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To: Members of the Minnesota House of Representatives Health Finance and Policy Committee

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Thank you for the opportunity to offer testimony related to HF 293. As background, I am a health economist at the University of Minnesota, where I teach and conduct research on health insurance and provider markets. In 2008-2009, I served as senior economist on health issues with the President's Council of Economic Advisers in the Bush and Obama Administrations, including early policy development of the Affordable Care Act, from which the current federal price transparency regulations originate. For the past two years, I have been actively conducting research on the implementation of federal hospital price transparency regulations that became effective on January 1, 2021.

Rationale for More Comprehensive and Accessible Price Transparency Information: Many privately insured individuals today are bearing significant financial exposure with respect to their healthcare utilization as many individuals now have insurance benefit designs that require significant cost-sharing provisions, typically in the form of high deductibles. For Minnesotans who are enrolled through an employer source, an estimated 92.7% have an annual deductible requirement. And, conditional on having a deductible, the average deductible for single coverage is $2,163 and $4,254 for family coverage in 2021, according to the Medical Expenditure Panel Survey-Insurance Component.[1]

Studies by the RAND Corporation[2] as well as other price transparency efforts[3] have documented fairly rapid growth over time in commercial health plan prices paid to providers and significant price variation for equivalent medical services across hospitals located in the same geographic market.

Together these factors strengthen consumers' incentives to search for and use pricing information when making choices about the providers from whom they seek care, particularly for non-urgent or non-emergency issues. The availability of comprehensive and accessible pricing information also creates important opportunities for economic research that informs state- and federal policymaking and regulatory action to promote competitive healthcare markets.

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[1] AHRQ, Medical Expenditure Panel Survey-Insurance Component. Data accessed January 28, 2023 at https://datatools.ahrq.gov/meps-ic?type=tab&tab=mepsich3ps

[2] Levinson et al. "Trends in Hospital Prices Paid to Health Plans Varied Substantially Across the US." April 2022, Health Affairs. Accessed January 28, 2023 at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01476

[3] See for example the Employers' Forum of Indiana. Available at: https://employersforumindiana.org/

Current Evidence on Federal Price Transparency Implementation: As of January 1, 2021, most U.S. hospitals are now required to publish pricing information on their website to promote more informed consumer decision-making. Under this rule, hospitals must post online five different types of standard charges, including payer-specific negotiated prices, for all healthcare services in a machine-readable format. Additionally, hospitals are required to publish a list of 300 "shoppable services" in a consumer-shoppable format, which can include a price estimator tool.

Hospitals' reporting of machine readable and consumer shoppable data on their websites has increased over time, but remains incomplete. This is based on studies designed to generate nationally representative estimates, including one that I, along with four of my School of Public Health colleagues published in 2022 and another that we have under peer review at present. In our first analysis,[4] we found that only 25% of hospitals had posted machine-readable negotiated rates, whereas approximately three-quarters of hospitals we examined had published a list of 300 'shoppable services' or offered a price estimator tool as of February 2021. We re-examined those same hospitals one year later.[5] Our findings revealed that 45% of US hospitals had posted both machine readable and consumer shoppable data, despite a large increase in the financial penalty that the Centers for Medicare and Medicaid Services (CMS) could impose on non-compliant hospitals.[6]

One more recent estimate generated by the private technology firm Turquoise Health, reported that as of October 2022 approximately 65% of US hospitals had published payer-specific rates. In reviewing their transparency scorecard in January 2023, most Minnesota hospitals are reporting complete data by their accounting. Exceptions include some psychiatric, critical access, and hospitals owned by M Health Fairview[7].

To better understand hospitals' strategic decision-making related to the federal price transparency rule, I have been undertaking research with colleagues from Virginia Commonwealth University and the Ohio State University[8]. Interviewing leaders from not-for-profit health systems across six geographic markets, we sought to understand both internal organizational and external market factors that have influenced hospitals' responses to the regulation. Some key themes regarding hospitals' decision-making emerged that are pertinent to the proposed legislation. They include:

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[4] Nikpay, S., E. Golberstein, H. Neprash, C. Carroll, and J. Abraham. "Taking the Pulse of Hospitals' Response to the New Price Transparency Rule." Medical Care Research and Review, 2022, 79(3): 428-434.
[5] Nikpay, S., E. Golberstein, C. Carroll, J. Abraham. "Playing by the Rules? Tracking U.S. Hospitals' Responses to Federal Price Transparency Regulation." Under peer review, January 2023.
[6] Other studies include Jiang et al, (2021), Ji and Kong (2022), and Haque et al. (2022). Our estimates are similar to Jiang et al. and Ji and Kong, but differ from Haque et al, who find very low compliance among hospitals as of mid-2021. A challenge for this area of research is that analyses can have different samples, timing, and measurement approaches for what constitutes "compliance."
[7] See Turquoise Health's website for more information. Available here: https://turquoise.health/mrf_transparency_score.
[8] Mittler, J., J. Abraham, J. Robbins, P. Song. "To Be or Not to Be Compliant: Hospital Strategic Responses to the Price Transparency Rule." Working Paper.

- Task Complexity: The anticipated task complexity required by hospitals to comply with the new regulation as well as the state of an organization's resources – amount, flexibility, and suitability – had a profound influence on their strategic approach. Complexity was a function of the number and variability in payer contract structures and chargemasters; the ease of extracting data and whether data were located in multiple places; (dis)agreement on the interpretation of the rule's language; and the human, technology, and financial resources to do the work. Several organizations noted their frustration with the optimistic assumptions made in the rule regarding the effort that would be required to comply.
- Avoiding reputational harm: Organizations frequently noted that their decision to comply was motivated by their desire to avoid significant, negative reputational effects that would impinge on their consideration by potential consumers or by purchasers in the context of contracting decisions related to health plan network formation.
- Uncertainty regarding impact on competitive market position. Organizations also worried about how posting these data would enhance or diminish their competitive position with respect to contract negotiations with private insurers or large self-funded employers.

Challenges in Using Price Transparency Data for Research and Policymaking Activities: Researchers across the country also have begun to conduct analyses to measure the extent of hospital price variation for narrow sets of services or to quantify how prices vary by organizational or market attributes. The use of the actual pricing information contained in the posted data files has been very challenging, given the lack of a standardized data structure format required by CMS per the regulation. As a result, it has been very difficult for researchers to combine data across hospital providers to support research in this space.

One option that has emerged for researchers is to acquire datasets through an agreement with a commercial technology vendor (e.g., Turquoise Health) and abide by the terms articulated in a data use agreement. Relying on private companies for data access can be risky as one does not have full control and cannot know the accessibility of these data in the future, should market conditions change or the firm be acquired. It is also not possible to know whether the data that are being captured will support longitudinal analyses, which are more valuable for research and regulatory purposes.

HF 293: Benefit-Cost Tradeoffs and Other Considerations

An important benefit of HF 293 is that it will improve the accessibility and usability of Minnesota-specific provider data generated via the federal hospital price transparency rule. HF293 would require hospitals and certain other providers to report their data in a particular file structure, which would facilitate the construction of complete files that could support analyses of important, state policy-relevant questions. For example, one could understand how prices are changing over time for different segments of privately insured populations in local geographic markets. One could also examine the relationship between changes in prices and provider market competition, which is important in light of

continuing consolidation via mergers and acquisitions in both provider and insurance markets.

Moreover, HF293 calls for expanding the set of providers to include outpatient surgical centers and large medical or dental practices where a majority of revenue is coming from diagnostic radiology services, diagnostic lab testing, orthopedic surgical procedures, oncology services, or dental services. These providers would also be required to publish standard charge data, consistent with what is currently required under the federal price transparency rule. The broadening of providers subject to price transparency reporting confers value to consumers, given the increasing shift of service provision to outpatient settings as well as cost differentials between services provided as part of hospital outpatient departments versus freestanding facilities.[9] It also has the potential to benefit employer purchasers as they can better understand potential savings from encouraging enrollees through benefit design or educational campaigns to switch to lower-cost providers or care settings.

For providers that have not been subject to price transparency, they will incur new administrative costs to comply. In my qualitative research discussed earlier, administrative burden of the new requirements were highlighted, though restricting attention to larger medical or dental practices should ensure that providers subject to these regulations have the resources to comply.

With respect to broadening the provider set, some may argue that this is redundant with information that will be provided by health insurers and self-insured employers as part of the federal Transparency in Coverage Rule, which went into effect in July 2022. It is true that such information will be generated within these files. However, accessibility of the health insurers' data by the research and policymaking communities is a major issue. These data files are extremely large in size with formats that render them extremely difficult to open or use, absent large quantities of data storage and sophisticated programming capabilities.

The third major provision within HF293 is to make available to the public a tool to compare standard charges for a specific item or service across medical and dental practices. In principle, I am supportive of providing consumers with timely, relevant, and accessible data to support their choice of provider. However, the out-of-pocket prices faced by consumers when they utilize medical care are directly tied to their specific insurance benefit design and their prior utilization of services during a given plan year (e.g., to assess whether they have met their annual deductible).[10] For individuals who are uninsured or

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[9] See for example Fronstin & Roebuck (2021) available at: https://www.ebri.org/content/location-location-location-cost-differences-in-health-care-services-by-site-of-treatment-a-closer-look-at-lab-imaging-and-specialty-medications

[10] My position also reflects my understanding that the Transparency in Coverage Rule will require insurers and self-insured employers (or their Third Party Administrators) to have real-time, personalized access to cost-sharing information through an internet-based self-service tool. See https://www.cms.gov/newsroom/fact-sheets/transparency-coverage-final-rule-fact-sheet-cms-9915-f.

simply desire for self-pay, the tool would be able to support effective decision-making. For insured persons, the value of the information may not be as relevant unless there is a way to integrate it with one's benefit design and claims experience.

Should HF293 be passed into law, I would encourage lawmakers to include resources to fund an evaluation of tool awareness and use to determine if investing in this information resource is in fact generating value for Minnesotans.

Finally, I would encourage members to support healthcare consumer information resources that facilitate the comparison of providers on multiple attributes --- prices, clinical quality, patient safety, and patient experience and in one place. Health care is multi-dimensional and if our collective goal is a more value-based health system, providing information on what drives value is a critical first step.