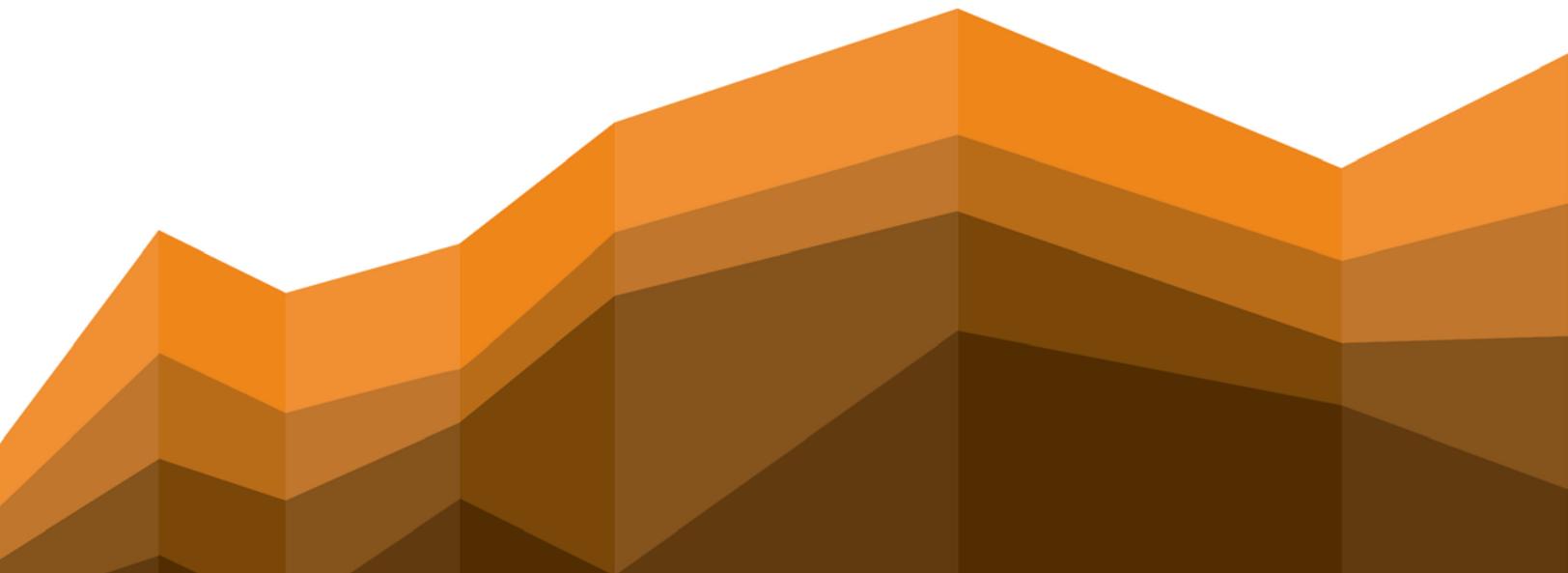


Knowing More, Managing Better:
Transparency and the Emergence of
Enterprise Healthcare Management

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American Health Policy Institute (AHPI) is a non-partisan 501(c)(3) think tank, established to examine the impact of health policy on large employers, and to explore and propose policies that will help bolster the ability of large employers to provide quality, affordable health care to employees and their dependents. The Affordable Care Act has catalyzed a national debate about the future of health care in the United States, and the Institute serves to provide thought leadership grounded in the practical experience of America's largest employers. To learn more, visit americanhealthpolicy.org.

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Introduction

With the conversation about health care policy over the past five years dominated by talk of the Affordable Care Act (ACA) and its impact on U.S. health care markets, it's easy to forget what has not changed. More than half of all Americans (54 percent in 2013)—169 million—still receive their health insurance from an employer. In 2013, employers spent \$621 billion on health care,¹ and the cost of providing that coverage has increased significantly, almost doubling from \$1,900 to \$3,600 per covered life from 2000 to 2013. Health costs continue to increase an average of 5.0 percent per year, more than twice as fast as inflation.² Moreover, employer health care costs are expected to increase an average of 5.0 percent per year over the next five years.³

In response, employers have increasingly implemented high-deductible health plans with health savings accounts, and have increased deductibles on the more traditional plans to incentivize employees to become better health care consumers and help hold down costs.⁴ This cost sharing effort puts additional pressure on employees, who are increasingly finding health plans to be less affordable. According to an analysis by the American Health Policy Institute (AHPI), over 13 million Americans are finding the cost of their employer plans' premiums and deductibles to be higher than 9.5 percent of their income.⁵

Employees will experience even more pressure in the future as employers will continue to make plan design changes to avoid the ACA's excise tax on high-cost employer provided plans. But cost-shifting is not a solution – nor should it be. As the Institute of Medicine has reported, the U.S. health care system wastes roughly 30 percent of every medical dollar on the unnecessary use of higher-cost services, inefficiently delivered services, missed prevention opportunities, and excess administrative costs.⁶ There is room for health care to focus more on quality and operate more efficiently, without degrading health outcomes. While there are a number of new payment arrangements trying to create incentives to reward value in health care, including accountable care organizations and patient-centered medical homes, it is clear that solving the business problem that rising health care costs pose to employers will demand more.

In recent years, many U.S. employers have taken on their own innovative programs and health benefit plan designs, particularly consumer-directed health plans (CDHPs). According to a recent analysis of the Mercer National Survey commissioned by the American Association and Preferred Provider Organizations, More than one-third of large employers (36 percent) offered CDHPs in 2012, up from 32 percent the year before, while 22 percent of small employers offered employees a CDHP option, up from 20 percent in 2011. The study also found that 59 percent of the nation's largest employers — those with 20,000 or more employees — offered CDHPs in 2012, up from 48 percent the year before. And 62 percent of these employers expect to offer CDHPs in 2013 and 68 percent by 2018.⁷

While consumer directed health plans offer the promise of cost savings to employer and employee alike, these benefits are negligible if the employee does not have all of the necessary cost, quality, and utilization information to make the most informed decisions regarding their health care.

Sending an employee to a CDHP, or other similar models, with today's level of transparency in the health care marketplace is comparable to sending someone on a road trip with all of the necessities--cash, a full tank of gas, snacks, and radio tunes--but no map. Today's traveler is accustomed to a world of interactive GPS, where even the simplest route features full disclosure on road closures, obstacles, speed traps, and traffic jams--why isn't the same for consumers navigating health care for themselves and their families? Transparency is the missing piece.

To provide more definition to this missing piece, the American Health Policy Institute (AHPI) partnered with Castlight Health to examine the real world effects of employing an operationalized transparency tool¹—a strategy that Castlight defines as “enterprise healthcare management (EHM)”². AHPI looked at internal data provided by Castlight, and engaged in an additional internal analysis to determine the potential value of a broader deployment of operationalized transparency measures. In doing so, AHPI found that the use of operationalized transparency had the ability to reduce health costs not only to employers, but also to reduce prices across a geographic area, and even provide real reductions in out of pocket spending by individual consumers.

Employer Interest in Transparency

Numerous surveys of senior executives show how concerned they are about the rising level of health care spending. According to a 2013 HR Policy Association survey, 71 percent of Chief Human Resource Officers saw their costs rising by more than 5 percent annually. In a 2014 survey, 82 percent did not believe that the Affordable Care Act would reduce their company's health care costs, and 64 percent feared that it would increase health care costs.

For this reason, industry groups such as the HR Policy Association have long backed transparency measures as a method to reduce health care costs and increase quality. In September of 2013, for example, the HR Policy Association issued “A Call to Action” for greater health care transparency, saying that “it is growing more and more important that robust price transparency be achieved allowing private purchasers and policymakers to fully understand the consequences of government actions such as dramatic reductions in payments to the health care supply chain for serving individuals covered by publicly funded programs.” In addition, the American Health Policy Institute has written a series of papers promoting transparency and suggesting ways to increase the amount of price transparency in the health care market.

In recent years, technological improvements have increased the capacity for transparency to bring about change in the health care cost curve. Concurrently with recent health care reform efforts, there has been a serious push for health care transparency. Specifically, this effort has included any number of approaches to making more market information such as price, quality, and patient experience. The movement for “transparency” has picked up recently, with major

¹ Operationalized transparency encompasses transparency measures that go beyond the availability of the data, including the focused analysis of data in order to identify opportunities for cost savings and increased efficiency for both employers and employees; aligned incentives to promote consumer and employee engagement and value-based decision making, and an evidence-based approach to health care and health benefits that is centered around affecting actual health outcomes.

² Enterprise Healthcare Management (EHM) is a term used by Castlight to depict the comprehensive, integrated practice of managing a company's healthcare investments and healthcare utilization. EHM typically involves using a broad set of healthcare data to gain insights into spending and health trends to inform benefit strategy. Programs are then designed and implemented to address healthcare challenges identified in the strategy.

exposés written in *The New York Times* and *Time* magazine about consumers being charged exorbitant process without their knowledge, data releases by Medicare and some state policy changes to make more information available, and for-profit companies entering the marketplace with “transparency” solutions.

While this process is encouraging, cost transparency alone is not enough. It must be meaningful and actionable, and enterprises must have the tools—including technology and benefit design—to use this data to manage their health care spending. It is important to present cost data along with quality and patient experience information. Thus, one cannot judge if a higher price is justified or not. Some kind of operationalized transparency, in which companies and employees not only have access to data but also the ability to act on that data, and provide incentives for employees to make value based decision is needed.

Increasingly, employers recognize this need and are adopting new approaches to understanding and managing health care costs. One of the primary focus areas for their health care strategy is to educate employees to be more informed consumers of health care (*e.g.*, price transparency, quality care information, treatment decision support).⁸ In 2014, 46 percent of large employers reported offering price and quality transparency tools to employees, and 60 percent said they would be using them in 2015.⁹ Many also believe the adoption of emerging technologies such as telemedicine, mobile applications, and e-visits will create new access points for health care delivery in the future.¹⁰

The Impact of Operationalized Transparency on Costs

Employers and health policy experts alike believe that greater price and quality transparency have the potential to reduce U.S. health care spending. Classic economic theory holds that if consumers are given information about the cost and quality of a product, they will become more efficient shoppers. When it comes to health care, preliminary data shows that to be the case. According to a 2012 study published in *Health Affairs*, when consumers are given easy-to-understand information on price and quality, 90 percent will choose the best value provider (defined as lowest price with best quality).¹¹ A recent study from West Health estimates that greater use of price transparency tools by employers would reduce total health spending by \$18 billion over 10 years.¹²

The theory is clear. The question is whether this theory works in the real world. For this reason, AHPI asked to look at data from 10 employers using operational transparency tools. According to the data, operationalized transparency reduced health care costs for employees and dependents who used the tool at those companies by 2 percent from year one to year two, while employees and dependents who did not use the tool had a 4 percent increase in health care costs over the same period.¹³ Listed below are the primary components of this cost differential, 6 of which resulted from 3 main factors:

1. **Using Low-Cost Providers Instead of High-Cost Providers** Using lower-cost, high-quality providers helped reduce the cost of their laboratory tests, advanced imaging services, and clinician office visits.

2. **Getting High-Cost Providers to Lower Prices** Once a significant number of lives were covered in an area, the higher cost providers not only lowered prices, but began calling the employers wanting to submit new price lists, often with reduced prices, so the employees would see the lower prices.¹⁴ This interaction suggests that if 10 percent of the population had access to operationalized transparency tools in a particular area, health care providers would reduce their prices an average of 1 percent across the board, and providers with above average costs would reduce their prices by 5 to 6 percent.¹⁵ Employers could save \$0.5 billion to \$3.5 billion in health care costs for office visits alone if just 10 percent of employees used an operational transparency tool.¹⁶
3. **Eliminating Unnecessary Care (For Example, Emergency Room Visits)** A targeted communications effort around emergency room (ER) over-utilization at a specific site for one employer resulted in a 21 percent reduction in unnecessary ER visits at the site and a 9 percent reduction overall.¹⁷ Furthermore, the data shows a reduction in ER visits and a corresponding increase in telehealth services.¹⁸

Potential Cost Savings for Total Employer Health Care Costs

The American Health Policy Institute then did its own analysis of the Castlight data and found that if put into effect more widely, these savings at the individual employee level could bring about significant system-wide savings for employers as a whole. This data suggest that applying the 6 percent reduction in trend could also have a broader impact on projected U.S. health care costs:

- If 3 percent more employees used employer-provided operational transparency tools each year, employers could save \$16.0 billion in total health care costs from 2016 to 2020;
- If 6 percent more employees used employer-provided operational transparency tools each year, employers could save \$32.1 billion in total health care costs from 2016 to 2020; and
- If 10 percent of the population in a geographic location has access an operationalized transparency tool, we would expect to see a 1 percent reduction in average prices across the board, and a 5 to 6 percent reduction in prices for providers who are above average in cost.
 - This means individuals could collectively save up to \$3.6 billion in out-of-pocket expenses in 2016, or \$28 per household; and
 - Employers could save up to \$5.3 billion in 2016.

Obstacles to Increasing Transparency: Private Sector

Although there is a clear need for increasing health care transparency, elements of the supply chain have concerns about implementing the concept of full transparency. In order to bring about the considerable benefits operationalized transparency has to offer, advocates, employers, and the health care industry have to work together to identify and mutually resolve those concerns and issues that currently limit market-based solutions for achieving full cost and quality transparency in the U.S. health care system.

Insurance Carriers and Health Plans

A 2013 report from the Catalyst for Payment Reform (CPR), *The State of the Art of Price Transparency Tools*, found “all of the major health plans now offer a price transparency tool or solution of some kind,”¹⁹ and America’s Health Insurance Plans “supports the promotion of easy-to-use transparency tools that include estimates of frequently used services, including overall cost and enrollee share.”²⁰ Yet while a lot of progress has been made on getting access to price data and advancing transparency for the plans and networks the carriers offer, according to the CPR report “a number of challenges to price transparency persist—such as provider gag clauses, weak state laws, and the fact that some self-insured employers still struggle to get contracted health plans to give them their own claims data to work with independent vendors to implement a solution or tool.”²¹ Moreover, employers are often restricted on the use and flexibility of the data they do get.

Pharmacy Benefit Managers (PBMs)

Pharmacy Benefit Managers (PBMs) are third party administrators (TPAs) of prescription drug programs and are a resource being increasingly utilized by large U.S. employers. Some PBMs have been particularly resistant to full transparency, especially as it pertains to the actual price they pay for drugs and other revenue streams they receive in administering prescription drug benefits. Since 2004, the HR Policy Association, the largest association of human resources professionals, representing many of the Fortune 500 companies, has advocated for cost-effective pharmacy benefits in a transparent manner, recognizing the high cost of pharmaceuticals for large employers. As the delivery of health care moves rapidly to CDHPs, there will be increased pressure by large employers as well as their employees and dependents to develop far more transparent systems around pharmaceutical purchasing. In August 2014, HRPA/PharmDirect urged the ERISA Advisory Council to consider implementing enhanced transparency measures in the pharmaceutical procurement process.

Today, the PBM market primarily operates based on negotiated discounts off what is called average wholesale price. With this approach, employers do not know what the actual cost is that the PBM is paying drug manufacturers, or the amount that the PBM is marking up that price when passing on a claim for the employer to pay. A recent report from the ERISA Advisory Council states: “Drug pricing methodologies and PBM compensation are complex and evolving, including rebates, price spreads, discounts, and other payments from retail pharmacy chains and manufacturers,” and that “many PBMs do not fully disclose their compensation in a manner which is readily understandable to even the most sophisticated plan sponsors and consultants.”²² The report also noted “the complexity of rebate arrangements with drug manufacturers and pricing spreads which are subject to continuous fluctuation, make it difficult for plan sponsors to monitor pricing.”²³

Health Care Providers

While the vast majority of clinicians strive to provide the best care possible, many health care providers resist public reporting. In some cases, providers go as far as requiring health plans to agree to non-disclosure terms in their contracts with them that prohibit the carriers from disclosing their negotiated fees. Provider resistance to transparency is also caused by a distrust of the measures and accuracy of both cost and quality indicators. Further, providers are concerned that more robust disclosure on the relative quality of their care could also increase their risk of malpractice claims.

However, within this provider paradigm there is an emerging movement supporting transparency and a growing recognition among provider systems about the need to engage in a dialogue about how to increase the availability of price and quality data. There have been recent high profile actions that signal the potential for greater transparency traction among providers. For example, the American Hospital Association recently said “hospitals and health systems must take a critical look at where they currently fall on the price transparency spectrum and take steps to improve how they communicate pricing information with patients and their community,”²⁴ and a recent poll by the American College of Physician Executives found 54 percent of physician leaders believe the move toward greater transparency in health care will improve the relationship between patients and doctors.” According to one physician, “If costs are to be reduced by a third, we need to know where the real corruption and waste lie, and physicians need to be at the forefront of fixing it. The more we resist the more we are part of the problem.” In January 2015, the Indiana Hospital Association introduced a website providing transparency into 165 hospitals in the state that reveals the prices for 100 common in-hospital procedures and presents quality metrics in four key areas. Although the website information is limited in scope and not personalized to consumers’ benefits coverage, it is an important example of how providers are now focused on working with employers and consumers to increase transparency.

Health Care Manufacturers

Medical device and drug manufacturers can also be resistant to cost and quality transparency. When drug companies and medical device manufacturers obtain patents, ownership of the patent confers significant health care market power. In the case of both devices and prescription drugs, new products may also replace an existing treatment alternative at a higher cost.²⁵ Without robust measures on both the cost and relative outcomes of these new technologies compared to other alternatives, the market has no way of rationally accepting or rejecting new products once they are approved by the FDA. While this can result in increased costs for these new treatment alternatives relative to the value of other existing options—manufacturers argue that the increased cost encourages companies and investors to incur the risks and costs of developing new drugs and devices.²⁶

Obstacles to Increasing Transparency: Public Sector

There are a number of policy obstacles that prohibit full cost and quality transparency in the U.S. health care system. These obstacles raise questions and warrant further policy and legal investigation related to any future health policy reform.

Federal Antitrust Laws

Current Federal Trade Commission (FTC) guidelines regard cost data sharing among insurers as a “collusion risk,” frustrating employer efforts to collect information on network pricing agreements. The FTC prevents private data sharing on costs due to concerns that competitor access to negotiated pricing schedules will cause providers to seek the highest prices that the market will bear. Stated differently, providers will be less inclined to grant network discounts if publicly-available pricing data shows that the market will bear higher costs.

ERISA Fiduciary Issues

Employers that sponsor self-insured health plans have a fiduciary duty under ERISA to prudently manage health plan assets. However, it is not clear if self-insured health plans have the pricing information they need to meet this obligation. Employers find it difficult to appropriately manage costs or insure that the plan assets are spent prudently in the absence of data that would allow them to compare negotiated provider cost across networks. Furthermore, as the financial strains on health care benefit programs grow more intense and employers move toward more self-directed health care options, the duty to provide accurate transparency data to employees weighs more heavily. This is particularly true in a CDHP environment, which is premised on employees having adequate information in order to make informed choices. For this reason, employers will need more clarity going forward regarding the scope of their ERISA fiduciary obligation to pursue health care cost transparency.

Employer Policy Recommendations

In our complex health care ecosystem, which is a hybrid between a public and private health care model, both the public and the private sector need to take steps to bring about real and useful transparency that can be operationalized in order to bring down prices and increase quality. Acting alone, even the nation’s largest employers do not have access to sufficient data or market influence to achieve full transparency. By acting together to promote policy actions, creating data warehouses, and identifying vendors who can support their needs, employers can make significantly more progress towards the elusive goal of a transparent health care market that promotes efficiency at the private plan level.

Create Incentives for Beneficiaries to Shop and Compare Until employees have more skin in the game, they will not fully embrace price transparency. A growing number of employers believe the best way to do that is by adopting consumer driven health plans and tiered or limited networks that give beneficiaries direct financial incentives to shop and compare alternatives. Employers who have been early adopters of consumer driven plans have often found that it is more effective to offer a consumer-driven design as the only option to employees—due to the tendency for sicker individuals to enroll in more traditional plans if they are still offered. As a result, those who consume the most resources do not have the incentives to

shop and compare before choosing a provider or treatment alternative. A high deductible, consumer driven health plan requires employees to shop health care to maximize their value. Engaging on price will also drive enhanced engagement on quality. Another alternative is to adopt centers of excellence for highly complicated and expensive procedures. Employers may also adopt more limited provider networks that also encourage beneficiaries to compare providers.

Give Employees Access to Meaningful Data in a Compelling Way A consumer driven health plan without a way to shop for health care is just a high deductible plan. As long as patients tend to believe their doctor or hospital is always best while not understanding how much health care quality and cost varies, it will be difficult to engage the consuming public to demand transparency. Employers should consider how they can engage employees to use health care data that may be made available to them. Employers need to provide beneficiaries with the tools and motivation to shop and compare their health care delivery alternatives.

Negotiate Aggressively With Vendors Until employers recognize and act on the importance of transparency, it would seem that vendors such as health plans, PBMs, providers and drug and device manufacturers will continue to resist and/or take modest steps to advance the concept. Employers should consider making transparency requirements as important as other financial terms in their contracts with carriers. For example, consideration could be given to refusing to sign nondisclosure agreements that prohibit them from sharing the negotiated prices paid to providers with their beneficiaries. They could also consider demanding that health plans refuse to include similar terms when they negotiate contracts with providers.

Get the Data Without claims data, results cannot be measured. Employers can start measuring those results by using their own claims and administrative data. Employers own this data, not the health plan or their data warehousing vendor. Employers can use this ownership to get health plans to pass not only the employer's specific data, but also the plan's "book of business" data to third party transparency and data warehousing vendors. Employers pay for the use of the plan's provider networks. They should get access to not only their own data but the data of all the providers in that network. In addition, the Department of Health and Human Services (HHS) has recently begun attempting to expand government access to claims data to advance transparency through HIPAA. Employers should support that and other reasonable government efforts to gain expanded access to data that will advance transparency. Many health plans have already agreed to share data with third parties, which is a good start, but more remains to be done on this front.

Use the Data Once they have access to a comprehensive database, employers can aggressively explore how this data can be most effectively used to report the cost and quality of all elements of the health care supply chain. Moreover, employers can use this data to better manage their health care expenditures more efficiently and effectively.

Protect the Data and Ensure Privacy As the February 2015 security breach at Anthem revealed, perhaps the greatest reputational risk that employers have as they pursue transparency is the risk of inadvertently disclosing patient data that is protected by HIPAA and other privacy laws. For that reason, it is critical to make sure platforms are in full compliance with privacy law, but also use that information to the degree permitted by the law.

Adopt Standard Measures Where Possible While Filling Gaps as Needed Employers should avoid enabling a “Measurement Tower of Babel” in which different measures and results are reported by various entities. This will only serve to confuse consumers and undermine their trust in any publicly reported cost and quality measures they see. Contracts with vendors should use standard measurement sets to the degree possible. To fill the gaps where consensus measurement sets do not exist, employers should seek out instruments to address those needs. This is particularly true in measuring and comparing costs, where the market generally lags compared to the availability of quality measures.

Report Results in Formats Main Street America Can Understand Measures have limited value if consumers cannot understand and act on the results. Employers should share results so that any reasonable layperson can understand and act on what is being reported.

Play Well With Others Acting alone, even the nation’s largest employers do not have access to sufficient data or market influence to achieve full transparency. By acting together to promote policy actions, create data warehouses, and identify vendors who can support their needs, employers can make significant progress toward the elusive goal of a fully transparent health care market. In order to advance each of these ten actions, employers may elect to pursue a number of initiatives both individually and in collaboration with other large employers.

Government Policy Actions

In addition to steps that employers can take, there are important steps that policymakers should consider to facilitate the spread of operationalized transparency utilization. These policy steps can help advance the cause of transparency and enable employees and employers to benefit from the cost savings opportunities outlined above. Overall, government should take the position that transparency is a given, and there should be a government presumption in favor of transparency and disclosure. One way to do this is to grant unfettered access for purchasers of health care to their claims data to enable price and quality transparency initiatives.

Recently, the government took an important step toward transparency with the signing of the bipartisan Medicare Access and CHIP Reauthorization Act of 2015, commonly known as the “SGR Repeal Bill” or “Doc Fix.” The bill will replace the Sustained Growth Rate (SGR) method for reimbursing Medicare providers with the Merit-based Incentive Payment System (MIPS), a process that combines existing Medicaid incentive programs and creates a composite performance score that will inform a provider’s reimbursement rates based on four performance categories: quality, resource use, meaningful use, and clinical practice improvement activities.

In the bill, the federal government calls for a number of changes, including: relaxed qualified entity restrictions on access to Medicare data without compromising patient privacy; expanded use of EHR technology and qualified clinical data registries for reporting quality measures; increased reporting requirements for providers; and the public availability of information regarding physician payments and resource utilization on the Centers for Medicare & Medicaid Services’ (CMS) Physician Compare website by 2016.

These measures demonstrate that the federal government is affirmatively on the side of transparency and it will encourage other health care actors to follow suit. CMS should act quickly to promulgate a rule implementing these reforms.

Conclusion

Recent technological improvements have brought about new opportunities for badly needed savings in the health care arena. Beginning with new tools for sharing health care prices and expanding into the area of operationalized transparency, these technological advancements give employers a newfound ability to finally bend or even break the health care cost curve. Technology alone, however, is not enough. A variety of obstacles still remain as barriers to adopting the new tools as they become available. One set of obstacles exists in the public policy arena, and government policymakers need to keep transparency in mind as they pursue reforms and other changes to our health care system. Another obstacle comes in the form of entrenched interests that fear that transparency may hurt their business model. And finally, there is the employer community, frustrated by consistently high cost hikes and system-wide inefficiencies. Trying a new approach to health care, especially in the face of a variety of obstacles, is always challenging, but recent improvements in technology as well as new data based on the use of new technologies suggest that adaptation could well be worth the effort.

Methodology Appendix

This study utilizes National Health Expenditure (NHE) data from the Department of Health and Human Services Centers for Medicare and Medicaid Services, as well as published and unpublished data from Castlight on the cost savings their employer clients achieve with implementation of their transparency tool.

The first step was to estimate the employer cost per covered life for 2016 to 2020 using National Health Expenditure projection data from Table 16 and Table 17. This study uses only the cost of employer contributions to private health insurance premiums and did not include the cost of “other” employer health care costs on Medicare payroll taxes, temporary disability insurance, workers' compensation, and worksite health care.

The second step was to estimate the number of lives who have access to and utilize a transparency tool by applying alternative assumptions of either a 3 percent or 6 percent annual increase in the number employees who have access to and utilize such a tool. These assumptions yield an increase in the number of lives utilizing a transparency tool from 5 million people in 2016 to 26 million people in 2020 for the 3 percent assumption, and from 10 million to 52 million for the 6 percent assumption. These are reasonable assumptions given: 1) survey data which suggests employers will increasingly adopt transparency tools over the next five years; and 2) the likelihood that more and more employees will utilize the tools currently being offered to them.

The third step was to multiply the NHE projected employer cost per covered life to the estimated increase in number of lives that would have access to and utilize a transparency tool from 2016 to 2020, given the assumptions in step two, and then to calculate the cost savings by applying the Castlight estimated 6 percent reduction in the cost trend to the NHE projected costs.

For example, in 2016, NHE data projects employer contributions to private health insurance premiums will be \$530 billion for 171 million covered lives, or \$3,099 per covered life. Assuming 3 percent more people with employer provided health care have access to and utilize a transparency tool in 2016, means 5.1 million people (171 million times 3%) who would cost employers \$15.9 billion on health care in 2016 without a transparency tool (5.1 million times \$3,099 per covered life), would save employers \$954 million in 2016 (\$15.9 billion times 6% cost savings).

¹ Centers for Medicaid and Medicare Services, National Health Expenditure Data, Table 5, National Health Expenditures by Type of Sponsor, 2013.

² Centers for Medicaid and Medicare Services, National Health Expenditure Data, Tables 5 and 22, 2013; and Bureau of Labor Statistics, Consumer Price Index, All Items, average annual increase 2000 to 2013 was 2.4%.

³ Centers for Medicaid and Medicare Services, National Health Expenditure Data, Projections, Table 16, National Health Expenditures by Type of Sponsor, Selected Years 2007-2023. Average increase for cost per covered life estimated to be 4.9% using NHE data projections from Tables 16 and 17.

⁴ From 2006 to 2014 the percentage of covered employees enrolled in high-deductible health plans increased from 4 to 20 percent, and the percentage of employees with a general annual deductible of \$1,000 or more for single coverage increased from 10 to 41 percent. Kaiser Family Foundation, Employer Health Benefit Plans, 2014 Annual Survey, Exhibits 8.4 and 7.9.

⁵ American Health Policy Institute. The Affordability of Employer Sponsored Care and the ACA Exchange Health Care Plans, February 2015.
http://americanhealthpolicy.org/content/documents/resources/Affordability_Employer_Sponsored_Care_and_ACA_Plans_.pdf

⁶ IOM (Institute of Medicine). 2013. Best care at lower cost: The path to continuously learning health care in America. Washington, DC: The National Academies Press.

⁷ <http://www.benefitspro.com/2013/06/17/cdhp-enrollment-surged-in-2012>

⁸ Towers Watson/National Business Group on Health, Employer Survey on Purchasing Value in Health Care, 2013, Figure 10.

⁹ Towers Watson/National Business Group on Health, Employer Survey on Purchasing Value in Health Care, 2014, Figure 31, pg. 22.

¹⁰ Towers Watson/National Business Group on Health, Employer Survey on Purchasing Value in Health Care, 2014, Figure 6.

¹¹ Hibbard JH, Greene J, Sofaer S, Firminger K, and J Hirsh “An Experiment Shows that a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care,” Health Affairs 2012 31(3) 560-568.

¹² Chapin White, Paul B. Ginsburg, Ha T. Tu, James D. Reschovsky, Joseph M. Smith and Kristie Liao, Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending, Westhealth Policy Center, May 2014.

¹³ Castlight analysis provided to AHPI.

¹⁴ J. K. Wall, Doctors, As Well As Patients, In the Dark About Prices,” Indianapolis Business Journal, September 12, 2013.

¹⁵ Castlight analysis provided to AHPI. These results are consistent with research that found the price variation for MRI’s between hospital and nonhospital facilities was reduced by 30 percent after implementation of a price transparency program, and price reductions in nonparticipating employer groups suggests provider competition was influenced by the transparency program. See: Sze-jung Wu, Gosia Sylwestrzak, Christiane Shah, and Andrea DeVries, Price Transparency For MRIs Increased Use Of Less Costly Providers And Triggered Provider Competition, Health Affairs, 33, no.8 (2014):1391-1398. However, New Hampshire’s experience with price transparency indicates some programs may have limited success in small markets with relatively few providers and a lack of lower-priced alternatives. See: Ha Tu and Rebecca Gourevitch, Moving Markets: Lessons from New Hampshire’s Health Care Price Transparency Experiment, California HealthCare Foundation and Robert Wood Johnson Foundation, April 2014. A second problem involves the contracts on prices that insurers negotiate with health care entities. Typically,

contract stipulations formally bind health care organizations and insurers to secrecy. Although it is possible to understand the quest for secrecy on prices from the commercial perspective of insurers and health care entities, that secrecy certainly interferes with creating the price- and quality-conscious consumer of health care services. See: Uwe E. Reinhardt, Health Care Price Transparency and Economic Theory, *Journal of American Medical Association*, October 2014, Volume 312, Number 16.

¹⁶ Castlight analysis provided to AHPI.

¹⁷ Castlight case study results anonymously provided to AHPI.

¹⁸ Castlight analysis provided to AHPI. Comparison of households with employer provided coverage where any member of the household had at least two visits to Castlight's transparency tool.

¹⁹ Suzanne Delbanco, *The State of the Art of Price Transparency Tools and Solutions, Catalyst for Payment Reform*, November 20, 2013.

²⁰ American Health Insurance Plans, *Enhancing Accessibility through Greater Transparency of Consumer Choices*, June 11, 2014, available at: <http://www.ahipcoverage.com/2014/06/11/enhancing-accessibility-through-greater-transparency-of-consumer-choices/>.

²¹ Suzanne Delbanco, *The State of the Art of Price Transparency Tools and Solutions, Catalyst for Payment Reform*, November 20, 2013.

²² Advisory Council on Employee Welfare and Pension Benefit Plans, *PPBM Compensation and Fee Disclosure*, November 2014.

²³ Advisory Council on Employee Welfare and Pension Benefit Plans, *PPBM Compensation and Fee Disclosure*, November 2014.

²⁴ American Hospital Association, *Achieving Price Transparency for Consumers: A Toolkit for Hospitals*, available at: <http://www.ahacommunityconnections.org/tools-resources/transparency.shtml>.

²⁵ Patents, Antitrust, and the High Cost of Health Care, Cotter, Thomas F, American Bar Association, theantitrustsource.com, April 2014.

²⁶ *Id.*