. The tool also shows the member’s deductible and the amount of the deductible spent to date, as well as the member’s annual out-of-pocket maximum. It appears BCBS has corrected this important deficiency in its earlier tool.

**Harvard Pilgrim HealthCare and Tufts Health Plan:** Increase number and types of health care services with cost information available, specifically inpatient procedures and behavioral health services.

Results: It appears that with its new tool, HPHC is planning to increase its number of healthcare services to 800, with 110 being inpatient. Tufts relays that it is increasing services from 300 to 684, including 226 inpatient procedures. It appears both carriers are significantly increasing the number of procedures for which price information is available.

Regarding additional price information for behavioral health services, HPHC advises that its behavioral health information is currently “limited,” but it hopes to improve that over the next year. Pioneer was unable to locate pricing information for any behavioral health services on HPHC’s tool, however. THP has included common behavioral health services along with pricing information. It appears that some progress has been made regarding this HCFA recommendation, but more needs to be done, especially with respect to HPHC.

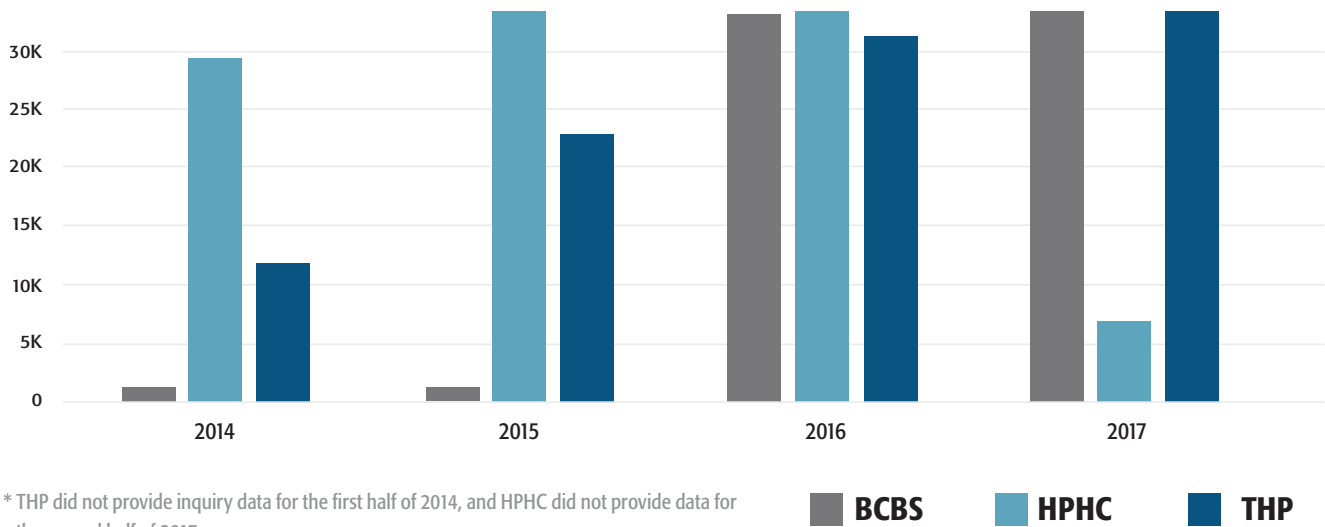
**Aggregate Numbers of Online Inquiries**

Two areas Pioneer looked at that the previous HCFA survey was unable to ascertain were usage by members of each carrier’s tool, and the development, marketing and promotion of their respective tools in the market.

One indication of the success or failure of carrier transparency efforts is the total number of inquiries made on each carrier’s cost estimator tool. The carriers have to report their total number of cost estimator inquiries on a quarterly basis to the Massachusetts Health Policy Commission (HPC). Although carriers gave us some recent data, Pioneer also obtained relevant data concerning aggregate inquiries from the HPC’s Cost Trends Reports from early 2014 through 2017.<sup>30,31</sup>

As can be seen in Table 4 and Graph 1, from the beginning of 2014 through the 2017, the three major Massachusetts carriers

Graph 1. Aggregate Number of Estimate Inquiries\*



\* THP did not provide inquiry data for the first half of 2014, and HPHC did not provide data for the second half of 2017.

experienced a grand total of 296,872 aggregate inquiries. While we do not know the exact number of unique visits this represents, it would, of course, be less than the total aggregate inquiries. How should we place this activity in context?

Table 4. Aggregate Number of Estimate Inquiries\*

Year	BCBS	HPHC	THP	Total
2014	1,218	29,368	11,805	42,391
2015	1,244	39,130	23,198	63,572
2016	33,221	38,718	31,345	103,284
2017	38,240	6,865	42,520	87,625
Total	73,923	114,081	108,868	296,872

\* THP did not provide inquiry data for the first half of 2014, and HPHC did not provide data for the second half of 2017.

We learned from the carriers that their cost estimator tools are marketed heavily to businesses that hire major carriers to design and manage their own self-funded health insurance plans for employees. The three carriers each told us that self-funded businesses account for over half their revenues. It's reasonable to estimate these three carriers cover at least three million people in Massachusetts either as third party administrators for self-funded plans or as insurers for the fully insured market.<sup>32</sup> The numbers of aggregate inquiries regarding cost transparency tools should be measured against a total potential market of over three million people.

The data yields a number of observations. First, HPHC seems to have done a much better job than its rivals in the total number of aggregate inquiries, even though its cost estimator tool was out of commission for half of 2016. HPHC explains that its CEO was very involved in promoting transparency even before the law went into effect and his leadership had

an impact on marketing and sales staff. However, the change in vendors hindered aggressive marketing of its old tool for most of 2016 and into 2017. With its new tool now in place, it is anticipated that HPHC will renew its vigorous efforts to market its transparency and incentive tools.

The largest carrier, BCBS, was slow getting out of the price transparency box but has made good progress in trying to catch its rivals during 2016 and 2017. Conversations with BCBS personnel reveal a team that is very committed to transparency and to becoming a leader in this area. However, more aggressive efforts aimed at promoting its new incentive programs, described *infra*, are needed to take the lead in this market.

THP has had a more steady progression, but because of their change in vendors it too did not heavily market its tool for a good part of 2016 or 2017. It does appear that currently, all three major carriers are committed to the benefits of price transparency in their marketing and sales plans.

All carriers also provide cost estimates by telephone but the number of calls total only a few thousand over the past several years. In addition, all carriers seem to require that the member calling provide a medical diagnostic code and the name of the provider about which s/he is asking. Pioneer's own testing by phone reveals that customer service representatives need more training in providing members with more options for comparative pricing purposes. Each plan informed us that they try to encourage members to go to their online tools rather than to call in. If the tools worked perfectly, which they have not, such diversion would make sense, but in light of the various deficiencies both HCFA and Pioneer have found, more robust information should be available from carrier call-in centers.

Additionally, consumers should not be expected to provide diagnostic codes. Pioneer's own research reveals that health-care workers can be easily trained to locate diagnostic codes for medical procedures from a member's verbal description.

When the size of the potential price transparency market of three million people is compared to the almost 297,000

**The cooperation of employers and employees is key, and the willingness of carriers to market and teach businesses and workers about the benefits of price transparency is critical.**

aggregated inquiries, the lost opportunities for moving the healthcare market toward high-value, lower-cost providers are demonstrable. In Massachusetts, carriers still have a way to go to maximize the opportunities that price transparency can bring. In conversations with the carriers, none indicated that they were able to track cost savings as a result of prior transparency initiatives. Tracking cost savings is challenging because a match

must be made between pre-service inquiries and actual claims. All three carriers, however, are hoping to capture more analytical data with their improved tools.

While the numbers of aggregate inquiries may be somewhat disappointing relative to the potential market, there is some reason to be hopeful that the industry is turning a corner in terms of promoting viable price transparency programs. First, it should be remembered that for transparency programs to work, several parties must embrace the notion that such programs can save money and provide quality care. The cooperation of employers and employees is key, and the willingness of carriers to market and teach businesses and workers about the benefits of price transparency is critical.

In the so-called small group or "merged market" (consisting of about 600,000 small business employees and individuals), small business employers do not have a great incentive to prioritize price transparency for their members. This is because the whole small group market is "community rated," that is, premiums are determined largely by the health status of all the people in the group rather than the status of only those at a particular company. So while savings may accrue to the market as a whole by wise employer/employee choices among healthcare providers, an individual company will not benefit directly from its employees choosing high-value, lower-cost providers, although its employees may benefit by paying lower out-of-pocket costs. That situation is slowly beginning to change.

BCBS has a program called Healthy Actions that is available in the small group market. While not directly a transparency program, it offers small groups the chance to be reimbursed

from 2.5 to 7.5 percent of their premiums depending on the number of company employees who participate in the plan. Employees also receive gift cards of up to \$300 when they participate. Employees and individuals have to complete a quick online health assessment, ask their physicians to complete a Clinical Health Review form, and then work toward achieving health goals set by the physician. HPHC also has a program available in the small group market called "Flex Benefit" that provides savings for members who use Flex facilities for general laboratory and day surgery services. Flex facilities are designated ambulatory care, laboratory or surgical centers that are not hospital based. According to HPHC, members receiving services at a Flex facility could save hundreds or even thousands of dollars in out-of-pocket costs. THP does not have a particular program aimed at the small group market but rather relies on tiering health care providers by price so members have an option of saving on co-pays depending on their choice of providers.

## Are Rewards Programs Finally Taking Hold?

The real game changer that appears to be shaping up among these carriers is in the self-funded rather than the fully-insured market. Each carrier appears to have a renewed commitment to competing for business in this market of companies with 250 or more employees, thereby competing with national carriers such as Aetna, Anthem (which owns UniCare) and United Health Care. To compete, carriers informed us that they must have viable cost estimator tools and plan designs that feature reward programs for employees who choose high-value, lower-cost providers.

In January 2018, BCBS launched Vitals SmartShopper Program for self-insured clients with more than 250 members. BCBS reports that they have seven municipal plans and two national plans participating in SmartShopper now. Through the BCBS SmartShopper program, subscribers can earn up to \$500 per procedure in cash rewards when they shop for and select care from high-value providers. Ninety-six procedures such as MRIs, mammograms, and colonoscopies are award eligible. BCBS has an engagement strategy for companies that use this option that includes reaching members at their homes and on their phones and computers. BCBS plans to communicate directly with members on a monthly basis by sending tailored messaging that highlights opportunities to save and get cash rewards. This program, however, is not available currently in the BCBS small group market.

**The real game changer that appears to be shaping up among these carriers is in the self-funded rather than the fully-insured market.**

In addition to its Flex Benefit program, which appears to be available to both the small group and large self-funded markets, HPHC offers a program called “SaveOn”. Employers who purchase this program give their employees the means to find care for covered outpatient procedures and diagnostic tests from participating providers at lower cost. The program works as follows: HPHC

...[T]he almost 296,000 aggregate inquiries from 2014 to the end of 2017 is a positive start. But compared to the potential market of over three million members, it shows there is a lot more that can be accomplished.

members voluntarily call the SaveOn phone number whenever their doctor recommends an outpatient procedure or test. SaveOn nurses inform members if there are any lower-cost HPHC participating providers available in their area and the nurse can reschedule the appointment and help with necessary paperwork. Members can earn between \$25 and \$75 for choosing a lower-cost provider. If the members are already seeing lower-cost providers, they receive \$10 just for

calling. Savings for the employers can range in the hundreds to thousands of dollars for employees who choose lower-cost providers and there are opportunities for the employer to earn discounted per employee, per month rates.

THP reported to Pioneer its belief that independent research shows around 80 percent of people would choose a cost-saving provider if given incentives as low as \$25. As mentioned earlier, THP has a new rewards platform available to self-funded customers and it is evaluating the option of offering this program to its fully insured employers later this year.

## Conclusions About Carrier Tools and the future of Carrier Transparency

The analysis above shows some significant improvements in the design and scope of carrier cost estimator tools since the 2015 HCFA report card. Simple changes such as those made by BCBS to the title and location of its tool can go a long way toward encouraging more frequent consumer use. Similarly, the extended scope of available procedures among all three carriers is very commendable. In general, the cost data presented on their tools is informative and easy for consumers to follow and understand.

The ability of consumers to compare several providers at once and to obtain results in a variety of ways such as low to high dollar values or distance from home or work is very helpful. Each carrier also has a drug price tool for members, and access to these separate tools is relatively straightforward.

From a technical standpoint, however, important deficiencies remain. For example, information on behavioral health procedures is still not available online from HPHC. Although BCBS reports its site is usable with online translation tools, no carrier’s site is readily available in a language other than English.

On the issue of presenting quality information alongside cost data and highlighting high-value options, the results are mixed. It seems that all carriers use the standard CMS quality rating system for hospitals but, except for BCBS, it does not appear that such information is presented in alongside provider options. Moreover, BCBS, HPHC and THP each have their own “star” system that requires further explanation if it is to be useful to consumers.

Regarding member use of their tools, the almost 297,000 aggregate inquiries from 2014 to the end of 2017 is a positive start. But compared to the potential market of over three million members, it shows there is a lot more that can be accomplished.

The brightest note in this assessment seems to be the carriers’ commitment to innovative rewards and incentive programs in the self-funded market. Yet it has taken almost four years for our home-grown carriers to heed the call that they have large national competitors in the self-funded market and employers in this market have a direct stake in reducing their healthcare costs. To do so, however, they need innovative plan designs, cash back programs, and ongoing education to engage employees.

The downside is that there is still a dearth of reward/incentive programs for the small group market. One of the carriers, HPHC, offers its Save-On program to the small group market in New Hampshire, but not Massachusetts. THP says it is considering expanding its rewards to small group later this year, and BCBS has its small group healthy employee re-imbursment program.

This assessment, of course, cannot reflect what might have happened if HPHC and THP had not had to change vendors when Castlight stopped servicing their respective tools. At a minimum, the transitions to new systems delayed aggressive marketing of transparency tools and the development of innovative reward programs.

Regarding state government’s role in transparency efforts, no carrier reported receiving any advice or help from the Commonwealth save for the initial guidance put out in late 2014. It is likely that most of the applicable state government agencies were not even aware that HPHC’s site was down for almost six months. It could be that after many years, the market in transparency among carriers is beginning to spur innovation and competition (at least for self-funded employers) because the employers appear to want such programs and Massachusetts



carriers do not want to lose their business to national firms. But it has taken a long time to get to this point. The state could have spurred adoption of such programs by rewarding or recognizing carriers and employers who were willing to embrace greater transparency in efforts to realign the Commonwealth's high healthcare costs. We don't know the answer because no compliance leadership has been provided in the regulated small group market and no exhortations or overtures to the large self-funded market have been made.

There is, however, finally a promising development from the state Legislature. In Senate Bill 2202, Amendment 109,<sup>33</sup> there is a provision, drafted by Pioneer and filed by Sen. Bruce Tarr, which would require each plan to offer at least one cash rewards incentive program in its offerings to the small group market. The bill, which is based on a similar bill adopted in Maine, passed the state Senate and is now in the House. Its passage would signal renewed state support for consumer transparency. Another section of S.2202 would make it somewhat easier for plan members to obtain services from out-of-network, lower-cost providers.<sup>34</sup>

### Pioneer's Provider Studies

As mentioned above, prior to this carrier assessment, Pioneer conducted three studies of Massachusetts providers. In 2015, and again in 2017, we surveyed 22 hospitals to try and obtain the price of a simple MRI of the left knee without contrast. In both surveys we found that despite a state law requiring that providers give price information to consumers within two business days upon request, it is a frustrating, time consuming, and sometimes futile effort for an average consumer seeking to obtain such information. We recommended better training of hospital personnel, developing coherent systems for consumers to navigate for price information, greater online advertising of price access, not requiring consumers to provide diagnostic codes, and other improvements. Our 2017 survey showed some improvement. Most hospitals had stopped requiring diagnostic codes from consumers and the majority were able to provide the actual discounted price information for self-pay patients within the required 48 hours. These studies, most importantly, showed dramatic price variations of up to 1,000 percent. Although few patients actually pay the discounted chargemaster rate, variations in these prices continue to be reflected in the prices paid by patients and carriers down the line, and as such underscore the need for consumer price transparency.

Pioneer also conducted a 2016 study among certain physician specialists (dermatologists, ophthalmologists and gastroenterologists) and dentists asking for basic examination price information. These practices are also covered by the law that governs hospitals and clinics. In general, the specialists' offices were not prepared for questions about price and it was

often difficult to extract meaningful price information. There was clearly a reluctance to provide such information, and this reflected lack of appropriate training of front office staff and knowledge of state law. In this survey, the best results came from dental offices, which presumably are more used to public disclosure of standard price lists because dental insurance coverage is limited and patients often pay in full. Most dental offices surveyed were in compliance with state law.

### The Future of Healthcare Price Transparency in Massachusetts

It has been almost six years since Ch. 224's transparency provisions were passed, and almost four years since they became effective for providers and carriers. For the past few years, Pioneer and others<sup>35</sup> have been advocating for greater transparency efforts by both providers and carriers. Pioneer in particular has made numerous specific recommendations to industry providers and the Legislature<sup>36</sup> to up their game in terms of promoting price transparency. Pioneer even penned an opinion piece in *Massachusetts Lawyers Weekly* that clearly spelled out how Executive Branch agencies have the authority to enforce state transparency laws.<sup>37</sup> We have called for an Executive Order to garner attention for compliance efforts. And we have mentioned in our surveys and through media outlets that the state's existing consumer protection law is broad enough to encompass enforcement of state transparency laws by the Attorney General or private parties.

In the meantime, as we have seen, the Legislature created a commission to study price variations and developed a set of rather tepid price transparency recommendations that explained how hard price transparency is to achieve and warned against adding to administrative burdens.<sup>38</sup> In its annual cost trends report the state's Health Policy Commission (HPC) advocates for more consumer price transparency as a way to tamp down unwarranted price variations and reduce healthcare costs, but the HPC has no regulatory authority in this sphere.

### So Where Do We Stand?

Provisions requiring consumer healthcare price transparency are present in state law, Ch. 224, and one federal law, the Affordable Care Act (ACA). The ACA requires that hospitals make prices available to consumers. We have seen the GIC

**In the last couple of years, more robust action by several private sector actors suggests that the market is waking up to the potential benefits of consumer price transparency and incentive programs.**



pilot an initiative to provide information and financial incentives to enrollees in order to drive a value-based approach to shopping for care. No other branch of Massachusetts state government has demonstrated the will to provide leadership on healthcare price transparency. Possible movement in state government may come from CHIA, which has proposed the creation of a transparency website and is also considering the release of a large amount of provider- and carrier-specific data. If CHIA takes these two steps, it could change the transparency landscape in Massachusetts.

For a long time movement in the private market was hindered by a litany of obstacles including dysfunctional pricing mechanisms, the lack of state support for change, resistance and negativity from providers, a carrier industry that was slow to move transparency forward, and even technical problems. In the last couple of years, more robust action by several private actors suggests that the market is waking up to the potential benefits of consumer price transparency and incentive programs.

Some of this change in private market attitude can be seen in how the three major carriers have recognized that their self-funded clients want rewards and incentive programs to help them reduce healthcare costs. The emergence of limited service clinics, ambulatory care and surgical centers, and other

alternatives to traditional hospital outpatient settings present lower-cost, high-value provider options for businesses and employees.

Some of the change in attitude in the private market is, of course, due to the fact that insurance plans increasingly include hefty deductibles for employees, who now need to know the price of the treatments they seek. In a competitive labor market, companies are especially interested in understanding how to meet the needs of their employees.

There are encouraging trends but it remains to be seen how quickly price transparency can take hold in Massachusetts.

In the meantime, Pioneer will continue to test and monitor the adoption of price transparency among providers and carriers, and we will continue to present information to industry stakeholders and government about what other jurisdictions are doing to advance this issue. In addition, Pioneer, through the use of APCD data purchased from CHIA, will be issuing discreet reports on provider prices for certain procedures across numerous providers and state geographic areas. Pioneer will continue to explore the dearth of limited service clinics and independent ambulatory care centers in Boston. We will also continue to explore actual consumer opinion surveys to gauge consumers' interest in saving on their healthcare costs.

## About the Authors

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**Scott Haller** graduated from Northeastern University with a Bachelor's Degree in Political Science. He started working at Pioneer Institute through the Northeastern's Co-op Program and continues now as the Lovett C. Peters Fellow in Healthcare. While Scott's original focus was on the MBTA, he has shifted his focus towards healthcare price transparency. He previously worked at the Massachusetts Office of the Inspector General.

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## Appendix A – Questionnaire Distributed to Carriers in Advance of Meeting with Pioneer Researchers

1. Since 2015, what changes has your company made to your cost estimator tool to make it easier for members to quickly locate it on your website? How would you describe how a member can find the tool?
2. What kind of consumer cost information does your tool show? For example, does it show a single estimate, a range of prices, or an out-of-pocket maximum, or some other number depicting the price a member would pay for a particular service? Does it show the member's remaining deductible?
3. What is the number of services available for which price is available?
  - a. Which in-patient services are available?
  - b. Which out-patient services are available?
  - c. Are behavioral health services included?
  - d. Are prescription drug prices available?
4. Do members have the ability to comparison shop? How many providers can be compared at once on the same screen, and does the tool help to locate geographically close providers? Does the tool offer suggestions for maximizing value or saving out-of-pocket costs to the member?
5. What information is required of a member in order to receive a cost estimate and remaining deductible online or on the phone? Specifically, do you require CPT codes online or on the phone? Is the member expected to obtain the CPT code or does the company obtain it? Does the company instruct consumers either online or over the phone to go back to their providers for the CPT code?
6. How does the estimate process differ online versus on the phone? Is there a dedicated line? Are there customer service representatives especially trained to provide price and deductible information? What resources do these customer representatives use that are not available online to members, or are they utilizing the same tool?
7. Do these customer services representative provide members with a list of provider options or are members asked to present their list to the company representative?
8. Since Jan 2015 to the present, what is the aggregate number of inquiries made via the tool? Since Jan 2015, what is the number of individual members who have actually used the tool to find price and provider for a procedure that was then performed? Since 2015, what is the number of aggregate inquiries via phone? What is the number of individual inquiries via phone to find price and provider for a procedure that was actually performed?
9. What has the state done to assist or guide you in providing price transparency to your members? What else could, or should, the state do to help you meet the requirements of Chapter 224? What obstacles have you reported to DOI regarding implementation of this tool, and what was its response?
10. Do you use programs involving cash incentives or other means to reward members for making high-value choices? Is there any incentive for members to value-shop once they've met their deductible?
11. What kind of education, promotion, or marketing of your tool does your company regularly engage in? Do you plan efforts to increase use of the tool? What are those efforts?
12. Is the cost estimator tool an important part of marketing to small business or other markets? Where is there the greatest demand for such a transparency tool? Do you plan on targeting marketing towards employers and/or employees/members?
13. Is your cost estimator tool available to self-funded companies that use your company as a TPA?
14. Has your company conducted any analysis regarding cost savings to your company or members generated as a result of the tool? If so, what do the results show? Has your company conducted research on member attitudes towards your tool? If so, what were the results? And what, if anything, is the company doing with these results?
15. Does your company plan to make further investments in improving the current tool? Why or why not? What improvements do you have in mind, and what do you wish you could do to improve the tool? What does the company expect to gain from such investments?
16. Is quality information about providers available on your tool? If yes, for what type of providers is such information available? What is the nature and source of such quality information? Can this quality information be used to compare multiple providers on one screen?
17. Is your tool available in a language other than English? If yes, which languages?
18. Is your tool available for users with disabilities? If yes, please explain.



## Appendix B – Quarterly Aggregate Inquiry Data

Quarter	BCBS	HPHC	THP	Total
CY14Q1	117	1,463		1,580
CY14Q2	268	6,395		6,663
CY14Q3	428	5,374	1,201	7,003
CY14Q4	405	16,136	10,604	27,145
CY15Q1	346	10,201	7,302	17,849
CY15Q2	299	9,338	4,169	13,806
CY15Q3	286	8,926	5,895	15,107
CY15Q4	313	10,665	5,832	16,810
CY16Q1	7,949	13,722	12,021	33,692
CY16Q2	7,012	10,504	10,516	28,032
CY16Q3	7,925	6,866	5,625	20,416
CY16Q4	10,335	7,626	3,183	21,144
CY17Q1	11,547	6,306	10,847	28,700
CY17Q2	8,371	559	11,720	20,650
CY17Q3	8,703		8,826	17,529
CY17Q4	9,619		11,127	20,746
<b>Total</b>	<b>73,923</b>	<b>114,081</b>	<b>108,868</b>	<b>296,872</b>

\* THP did not provide inquiry data for the first half of 2014, and HPHC did not provide data for the second half of 2017.

