TENNESSEE'S RIGHT TO SHOP LEGISLATION

Tennessee Advisory Commission on Intergovernmental Relations (TACIR)

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Josh Archambault

Senior Fellow

Foundation for Government Accountability

Mister Chairman and members of the Commission,

My name is Josh Archambault and I am a senior fellow at the Foundation for Government Accountability (FGA). We are a national, non-profit think tank that works in more than 30 states and D.C. researching and sharing ideas. I wanted to start with a short story.

> Paula Bennett is in her early 50s and suffers from Crohn's disease. Her infusion treatments at the hospital cost $40,000 per treatment—which are every eight weeks—with a $30 co-pay every visit. Even with generous insurance the costs added up and pushed premiums higher the next year.[1]
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> Under a program very similar to what is contemplated in the bill passed here in Tennessee, Paula was informed of a provider that charged 90 percent less—who was still in-network– and in return she got paid $500 per visit instead of paying a copay.[2]
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> Same drug, same delivery, same frequency, but higher quality one-on-one care–and for less. That is what is possible as she was granted the Right to Shop.

Sadly, wild price differences are not that uncommon—maybe not 90 percent every time, but huge nonetheless. It is similar to a car being listed for $15,000 at one dealer and over $100,000 down the street for the same car.

Locally, Healthcare Bluebook has documented these price differences all over Tennessee.[3] When Tennessee families overpay for health care, they have less money for groceries and education, or can end up in medical bankruptcy.

Now, price transparency sounds good on paper, but does it work? The short answer is yes.

To change consumer behavior, it will require time and energy, but real price transparency can deliver a positive cost savings trend.

For example, in New Hampshire, a program for public employees has seen:

- For those using a transparency tool, 75 percent are shopping *every year.*
- Average savings when an incentive is paid are over $500—which translates to savings of $392 per employee, per year, even for those that don't use the program.
- And perhaps most encouraging is that patients and providers have started to internalize change, as the amount of shopping resulting in incentives has increased 600 percent since the first year.[4]

When done right, patients win, high-value providers win, and those paying the bills win.

I should mention many large self-insured companies have had price transparency for years and added incentive-based programs to invest in their employees' health and save money in the process.

We have learned a few key factors that are needed for price transparency to be most effective to change behavior:

- **What information matters for price transparency?** What matters is disclosure of an estimate of what will actually be paid, for all or most services, for the insurance plan that the consumer is enrolled—even post out-of-pocket responsibility, or even once they have exceeded their deductible. Average prices play a role as an anchor for patients, so they should be paired with actual prices. This all should be presented in a consumer-friendly manner.

- **Shared savings incentives increase engagement**: When real price transparency is paired with shared savings incentives it is a powerful carrot over the medium to long term to change patient and provider behavior.

- **Education is needed**: A commitment to basic education of the program by an employer, or insurer is important. That includes before an interaction, but also after if a patient overpaid.

- **And consumers access to lower-cost, out-of-network providers protect patients from overpaying.** When paired with robust in-network real price transparency, consumers and providers are able to pick the highest-value care setting regardless of network status.

Twelve states have/or are in the process of launching Right to Shop-like transparency and shared savings programs.[5] They all look a little different, and many are starting with their public employees.

In addition, numerous Blue Cross Blue Shield (BCBS) affiliates around the country have started to add products with limited shared savings programs.[6] My point is that these programs are not administratively costly or complex, as numerous vendors already have good, affordable products on the market. Most of these programs have achieved positive return on investment in year one.

Experience has shown that not everyone will shop for their health care—but even those that don't appear to indirectly reap a benefit as new lower cost providers enter the market, or a non-shopper sees a provider that has adjusted their price. Some helpful research from University of Michigan has highlighted this.[7]

When comparing the Tennessee law to other states, the one here is more limited. I noticed at least four major differences, which I would be happy to discuss further.

I did want to mention FGA has no financial relationship with any transparency company, insurer, or other related company on this topic. But we do ask lots of questions about what seems to work and what doesn't on price transparency.

In closing, it is important to highlight some recent federal action on price transparency. New rules for hospitals and insurers will require disclosure that is far more robust than contemplated in this new law. The new federal rules are not in conflict with the Tennessee law, but I would argue they build on the concept and will require more robust disclosure. In addition, the insurer rule does contemplate shared savings incentive programs, which is a win-win for consumers and insurers alike.

Thank you for having me. I look forward to our discussion.

Appendix.

The four major differences between the Tennessee Right to Shop law when compared to other state versions and new federal rule are listed below:

1) Other states and the new federal rules have real price disclosure for all or far more services than the Tennessee law. The Tennessee law is more limited and revolves around average prices.

2) All plans, or whole segments of the individual and small business market are required to incorporate shared savings for patients in their plan design. The Tennessee law does not require it.

3) Most other state laws have no cap on the amount of shared savings incentives that consumers can earn if they shop. The Tennessee law has a cap of $599 every year.

   The policy tradeoff is that a cap does not keep patients engaged in caring about pricing year-round, or when they have exceeded their out-of-pocket responsibility. As an illustration, the woman with Crohn's disease I mentioned before remained committed to save her health plan $36,000 per treatment because she was paid $500 each time she shopped. Under most common plan designs today, she would exceed her deductible at her first visit and not be concerned about cost ever, missing the chance to afford overspending of hundreds of thousands of dollars every year.

   By contrast, if a consumer does make more than $600, they would need to report it as income to the IRS. That is likely the rationale for the $599 cap.

4) States like Arizona and Maine they have passed laws that protects consumer access to lower cost out-of-network providers, and grant patients credit toward their in-network out-of-pocket responsibility if they see these providers for covered services as the consumer saved money.

5) Finally, the new federal rules require price disclosure by both insurers and hospitals. The Tennessee law focuses, like most other state Right to Shop laws, on insurers.

[1] Tom Costello, "Get Paid For Choosing Lower-Cost Care," NBC Nightly News (2016), https://www.youtube.com/watch?v=d4EyseQelEw
[2] Ibid
[3] Alex Tolbert, "'Bluebook' Reveals Health Care Prices," Tennessean (2017), https://www.tennessean.com/story/money/industries/health-care/2017/03/26/can-nashville-find-cure-price-blindness-health-care/99562916/
[4] Shared with author by SmartShopper which administers the New Hampshire program.
[5] Author's calculation.
[6] John Murawski, "Blue Cross to Pay NC Patients up to $500 Rebate For Choosing Cheaper Doctor," The News & Observer (2018), https://www.newsobserver.com/news/business/article215358360.html
[7] Zach Brown, "Equilibrium Effects of Health Care Price Information," The Review if Economics and Statistics, Volume 101, Issue 4 (2019), https://www.mitpressjournals.org/doi/full/10.1162/rest_a_00765