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Summary: Cost Savings of Right to Shop Programs in Other States

In the US, healthcare is expensive. Costs have been increasing and are expected to continue rising over the next few years. From 2017 to 2018, spending increased 4.6% to a total of $3.6 trillion, or $11,172 per person, and it is expected to rise from 17.7% of gross domestic product (GDP) in 2018 to 19.7% in 2028—almost one of every five dollars spent in the US. While healthcare costs are rising overall, the amounts that healthcare providers—such as physicians, clinics, testing centers, and hospitals—charge for services vary widely. Consumers might not be aware of the price differences for these services and might not consider shopping for healthcare as an option. As a result, some pay high prices when they could be paying less for similar quality healthcare services. The existing wide price variation creates an opportunity for people to shop for lower-cost healthcare providers.

Tennessee has taken steps to ensure that better price information and shopping tools are available so consumers can better compare prices for healthcare services and potentially save money. Tennessee's Public Chapter 407, Acts of 2019, requires that private insurance carriers (insurers) in the state provide healthcare price and quality information to help insurance enrollees shop for lower-price, high-quality services and providers within their insurer's network. The legislation also authorizes the Tennessee State Insurance Committee and private insurers to implement incentive programs that reward insurance enrollees for shopping and choosing lower-cost healthcare providers. In addition, it directs the Tennessee Advisory Commission on Intergovernmental Relations to perform a study of any cost savings realized by enrollees with health plans in other states that have adopted incentive program legislation or incentive programs. The study is to include cost savings that result from programs offered by both private health plans and state employee health plans.

The Commission's study has found that shopping for healthcare services can result in some savings for consumers and insurers, and when price tools are combined with incentive programs, they have the potential to save more. But usage for both the tools and the incentive programs varies widely. A few states have implemented incentive programs for state employee health plans or have required private plans to implement them. The data show that the programs produce cost savings, but there is not yet enough data to determine whether the savings are significant over the long term.

Shopping for healthcare services can result in savings for consumers and insurers.

People can shop for lower-price healthcare services in several ways. Whether they have health insurance or not, consumers can directly contact healthcare providers or search their websites to find and compare cost information for a service or procedure. Those with insurance can also directly contact their insurer and talk with a representative to request price information, and most, but not all, insurers provide cost comparison tools that their enrollees can access through the insurer's website to compare prices and shop. Shopping for healthcare services helps uninsured consumers save money because they are paying for services out of pocket. It also helps insured consumers save because they can shop for lower-price services both before and after they have met their deductible amount. Once these individuals have met their deductible for the year, shopping can help them find lower-price services that would reduce the amount of coinsurance they might have to pay until they reach the out-of-pocket maximum. Insurers and employers also pay less for claims when consumers choose lower-price services.

Public Chapter 407 requires that private insurers in the state maintain a website and toll-free phone number that provides healthcare price and quality information to help insurance enrollees shop for services and providers within their insurer's network. But this requirement only applies to certain types of individual and small group health plans that they offer, covering approximately 11.4% of Tennesseans. Still, most, but not all, insurers in the state already provide cost tools on their websites along with toll-free phone numbers for enrollees in their health plans. The tools offered by insurers do not help people without insurance.

Other states are also taking steps to improve access to price information. In addition to Tennessee, seven states require insurers to provide price information for their insurance enrollees. Fourteen states manage publicly accessible websites themselves, with health cost information that could help people both with or without insurance shop for lower-price services. Five states do both. Though helpful for residents, these public websites can be expensive for a state to maintain. New Hampshire, for example, spent $1.8 million from 2014 to 2018 maintaining its website. Unlike these 14 states, Tennessee does not have a publicly available tool.

Any potential savings from shopping is limited, in part because the types of healthcare services that people can shop for are limited. Services that are "shoppable"—an estimated 43% of all healthcare services—are elective and planned, not urgent. For example, imaging, diagnostic testing, physical therapy, and common surgeries such as knee and hip replacements are types of services that are considered shoppable, as opposed to emergency procedures or specialized treatment for such serious conditions

as cancer. Furthermore, patients often have a relationship with their doctors. Because they know and trust their doctors and might be concerned about quality, they are likely to follow the doctor's recommendation rather than shop for a lower-cost provider for the procedure, especially for serious health issues. Consumers also need enough providers in their geographic area to have a choice. In rural areas, there might be no provider or only one provider offering a particular service, and the patient might need to travel a long distance to have access to the service or a choice in providers.

Nevertheless, studies have shown that having access to price tools can result in some savings for insurers and consumers. For example, one study looked at the effect of New Hampshire's price tool on costs for both the insured and the insurers. The price tool is a state-run website available to the public that allows people to search for prices for healthcare services by provider. It also allows the insured to search for out-of-pockets costs for services based on their insurance company. Over the five-year period after the website launched, the cost of medical imaging procedures was reduced by 5% for patients with insurance and 4% for insurers. The author calculated that individuals with insurance saved approximately $7.9 million, and insurers saved $36 million on imaging services over that time period. The study did not look at the impact the website had on costs paid by the uninsured.

But savings are not guaranteed. Another study found that out-of-pocket spending for outpatient services by employees of two private businesses increased by $59 (2.9%) during the 15 months after the introduction of the tool. The authors of this study speculate that spending could have increased because people using the tools might relate higher prices to higher quality and as a result choose higher-price providers, especially when they have already met their out-of-pocket maximum.

Further, money can't be saved if people don't use the tools. Studies have found that even with accessible price tools usage rates can be low, ranging from approximately 1% to 26.8%. To encourage patients to shop, several states either authorize or require insurers to implement incentive programs that reward insurance enrollees for shopping and choosing lower-cost healthcare providers. In Tennessee, Public Chapter 407 authorizes the state insurance committee and private insurers to create incentive programs.

Incentive programs can motivate people to use price tools and shop for services, but savings still vary widely.

Incentive and reference pricing programs can help address low usage of price comparison tools by encouraging insurance enrollees to shop and choose lower-cost providers, but studies have found that even with incentive programs, usage and savings vary widely. Incentive programs—also called rewards, shared savings, or "right to shop"

programs—can be offered by state employee health plans, employers, or insurers who share savings with a patient if the patient chooses a lower-cost provider. These incentives can include gift cards or cash, often ranging in amounts from $25 to $500. Such programs are viewed as a "carrot" approach in contrast to reference pricing programs, which are seen as a "stick" approach. Reference pricing places an upper limit on the amount an insurer will pay for a medical service, and if an insurance enrollee chooses to receive care from a provider that charges above that amount—known as the "reference price"—the enrollee is responsible for paying the difference. California's state employee health plan, CalPERS, is the only state plan that uses reference pricing in this way.

In its 2019 study, the Tennessee State Insurance Committee found that offering price comparison tools alone does not increase enrollee shopping. Instead, they found that pairing incentive programs with price tools works better. The Committee reported that state employee health plans with incentive programs achieved modest savings that were immediate and measurable in the short term. Similarly, another 2019 study of 29 employers that had instituted an incentive program in 2017 found that prices paid for targeted services decreased 2.1% in the first 12 months of the program, saving employers a total of $2.3 million—approximately $8 per health plan enrollee. These savings resulted mostly from MRIs and ultrasounds. Prices paid for surgical procedures included in the programs did not decrease. The authors of the study also noted that, in comparison, reference pricing programs saved 15%. In contrast to states that have implemented programs, the Arizona state employee health plan was required in 2018 to study the cost effectiveness of an incentive program and based on its analysis decided not to implement a program because it wouldn't save money. Instead, it chose to address cost by designing its employee health plan with tiered networks.

Eight states—Florida, Kansas, Kentucky, Missouri, New Hampshire, Texas, Utah, and Virginia—have incentive programs as a part of their health plans for state or other public employees, such as city, county, and school district employees. Four of the eight states—Florida, Texas, Utah, and Virginia—are required by legislation to have incentive programs for their employees, and the other four—Kansas, Kentucky, Missouri, and New Hampshire—chose to create their programs without being directed to do so by legislation. Most of the state programs are relatively new, and their available data is somewhat limited. Kentucky's program and New Hampshire's state employee program are the oldest and began in 2013 and 2010, respectively. Participation rates in these programs vary from state to state. Depending on the state, anywhere from 1% to 53.2% of health plan enrollees have shopped for health care services while 1% to 43.7% of enrollees have received incentives.

Overall, staff in states with incentive programs view the programs as beneficial and worth the investment and say the administrative costs have not been significant. The

savings resulting from the eight states' programs vary. The Commission staff was able to get only a limited amount of data from the states. However, based on the information it did receive, states have saved anywhere from $486,758, as Virginia did during the first seventeen months of its program, to $12.6 million, as Kentucky has over the seven years of its program. The average amount saved per enrollee (meaning the employee with the health insurance policy) can also vary. For example, New Hampshire's state employee program, which began in 2010, saved the state $4.7 million in 2019. Based on the total 11,700 enrollees that year, New Hampshire saved $402 per enrollee. Virginia's program, which began more recently in 2019, saved the state $391,630 in 2019. Based on the total 75,835 enrollees that year, Virginia saved $5 per enrollee.

The incentive programs also helped the health plan enrollees themselves save money. The total amount of rewards ranged from $47,225 paid to enrollees during the first year of Utah's program to $2.3 million paid to enrollees during the seven years of Kentucky's program. The average amount saved per enrollee varies. For example, New Hampshire's state employee program paid $674,000 in rewards in 2019, and the average amount paid in incentives was $58 per enrollee. Virginia's program, on the other hand, paid $82,625 in rewards in 2019, and the average incentive amount per enrollee was $1. See table 1 for a summary of savings from other state health plan incentive programs.

Going beyond programs that affect only state and other government employees, a few states either require or, as with Tennessee, authorize private insurers to offer incentive programs to their enrollees as part of their individual and small group plans—the latter being plans offered by employers with 50 or fewer employees. Two states—Maine and Virginia—require insurers to have incentive programs. In Maine, insurers are only required to offer the program for at least two years between 2019 and 2024. In 2019, of the seven insurers that are required to implement a program, three paid $5,705 in incentives to a total of 82 enrollees—an average of $70 per enrollee. In Virginia, insurers are required to offer incentive programs to small group plans by January 1, 2021. Insurers who are not able to demonstrate cost savings by showing that the claim savings are greater than the paid incentives plus the administration cost are not required to operate an incentive program. Additionally, when a health plan has a limited provider network that is incompatible with a program, insurers can apply for an exemption from the requirement. As of August 2020, of the 16 insurers with small group plans in Virginia, four were not able to demonstrate cost savings, and four had applied for an exemption; the remaining eight are required to implement a program. In addition to Tennessee, three states—Florida, Nebraska, and Utah—authorize private insurers to enact incentive programs. As of August 2020, no insurers have started programs in these states, including Tennessee.

Table 1. State or Other Public* Employee Health Plans with Incentive Programs

State	Year Started	Data Timeframe	Total Amount of Rewards Received by Enrollees	Net Amount Saved by Health Plan
Florida (state employees)	2019	12 months (2019)	$645,500	$2,982,835
		19 months (January 2019-July 2020)	$1,372,215	$5,268,086
Kentucky (state and other public employees)	2013 (pilot) 2014 (full program)	7 years (2013-2014)	$2.3 million	$12.6 million
New Hampshire (state employees)	2010 (pilot, full program evolved)	12 months (2019)	$674,000	$4.7 million
New Hampshire (other public employees)	2014	12 months (2019)	$489,375	$2,830,898
		6 years (2014-2019)	$1,707,890	$10,014,396
Utah (state and other public employees)	2018	12 months (October 2018 - September 2019)	$47,225	$1 million
Virginia (state employees)	2018	12 months (2019)	$82,625	$391,630
		17 months (October 2018 - February 2020)	$99,950	$486,758

*Other public employees could include employees of city or county governments, higher education, school districts, or special districts.

Kansas available data is limited as of writing. Missouri and Texas began their programs in 2020 and do not yet have data to report.

Source: Interviews with and emails from representatives in other states; Tennessee Division of Benefits Administration 2019; and Foundation for Government Accountability 2019.

Analysis: Cost Savings of Right to Shop Programs in Other States Varies

Because of the importance of price transparency and the potential of online price tools and incentive programs to address rising healthcare costs, the Tennessee General Assembly passed Public Chapter 407, Acts of 2019, which requires insurers to provide online tools and authorizes both insurers and the State Insurance Committee to offer incentive programs to their enrollees. The law also directs the Commission to conduct a study of any cost savings realized by enrollees with either private or state employee health plans in other states that have adopted incentive program legislation or incentive programs. The study shall include, at a minimum, an examination of savings realized by such programs in Arizona, Florida, Kentucky, Maine, and New Hampshire.

Healthcare costs are increasing, and consumers are spending more of their income on healthcare.

In the US, the overall cost of healthcare is rising—from 2017 to 2018, spending increased 4.6% to a total of $3.6 trillion, or $11,172 per person.[1] Private health insurance prices, or payment rates, which are negotiated between insurers and healthcare providers, have increased compared to payment rates for government-based healthcare, such as Medicare, which is commonly viewed as a yardstick or standard for comparison in the healthcare industry.[2] In the late 1990s, average private payment rates for inpatient healthcare services were 10% more than Medicare payment rates.[3] By 2012, average private payment rates were 75% more than Medicare rates,[4] and in 2017 they were more than double Medicare rates, according to a study that looked at a sample of 25 states.[5] The same study found that the combined average of private inpatient and outpatient prices was almost one and a half times Medicare prices.

Healthcare costs are expected to rise over the next few years as well. According to the Centers for Medicare and Medicaid Services (CMS), health spending is projected to grow at an average annual rate of 5.4% between 2019 and 2028, which is 1.1 percentage points faster than gross domestic product (GDP) per year on average during that time period.[6]

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[1] CMS.gov 2019b.

[2] Berenson et al. 2020.

[3] Selden et al. 2015.

[4] Ibid.

[5] White and Whaley 2019.

[6] CMS.gov 2020b.

It is expected to rise from 17.7% of GDP in 2018 to 19.7% in 2028—almost one of every five dollars spent in the US.[7] Because of increasing costs, paying for healthcare is becoming a challenge for many people, even those with insurance.

The amount that Americans with health insurance are paying out of pocket for their healthcare has also been increasing. Most Americans, approximately 55%, are insured through their employers.[8] Over the last decade, employers are sharing more of the increased healthcare cost with their employees through higher premiums, deductibles, copayments, coinsurance, and out-of-pocket maximums—payment mechanisms that are commonly called cost-sharing. In 2008, private-sector employees with employer-sponsored insurance paid an average of $4,160 for premiums and deductibles, the equivalent of 7.8% of median income. In 2018, they paid approximately $7,388, 11.5% of median income.[9] Along with the rest of the country, Tennesseans are paying more for healthcare services. In 2018, approximately 90% of Tennesseans had health insurance, either private or government-based, and 52% were insured through their employer.[10] Even with employer-sponsored insurance, these insured people are paying thousands of dollars a year for healthcare. The average amount paid by Tennesseans with private-sector employer-sponsored insurance for their share of health plan premiums and deductibles increased from $4,090 in 2008—9.1% of median income—to $7,966 in 2018—13.5% of median income.[11] Table 2 shows the average amount that private-sector employees paid for premiums and deductibles in both Tennessee and the United States from 2008 to 2018.

[7] These estimates do not consider the effect of Covid-19.

[8] Berchick, Barnett, and Upton 2019.

[9] Collins, Radley, and Baumgartner 2019.

[10] Pellegrin 2020.

[11] Collins, Radley, and Baumgartner 2019.

Table 2. Total Private-Sector Employee Contribution to Insurance Premiums and Deductibles, Tennessee and United States, 2008-2018

		Year						Average Annual Change 2008-2018
		2008	2010	2012	2014	2016	2018	
Tennessee	Average of Premiums and Deductibles	$4,090	$4,618	$5,378	$7,173	$7,131	$7,966	6.9%
	Percent of Median Income	9.1%	10.3%	11.2%	14.9%	13.4%	13.5%	
United States	Average of Premiums and Deductibles	$4,160	$4,688	$5,372	$5,995	$6,776	$7,388	5.9%
	Percent of Median Income	7.8%	9.1%	10.3%	10.7%	11.3%	11.5%	

Note: Single and family premium, contribution, and deductible costs are weighted to the state distribution of single and family households.

Source: Collins, Radley, and Baumgartner 2019.

Prices for healthcare services vary within and between healthcare markets.

While healthcare costs are rising overall, prices for services vary widely between healthcare providers, which include physicians and facilities such as hospitals, stand-alone clinics or surgery centers, and testing centers. Studies show that not only do commercial healthcare prices for the same service vary widely between regional healthcare markets, they also vary also within markets.[12] For example, one 2013 study analyzing claims in 13 communities across the US found that prices within the communities widely varied—the highest-paid hospitals had negotiated rates 60% higher than the lowest-priced hospital for inpatient services. For outpatient care the price gap was almost double.[13] A 2019 study examined the price variation for magnetic resonance imaging (MRI) in Kentucky.[14] It found that costs for the same procedure could vary from $401 to $3,811 within the same region of the state. Between different regions of the state, costs ranged from $253 to $3,811. Patients with the same insurer can also pay different

[12] Berenson et al. 2020; Desai et al. 2017; Rhoads 2019; Sinaiko, Kakani, and Rosenthal 2019; Sinaiko and Rosenthal 2011; Tu and Lauer 2009; Zhang et al. 2012.

[13] White, Bond, and Reschovsky 2013.

[14] Rhoads 2019.

prices for the same procedure. For example, the US Government Accountability Office found that the estimated total cost of laparoscopic gallbladder surgery ranged from $3,281 to $40,626 across providers for patients with the same commercial insurer in Denver, Colorado.[15]

Although the difference in prices is clear, the factors affecting prices and the reasons for variation are complex. Prices could vary because of differences between markets, such as cost of living and availability of healthcare services and providers.[16] Prices can also vary within the same market, sometimes because of the type of facility. For example, the American Hospital Association says costs are higher at hospital outpatient departments than at physician offices because they provide 24/7 care to all types of patients, are prepared to handle emergencies and disasters, and are subject to more regulations.[17] Further, some studies found that prices paid for the same service can vary within the same market because providers often negotiate different prices with insurers for different health plans depending on the leveraging power of the providers and insurers during negotiations.[18] Most likely the cost variation is the result of several driving factors. But regardless of cause, consumers might not be aware of the existing price gaps and the potential to save money by choosing a lower-cost provider.

Wide price variation creates an opportunity for people to shop for lower-cost providers.

Because prices often vary for the same healthcare service, people can choose to shop for providers who charge less for the service. This can be difficult in rural areas, however, where there are few or no healthcare providers. But if there are enough providers in an area, shopping for healthcare services does provide an opportunity for people with or without insurance to save money by choosing lower-cost providers. If they have insurance, their savings depends on their health plan design and cost-sharing requirements, for example whether they have met their deductible or out-of-pocket maximum amounts.[19] Insured people can shop to save money by choosing lower-price providers before they meet their deductible. Once they have met their deductible for the year, shopping can help them find lower-price services that would reduce the amount of

[15] US Government Accountability Office 2014.

[16] Berenson et al. 2020.

[17] American Hospital Association 2014.

[18] Berenson et al. 2020; Massachusetts Office of the Attorney General Martha Coakley 2010; Minnesota Department of Health 2015; Roberts, Chernew, and McWilliams 2017; Scheffler and Arnold 2017; Sinaiko, Kakani, and Rosenthal 2019; White, Bond, and Reschovsky 2013.

[19] Frakt and Mehrotra 2019.

coinsurance they might have to pay. Employers and insurers could also save on claim payments if their health plan enrollees use lower-cost providers. Some proponents of accessible healthcare prices maintain that competition between providers is stimulated when consumers shop for healthcare services, potentially lowering prices in the broader market, as well as for those consumers doing the shopping.[20] However, there is an opposing view that when prices are publicly available and providers see their competitors charging more, they might increase their prices rather than lower them.[21]

Though shopping holds potential for overall healthcare costs savings, there are also some limits on it. One limitation is that people can only shop for certain types of services. Services that are "shoppable"—an estimated 43% of all healthcare services—[22] are elective and planned, not urgent. Imaging, diagnostic testing, physical therapy, and common elective surgeries such as knee and hip replacements are examples of services that are considered shoppable, as opposed to emergency procedures. People do not have the time or ability to shop in an emergency situation.[23] Specialized treatment for serious conditions such as cancer are also not considered shoppable; whereas, in fact, serious illnesses contribute to much of the increase in healthcare spending.[24] To be shoppable, the price for a service also needs to vary between providers so that consumers have an incentive to shop and a potential to save money by choosing a lower-cost provider.[25] Consumers also need a choice between providers—more than one provider in the patient's geographic area that is accessible and offers that service. In rural areas, there might be no provider or only one provider offering a particular service, and the patient might need to travel a long distance in order to have access to the service or a choice in providers.[26]

[20] Sinaiko and Rosenthal 2011; interview with Larry Van Horn, economist, Vanderbilt Owen Graduate School of Management, March 24, 2020.

[21] Ubel 2013; interview with Lacey Blair, senior director, advocacy, and Joe Burchfield, senior vice president, government affairs, Tennessee Hospital Association, February 27, 2020.

[22] Antos and Rivlin 2019.

[23] Gudiksen 2019.

[24] Antos and Rivlin 2019.

[25] Gudiksen 2019.

[26] Fox et al. 2019; interview with and email received from Jacy Warrell, executive director, Rural Health Association of Tennessee, and former executive director, Tennessee Health Care campaign, February 24 and May 12, 2020.[27] Antos and Rivlin 2019; Frakt and Mehrotra 2019; Gudiksen 2019; Whaley, Brown, and Robinson 2019.

Another potential limitation is that people with insurance might not be motivated to shop because their insurance protects them from the full cost of a procedure. Someone who has met their plan's designated cost-sharing requirement, usually by paying the deductible or out-of-pocket maximum amount, has less incentive to shop—their insurer pays more, or all, of the cost at that point, depending on their plan.[27] Table 3 provides hypothetical scenarios that illustrate how health plan design and cost-sharing can affect how much insured consumers and insurers might pay for two different procedures. The scenarios assume the health plan's cost-sharing design requires the patient to pay 20% of the cost after they have paid their full deductible amount for the year—commonly called coinsurance. Because the health plan's out-of-pocket maximum for the year is $5,000 in these scenarios, the insurer covers the cost over that amount. For example, in a scenario for a procedure that costs $35,000, the insured person could pay between $2,500 and $5,000, and the insurer could pay between $30,000 and $32,500, depending on the deductible and how much the patient has already paid that year. However, even if the procedure cost more than $35,000, the patient would not pay more than $5,000. In contrast, for a less expensive procedure with a price ranging from $3,000 to $6,000, the patient does not reach the $5,000 out-of-pocket maximum in any of the hypothetical scenarios and could pay from $600 to $3,200 for the procedure. There are countless possible scenarios, but generally, because of health insurance plans and cost sharing, people with health insurance are often not aware of and do not pay the full cost of their healthcare and therefore might not be motivated to search for the procedures they need for a lower cost.

[27] Antos and Rivlin 2019; Frakt and Mehrotra 2019; Gudiksen 2019; Whaley, Brown, and Robinson 2019.

Table 3. Hypothetical Cost-Sharing Scenarios for Two Procedures

Procedure 1

Deductible		Price	Accounting for Deductible and Coinsurance	Price Before Accounting for $5,000 Out-of-Pocket Maximum	Price Patient Pays After Accounting for $5,000 Out-of-Pocket Maximum	Insurer or Employer Pays	Patient's total out-of-pocket cost for that year
$1,000	**Before Deductible is Met (patient has paid zero dollars that year)**	$20,000	$1000 + ($19,000 x 20%)	$4,800	$4,800	$15,200	$4,800
		$35,000	**$1000 + ($34,000 x 20%)**	**$7,800**	**$5,000**	**$30,000**	**$5,000**
		$50,000	$1000 + ($49,000 x 20%)	$10,800	$5,000	$45,000	$5,000
	After Deductible is Met (patient has paid $1,000 that year)	$20,000	$20,000 x 20%	$4,000	$4,000	$16,000	$5,000
		$35,000	**$35,000 x 20%**	**$7,000**	**$4,000**	**$31,000**	**$5,000**
		$50,000	$50,000 x 20%	$10,000	$4,000	$46,000	$5,000
$2,500	**Before Deductible is Met (patient has paid zero dollars that year)**	$20,000	$2,500 + ($17,500 x 20%)	$6,000	$5,000	$15,000	$5,000
		$35,000	**$2,500 + ($32,500 x 20%)**	**$9,000**	**$5,000**	**$30,000**	**$5,000**
		$50,000	$2,500 + ($47,500 x 20%)	$12,000	$5,000	$45,000	$5,000
	After Deductible is Met (patient has paid $2,500 that year)	$20,000	$20,000 x 20%	$4,000	$2,500	$17,500	$5,000
		$35,000	**$35,000 x 20%**	**$7,000**	**$2,500**	**$32,500**	**$5,000**
		$50,000	$50,000 x 20%	$10,000	$2,500	$47,500	$5,000

Table 3. Hypothetical Cost-Sharing Scenarios for Two Procedures (continued)

Procedure 2

Deductible		Price	Accounting for Deductible and Coinsurance	Price Patient Pays*	Insurer or Employer Pays	Patient's total out-of-pocket cost for that year
$1,000	Before Deductible is Met (patient has paid zero dollars that year)	$3,000	$1000 + ($2,000 x 20%)	$1,400	$1,600	$1,400
		$4,500	$1000 + ($3,500 x 20%)	$1,700	$2,800	$1,700
		$6,000	$1000 + ($5,000 x 20%)	$2,000	$4,000	$2,000
	After Deductible is Met (patient has paid $1,000 that year)	$3,000	$3,000 x 20%	$600	$2,400	$1,600
		$4,500	$4,500 x 20%	$900	$3,600	$1,900
		$6,000	$6,000 x 20%	$1,200	$4,800	$2,200
$2,500	Before Deductible is Met (patient has paid zero dollars that year)	$3,000	$2,500 + ($500 x 20%)	$2,600	$400	$2,600
		$4,500	$2,500 + ($2,000 x 20%)	$2,900	$1,600	$2,900
		$6,000	$2,500 + ($3,500 x 20%)	$3,200	$2,800	$3,200
	After Deductible is Met (patient has paid $2,500 that year)	$3,000	$3,000 x 20%	$600	$2,400	$3,100
		$4,500	$4,500 x 20%	$900	$3,600	$3,400
		$6,000	$6,000 x 20%	$1,200	$4,800	$3,700

*In these scenarios, the patient does not reach the $5,000 out-of-pocket maximum for that year.

Note: These scenarios consider only cost, not quality, of services and illustrate coverage for an individual plan, not a family plan. They also assume that the patient pays 20% coinsurance, and the out-of-pocket maximum is $5,000.

Source: Commission staff created the scenarios based on cost-sharing amounts common in the healthcare industry. The prices used in the scenarios are general, estimated prices for hypothetical procedures. They are not actual negotiated rates between providers and insurers; negotiated rates are used as the basis for cost-sharing and are considered proprietary information.

When making decisions about their healthcare, consumers are often also concerned about the quality of services, which can affect their choice of providers. They might prioritize quality over cost, assuming that higher cost means higher quality. One study found a substantial minority of consumers didn't choose low-cost providers and equated higher

prices with higher quality.[28] In a 2014 study, the US Government Accountability Office also reported that "researchers have found that many consumers assume that all providers offer good quality care, while others have the misconception that higher-cost providers will provide higher quality of care than lower-cost providers."[29] But a nationally representative survey conducted by researchers in 2014 showed that 58% to 71% of Americans do not think that price and quality were associated, while 21% to 24% thought there was an association, and 8% to 16% were unsure.[30] Furthermore, patients often have a relationship with their doctors and trust them, and because they might be concerned about quality, they are likely to follow the doctor's recommendation rather than shop for a lower-cost provider for the procedure, especially for serious health issues.[31]

Even if a consumer does choose to shop, it can be more difficult to assess the quality of healthcare than other goods and services. Measuring and communicating quality is challenging—quality is measured in different ways, and the data is not always available or easy to interpret.[32] For example, the Centers for Medicare & Medicaid Services (CMS) has been collecting quality data from hospitals for about ten years, and it has only recently started to include data from other types of facilities, such as ambulatory surgical centers.[33] In fact, higher-cost healthcare does not always mean the care is higher quality. Authors of a meta-analysis of 61 studies conducted on the relationship of healthcare cost and quality found that the research is inconsistent.[34] Most of these studies found the association between cost and quality—regardless of whether it's positive or negative—is small to moderate. Regardless, consumers commonly do not have clear information or understanding about healthcare quality and cost, and stakeholders agree that they should have both.

[28] Hibbard et al. 2012.

[29] US Government Accountability Office 2014.

[30] Phillips, Schleifer, and Hagelskamp 2016.

[31] Antos and Rivlin 2019; Chernew et al. 2019; Frakt and Mehrotra 2019; interviews with Judy Muck, executive director, Missouri Consolidated Health Care Plan, April 22, 2020; and Gloria Sachdev, president and CEO, Employers' Forum of Indiana, May 6, 2020.

[32] Sinaiko and Rosenthal 2011; interviews with Larry Van Horn, economist, Vanderbilt Owen Graduate School of Management, March 24, 2020; and Laurie Lee, executive director, Benefits Administration, Tennessee Department of Finance and Administration, February 4, 2020.

[33] CMS.gov 2020a; interview with Rob Graybill, vice president, Strategy and Business Development, Sapphire-Digital, SmartShopper, October 16, 2020.

[34] Hussey, Wertheimer, and Mehrotra 2013.

Price comparison tools and incentive and reference pricing programs are examples of strategies used to help and encourage people to shop for healthcare services.

If consumers choose to shop for healthcare services, they need to know the prices of the services before they receive them, as they do in markets for other goods and services. In his book *The Price We Pay, What Broke American Health Care—and How to Fix It*, author Marty Makary summarizes the importance of price transparency as follows: "The prerequisite of any free market is viewable pricing information. . ."[35] Within healthcare, where prices are not always clear or easy to find, creating transparency is viewed as a necessary foundation before implementing policy efforts to reduce costs such as incentive and reference pricing programs.[36] To make it easier for people to shop, the federal government, states, and insurers are taking steps to make more pricing information easily available to consumers. Online tools, for example, can help make prices more transparent and accessible, making shopping easier. Taking it a step further, some states are implementing incentive and reference pricing programs with the intent to encourage people to use the tools to shop.

There a variety of ways to shop for lower-cost healthcare services.

Consumers can shop for healthcare in several ways—whether they have health insurance or not.[37] They can directly contact healthcare providers or possibly search their websites to find and compare cost information for a procedure. A few states have publicly accessible websites with cost comparison tools that both insured and uninsured people can use to shop.[38] Although consumers could locate lower-cost healthcare providers and services using these methods, it would require considerable time and effort to gather and compare the information, and even after searching, they might not find useful information or save money. Patients might not know exactly which procedures or services they need, and complications might lead to the need for additional services that they did not anticipate. Prices for healthcare services are not always easy to find or understand and might not be specific to the patient's situation.[39]

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[35] Makary 2019.

[36] Berenson et al. 2020; Pacific Business Group on Health 2013; Sachdev, White, and Bai 2019; interview with Chris Whaley, policy researcher, RAND Corporation, April 1, 2020.

[37] Information gathered from Commission staff interviews with stakeholders; The Wall Street Journal 2009; and Schencker 2018.

[38] Arizona, Colorado, Connecticut, Florida, Maine, Maryland, Massachusetts, New Hampshire, New York, New Mexico, North Carolina, Texas, Virginia, and Washington.

[39] Mehrotra, Chernew, and Sinaiko 2018; Mehrotra et al. 2017.

People with health insurance have more options for searching price information than those without insurance. They could directly contact their insurer, often with a toll-free number, and talk with a representative to request price information in order to get a more accurate idea of their out-of-pocket costs based on their specific health plan. Insurers also commonly make online tools available so that their enrollees can search and compare costs.[40] However, these options could be challenging for some people if, for example, they don't have access to reliable internet or aren't comfortable using the internet and the online tools. People without insurance must navigate the shopping process and the healthcare system without the help of or tools offered by an insurer. Without consumer-friendly and accessible tools making prices transparent, helping to compare costs, and locating lower-cost providers, shopping for healthcare would likely be more challenging and burdensome for most people, insured or not.

The federal government is working towards greater healthcare price transparency for consumers.

Both the legislative and executive branches of the US government are moving to make healthcare price information more available to the public. As of January 2019, a federal rule requires hospitals to make available online to the public a list of the standard charges for each item and service they provide. This information is to be updated at least annually.[41] These charge lists, called chargemasters, are typically long and complex and use billing codes that most consumers likely don't understand, rather than clear descriptions.[42] The information can be difficult to find and is not organized in a way that allows the average consumer to easily compare prices. Additionally, the chargemaster lists do not represent the prices insured people pay for services because hospitals and insurers negotiate other prices based on those lists. These negotiated prices are amounts actually paid and are typically lower than amounts itemized on the chargemaster lists.[43]

Two additional federal rules address healthcare price transparency. One is a final rule clarifying that the charge lists hospitals are required to make available to the public

[40] Interviews with Rachel Jrade-Rice, assistant commissioner, Division of Insurance, Tennessee Department of Commerce and Insurance, March 12, 2020; and David Locke, vice president, state government relations, BlueCross BlueShield of Tennessee, April 7, 2020.

[41] *Federal Register* 83, no. 160 (August 17, 2018): 41144, https://www.govinfo.gov/content/pkg/FR-2018-08-17/pdf/2018-16766.pdf; *Federal Register* 83, no. 192 (October 3, 2018): 49836, https://www.govinfo.gov/content/pkg/FR-2018-10-03/pdf/2018-21500.pdf. See also CMS.gov 2018.

[42] Gee 2019; National Conference of State Legislatures 2020b.

[43] Meyer 2019.

include negotiated rates with third-party payers (insurers) effective January 1, 2021.[44] However, the final rule was challenged in the US District Court for the District of Columbia.[45] The plaintiffs allege the US Department of Health and Human Services "lacks statutory authority to require and enforce this provision" and that it "violates the First Amendment by compelling the public disclosure of individual rates negotiated between hospitals and insurers in a manner that will confuse patients and unduly burden hospitals."[46] The court upheld the federal rule in June 2020, and the plaintiffs have appealed.[47] Another proposed federal rule would require insurers to either provide their enrollees with an online tool that would estimate their out-of-pocket costs for all covered services or provide the information in writing if requested by enrollees. Insurers would also be required to disclose their negotiated rates for in-network providers and allowed amounts paid for out-of-network providers on a public website.[48]

Congress has recently introduced legislation that would improve price transparency. In June 2019, the Senate introduced the Lower Health Care Costs Act, which would make several changes relating to healthcare coverage, costs, and services, including requiring insurers to make certain information, such as estimated out-of-pocket costs, accessible to enrollees through technology like mobile applications.[49] No action has been taken on this bill since July 2019. The Senate also introduced the Healthcare PRICE Transparency Act in June 2020, which would essentially codify the two recent final and proposed executive branch rules.[50] No further action has been taken on this bill as of August 2020.

The Tennessee General Assembly has passed legislation to improve healthcare price transparency and enable shopping for healthcare services.

Public Chapter 407, Acts of 2019, requires private insurance carriers (insurers) in Tennessee to provide healthcare price information for their enrollees to help them shop

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[44] *Federal Register* 84, no. 229 (November 27, 2019): 65524; https://www.govinfo.gov/content/pkg/FR-2019-11-27/pdf/2019-24931.pdf. See also CMS.gov 2019a.

[45] American Hospital Association et al v Azar, Case 1:19-cv-03619-CJN.

[46] American Hospital Association 2019.

[47] Armour 2020.

[48] *Federal Register* 84, No. 299 (November 27, 2019): 65464; https://www.govinfo.gov/content/pkg/FR-2019-11-27/pdf/2019-25011.pdf. See also CMS.gov 2019c.

[49] U.S. Congress, Senate, *Lower Health Care Costs Act*, S 1895, 116th Cong., 1st sess., introduced in Senate June 19, 2019, https://www.congress.gov/116/bills/s1895/BILLS-116s1895rs.pdf.

[50] U.S. Congress, Senate, *Health Care PRICE Transparency Act*, S 4106, 116th Cong., 2nd sess., introduced in Senate June 30, 2020, https://www.congress.gov/116/bills/s4106/BILLS-116s4106is.pdf. See also Grassley 2020.

for lower-price services and providers. See appendix A for a copy of that legislation. Beginning December 1, 2020, insurers must provide interactive websites and toll-free phone numbers to help their enrollees get information on their out-of-pocket costs or average costs paid by the insurers to service providers within the insurer's network for comparable services.[51] Comparable healthcare services include, but are not limited to, physical and occupational therapy, radiology and imaging, laboratory, and infusion therapy services.[52] Along with cost information, insurers are required to include quality data for their in-network service providers to the extent available.[53] Some insurers already provide price tools on their websites, along with toll-free phone numbers, because they want their enrollees to have access to the information, and they consider these tools a market expectation.[54] The state has now made these tools mandatory for a limited subset of plans but is prohibited from mandating them for others under federal law. However, the tools offered by insurers do not help people without insurance.

Tennessee's new law applies only to certain types of individual and group health plans, covering approximately 11.4% of Tennesseans.[55] The state law does not apply to health plans that are regulated by the federal Employee Retirement Income Security Act of 1974 (ERISA),[56] which cover approximately 38.5% of people in Tennessee.[57] See figure 1 for an explanation of the types of plans that are regulated by ERISA. However, these types of health plans could, and some do, offer cost tools for their enrollees in the state.[58] Tennessee's law also doesn't apply to Medicare plans because they are regulated by the

[51] Tennessee Code Annotated, § 56-7-604.

[52] Tennessee Code Annotated, § 56-7-602.

[53] Tennessee Code Annotated, § 56-7-604.

[54] Interviews with Rachel Jrade-Rice, assistant commissioner, Division of Insurance, Tennessee Department of Commerce and Insurance, March 12, 2020; David Locke, vice president, state government relations, BlueCross BlueShield of Tennessee, April 7, 2020; Mandy Haynes Young, lobbyist, Butler Snow LLP, December 16, 2019; and Rob Graybill, vice president, Strategy and Business Development, Sapphire-Digital, SmartShopper, March 9, 2020.

[55] Emails received from Rachel Jrade-Rice, assistant commissioner, Division of Insurance, Tennessee Department of Commerce and Insurance, May 19 and 20, 2020.

[56] 29 U.S.C. S. § 1144 (ERISA Act sec. 514).

[57] Emails received from Rachel Jrade-Rice, assistant commissioner, Division of Insurance, Tennessee Department of Commerce and Insurance, May 19 and 20, 2020.

[58] Interviews with Laurie Lee, executive director, Benefits Administration, Tennessee Department of Finance and Administration, February 4, 2020; and Rob Graybill, vice president, Strategy and Business Development, Sapphire-Digital, SmartShopper, March 9, 2020.

federal law.[59] Additionally, the state, local education, and local government health plans that are managed by the Tennessee Division of Benefits Administration are not affected.[60] TennCare—Tennessee's version of Medicaid—and individual plans that are "grandfathered" under the federal Patient Protection and Affordable Care Act are specifically exempted from Tennessee's law to prevent unintentional conflicts with existing state or federal laws.[61]

Figure 1. Self-Insured Health Plans Offered by Private Employers are Regulated by ERISA

Under self-insured health insurance plans, also called self-funded plans, "a group sponsor (like the state) or employer, rather than an insurance company, is financially responsible for paying the plan's expenses, including claims and plan administration costs."[a] Instead of paying premiums to insurance companies, the sponsors of these plans take on the risk, do the insuring, and pay claims from an insurance fund or claims reserve funded by the premiums paid by their insured employees. The sponsors contract with third-party companies to administer the services for the plan. For example, the Tennessee Division of Benefits Administration currently contracts with BlueCross BlueShield of Tennessee and Cigna to administer services for state, local education, and local government employees who are enrolled in one of the self-funded health plans offered by the Division. Many state and public employee health insurance plans, including Tennessee's, and health plans offered by large private companies to their employees are self-insured. Self-insured plans offered by private employers are regulated by the federal Employee Retirement Income Security Act of 1974 (ERISA)—not by states.

[a] Partners for Health "Definitions."

See also: Claxton et al. 2019; National Conference of State Legislators 2020a; Partners for Health "Health Insurance;" interview with Laurie Lee, executive director, Benefits Administration, Tennessee Department of Finance and Administration, February 4, 2020.

[59] 42 CFR § 422.402; interview with Rachel Jrade-Rice, assistant commissioner, Division of Insurance, Tennessee Department of Commerce and Insurance, March 12, 2020.

[60] Email received from Laurie Lee, executive director, Benefits Administration, Tennessee Department of Finance and Administration, June 11, 2020. Health plans provided through the Tennessee Farm Bureau are also exempt under Tennessee Code Annotated, § 56-2-121. See also Pellegrin 2020.

[61] Tennessee Code Annotated, § 56-7-608; email received from Brian Hoffmeister, director, policy analysis, Division of Insurance, Tennessee Department of Commerce and Insurance, July 10, 2020.

Other states are also improving price transparency and access to price comparison tools for both insured and uninsured consumers.

Tennessee is not the only state with laws requiring healthcare price comparison tools. An additional seven states—Connecticut, Florida, Georgia, Maine, Massachusetts, Missouri, and Virginia—require private insurers to provide price information for their insurance enrollees.[62] While these tools are not all necessarily available to the public, some are, such as Georgia, which requires that the information is publicly accessible.[63] The laws vary, but in general do not have many specific requirements for insurers. Connecticut, Maine, Massachusetts, Missouri, and Virginia require insurers to provide cost information through a website and a toll-free telephone number; Maine also gives insurers the option to refer enrollees to the Maine health price comparison tool, which is available to the public. Connecticut, Maine, and Virginia require the insurer to also provide quality information, while Massachusetts and Missouri do not. Florida's law differs.[64] It applies only to health maintenance organizations (HMO) and requires insurers to make available to its enrollees on its website or by request the estimated copayment, coinsurance percentage, or deductible, whichever is applicable, for any covered services. It does not specify that insurers provide a phone number or require them to provide information about quality. Several other states have price transparency legislation pending.[65] Figure 2 shows examples of the tools offered by two private insurers.

[62] Connecticut General Statute. § 38a-477e; Florida Statute § 641.54; Georgia Code Annotated § 33-24-59.27; Maine Revised Statutes Title 24-A § 4303; Massachusetts General Laws Part I, Title XXII, Chapter 1760, § 23; Missouri Revised Statutes § 376.446; Virginia Code Annotated § 38.2-3463.

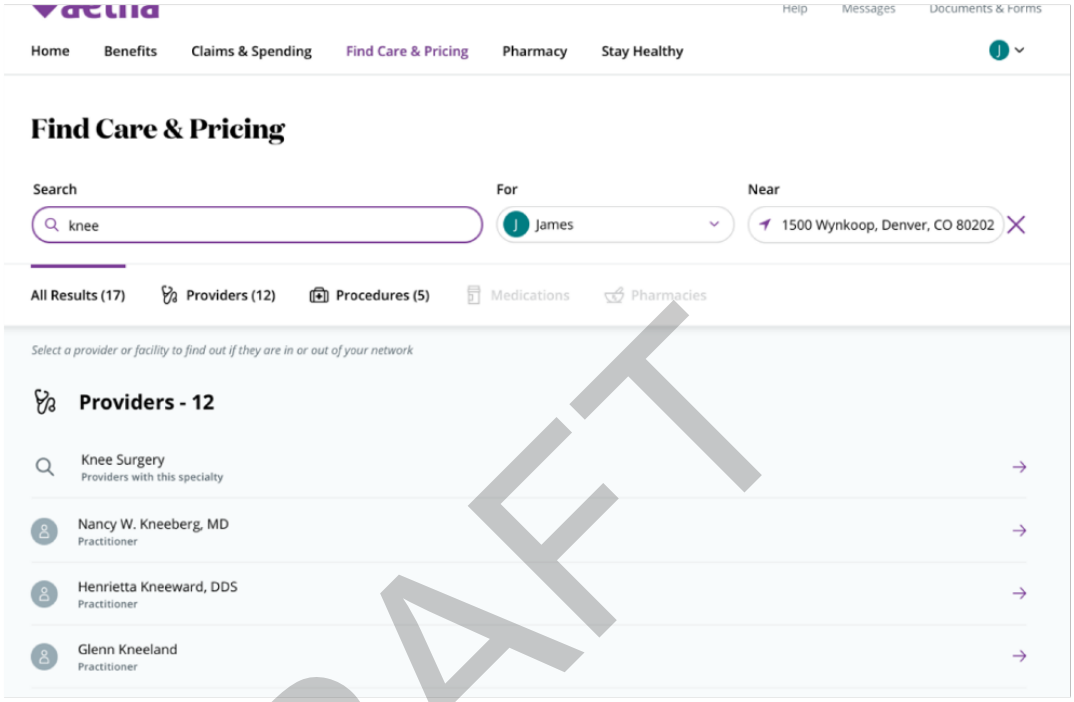
[63] Georgia Code Annotated § 33-24-59.27.

[64] Florida Statutes §641.54.

[65] As of October 2020, Alaska, Louisiana, Oklahoma, Minnesota, and Illinois have price transparency legislation pending.

Figure 2. Examples of Private Insurers' Healthcare Price Comparison Tools

Aetna



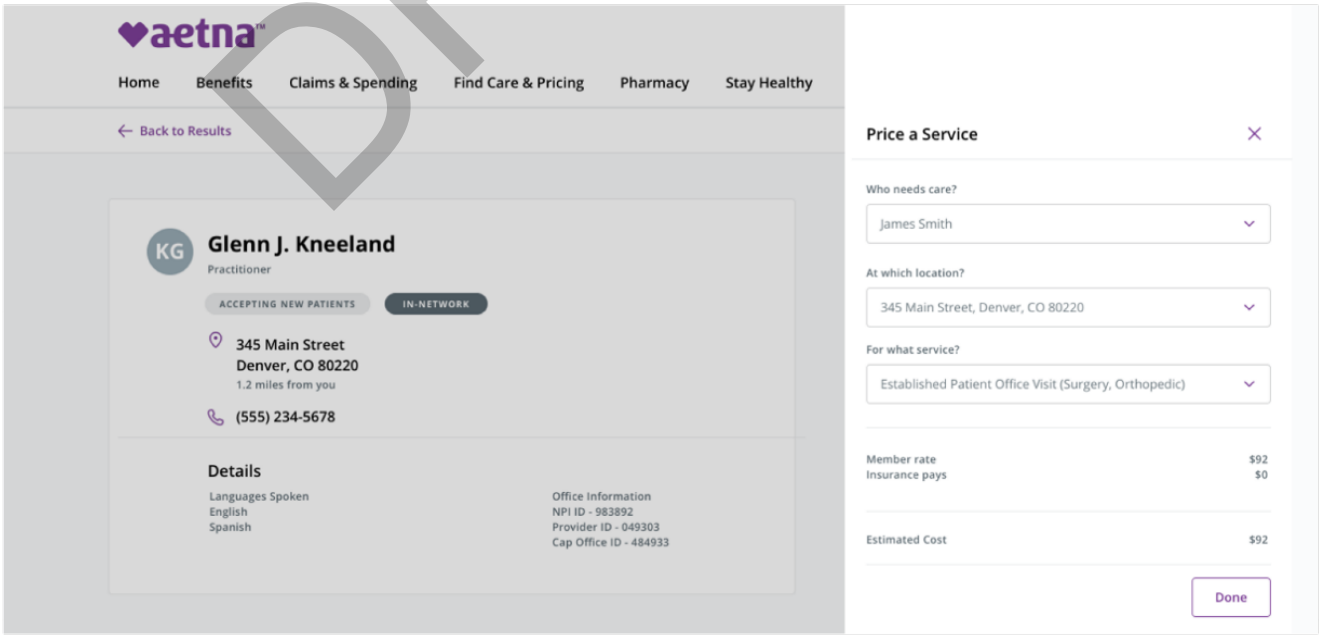
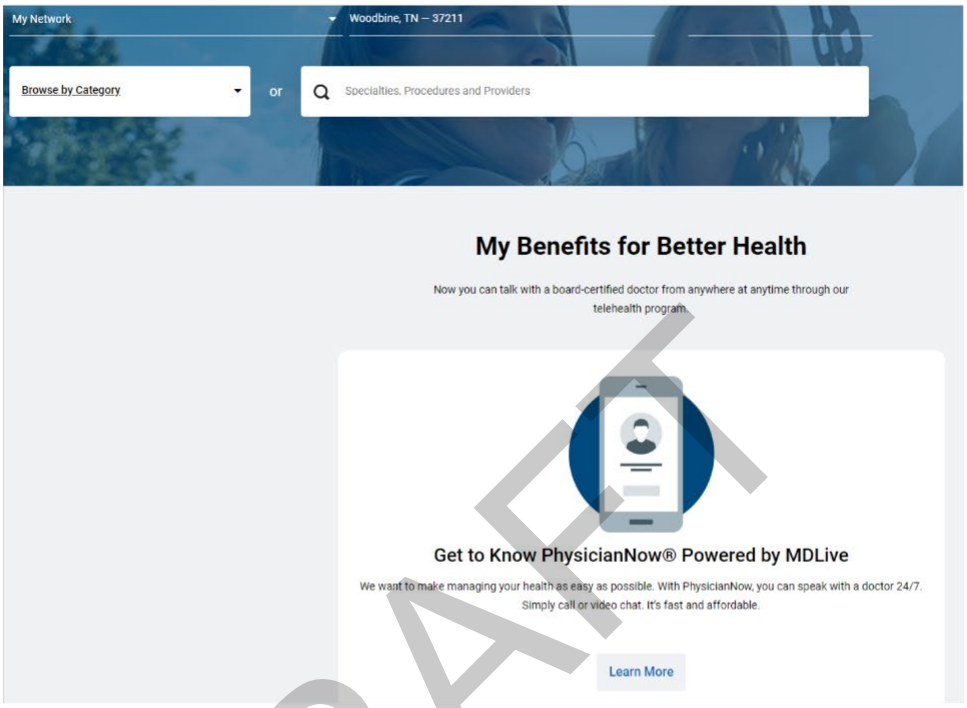
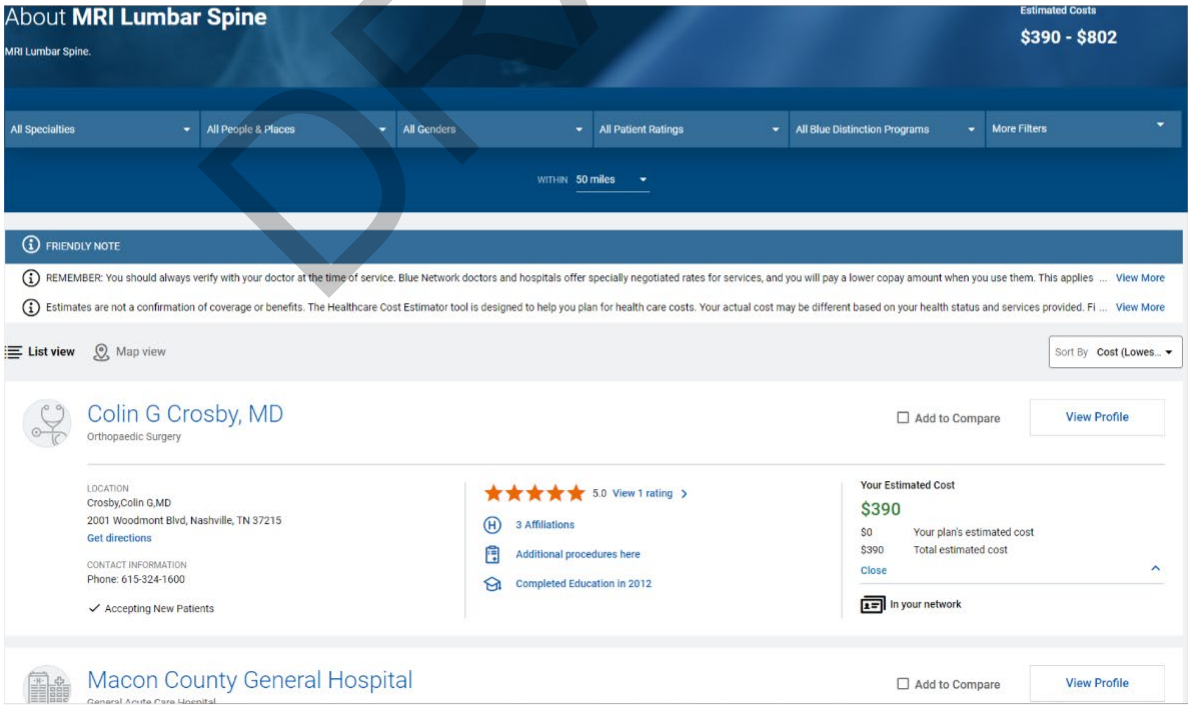


Figure 2. Examples of Private Insurers' Healthcare Price Comparison Tools (continued)

BlueCross BlueShield of Tennessee





Source: Emails received from Mandy Haynes Young, lobbyist, Butler Snow LLP, August 20, 2020; Carla Raynor, vice president consumer experience and brand management, BlueCross BlueShield of Tennessee, August 18, 2020.

Fourteen states—Arizona, Colorado, Connecticut, Florida, Maine, Maryland, Massachusetts, New Hampshire, New York, New Mexico, North Carolina, Texas, Virginia, and Washington—have at least some health cost information available to the public on their websites.[66] See appendix B for information about these 14 states' websites. Five of these states—Connecticut, Florida, Maine, Massachusetts, and Virginia—also require private insurers to provide price information for their insurance enrollees. Public websites showing prices could help people with or without insurance compare prices for healthcare services and providers. The level of detail and format of the information in each state's tool varies, and some are relatively new. New Hampshire has had a public website since 2007, and it is one of the oldest.[67] Indiana's state legislature passed legislation in 2020 mandating that the state request proposals from companies to set up a consumer website.[68] Tennessee does not have a publicly available online tool. People in Tennessee without health insurance will still have to contact providers directly to gather price information and shop for healthcare. Figure 3 shows screenshots of Maine, Massachusetts, and New Hampshire's public healthcare price comparison tools.

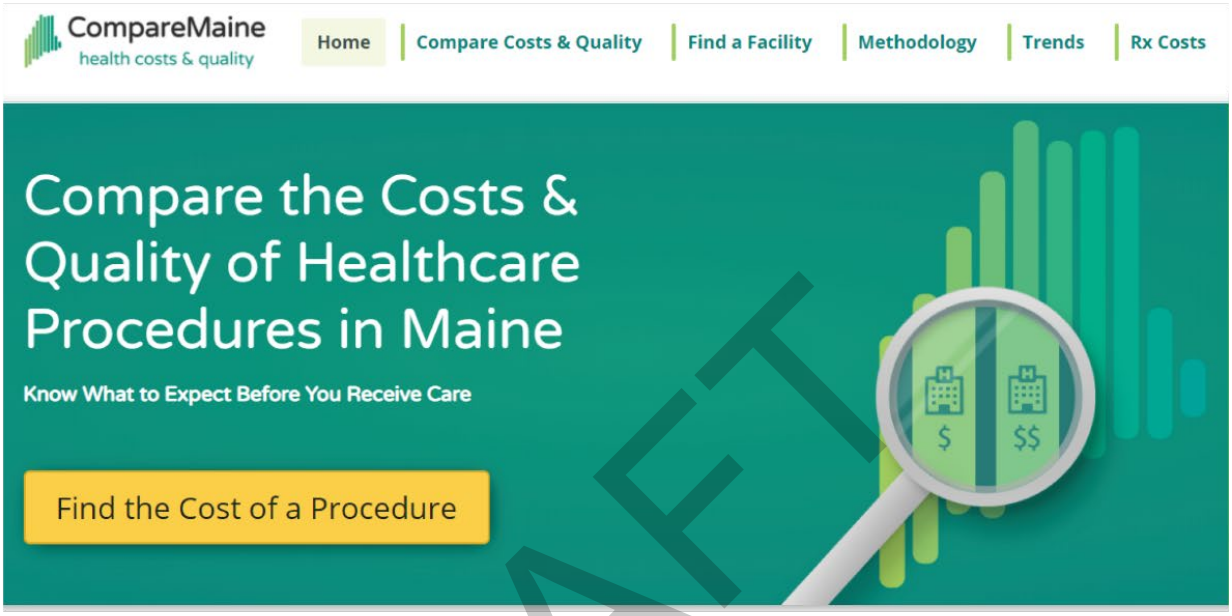
[66] California is required to have one substantially completed by July 1, 2023. CA Health & Safety Code Section 127671.

[67] Tu and Lauer 2009; Tu and Gourevitch 2014.

[68] Indiana Code Annotated Title 16, Article 21, Chapter 17.

Figure 3. Examples of States' Public Healthcare Price Comparison Tools

Maine
CompareMaine – https://comparemaine.org/



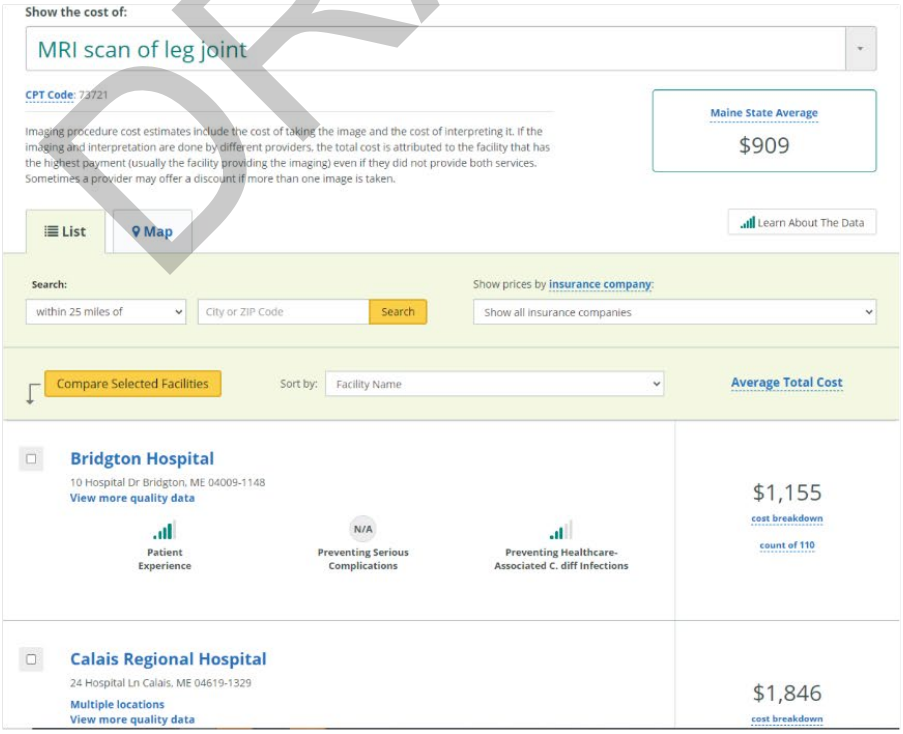


Figure 3. Examples of States' Public Healthcare Price Comparison Tools (continued)

Massachusetts

CompareCare – https://masscomparecare.gov/

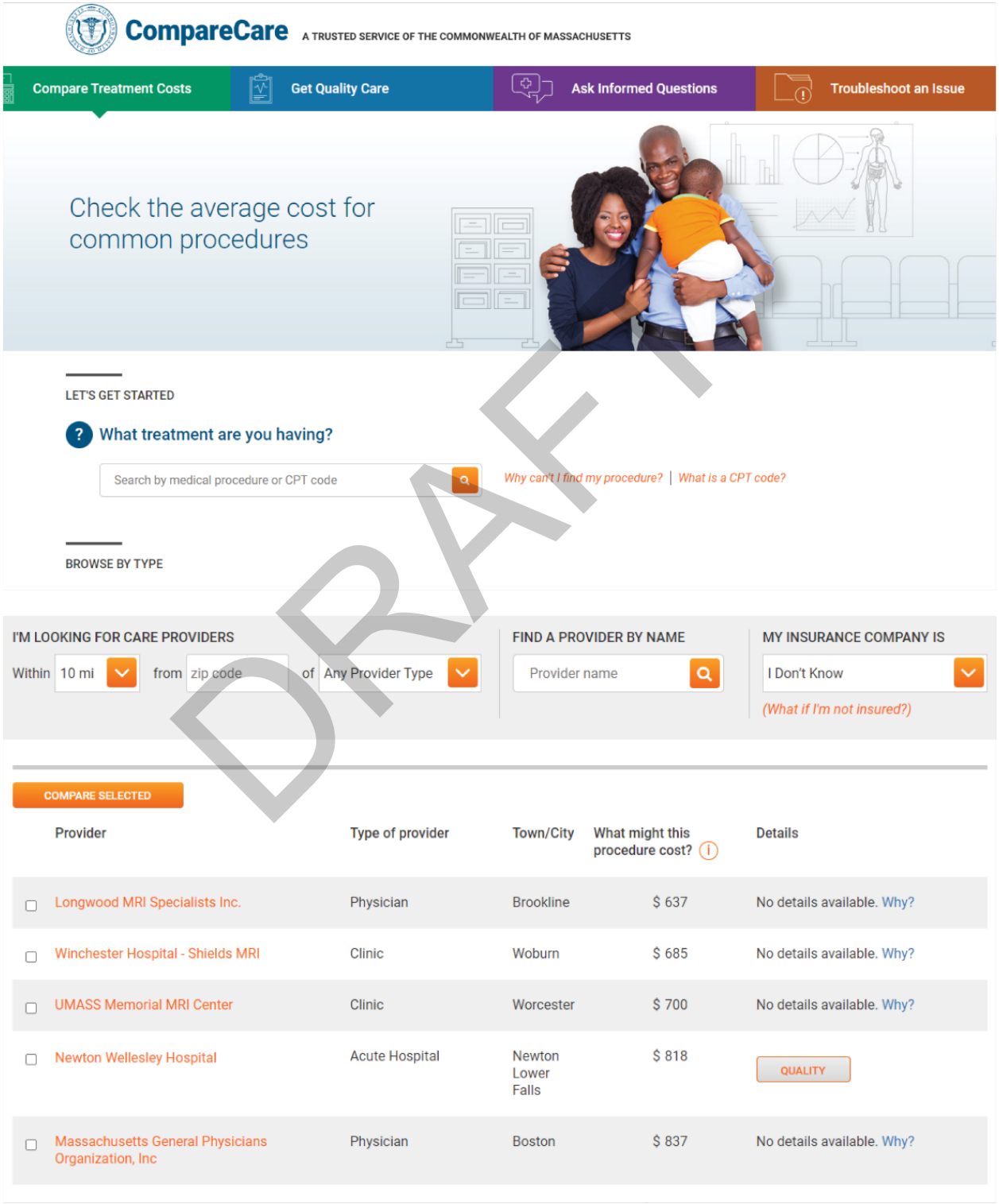
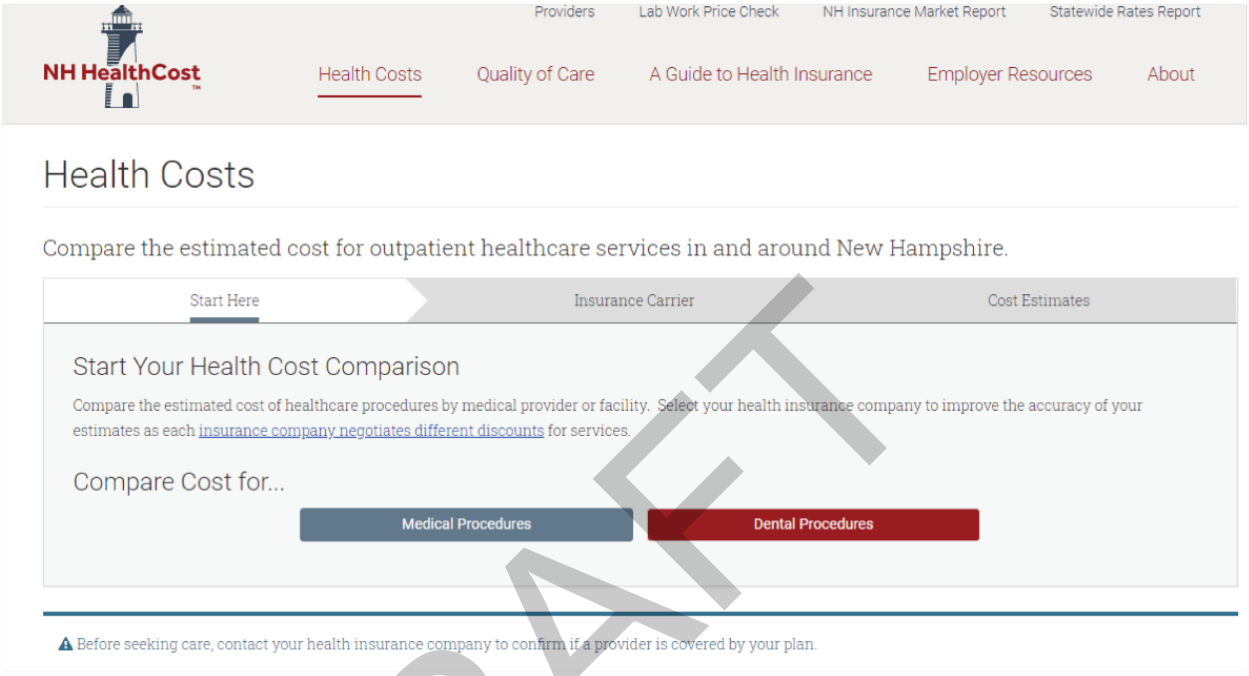
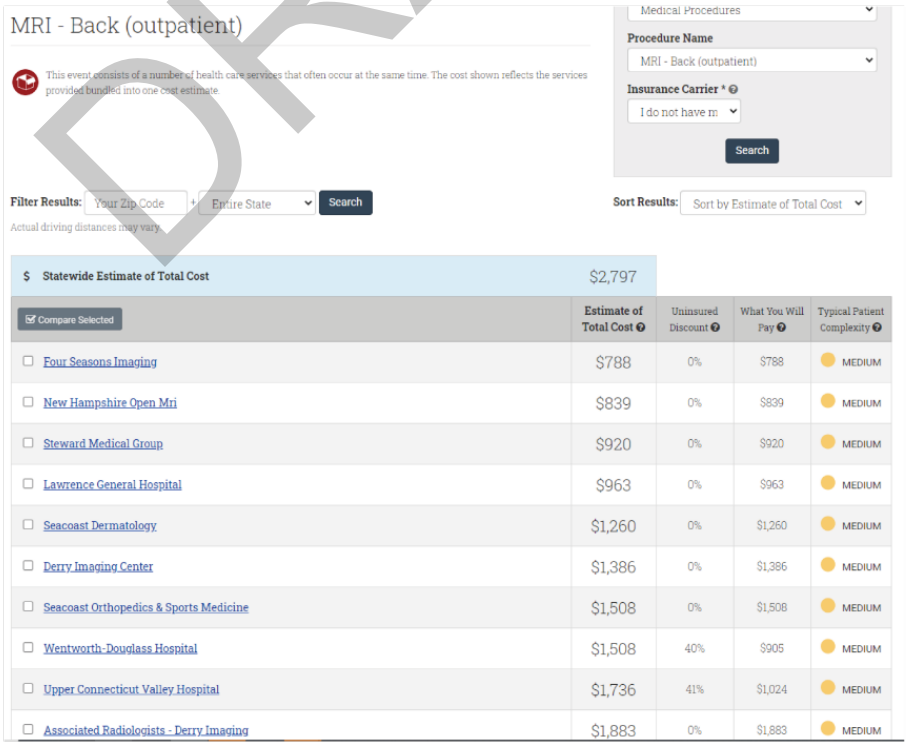


Figure 3. Examples of States' Public Healthcare Price Comparison Tools (continued)

New Hampshire
NH HealthCost – https://nhhealthcost.nh.gov/





Most of the states providing public tools get their data from an all-payer claims database (APCD), which supplies the price information that consumers can then search and use. APCDs are repositories of health insurance claims costs and quality data that is collected from various sources, including Medicaid and Medicare, private insurers, dental and drug plans, state health plans, and others.[69] They are typically started and managed by states, although there are some APCDs run by private organizations as well.[70] Each state creates its own guidelines and rules for gathering data and managing its database. Although they are used as a source of data for public websites, they more commonly serve as a database available to researchers and government agencies when analyzing policy strategies and making decisions about healthcare cost and quality. At least 18 states have APCDs that are available to researchers and government agencies,[71] and at least ten states are in process of, or are studying implementation of, an APCD.[72] Eleven of the fourteen states that have public websites use an APCD to support their consumer website;[73] New Mexico uses average Medicaid cost estimates, not an APCD;[74] Arizona uses 2011 inpatient discharge data from Arizona hospitals;[75] and North Carolina also uses data collected from hospitals.[76]

Gathering data from the various sources can be a challenge for states, particularly from health plans that are regulated by ERISA. In 2016, the United States Supreme Court ruled in *Gobeille v. Liberty Mutual Insurance Company* that ERISA essentially preempts state law, prohibiting states from requiring ERISA health plans to submit claims data.[77] However, some ERISA plans do work with states and submit their data voluntarily to ACPDs. Tennessee passed a law to establish an APCD in 2009.[78] In 2016, the Tennessee Attorney

[69] National Conference of State Legislatures 2018a; National Conference of State Legislatures 2018b.

[70] Examples include Fairhealth.org, guroo.com, and Health Care Cost Institute.

[71] Arkansas, Colorado, Connecticut, Delaware, Florida, Hawaii, Kansas, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New York, Oregon, Rhode Island, Utah, Vermont, and Washington. Berenson et al. 2020.

[72] Alaska, California, Idaho, North Carolina, New Jersey, New Mexico, Montana, Pennsylvania, West Virginia, and Wyoming. Berenson et al. 2020.

[73] Colorado, Connecticut, Florida, Maine, Maryland, Massachusetts, New Hampshire, New York, and Washington. Information gathered from other states' websites.

[74] New Mexico Department of Health 2017.

[75] Arizona Department of Health Services 2020.

[76] North Carolina Department of Health and Human Services "Transparency in Health Care Costs."

[77] Gobeille v. Liberty Mut. Ins. Co., 136 S. Ct. 936 (2016); Abdeljaber et al. 2020.

[78] Tennessee Code Annotated, § 56-2-125.

General opined that because of the Supreme Court's decision, the state is prohibited from requiring health plans governed by ERISA to submit data and therefore can't enforce the law as written.[79] Because ERISA regulates over a third of all health plans in Tennessee and a large amount of data was not accessible, the usefulness of the APCD was viewed as limited, and the initiative was ended.[80] Although Tennessee does not currently have an ACPD, the language for its establishment and maintenance remains in statute.

Even though public price tools and APCDs can benefit more people than the tools provided enrollees by private insurers, they can be expensive and challenging to create and maintain. It generally takes about a year and a half from the startup of an APCD to data availability, and startup and annual maintenance costs can range from less than $500,000 to as much as $4 million.[81] For example, the Indiana Legislative Service estimated that an Indiana APCD database could cost $1.8 million to $2.4 million in its first year and $250,000 per year to operate.[82] New Hampshire spent over $1.8 million between 2014 and 2018 upgrading and maintaining both its database and the NH HealthCost website, which originally launched in 2007.[83] Although both the database and public website are complex undertakings, and the costs associated with their development can be intertwined, the database is typically the larger and more costly portion of the overall effort.

Price comparison tools can help people save money, but not a lot of people use them.

While the goal of price comparison tools is to provide healthcare price and quality information for consumers in a way that is accessible and easy to use, cost savings resulting from the use of price tools varies. Several studies, however, do show some price savings.[84] For example, a 2014 study of 18 employers who provided a price comparison tool for their insured employees, found that for employees who accessed and used the tool, claims payments were $3.45 (13.93%) lower for lab tests, $124.74 (13.15%) for MRIs,

[79] Opinion No. 16-42, Office of the Tennessee Attorney General, December 7, 2016.

[80] Interview with Larry Van Horn, economist, Vanderbilt Owen Graduate School of Management, March 24, 2020.

[81] Abdeljaber et al. 2020.

[82] Erdody 2020.

[83] Email received from Maureen Mustard, director of healthcare analytics, New Hampshire Insurance Department, May 29, 2020.

[84] Lieber 2017; Whaley 2019; White et al. 2014; Wu et al. 2014.

and $1.18 (1.02%) for clinic visits.[85] The study authors did not analyze the amount that patients paid out of pocket for the procedures, but they concluded that when people have access to and use price information before receiving services, total claims payments for these services are lower. A study of New Hampshire's public cost comparison tool, NH HealthCost, looked at the effect the tool had on costs. The tool is a state-run website available to the public that allows people to search for healthcare prices by service provider. It also allows the insured to search for out-of-pockets costs for services based on their insurance company. The study showed that during the five-year period after the website's launch, the cost of medical imaging procedures—including x-rays, computed tomography (CT) scans, and MRIs—decreased by 5% for patients with insurance and 4% for insurers.[86] Patients saved approximately $7.9 million, and insurers saved $36 million over the study period. The study did not look at the effect on costs paid by the uninsured in the state. A 2017 study of the California Public Employees' Retirement System (CalPERS) also found savings—though use of the tool did not result in lower prices paid for lab tests or visits, it did result in an average 14% lower prices paid for imaging in the first 15 months.[87] One study found that consumer access to a price comparison tool by employees of private businesses led to a reduction of 1% to 4% in providers' laboratory test prices but had no effect on office visit prices.[88]

Overall, tools can help save money, but these savings are limited and not guaranteed. While some studies show savings, one actually showed an increase in out-of-pocket spending for patients who used the tools. Researchers found in a 2016 study that out-of-pocket spending for outpatient services by employees of two private businesses increased by $59 (2.9%) during the 15 months after the introduction of the tool.[89] The researchers speculate that spending might have increased because people using the tools related higher prices to higher quality and as a result chose higher-price providers, especially when they had already met their out-of-pocket maximum. They also noted that the study did not find evidence of meaningful savings associated with availability of a price transparency tool. One study concluded "Simply offering a price comparison tool is not sufficient to meaningfully decrease health care prices or spending."[90]

[85] Whaley et al. 2014.

[86] Brown 2019.

[87] Desai et al. 2017.

[88] Whaley 2019.

[89] Desai et al. 2016.

[90] Desai et al. 2017.

Even when tools are accessible, people typically don't use them to search for shoppable services. Studies have found that while transparency tool usage-rates vary, they are generally low,[91] ranging from approximately 1% to 26.8%.[92] For example, one study found that over a three-year period, 1% of New Hampshire's residents used its tool; 41% of the searches were conducted by people without insurance and 59% by those with insurance.[93] The three most common searches were for outpatient services, MRIs, and CT scans. A 2017 study of the CalPERS price tool found that 12% of state employees and retirees used it in the first 15 months it was available.[94] At the other end of the range, one study found that 26.8% of insured employees used tools provided by their employers to search before visiting clinics.[95] During interviews with Commission staff, several stakeholders emphasized the importance of promoting the tools to encourage their use.[96] Cost savings are restricted by the low usage rate of the tools.

Incentive and reference pricing programs can encourage people to use price comparison tools to shop for healthcare services.

One way to address low usage of price comparison tools is to offer incentives that encourage people to shop and choose lower-cost healthcare providers. Incentive programs, also called rewards, shared savings, or "right to shop" programs, can be offered by state employee health plans, employers, or insurers who will share savings if the patient shops and chooses a lower-cost provider.[97] Not all procedures and services are rewarded—although programs vary, they usually include shoppable services that have large enough cost differences between providers to result in savings and make a reward worthwhile. Higher cost procedures such as surgeries have the potential to save

[91] Frakt and Mehrotra 2019.

[92] Mehrotra, Brannen, and Sinaiko 2014; Whaley et al. 2014. See also Berenson et al. 2020; Desai et al. 2016; Desai et al. 2017; Gourevitch et al. 2017; Lieber 2017; ; Whaley, Brown, and Robinson 2019.

[93] Mehrotra, Brannen, and Sinaiko 2014.

[94] Desai et al. 2017.

[95] Whaley et al. 2014.

[96] Interviews with Lacey Blair, senior director, advocacy, and Joe Burchfield, senior vice president, government affairs, Tennessee Hospital Association, February 27, 2020; Rob Graybill, vice president, Strategy and Business Development, Sapphire-Digital, SmartShopper, March 9, 2020; David Locke, vice president, state government relations, BlueCross BlueShield of Tennessee, April 7, 2020; Scott Weden, benefits & wellness manager, New Hampshire HealthTrust, August 6, 2020; and Chris Whaley, policy researcher, RAND Corporation, April 1, 2020.

[97] Gudiksen 2019; Foundation for Government Accountability 2019.

more than lower-cost procedures such as lab tests.[98] Often health plans or insurers will contract with a third-party vendor such as Sapphire Digital or Healthcare Bluebook to operate and maintain the tools and programs. These companies charge either a flat fee (per health plan enrollee) or a percentage of the savings that result from the incentive program.[99]

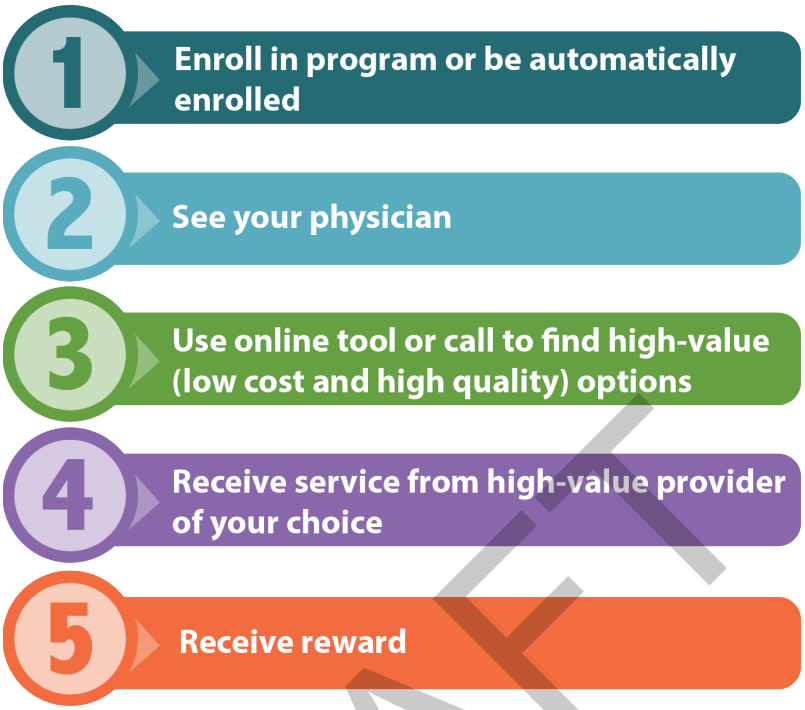
Patients can choose to participate and then take a few basic steps to shop and receive incentives that vary depending on the program.[100] See figure 4. Patients can search prices for services and choose providers using an online tool or a toll-free number either with or without first obtaining a doctor's recommendation. The reward they receive is typically cash, a gift card, or a credit to a health savings account that can only be used on future healthcare services. The reward amounts are calculated as a percentage of the average savings for services and procedures—often ranging from $25 to $500 per procedure—and usually patients must use their insurer's tool to shop before receiving the reward. Figure 5 shows hypothetical cost scenarios accounting for reward and cost sharing between patients and insurers for three procedures with different price ranges, including both before and after the patient has met the deductible amount designated by their health plan. See appendix C for additional hypothetical cost scenarios.

[98] Interviews with Rob Graybill, vice president, Strategy and Business Development, Sapphire-Digital, SmartShopper, March 9, 2020; and Bill Kampine, co-founder & senior vice president, Healthcare Bluebook, September 11, 2020.

[99] Interviews with Delos DeCelle, senior manager, State Employee Health Plan, Kansas State Self Insurance Fund, April 14, 2020; Judy Muck, executive director, Missouri Consolidated Health Care Plan, April 22, 2020; Kodie Nix, project manager, shared savings program contract manager, Florida Department of Management Services, March 17, 2020.

[100] Whaley et al. 2019; Commission staff interviews with representatives from other states with incentive programs.

Figure 4. Basic Steps of Healthcare Shopping Incentive Programs



The process varies depending on the program. Consumers could use the tools to shop for physicians as well as procedures and services.

Source: Commission staff interviews with representatives from other state employee health plans with incentive programs; Foundation for Government Accountability "Right to Shop."

Figure 5. Hypothetical Cost Scenarios for an Incentive Program

The following three scenarios assume the patient has paid zero towards their $1,000 annual deductible before receiving the procedure.

PROCEDURE ONE – $300	
Patient would pay before reward $300 deductible + $0 coinsurance	**$300**
Reward	$50
Net price for patient (after receiving reward)	**$250**
Insurer/employer pays (including reward)	$50
Net amount patient spends that year*	**$250**

PROCEDURE TWO – $3,000	
Patient would pay before reward $1,000 deductible + $400 ($2,000 x 20%) coinsurance	**$1,400**
Reward	$150
Net price for patient (after receiving reward)	**$1,250**
Insurer/employer pays (including reward)	$1,750
Net amount patient spends that year*	**$1,250**

PROCEDURE THREE – $20,000	
Patient would pay before reward $1,000 deductible + $3,800 ($19,000 x 20%) coinsurance	**$4,800**
Reward	$500
Net price for patient (after receiving reward)	**$4,300**
Insurer/employer pays (including reward)	$15,700
Net amount patient spends that year*	**$4,300**

The following three scenarios assume the patient has already paid $1,000 towards their $1,000 annual deductible before receiving the procedure and pays 20% coinsurance.

PROCEDURE ONE – $300	
Patient would pay before reward ($300 x 20% = $60 coinsurance)	**$60**
Reward	$50
Net price for patient (after receiving reward)	**$10**
Insurer/employer pays (including reward)	$290
Net amount patient spends that year*	**$1,010**

PROCEDURE TWO – $3,000	
Patient would pay before reward ($3,000 x 20% = $600 coinsurance)	**$600**
Reward	$150
Net price for patient (after receiving reward)	**$450**
Insurer/employer pays (including reward)	$2,550
Net amount patient spends that year*	**$1,450**

PROCEDURE THREE – $20,000	
Patient would pay before reward ($20,000 x 20% = $4,000 coinsurance)	**$4,000**
Reward	$500
Net price for patient (after receiving reward)	**$3,500**
Insurer/employer pays (including reward)	$16,500
Net amount patient spends that year*	**$4,500**

*The amount that would count towards the patient's out-of-pocket maximum designated by the health plan for that year is the price before they receive the reward.

Note: These scenarios consider only cost, not quality of services, illustrate coverage for an individual plan, not a family plan, and assume that the patient chooses the lowest cost option available to them. They also assume that the deductible is $1,000, and the patient pays 20% coinsurance.

Source: Commission staff created the scenarios based on cost-sharing amounts common in the healthcare insurance industry. The prices used in the scenarios are general, estimated prices for hypothetical procedures. They are not actual negotiated rates between providers and insurers; negotiated rates are the basis for cost-sharing and are considered proprietary information.

Reference pricing is another approach used to encourage patients to choose lower-cost providers. While incentive programs are viewed as a "carrot" approach, reference pricing programs are seen as a "stick" approach. Reference pricing places an upper limit on the amount an insurer will pay for a medical service, and if an insurance enrollee chooses to receive care from a provider that charges above that amount—the reference price—the enrollee is responsible for paying the difference.[101] Generally, the reference price is set to a specific percentile of the distribution of provider reimbursements in a market, such as the median reimbursement. Because consumers could potentially pay more for not choosing a lower-cost provider, rather than receiving rewards for choosing one, these programs are not as popular as incentive programs.

Some studies suggest using incentive programs or reference pricing to encourage price shopping, and results show some cost savings.[102] For example, one 2019 study of 29 employers that started an incentive program in 2017 found that prices paid for targeted services decreased 2.1% in the first 12 months of the program. Employers saved a total of $2.3 million, or about $8 per health plan enrollee, which mostly resulted from MRIs and ultrasounds.[103] Prices paid for surgical procedures included in the programs did not decrease. The study authors note that, in comparison, reference pricing programs saved 15% per procedure. In Tennessee, the State Insurance Committee had similar findings in its 2019 study of incentive programs started by other state employee health plans. The Committee found that, in those programs, offering price comparison tools alone does not increase enrollee shopping and that pairing incentive programs with tools works better.[104] State employee health plans that utilized incentive programs were found to have achieved modest savings that were immediate and measurable in the short term.

In Tennessee, private insurers and the State Insurance Committee are authorized to implement incentive programs for enrollees in their health plans.

In addition to requiring private insurers to have price transparency websites, Public Chapter 407, Acts of 2019, Tennessee's Right to Shop law, authorizes the State Insurance Committee and insurers to offer incentive programs to enrollees in their health plans beginning January 1, 2021.[105] The law requires the State Insurance Committee to complete a study of programs in other states and authorizes it to implement an incentive program for its employee health plans, if it determines that one might be cost effective. The

[101] US Department of Health and Human Services 2019.

[102] Benavidez and Frakt 2019; Tu and Lauer 2009; White et al. 2014.

[103] Whaley et al. 2019.

[104] Tennessee Division of Benefits Administration 2019.

[105] Public Chapter 407, Acts of 2019; Tennessee Code Annotated, § 56-7-601 et seq.

Committee released its report in December 2019, and as of September 2020, the Benefits Administration is not planning to implement an incentive program.[106] The law also allows private insurers to determine whether an incentive program would be beneficial for the plans and their enrollees. According to Division of Insurance staff, as of October 2020, they have not yet received a filing from any insurers in the state for an incentive program.[107] The programs are to provide incentives to insurance enrollees who choose to shop and receive a service from a lower-cost healthcare provider within the insurer's network. Services that are considered lower cost are ones that are less than the average cost paid by the insurers to providers for comparable services both before and after an enrollee's out-of-pocket limit has been met. Comparable healthcare services as defined by the law include, but are not limited to, physical and occupational therapy, radiology and imaging, laboratory, and infusion therapy services.[108]

Although incentive programs are not required in Tennessee, the Right to Shop law describes some required and optional program elements related to incentives if insurers did decide to offer a program.[109] Incentives may be calculated as a percentage of the difference between the amount actually paid by the insurer for a service and the average allowed amount for that service—the savings. The incentive amount may be at least 50% of the insurer's saved costs for each service, and insurers can exclude incentives for services where the savings are less than $50. Incentives may be provided as a cash payment, a credit toward the enrollee's annual in-network deductible and out-of-pocket limit, or a credit or reduction of a premium, a copayment, cost sharing, or a deductible. The total value of incentives that one person receives in one year cannot exceed $599.[110]

A few states use incentive or reference pricing programs in their state or other public employee health plans.

To help address high and rising healthcare costs, states have considered, are considering, or are implementing incentive programs in their employee health plans. Eight states—Florida, Kansas, Kentucky, Missouri, New Hampshire, Texas, Utah, and Virginia—have

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[106] Email received from Laurie Lee, executive director, Benefits Administration, Tennessee Department of Finance and Administration, September 21, 2020.

[107] Email received from Brian Hoffmeister, director, policy analysis, Division of Insurance, Tennessee Department of Commerce and Insurance, June 29, 2020.

[108] Tennessee Code Annotated, § 56-7-602.

[109] Tennessee Code Annotated, § 56-7-601 et seq.

[110] The amount was capped at $599 because insurance carriers are required to report miscellaneous income of $600 or more paid to an individual using a 1099-MISC form. Internal Revenue Service 2019; testimony to Commission by Josh Archambault, senior fellow, Foundation for Government Accountability, January 16, 2020.

incentive programs as a part of their health plans for state or other public employees, such as city, county, and school district employees.[111] Four of the eight states—Florida, Texas, Utah, and Virginia—are required by legislation to have incentive programs for their employees, and the other four—Kansas, Kentucky, Missouri and New Hampshire—chose to create their programs without being directed to do so by legislation. New Hampshire and Texas each have two distinct programs—New Hampshire has one for its state employee health plan and one for its health plan for other public employees, while Texas has one for state employees and one for teachers. Because most of the programs are relatively new, data is somewhat limited—Kentucky's program and New Hampshire's state program are the oldest and began in 2013 and 2010, respectively. The newest programs, in Missouri and Texas, started in 2020. Appendix D includes more detail about the incentive programs in each states' employee health plans.

Other states have considered or are considering programs. The Arizona state employee health plan was required in 2018 to study the cost effectiveness of an incentive program, and based on its analysis decided not to implement a program because it wouldn't save money.[112] Massachusetts also had an incentive program but discontinued it because of low participation.[113] The Nebraska state legislature passed legislation authorizing the state to incorporate a rewards program in its state employee health plan, but so far it has not done so.[114] Louisiana has legislation pending.[115]

The structure of the programs varies in each state, although there are similarities.[116] All states but Utah, which created and runs its program in-house, contract with a third-party vendor to implement their programs. The process by which enrollees are registered varies, but in all programs, enrollees voluntarily shop for lower-price services—there is no requirement that they shop. All programs limit the services that are shoppable and

[111] Information on other states' programs was gathered from Commission staff review of other states' statutes; interviews with representatives from employee health plans in Florida, Kansas, Kentucky, Missouri, New Hampshire, Texas, Utah, and Virginia; and Tennessee Division of Benefits Administration 2019.

[112] Arizona Revised Statute. § 38-651.06; interview with Scott Bender, plan administration manager, Arizona Department of Administration, Benefit Services Division, March 31, 2020.

[113] Interview with Denise Donnelly, director of benefit procurement and vendor management, Group Insurance Commission, Commonwealth of Massachusetts, March 16, 2020.

[114] Nebraska Legislative Bill No.1119 (2018); interview with Laura Arp, life and health administrator, Nebraska Department of Insurance, March 10, 2020.

[115] Louisiana House Bill No. 839 (2020).

[116] Information on other states' programs was gathered from Commission staff review of other states' statutes; interviews with representatives from employee health plans in other states; and Tennessee Division of Benefits Administration 2019.

rewardable; some states include services similar to those in Tennessee's law, and some also include surgeries and other complex procedures. Typically, in order to receive an incentive, enrollees have to shop and use a lower-cost provider. However, in an effort to encourage more use of its shopping tool, the Texas teacher program pays an incentive to enrollees just for shopping, regardless of whether they use a lower-cost provider. Most programs offer incentives only when using in-network providers, although Florida also offers an additional program for certain surgeries, which uses a separate provider network. The amount of incentives depends on the type of procedure, ranging from $25 to $6,000. Texas and Utah are the only states with annual limits on the total amount of incentives that enrollees can receive—a maximum of $500 and $3,900, respectively. Incentives are usually paid in cash, either with mailed checks or payroll deposits. Florida is different—it pays its incentives into tax-free health saving and spending accounts.

The available data from the other states' programs shows widely varying participation rates. Many factors affect both participation and savings, including how heavily the program is promoted, the number and types of services included in the program, and geographic effects, such as regional cost variation and accessibility in rural areas. The time periods and methods used to calculate the results reported by the programs also vary, making it difficult to compare results between programs. Depending on the state, anywhere from 1% to 53.2% of health plan enrollees have shopped for healthcare services, while 1% to 43.7% of enrollees have received incentives.[117] Generally, participation in programs increases over time. For example, two of the oldest programs—New Hampshire's state and other public employee programs—reported the highest participation, while two of the newest—Utah and Virginia—reported the lowest participation.

Overall, staff in states with incentive programs view those programs as beneficial and worth the investment and also say the administrative costs have not been significant. The savings resulting from the eight states' programs vary. The Commission staff was only able to get a limited amount of data from the states. But based on the information it did receive, states have saved anywhere from $486,758, as Virginia did during the first seventeen months of its program, to $12.6 million, as Kentucky has over the seven years of its program. The average amount saved per enrollee—meaning the employee with the insurance policy—can also vary. For example, New Hampshire's state employee program, which began in 2010, saved the state $4.7 million in 2019. Based on the total 11,700 enrollees that year, New Hampshire saved $402 per enrollee. Virginia's recently instituted program, which began in 2019, saved the state $391,630 that year. Based on the total 75,835 enrollees, Virginia saved $5 per enrollee.

[117] Participation rates are estimated based on data received in emails from stakeholders in other states.

The incentive programs also helped enrollees to save money. The total amount of rewards ranges from $47,225 paid to enrollees during the first year of Utah's program to $2.3 million paid to enrollees during the seven years of Kentucky's program. The average amount saved per enrollee varies. For example, New Hampshire's state employee program paid $674,000 in rewards in 2019, and the average amount paid in incentives was $58 per enrollee. Virginia's program, on the other hand, paid $82,625 in rewards in 2019, and the average incentive amount per enrollee was $1. Figure 6 highlights the New Hampshire HealthTrust's program for other public employees and shows participation and savings results from its first full year—2015—and the most recent year with data—2019. Table 4 shows a summary of estimated savings in other states' incentive programs.

California's state employee health plan, CalPERS, is the only state plan that has chosen to implement a reference pricing program.[118] Reference pricing requires the insured person to pay the difference between the reference price and the price charged by the healthcare provider. California's program applies only to colonoscopies, knee and hip replacements, and certain outpatient surgeries like cataract removal.[119] Studies show that over a two-year period, reference pricing saved California $7 million on colonoscopies,[120] $14.7 million on knee and hip replacements,[121] and $1.3 million on cataract removals.[122] Because insurance enrollees are responsible for paying the amount over the reference price, and there are concerns about whether this type of program is fair to enrollees, these programs are not as common as incentive programs.

Arizona is also taking a different approach. The state considered an incentive program but decided to use another cost-cutting strategy.[123] As required by a 2018 law, Arizona's Benefit Services Division studied the cost effectiveness of an incentive program for its state employee health plan and based on that analysis it decided not to implement one. Instead, it determined that more money could be saved by designing an employee health plan with tiered networks, which are common in health insurance plans and are designed and implemented in a variety of ways. In these networks, healthcare providers are often

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[118] At least two states—Montana and Oregon—use reference pricing where the providers pay the difference, rather than consumers. California is the only state health plan that uses the type of reference pricing where the consumer pays the difference. Interview with Chris Whaley, policy researcher, RAND Corporation, April 1, 2020.

[119] Interview with Chris Whaley, policy researcher, RAND Corporation, April 1, 2020.

[120] Robinson, Brown, and Whaley 2015a.

[121] Zhang, Cowling, and Facer 2017.

[122] Robinson, Brown, and Whaley 2015b.

[123] Ariz. Rev. Stat. § 38-651.06; interview with Scott Bender, plan administration manager, Arizona Department of Administration, Benefit Services Division, March 31, 2020.

ranked based on cost and quality, and lower-cost, high quality providers are placed in the preferred tier; patients pay less out-of-pocket if they choose from the preferred tier. Tiered, or narrow, networks exclude high-price providers from the network, and if patients go to an out-of-network provider, they pay much more out-of-pocket.[124] Many states, including Tennessee,[125] use some version of tiered or narrow networks in their state employee health plans.

[124] Mehrotra, Chernew, and Sinaiko 2018.

[125] Partners for Health "Annual Enrollment for 2021 Benefits."

Figure 6. New Hampshire HealthTrust Shared Savings Program

The New Hampshire HealthTrust is a non-profit association that manages benefits, including health benefits, for its enrollees—employees of schools, cities, towns, and counties in New Hampshire. It does not manage benefits for state employees. In 2014, to control rising healthcare claims costs, HealthTrust started a shared savings program for its enrollees. After releasing a request for proposals, HealthTrust chose to contract with SmartShopper to administer the program.

HealthTrust started by offering the program to a few of its enrollee groups, and quickly expanded to offer the program to all of its enrollee groups because of its initial success. Currently, 62 healthcare services are included, and enrollees who shop can receive rewards ranging from $25 to $500. HealthTrust field staff do a lot of outreach and communication with enrollees, including promotion of the program during open enrollment at screening and health events and sending postcards and emails. SmartShopper also does some promotion. The program has grown every year, and savings and participation have increased. Data from 2015, the first full year of the program, and 2019, the most recent year, is shown below.

First Full Year (2015) Compared to Most Recent Year (2019)

	2015	2019
Number of HealthTrust Enrollees*	49,635	43,911
Total Amount of Rewards Received by Enrollees	$174,725	$489,375
Amount of Rewards Received per Enrollee	$3.52	$11.14
Net Amount Saved by HealthTrust	$952,386	$2,830,898
Net Amount Saved by HealthTrust per Enrollee	$19.19	$64.47
Total Number of Shopping Visits	11,749	24,785
Number of Enrollees that Shopped	2,795	4,969
Percent of Enrollees that Shopped	5.6%	11.3%
Total Number of Incentive Payments	2,292	7,156
Number of Enrollees who Received Incentives	1,413	3,102
Percent of Enrollees that Received Incentives	2.8%	7.1%

*Enrollees are employee health insurance policy holders of New Hampshire HealthTrust.

Source: Interview with Scott Weden, benefits & wellness manager, New Hampshire HealthTrust, April 6, 2020; emails received from Scott Weden, October 6 and 8, 2020. See also https://www.healthtrustnh.org/.

Table 4. State or Other Public* Employee Health Plans with Incentive Programs

State	Year Program Started	Required by Legislation	Data Timeframe	Total Amount of Rewards Received by Enrollees	Net Amount Saved by Health Plan	Total Number of Incentive Payments	Data Sources
Florida (state employees)	2019	yes	12 months (2019)	$645,500	$2,982,835	4,915	Kodie Nix, project manager, shared savings program, Florida Department of Management Services
			19 months (January 2019-July 2020)	$1,372,215	$5,268,086	9,028	
Kentucky (state and other public employees)	2013 (pilot) 2014 (full program)	no	7 years (2013-2019)	$2.3 million	$12.6 million	22,839	Jenny Goins, commissioner, Department of Employee Insurance, Kentucky Personnel Cabinet
New Hampshire (state employees)	2010 (pilot, full program evolved)	no	12 months (2019)	$674,000	$4.7 million	9,697	Rob Graybill, vice president, Strategy and Business Development, Sapphire-Digital
New Hampshire (other public employees)	2014	no	12 months (2019)	$489,375	$2,830,898	7,156	Scott Weden, benefits & wellness manager, New Hampshire HealthTrust
			6 years (2014-2019)	$1,707,890	$10,014,396	22,252	
Utah (state and other public employees)	2018	yes	12 months (October 2018 - September 2019)	$47,225	$1 million	590	Paul Anderton, chief actuary, Utah PEHP Health & Benefits
Virginia (state employees)	2018	yes	12 months (2019)	$82,625	$391,630	941	Todd Taylor, program manager, Virginia Office of Health Benefits Programs
			17 months (October 2018 - February 2020)	$99,950	$486,758	1,164	

*Other public employees could include employees of city or county governments, higher education, school districts, or special districts.

Kansas available data is limited as of writing. Missouri and Texas began their programs in 2020 and do not yet have data to report.

Source: Interviews with and emails from representatives in other states, other states' statutes, Tennessee Benefits Administration December 2019, Foundation for Government Accountability 2019.

Two states—Maine and Virginia—require private insurers to offer incentive programs to their enrollees while three other states make it optional.

Maine's state legislature passed a law in 2017 requiring insurers with small group plans (plans offered by employers with 50 or fewer employees) that are compatible with a health savings account (HSA) to offer incentive programs for their enrollees for at least two years between 2019 and 2024.[126] The law requires insurers to offer incentives for physical and occupational therapy, radiology and imaging, lab tests, and infusions and does not limit the amount of incentives an enrollee can receive or dictate how the rewards must be paid out. As an example, a state Department of Insurance representative described one insurer offering enrollees a $100 gift card for an infusion treatment, but offering a $5 gift card for other procedures.[127] In 2019, of the seven insurers that are required to implement a program, three paid a total of $5,705 in incentives to 82 enrollees—an average of $70 per enrollee.[128]

Maine's law also allows some use of out-of-network providers.[129] Enrollees are permitted to use out-of-network providers if the price is no higher than the average price paid to network providers for a comparable health care service covered under their health plan. The providers must be located in Maine, New Hampshire, or Massachusetts and must be enrolled in the MaineCare program and participate in Medicare. Upon the enrollee's request, the insurer must apply the enrollee's payment for the service toward their deductible and out-of-pocket maximum as if the service was received in-network.

In Virginia, the state legislature passed a healthcare incentive program law in 2019. That law requires insurers offering small group plans to offer an incentive program by January 1, 2021 and gives them discretion to decide how to implement their program, along with some broad guidelines.[130] For example, the law doesn't limit annual incentive amounts, but does include examples of incentives. And while it does require that quality data is included to the extent available, the details are not specified. Insurers who are not able to demonstrate cost savings by showing that the claim savings are greater than the paid incentives plus the administration cost are not required to operate an incentive

[126] Maine Revised Statute Title 24-A, § 4318-A; Healthcare.gov "Health Insurance for Businesses."

[127] Interview with Pam Stutch, health care attorney, Consumer Health Care Division, Maine Bureau of Insurance, April 2, 2020.

[128] Maine Bureau of Insurance 2020.

[129] Maine Revised Statute Title24-A, § 4318-B.

[130] Virginia Code Annotated § 38.2-3462; interview with Julie Blauvelt, deputy commissioner, Life & Health Division, Virginia Bureau of Insurance, March 17, 2020.

program.[131] Additionally, when a health plan has a limited provider network that is incompatible with a program, insurers can apply for an exemption from the incentive program requirement—but not the price comparison tool that is also required by the law.[132] According to a state Bureau of Insurance staff member, as of August 2020, of the 16 insurers in the state with small group plans, four were not able to show cost effectiveness and are not required to implement a program, four applied and were approved for an exemption, and the remaining eight are required to implement a program.

In addition to Tennessee, three states—Florida, Nebraska, and Utah—authorize rather than require private insurers to offer incentive programs as part of their individual and small group health insurance plans. Florida authorized it in 2019, and it became effective January 1, 2020.[133] According to Division of Consumers Services staff, Florida's law gives insurers wide latitude to decide how to design their programs, and the Division would approve programs that comply with the minimum requirements.[134] Nebraska and Utah's laws both passed in 2018.[135] In Utah, Department of Insurance staff say the law is vague regarding how the programs are designed and implemented and doesn't require insurers to report to the state about the programs.[136] As of August 2020, staff in these three states do not know of any insurers that have started programs in their states.

[131] White 2020.

[132] Emails received from Julie Blauvelt, deputy commissioner, Life & Health Division, Virginia Bureau of Insurance, August 18 and 19, 2020.

[133] Florida House Bill No. 1113 (2019); Florida Statute § 627.6387; Florida Administrative Code & Florida Administrative Register Rule: 69O-240.001.

[134] Interview with Pam White, senior management analyst, Division of Consumer Services, Florida Department of Financial Services, June 4, 2020.

[135] Nebraska Legislative Bill No. 1119 (2018); Utah House Bill No. 19 (2018); interview with Laura Arp, life and health administrator, Nebraska Department of Insurance, March 10, 2020.

[136] Interview with Tanji Northrup, deputy commissioner, Utah Department of Insurance, April 21, 2020.

References

Abdeljaber, Mahmuod, Carrie Kovacik, Rene Morcos, Quynh Nguyen, and Gloria Sachdev. 2020. *White Paper: Overview of All-Payer Claims Databases in the United States, A Report for Employers and Other Health Care Purchasers*. Employers' Forum of Indiana, February 9. https://employersforumindiana.org/media/2020/02/APCD-White-Paper-by-Employers-Forum-of-Indiana-2-9-20.pdf.

American Hospital Association. 2014. "Hospital Outpatient Department (HOPD) Costs Higher than Physician Offices Due to Additional Capabilities, Regulations." https://www.aha.org/system/files/2018-09/info-hopd.pdf.

____. 2019. "Hospital Groups File Lawsuit Over Illegal Rule Mandating Public Disclosure of Individually Negotiated Rates." press release, December 4. https://www.aha.org/press-releases/2019-12-03-hospital-groups-file-lawsuit-over-illegal-rule-mandating-public.

Antos, Joseph, and Alice Rivlin. 2019. *A New Vision for Health Reform*. American Enterprise Institute and Brookings Institute. September 24. https://www.brookings.edu/research/a-new-vision-for-health-reform/.

Arizona Department of Health Services. 2020. "Hospital Discharge Data." https://www.azdhs.gov/preparedness/public-health-statistics/hospital-discharge-data/index.php#hospital-patient-statistics-home.

Armour, Stephanie. 2020. "Trump Administration Price-Transparency Rule Covering Hospitals Upheld." *The Wall Street Journal*, June 23. https://www.wsj.com/articles/trump-administration-price-transparency-rule-covering-hospitals-upheld-11592945973.

Benavidez, Gilbert, and Austin Frakt. 2019. "Price Transparency in Health Care Has Been Disappointing, but It Doesn't Have to Be." *JAMA Network*, August 22. https://newsatjama.jama.com/2019/08/22/jama-forum-price-transparency-in-health-care-has-been-disappointing-but-it-doesnt-have-to-be/.

Berchick, Edward R., Jessica C. Barnett, and Rachel D. Upton. 2019. "Health Insurance Coverage in the United States: 2018." United States Census Bureau, Report Number P60-267 (RV), November 8. https://www.census.gov/library/publications/2019/demo/p60-267.html.

Berenson, Robert A., Jaime S. King, Katherine L. Gudiksen, Roslyn Murray, and Adele Shartzer. 2020. *Addressing Health Care Market Consolidation and High Prices: The Role of the States*. Urban Institute and UC Hastings Law San Francisco, January 13. https://www.urban.org/research/publication/addressing-health-care-market-consolidation-and-high-prices.

Brown, Zach Y. 2019. "Equilibrium Effects of Health Care Price Information." *Review of Economics and Statistics* 101 (4): 699-712. https://www.mitpressjournals.org/doi/abs/10.1162/rest_a_00765.

Chernew, Michael, Zack Cooper, Eugene Larsen-Hallock, and Fiona Scott Morton. 2019. "Are Health Care Services Shoppable? Evidence from the Consumption of Lower Limb MRI Scans." *National Bureau of Economic Research*, January. NBER Working Paper No. 24869. https://www.nber.org/papers/w24869.

Claxton, Gary, Matthew Rae, Anthony Damico, Gregory Young, and Daniel McDermott. 2019. *Employer Health Benefits – 2019 Annual Survey*. Kaiser Family Foundation. http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2019.

CMS.gov. 2018. "Fiscal Year (FY) 2019 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Acute Care Hospital (LTCH) Prospective Payment System Final Rule (CMS-1694-F)." August 2. https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2019-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute-0.

____. 2019a. "CY 2020 Hospital Outpatient Prospective Payment System (OPPS) Policy Changes: Hospital Price Transparency Requirements (CMS-1717-F2)." November 15. https://www.cms.gov/newsroom/fact-sheets/cy-2020-hospital-outpatient-prospective-payment-system-opps-policy-changes-hospital-price.

____. 2019b. "Historical." Page last modified, December 17. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical#:~:text=The%20data%20are%20presented%20by,spending%20accounted%20for%2017.7%20percent.

____. 2019c. "Transparency in Coverage Proposed Rule (CMS- 9915 –P)." November 15. https://www.cms.gov/newsroom/fact-sheets/transparency-coverage-proposed-rule-cms-9915-p.

____. 2020a. "Hospital Quality Initiative." Page last modified, July 28. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalOutpatientQualityReportingProgram.

____. 2020b. "NHE Fact Sheet." Page last modified, March 24. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.

Collins, Sara R., David C. Radley, and Jesse C. Baumgartner. 2019. "Trends in Employer Health Care Coverage, 2008–2018: Higher Costs for Workers and Their Families". *The Commonwealth Fund*, November 21. https://www.commonwealthfund.org/publications/2019/nov/trends-employer-health-care-coverage-2008-2018.

Desai, Sunita, Laura A. Hatfield, Andrew L. Hicks, Michael E. Chernew, and Ateev Mehrotra. 2016. "Association Between Availability of a Price Transparency Tool and Outpatient Spending." *Journal of the American Medical Association* 315 (17): 1874-1881. https://www.ncbi.nlm.nih.gov/pubmed/27139060.

Desai, Sunita, Laura A. Hatfield, Andrew L. Hicks, Anna D. Sinaiko, Michael E. Chernew, David Cowling, Santosh Gautam, Sze-jung Wu, and Ateev Mehrotra. 2017. "Offering A Price Transparency Tool Did Not Reduce Overall Spending Among California Public Employees and Retirees." *Health Affairs* 36 (8): 1401-1407. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.1636.

DiBiase, Caterina, Lauren Corvese, Scott Haller, Barbara Anthony, Josh Archambault, and Seher Chowdhury. 2020. *White Paper Status of Healthcare Price Transparency across the United States.* Pioneer Institute, May. https://pioneerinstitute.org/wp-content/uploads/dlm_uploads/StateTransparency-WP.pdf.

Erdody, Lindsey. 2020. "Health care bills unlikely to remedy cost crisis." *Indianapolis Business Journal* 40 (48): 1-6. https://www.ibj.com/articles/health-care-bills-unlikely-to-remedy-cost-crisis.

Foundation for Government Accountability. 2019. "Right to Shop." https://thefga.org/solution/health-care/right-to-shop/#:~:text=FGA's%20Right%20to%20Shop%20solution,lowering%20costs%20and%20increasing%20options.

Fox, Kimberley S., Carolyn E. Gray, Martha Elbaum Williamson, and Jennifer A. MacKenzie. 2019. "Using Public Cost Information During Low Back Pain Visits:

A Qualitative Study." *Annals of Internal Medicine* 170: S93-S102. https://www.acpjournals.org/doi/pdf/10.7326/M18-2223.

Frakt, Austin, and Ateev Mehrotra. 2019. "What Type of Price Transparency Do We Need in Health Care?" *Annals of Internal Medicine* 170 (8): 561-562. https://annals.org/aim/fullarticle/2729812/what-type-price-transparency-do-we-need-health-care.

Gee, Emily. 2019. *The High Price of Hospital Care*. Center for American Progress, June 26. https://www.americanprogress.org/issues/healthcare/reports/2019/06/26/471464/high-price-hospital-care/#:~:text=Hospitals%20receive%20%241%20out%20of,industry%20or%20the%20insurance%20industry.

Gourevitch, Rebecca A., Sunita Desai, Andrew L. Hicks, Laura A. Hatfield, Michael E. Chernew, and Ateev Mehrotra. 2017. "Who Uses a Price Transparency Tool? Implications for Increasing Consumer Engagement." *Inquiry: A Journal of Medical Care Organization, Provision and Financing* 54 (2): 1-5. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5812034/.

Grassley, Chuck. 2020. "Grassley, Colleagues introduce The Healthcare PRICE Transparency Act." press release, June 30. https://www.grassley.senate.gov/news/news-releases/grassley-colleagues-introduce-healthcare-price-transparency-act#:~:text=The%20Health%20Care%20PRICE%20Transparency%20Act%20Would%20Require%20Insurers%20to,covered%20healthcare%20items%20and%20services.

Gudiksen, Katie. 2019. "Right-to-Shop Programs: Encouraging Patients to Shop for High-Value Health Care." *The Source Blog*, February 11. https://sourceonhealthcare.org/right-to-shop-programs-encouraging-patients-to-shop-for-high-value-health-care/.

Healthcare.gov. "Health Insurance for Businesses." Accessed on October 12, 2020. https://www.healthcare.gov/small-businesses/learn-more/explore-coverage/.

Hibbard, Judith H., Jessica Greene, Shoshanna Sofaer, Kirsten Firminger, and Judith Hirsh. 2012. "An Experiment Shows that a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care." *Health Affairs* 31 (3): 560-568. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2011.1168.

Hussey, Peter S., Samuel Wertheimer, and Ateev Mehrotra. 2013. "The Association Between Health Care Quality and Cost: A Systematic Review." *Annals of Internal Medicine* 158 (1): 27-34. https://annals.org/aim/fullarticle/1487781/association-between-health-care-quality-cost-systematic-review.

Internal Revenue Service. 2019. "Instructions for Forms 1099-MISC and 1099-NEC (2020) - Miscellaneous Income and Nonemployee Compensation." *Department of the Treasury*, December 6. https://www.irs.gov/pub/irs-pdf/i1099msc.pdf.

Lieber, Ethan M. J. 2017. "Does It Pay to Know Prices in Health Care?" *American Economic Journal: Economic Policy* 9 (1): 154-179. https://www.aeaweb.org/articles?id=10.1257/pol.20150124.

Maine Bureau of Insurance. 2020. *Report on Law to Encourage Consumers to Comparison-shop for Certain Health Care Procedures.* Department of Professional and Finance Regulation, August. https://www.maine.gov/pfr/sites/maine.gov.pfr/files/inline-files/LD445_Healthcare_Incentives_Report.pdf.

Makary, Marty. 2019. *The Price We Pay: What Broke American Health Care—and How to Fix It*. Bloomsbury Publishing, New York.

Massachusetts Office of the Attorney General Martha Coakley. 2010. *Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 118G, § 6½(b).* Report for Annual Public Hearing, March 16. https://www.mass.gov/doc/2010-examination-of-health-care-cost-trends-and-cost-drivers-with-appendix/download.

Mehrotra, Ateev, Tyler Brannen, and Anna D. Sinaiko. 2014. "Use Patterns of a State Health Care Price Transparency Web Site: What Do Patients Shop For?" *Inquiry: A Journal of Medical Care Organization, Provision and Financing* 51 (1): 1-3. https://www.ncbi.nlm.nih.gov/pubmed/25466414.

Mehrotra, Ateev, Katie M. Dean, Anna D. Sinaiko, and Neeraj Sood. 2017. "Americans Support Price Shopping for Health Care, But Few Actually Seek Out Price Information." *Health Affairs* 36 (8): 1392–1400. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1471.

Mehrotra, Ateev, Michael E. Chernew, and Anna D. Sinaiko. 2018. "Promise and Reality of Price Transparency." *The New England Journal of Medicine* 378: 14. https://www.nejm.org/doi/full/10.1056/NEJMhpr1715229.

Meyer, Harris. 2019. "Hospitals Vary in Publishing CMS Chargemaster Prices." *Modern Healthcare*, January 7. https://www.modernhealthcare.com/article/20190107/TRANSFORMATION04/190109931/hospitals-vary-in-publishing-cms-chargemaster-prices.

Minnesota Department of Health. 2015. "Commercial Case Price Variation among High-Volume Inpatient Treatments in Minnesota Hospitals (Part 2): July 2014 - June 2015." St. Paul: Minnesota Department of Health. https://www.health.state.mn.us/data/apcd/docs/pricevariationpt2.pdf.

National Conference of State Legislatures. 2018a. "All-Payer Claims Databases (APCDs)." January 1. https://www.ncsl.org/research/health/apcd-postcard.aspx.

____. 2018b. "Collecting Health Data: All-Payer Claims Databases." April 1. https://www.ncsl.org/research/health/collecting-health-data-all-payer-claims-database.aspx.

____. 2020a. "State Employee Health Benefits, Insurance and Costs." May 1. https://www.ncsl.org/research/health/state-employee-health-benefits-ncsl.aspx.

____. 2020b. "Transparency of Health Costs: State Actions." https://www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx.

New Mexico Department of Health. 2017. "Compare Healthcare Costs & Quality of Care in New Mexico." http://nmhealthcarecompare.com.

North Carolina Department of Health and Human Services. "Transparency in Health Care Costs." Accessed on October 14, 2020. https://info.ncdhhs.gov/dhsr/ahc/hb834/search.asp.

Pacific Business Group on Health. 2013. "PBGH Policy Brief: Price Transparency." August 1. https://www.rwjf.org/en/library/research/2013/08/pbgh-policy-brief--price-transparency.html?cid=XEM_A7418.

Partners for Health. "Annual Enrollment for 2021 Benefits." Accessed on October 5, 2020. https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/ST_HE_News_final_links.pdf.

____. "Definitions." Accessed on August 24, 2020. https://www.tn.gov/partnersforhealth/definitions.html.

____. "Health Insurance." Accessed on October 12, 2020. https://www.tn.gov/partnersforhealth/health-options/health.html.

Pellegrin, Mandy. 2020. "A Deep Dive into Health Insurance Coverage in Tennessee Trends in Coverage, Choice, and Costs Since 2010." The Sycamore Institute, February 20. https://www.sycamoreinstitutetn.org/health-insurance-coverage-trends-tennessee/.

Phillips, Katherine A., David Schleifer, and Caroline Hagelskamp. 2016. "Most Americans Do Not Believe that there is an Association Between Health Care Prices and Quality of Care." *Health Affairs* 35 (4): 647-653. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5029784/.

Rhoads, Jared. 2019. *Right to Shop for Public Employees: How Health Care Incentives are Saving Money in Kentucky*. Foundation for Government Accountability. March 8. https://thefga.org/research/kentucky-health-care-savings-vitals-smartshopper/.

Roberts Eric T., Michael E. Chernew, and J. Michael McWilliams. 2017. "Market Share Matters: Evidence of Insurer and Provider Bargaining over Prices." *Health Affairs* 36 (1):141–8. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0479.

Robinson, James C., Timothy Brown, and Christopher Whaley. 2015a. "Association of Reference Payment for Colonoscopy with Consumer Choices, Insurer Spending, and Procedural Complications." *Journal of the American Medical Association Internal Medicine* 175 (11): 1783-1789. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2434733.

____. 2015b. "Reference-Based Benefit Design Changes Consumers' Choices and Employers' Payments for Ambulatory Surgery." *Health Affairs* 34 (3): 415-422. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.1198.

Sachdev, Gloria, Chapin White, and Ge Bai. 2019. "Self-insured Employers are Using Price Transparency to Improve Contracting with Health care Providers: The Indiana experience." *Health Affairs Blog*, October 7. https://www.healthaffairs.org/do/10.1377/hblog20191003.778513/full/.

Scheffler, Richard M., and Daniel R. Arnold. 2017. "Insurer Market Power Lowers Prices in Numerous Concentrated Provider Markets." *Health Affairs* 36 (9):1539–46. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0552.

Schencker, Lisa. 2018. "Why don't more people shop for health care? Online tools exist, but most don't use them." *Chicago Tribune*, July 20. https://www.chicagotribune.com/business/ct-biz-hospital-price-transparency-0722-story.html.

Selden, Thomas M., Zeynal Karaca, Patricia Keenan, Chapin White, and Richard Kronick. 2015. "The Growing Difference between Public and Private Payment Rates for Inpatient Hospital Care." *Health Affairs* 34 (12): 2147–50. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2015.0706.

Sinaiko, Anna D., and Meredith B. Rosenthal. 2011. "Increased Price Transparency in Health Care — Challenges and Potential Effects." *New England Journal of Medicine* 364 (10): 891-893. https://www.nejm.org/doi/full/10.1056/NEJMp1100041.

Sinaiko, Anna D., Pragya Kakani, and Meredith B. Rosenthal. 2019. "Marketwide Price Transparency Suggests Significant Opportunities for Value-Based Purchasing." *Health Affairs* 38 (9): 1514–1522. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05315.

Tennessee Division of Benefits Administration. 2019. *Report of Shared Savings Incentive Programs*. Department of Finance and Administration. December 6. https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/shared_savings_incentive_programs_report.pdf.

Tu, Ha, and Rebecca Gourevitch. 2014. *Moving Markets: Lessons from New Hampshire's Health Care Price Transparency Experiment*. California Health Care Foundation and Robert Wood Johnson Foundation, April. https://www.nh.gov/insurance/reports/documents/moving-markets.pdf.

Tu, Ha T., and Johanna R. Lauer. 2009. *Issue Brief: Impact of Health Care Price Transparency on Price Variation: The New Hampshire Experience*. Center for Studying Health Care System Change. No. 128, November. https://www.apcdcouncil.org/publication/impact-health-care-price-transparency-price-variation-new-hampshire-experience.

Ubel, Peter. 2013. "How Price Transparency Could End Up Increasing Health-Care Costs." *The Atlantic*, April 9. https://www.theatlantic.com/health/archive/2013/04/how-price-transparency-could-end-up-increasing-health-care-

costs/274534/?gclid=EAIaIQobChMIoLnOs7G56gIVCYizCh1HDg1sEAMYASAAEgLdt_D_BwE.

US Department of Health and Human Services. 2019. *Reforming America's Healthcare System Through Choice and Competition*. https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf.

US Government Accountability Office. 2014. *Health Care Transparency: Actions Needed to Improve Cost and Quality Information for Consumers*. Report to Congressional Requesters, GAO-15-11, October. https://www.gao.gov/assets/670/666572.pdf.

The Wall Street Journal. 2009. "How to Research Health Care Prices." December 4. http://guides.wsj.com/health/health-costs/how-to-research-health-care-prices/.

Whaley, Christopher. 2019. "Provider Responses to Online Price Transparency." *Journal of Health Economics* 66: 241-259. https://www.sciencedirect.com/science/article/pii/S0167629618310476.

Whaley, Christopher, Jennifer Schneider Chafen, Sophie Pinkard, Gabriella Kellerman, Dena Bravata, Robert Kocher, and Neeraj Sood. 2014. "Association Between Availability of Health Service Prices and Payments for These Services." *Journal of the American Medical Association.* 312 (16): 1670-1676. https://www.ncbi.nlm.nih.gov/pubmed/25335149.

Whaley, Christopher, Timothy T. Brown, and James C. Robinson. 2019. "Consumer Responses to Price Transparency Alone Versus Price Transparency Combined with Reference Pricing." *American Journal of Health Economics* 5 (2): 227-249. https://www.journals.uchicago.edu/doi/10.1162/ajhe_a_00118.

Whaley, Christopher, Lan Vu, Neeraj Sood, Michael E. Chernew, Leanne Metcalfe, and Ateev Mehrotra. 2019. "Paying Patients to Switch: Impact of a Rewards Program on Choice of Providers, Prices, and Utilization." *Health Affairs* 38 (3): 440-447. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2018.05068.

White, Chapin, Amelia M. Bond, and James D. Reschovsky. 2013. "High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power." *Res Brief*. Sep; (27):1-10. PMID: 24073466. https://pubmed.ncbi.nlm.nih.gov/24073466/.

White, Chapin, Paul B. Ginsburg, Ha T. Tu, James D. Reschovsky, Joseph M. Smith, and Kristie Liao. 2014. *Healthcare Price Transparency: Policy Approaches and Estimated*

Impacts on Spending. West Health Policy Center. May. https://www.westhealth.org/wp-content/uploads/2015/05/Price-Transparency-Policy-Analysis-FINAL-5-2-14.pdf.

White, Chapin, and Christopher Whaley. 2019. *Prices Paid to Hospital by Private Health Plans Are High Relative to Medicare and Vary Widely: Findings from an Employer-Led Transparency Initiative.* Santa Monica, CA: RAND Corporation. https://www.rand.org/pubs/research_reports/RR3033.html.

White, Scott A. 2020. "Administrative Letter 2020-01." Commonwealth of Virginia, February 24. https://www.scc.virginia.gov/getattachment/ec8a9d8a-2895-4131-8f6d-7824edf7c715/20-01.pdf.

Wu, Sze-jung, Gosia Sylwestrzak, Christiane Shah, and Andrea DeVries. 2014. "Price Transparency for MRIs Increased Use of Less Costly Providers and Triggered Provider Competition." *Health Affairs* 33 (8): 1391-1398. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.0168.

Zhang, Yuting, Seo Hyon Baik, A. Mark Fendrick, and Katherine Baicker. 2012 "Comparing Local and Regional Variation in Health Care Spending." *The New England Journal of Medicine* 367 (18): 1724-31. https://www.nejm.org/doi/pdf/10.1056/NEJMsa1203980.

Zhang, Hui, David W. Cowling, and Matthew Facer. 2017. "Comparing the Effects of Reference Pricing and Centers-of-Excellence Approaches to Value-Based Benefit Design." *Health Affairs* 36 (12): 2094-2101. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.0563.

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State of Tennessee

PUBLIC CHAPTER NO. 407

SENATE BILL NO. 510

By Roberts, Jackson, Massey, Pody

Substituted for: House Bill No. 419

By Smith; Mr. Speaker Casada; Cameron Sexton, Helton, Howell, Daniel, Powers, Terry, Tillis, Marsh, White, Coley, Zachary, Lafferty, Weaver, Ragan, Hardaway, Kumar, Sparks, Parkinson, Haston

AN ACT to amend Tennessee Code Annotated, Title 8; Title 33; Title 56; Title 63 and Title 68, relative to health care.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, is amended by adding the following as a new part:

56-7-3501. This part shall be known and may be cited as the "Tennessee Right to Shop Act."

56-7-3502. As used in this part:

(1) "Allowed amount" means the contractually agreed upon payment amount between a carrier and a healthcare entity participating in the carrier's network, excluding any member deductible, co-pay, or other obligation;

(2) "Commissioner" means the commissioner of commerce and insurance;

(3) "Comparable healthcare service" includes, but is not limited to:

(A) Physical and occupational therapy services;

(B) Radiology and imaging services;

(C) Laboratory services; and

(D) Infusion therapy;

(4) "Department" means the department of commerce and insurance;

(5) "Health plan" means health insurance coverage as defined in § 56-7-109;

(6) "Healthcare entity" means:

(A) Any healthcare facility licensed under title 33 or 68; and

(B) Any healthcare provider licensed under title 63 or 68;

(7) "Insurance carrier" or "carrier" means a health insurance entity as defined in § 56-7-109; and

(8) "Shopping and decision support program" means the program established by a carrier pursuant to this part.

56-7-3503.

(a)(1) Beginning upon approval of the next health insurance rate filing on or after January 1, 2021, a carrier offering a health plan in this state shall implement a shopping and decision support program that provides shopping capabilities and decision support services for enrollees in a health plan. Beginning on January 1, 2021, a carrier may provide incentives for enrollees in a health plan who elect to receive a comparable healthcare service from a network provider that is covered by the health plan and that is paid less than the average allowed amount paid by that carrier to network providers for that comparable healthcare service before and after an enrollee's out-of-pocket limit has been met.

(2) Incentives, effective January 1, 2021, may be calculated as a percentage of the difference between the amount actually paid by the carrier for a given comparable healthcare service and the average allowed amount for that service. Incentives may be provided as a cash payment to the enrollee, a credit toward the enrollee's annual in-network deductible and out-of-pocket limit, or a credit or reduction of a premium, a copayment, cost sharing, or a deductible.

(3) The shopping and decision support program may provide each enrollee with at least fifty percent (50%) of the carrier's saved costs for each comparable healthcare service. However, the shopping and decision support program may exclude incentive payments, credits, or reductions for services where the savings to the carrier is fifty dollars ($50.00) or less.

(4) The average allowed amount must be based on the actual allowed amounts paid to network providers under the enrollee's health plan within a reasonable timeframe, not to exceed one (1) year.

(5) Annually, at enrollment or renewal, a carrier shall provide, at a minimum, notice to enrollees of the right to obtain information described in subdivision (a)(4) and the process for obtaining the information, and a description of how to earn any incentives. A carrier shall provide this notice on the carrier's website and in health plan materials provided to enrollees.

(b) An insurance carrier shall make the shopping and decision support program available as a component of all health plans offered by the carrier in this state.

(c) Prior to offering the shopping and decision support program to any enrollee, a carrier shall file a description of the shopping and decision support program established by the carrier pursuant to this section with the department. The insurance carrier has discretion as to the appropriate format for providing the information required and may customize the format in order to provide the most relevant information necessary to permit the department to determine compliance. The department may review the filing made by the carrier to determine if the carrier's shopping and decision support program complies with this section.

(d)(1) Beginning January 1, 2022, a carrier shall annually file with the department for the most recent calendar year the total number of comparable healthcare service incentive payments made pursuant to this section, the use of comparable healthcare services by category of service for which comparable healthcare service incentive payments were made, the total incentive payments made to enrollees, the average amount of incentive payments made by service for the transactions, and the total number and percentage of a carrier's enrollees that participated in the transactions.

(2) Beginning in 2022 and by April 1 of each year thereafter, the commissioner shall submit an aggregate report for all carriers filing the information required by this subsection (d) to the commerce and labor committee of the senate and the insurance committee of the house of representatives. The commissioner may set reasonable limits on the annual reporting requirements on carriers to focus on the more popular comparable healthcare services.

56-7-3504.

(a)(1) Except as provided in subdivision (a)(2), beginning upon approval of the next health insurance rate filing on or after January 1, 2020, a carrier offering a health plan in this state shall comply with this section.

(2) On and after December 1, 2020, a carrier offering a health plan in this state shall make available the interactive member portal described in subsection (b), and may make available the toll-free phone number described in subsection (b).

(b)(1) A carrier shall make available an interactive member portal or a toll-free phone number that enables an enrollee to request and obtain from the carrier information on out-of-pocket costs to the enrollee for the comparable healthcare services or on the average payments made by the carrier to network entities or providers for comparable healthcare services, as well as quality data for those providers, to the extent available.

(2) The member portal or toll-free phone number must allow an enrollee seeking information about the cost of a particular healthcare service to estimate out-of-pocket costs applicable to that enrollee and compare the average allowed amount paid to a network provider for the procedure or service under the enrollee's health plan within a reasonable timeframe not to exceed one (1) year.

(3) The out-of-pocket estimate must provide a good faith estimate based on the information provided by the enrollee or the enrollee's provider of the amount the enrollee will be responsible to pay out-of-pocket for a proposed non-emergency procedure or service that is determined by the carrier to be a medically necessary covered benefit from a carrier's network provider, including any copayment, deductible, coinsurance, or other out-of-pocket amount for any covered benefit, based on the information available to the carrier at the time the request is made, and subject to further medical necessity review by the carrier. A carrier may contract with a third-party vendor to comply with this subsection (b).

(4) A carrier shall provide the information described in this subsection (b) by the carrier's member portal or toll-free phone number even if the enrollee requesting the information has exceeded the enrollee's deductible or out-of-pocket costs according to the enrollee's health plan. Existing transparency mechanisms or programs that estimate out-of-pocket costs for enrollees still within their deductible qualify under this section as long as those mechanisms or programs continue to disclose the estimated average allowed amount even after an enrollee has exceeded the enrollee's deductible as well as any estimated out-of-pocket cost.

(c) Nothing in this section prohibits a carrier from imposing cost-sharing requirements disclosed in the enrollee's policy, contract, or certificate of coverage for unforeseen healthcare services that arise out of the non-emergency procedure or service or for a procedure or service provided to an enrollee that was not included in the original estimate.

(d) A carrier shall notify an enrollee that the provided costs are estimated costs, and that the actual amount the enrollee will be responsible to pay may vary due to unforeseen services that arise out of the proposed non-emergency procedure or service.

56-7-3505.

At the request of a patient, a healthcare provider licensed under title 63 or 68 shall provide a copy of an order for a comparable healthcare service within two (2) business days of the request.

56-7-3506.

The state insurance committee, created by § 8-27-201, shall publish a report no later than January 1, 2020, on examples of shared savings incentive programs that directly incentivize current enrollees and retirees to shop for lower cost care in other states and consider implementation of such a program in this state. The state insurance committee may implement such a program as part of the next open enrollment period if it is believed to be cost effective. The state insurance committee shall share the report in writing to the government operations committees in both the senate and house of representatives.

56-7-3507.

The commissioner is authorized to promulgate rules as necessary to implement this part. The rules must be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

56-7-3508.

Except for § 56-7-3506, and notwithstanding § 56-7-1005, this part does not apply to:

(1) Any managed care organization contracting with the state to provide insurance through the TennCare program or the CoverKids program; or

(2) Any plan described in Section 1251 of the federal Patient Protection and Affordable Care Act (42 U.S.C. § 18011) and Section 2301 of the federal Health Care and Education Reconciliation Act.

56-7-3509.

Notwithstanding this part, the total value of incentives offered to any one (1) enrollee must not exceed five hundred ninety-nine dollars ($599) in any year.

56-7-3510.

(a) The Tennessee advisory commission on intergovernmental relations (TACIR) is directed to perform a study of any cost savings realized by enrollees with health plans, including private health plans and state funded health plans, in states that have adopted legislation or programs that require carriers offering health plans in those states to offer incentive programs to enrollees for shopping for healthcare services at lower costs, commonly referred to as "Right to Shop" legislation or programs. The study shall include, at a minimum, an examination of savings realized by such programs in Maine, New Hampshire, Florida, Arizona, and Kentucky.

(b) All appropriate state departments and agencies shall provide assistance to TACIR.

(c) TACIR shall report its findings to the general assembly no later than December 2020.

SECTION 2. For purposes of promulgating rules, this act shall take effect upon becoming a law, the public welfare requiring it. For all other purposes, this act shall take effect January 1, 2020, the public welfare requiring it, and shall apply to all health plans entered into or renewed on or after that date.

SENATE BILL NO. 510

PASSED: May 2, 2019

RANDY McNALLY
SPEAKER OF THE SENATE

GLEN CASADA, *SPEAKER*
HOUSE OF REPRESENTATIVES

APPROVED this 21st **day of** May **2019**

BILL LEE, *GOVERNOR*

Appendix B: Other States' Healthcare Price Websites

State	Website Link	Search by Service Provider	Search by Insurance Provider	Search by Geographic Location	Type of Price Information	Shows Price Paid by Uninsured	Services Covered	Data Timeframe	Shows Quality Ratings
Arizona	https://pub.azdhs.gov/hospital-discharge-stats/2011/index.html	Yes	No	Yes (Zip Code and Region)	Mean Charges	No	Extensive	2011	Yes
Colorado	civhc.org/shop-for-care/	Yes	No	Yes (Zip Code)	Average price and range of prices paid in total to the facility by the insured and insurer.	No	Limited - twelve services including imaging, gallbladder surgery, and colonoscopies	Website indicates data was updated January 2019.	Yes
Connecticut	https://healthscorect.com/	Yes	No	Yes (City or town)	Median price paid to the facility by the insurer.	Yes	Extensive	Not available	Yes
Florida	https://www.floridahealthfinder.gov/index.html	No	No	Yes (Address, City, State, Zip Code)	Range of prices is estimated and is based on roughly 70.3 million claims from a set of insurers and their reported negotiated rates with providers.	Possibly	Extensive	The estimates are trended to and considered valid through July 1, 2019 based upon claims paid between January 1, 2016 and December 31, 2017.	Yes
Maine	comparemaine.com	Yes	Yes	Yes (City, County, and Zip Code)	Average price paid to the facility by the insured and insurer.	No	Extensive	Cost information is based on claims from April 1, 2018 through March 31, 2019.	Yes
Maryland	wearthecost.org	Yes	No	No	Average price and range of prices based on information from private insurance provider.	No	Limited - four services	Shows data for 2014-2015 and 2015-2016.	Yes

Appendix B: Other States' Healthcare Price Websites (continued)

State	Website Link	Search by Service Provider	Search by Insurance Provider	Search by Geographic Location	Type of Price Information	Shows Price Paid by Uninsured	Services Covered	Data Timeframe	Shows Quality Ratings
Massachusetts	http://www.masscomparecare.gov/	Yes	Yes - people can search by individual provider and cost estimates.	Yes (Zip Code)	Prices are estimates and include the full cost of the procedure based on the amount paid by the insurer and insured.	No - Website specifically says that the cost information is not for the uninsured.	Extensive	2015	Yes
New Hampshire	https://nhhealthcost.nh.gov/	Yes	Yes - People can search for costs if they have Aetna, CIGNA, or Harvard Pilgrim. The remaining providers are rolled into one category that can be searched.	No	Prices are estimated amounts paid to the provider by the insurer and insured. The cost information for both insured and uninsured estimates is derived from claims data collected from New Hampshire's health insurers and stored as a part of the Comprehensive Health Care Information System.	Yes - Also includes uninsured discounts if any	Extensive	The rates on the website are based on actual patient experiences between April 2018 and June 2019 and are increased to recognize price inflation of 5%. It is updated periodically.	Yes
New Mexico	http://nmhealthcarecompare.com	Yes	No	Yes (County)	Average Medicaid cost estimates by facility.	No	Limited - nine procedures	2016	Yes

Appendix B: Other States' Healthcare Price Websites (continued)

State	Website Link	Search by Service Provider	Search by Insurance Provider	Search by Geographic Location	Type of Price Information	Shows Price Paid by Uninsured	Services Covered	Data Timeframe	Shows Quality Ratings
New York	https://nyshc.health.ny.gov/web/nyapd/home	No	No	Yes (Region)	Median price based on institutional cost report data that includes facility specific Ratios of Cost to Charges (RCCs). Estimated cost calculation example: if hospital charge is $20,000 and the RCC is 50%, the estimated cost is $10,000. Costs are the actual expenses incurred by a hospital in providing patient care.	Yes	Extensive	2017 is the latest. Previous year data can be searched up to 2015.	Yes
North Carolina	https://info.ncdhhs.gov/dhsr/ahc/hb834/search.asp	Yes	No	Yes (County and City)	Lowest, highest and average amounts paid by insurers as well as Medicaid and Medicare reimbursement amounts.	No	Extensive	April 1, 2014 through September 30, 2018	No
Texas	https://rates.texashealthcarecosts.org/	No	No	Yes (Zip Code)	Total amount billed to insurers and maximum amount that health plans will pay to providers for a service both in and out of network.	No	Extensive	Not available	No
Virginia	http://www.vhi.org/	No	No	Yes (Region)	Statewide median price and range of prices for a procedure based on claims paid by insurers. It also shows regional median prices.	No	Limited	2018	No
Washington	https://www.wahealthcarecompare.com/	No	No	Yes (Zip Code)	Median price and range of prices paid in total to the facility by the insured and insurer.	No	Limited	2018	Yes

Source: Commission staff review of other states' statutes and websites.

Appendix C: Incentive Program Hypothetical Cost Scenarios

Procedure 1

Deductible		Price	Accounting for Deductible and 20% Coinsurance	Price Before Reward	Reward	Net Price for Patient (after receiving reward)	Patient's Maximum Potential Savings for Procedure	Net Amount Patient Spends that Year*	Insurer/Employer Pays (including reward)
$1,000	Before Deductible is Met (patient has paid zero dollars that year)	$300	$300	$300	$50	**$250**	$350	**$250**	$50
		$450	$450	$450	$25	**$425**		**$425**	$25
		$600	$600	$600	0	**$600**		**$600**	$0
	After Deductible is Met (patient has paid $1,000 that year)	$300	$300 x 20%	$60	$50	**$10**	$110	**$1,010**	$290
		$450	$450 x 20%	$90	$25	**$65**		**$1,065**	$385
		$600	$600 x 20%	$120	0	**$120**		**$1,120**	$480
$2,500	Before Deductible is Met (patient has paid zero dollars that year)	$300	$300	$300	$50	**$250**	$350	**$250**	$50
		$450	$450	$450	$25	**$425**		**$425**	$25
		$600	$600	$600	0	**$600**		**$600**	$0
	After Deductible is Met (patient has paid $2,500 that year)	$300	$300 x 20%	$60	$50	**$10**	$110	**$2,510**	$290
		$450	$450 x 20%	$90	$25	**$65**		**$2,565**	$385
		$600	$600 x 20%	$120	0	**$120**		**$2,620**	$480

Appendix C: Incentive Program Hypothetical Cost Scenarios (continued)

Procedure 2

Deductible		Price	Accounting for Deductible and 20% Coinsurance	Price Before Reward	Reward	Net Price for Patient (after receiving reward)	Patient's Maximum Potential Savings for Procedure	Net Amount Patient Spends that Year*	Insurer/Employer Pays (including reward to patient)
$1,000	Before Deductible is Met (patient has paid zero dollars that year)	$3,000	$1000 + ($2,000 x 20%)	$1,400	$150	**$1,250**	$725	**$1,250**	$1,750
		$4,500	$1000 + ($3,500 x 20%)	$1,700	$75	**$1,625**		**$1,625**	$2,875
		$6,000	$1000 + ($5,000 x 20%)	$2,000	25	**$1,975**		**$1,975**	$4,025
	After Deductible is Met (patient has paid $1,000 that year)	$3,000	$3,000 x 20%	$600	$150	**$450**	$725	**$1,450**	$2,550
		$4,500	$4,500 x 20%	$900	$75	**$825**		**$1,825**	$3,675
		$6,000	$6,000 x 20%	$1,200	25	**$1,175**		**$2,175**	$4,825
$2,500	Before Deductible is Met (patient has paid zero dollars that year)	$3,000	$2,500 + ($500 x 20%)	$2,600	$150	**$2,450**	$725	**$2,450**	$550
		$4,500	$2,500 + ($2,000 x 20%)	$2,900	$75	**$2,825**		**$2,825**	$1,675
		$6,000	$2,500 + ($3,500 x 20%)	$3,200	$25	**$3,175**		**$3,175**	$2,825
	After Deductible is Met (patient has paid $2,500 that year)	$3,000	$3,000 x 20%	$600	$150	**$450**	$725	**$2,950**	$2,550
		$4,500	$4,500 x 20%	$900	$75	**$825**		**$3,325**	$3,675
		$6,000	$6,000 x 20%	$1,200	25	**$1,175**		**$3,675**	$4,825

Appendix C: Incentive Program Hypothetical Cost Scenarios (continued)

Procedure 3

Deductible		Price	Accounting for Deductible and 20% Coinsurance	Price Before Accounting for $5,000 Out-of-Pocket Maximum	Price Patient Pays after Accounting for $5,000 Out-of-Pocket Maximum	Reward	Net Price for Patient (after receiving reward)	Patient's Maximum Potential Savings for Procedure	Net Amount Patient Spends that Year*	Insurer/Employer Pays (including reward to patient)
$1,000	Before Deductible is Met (patient has paid zero dollars that year)	$20,000	$1000 + ($19,000 x 20%)	$4,800	$4,800	$500	**$4,300**	$700	**$4,300**	$15,700
		$35,000	$1000 + ($34,000 x 20%)	$7,800	$5,000	$250	**$4,750**		**$4,750**	$30,250
		$50,000	$1000 + ($49,000 x 20%)	$10,800	$5,000	0	**$5,000**		**$5,000**	$45,000
	After Deductible is Met (patient has paid $1,000 that year)	$20,000	$20,000 x 20%	$4,000	$4,000	$500	**$3,500**	$500	**$4,500**	$16,500
		$35,000	$35,000 x 20%	$7,000	$4,000	$250	**$3,750**		**$4,750**	$31,250
		$50,000	$50,000 x 20%	$10,000	$4,000	0	**$4,000**		**$5,000**	$46,000
$2,500	Before Deductible is Met (patient has paid zero dollars that year)	$20,000	$2,500 + ($17,500 x 20%)	$6,000	$5,000	$500	**$4,500**	$500	**$4,500**	$15,500
		$35,000	$2,500 + ($32,500 x 20%)	$9,000	$5,000	$250	**$4,750**		**$4,750**	$30,250
		$50,000	$2,500 + ($47,500 x 20%)	$12,000	$5,000	0	**$5,000**		**$5,000**	$45,000
	After Deductible is Met (patient has paid $2,500 that year)	$20,000	$20,000 x 20%	$4,000	$2,500	$500	**$2,000**	$500	**$4,500**	$18,000
		$35,000	$35,000 x 20%	$7,000	$2,500	$250	**$2,250**		**$4,750**	$32,750
		$50,000	$50,000 x 20%	$10,000	$2,500	0	**$2,500**		**$5,000**	$47,500

*The amount that would count towards the patient's out-of-pocket maximum designated by the health plan for that year is the price before they receive the reward.

Note: These scenarios consider only cost, not quality, of services, and illustrate coverage for an individual plan, not a family plan.

They also assume that the patient pays 20% coinsurance, and the out-of-pocket maximum is $5,000.

Source: Commission staff created the scenarios based on cost-sharing amounts common in the healthcare insurance industry and rewards amounts common in incentive programs.

The prices used in the scenarios are general, estimated prices for hypothetical procedures.

They are not actual negotiated rates between providers and insurers; negotiated rates are used as the basis for cost-sharing and are considered proprietary information.

Appendix D: State or Other Public* Employee Health Plans with Incentive Programs

State	Type of Employee Health Plan	Date Program Started	Legislation	Services Covered	Limit on Total Annual Incentives Paid per Enrollee	Incentive Payment Method	Incentive Amounts	Quality Information	Total Amount of Rewards Received by Employee Policyholders	Net Amount Saved by Health Plan	Total Number of Incentive Payments	Administrative Cost	Time Period for Reported Data	Data Sources
Florida	State employees	2019	yes (2017)	Extensive - Surgery bundle does not include dental, vision, maternity, cancer, and brain surgeries	no	No cash - Rewards go into tax-free savings and spending accounts such as HSAs and HRAs	Healthcare Bluebook (HCCB) $25-$6,000 Surgery Plus (SP) $500-$6,000	yes	$1.4 million	$5.3 million	9,028	Flat fee for HCBB; per employee per month fee for SP	19 months (January 2019-July 2020)	Kodie Nix, project manager, shared savings program, Florida Department of Management Services
Kansas	State and other public employee	2018	no	Extensive	no	Cash/check	$25-$500	yes	na	$15,000-$25,000 per month	na	Percentage of savings, only if there are savings	na	Delos DeCelle, senior manager, State Employee Health Plan, Kansas State Self Insurance Fund
Kentucky	State and other public employee	2013 (pilot) 2014 (full program)	no	Extensive	no	Cash/check	$15-$500	yes	$2.3 million	$12.6 million	22,839	Total for health plan stays within 2%	7 years (2013-2019)	Jenny Goins, commissioner, Department of Employee Insurance Kentucky Personnel Cabinet
Missouri	State employees	2020 (January 1)	no	Electable services with price gaps, such as mammograms, colonoscopies, imaging, and labs	no	Cash/check	$25-$500	yes	na	na	na	Approximately 41-42 cents per employee per month	na	Judith Muck, executive director, Missouri Consolidated Health Care Plan
New Hampshire	State employees	2010 (pilot, full program evolved)	no	Approximately 50 procedures	no	Cash/check	$25-$500	None other than basic credentialing	$674,000	$4.7 million	9,697	Per employee per month fee	12 months (2019)	Rob Graybill, VP, Strategy and Business Development, Sapphire-Digital
New Hampshire	Other public employees	2014	no	Started with 40, now have 62 shoppable services	no	Cash/check	$25-$500	All services are in network and are high quality	$1.7 million	$10 million	22,252	Per employee per month fee	6 years (2014-2019)	Scott Weden, benefits & wellness manager, New Hampshire HealthTrust
Texas	State employees	2020 (September 1)	yes (2019)	na	$500	No cash - Rewards go into FSAs	na	na	na	na	na	na	na	Jennifer Chambers, director of government relations, Texas Employee Retirement System
Texas	Teachers	2020 (September 1)	yes (2019)	Select procedures, such as imaging and other high-cost procedures that are scheduled in advance	$500	No cash - Rewards go into tax-free HRAs	$50 - $200	yes	na	na	na	25 cents per employee per month	na	Yimei Zhao, director of finance, Texas Teacher Retirement System
Utah	State and other public employees	2018	yes (2018)	Extensive - procedures commonly done in outpatients settings with large price spread and soome high cost drugs (Pharmacy Tourism program)	$3,900	Cash/check	$50 - $2,000	In development - provide links to quality information on providers pages	$47,225	$1 million	590	Internal resources	12 months (October 2018 - September 2019)	Paul Anderton, chief actuary, Utah PEHP Health & Benefits

Appendix D: State or Other Public* Employee Health Plans with Incentive Programs (continued)

State	Type of Employee Health Plan	Date Program Started	Legislation	Services Covered	Limit on Total Annual Incentives Paid per Enrollee	Incentive Payment Method	Incentive Amounts	Quality Information	Total Amount of Rewards Received by Employee Policyholders	Net Amount Saved by Health Plan	Total Number of Incentive Payments	Administrative Cost	Time Period for Reported Data	Data Sources
Virginia	State employees	2018	yes (2017)	Extensive	no	Cash paid into payroll and checks for retirees	$25-$500	yes	$99,950	$486,758	1,164	Rolled into overal health plan cost; has not seen a substantial increase	17 months (October 2018 - February 2020)	Todd Taylor, program manager, Office of Health Benefits Programs, Virginia Department of Human Resource Management

*Other public employees could include employees of city or county governments, higher education, school districts, or special districts.
Source: Commission staff interviews with and emails received from representatives from other states; Rhoads 2019; Tennessee Benefits Administration 2019.