PATIENT ACCESS & AFFORDABILITY PROJECT

Empowering Patient Perspective.

Giving Patients a Window into Healthcare Costs: A Path Toward Healthcare Transparency

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Providing transparency in health spending for patients has been a goal for many policy makers for some time. However, the numerous opaque and perverse financial incentives currently embedded across the healthcare system are a constant barrier. The Patient Access and Affordability Project, a program of Patients Rising, convened healthcare experts over the summer of 2021 to discuss the progress made in offering real price transparency to patients and where work needs to continue.

Our nation's complex and intertwined healthcare system is ripe for a significant disruption. Presently, consolidation across sectors has shifted power toward health plans and pharmacy benefit managers (PBMs), leaving all other stakeholders dependent on their decision-making.[1] A complex web of rebates and discounts has reinforced that dependence on the health plans and PBMs, which stifles any attempt to create a better model. Under this current paradigm, every year patients are forced to pay more, and providers, manufacturers, and suppliers are expected to offer bigger concessions.

Transparency in healthcare will come through releasing simple-to-understand cost and quality information to the public. Transparency is not just about price, it's about results, access, process, sharing of information, and knowledge at a level the patient and family can understand. It's about transparency of how the system works.

This paper discusses health policy issues, possible solutions on transparency, and promoting examples that may lead to a patient-focused health system.

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[1] https://www.commonwealthfund.org/publications/issue-briefs/2015/nov/evaluating-impact-health-insurance-industry-consolidation

Health Insurance

Many recent health surveys, including this one from Patients Rising, show that insurance premiums are a greater financial burden than other healthcare-related costs. In addition, high-deductible health plans are being purchased by more Americans than ever before, leaving them responsible for thousands of dollars in costs before coverage kicks in.[2]

Patient out-of-pocket (OOP) costs continue to rise year after year, including a 10 percent increase last year alone. We must ask: is an annualized increase of nearly 10 percent reasonable or sustainable?[3]

Get Clear on Insurance

Patients purchase health insurance to minimize their financial exposure to healthcare costs and provide a critical safety net for catastrophic health events. The opacity of health insurance has made it impossible to understand how much anything costs and has diminished the patient's ability to determine their financial responsibility for any health intervention.

Health plans must not only be transparent; they must also simplify the information they provide patients. Previous efforts to force health plans to be simpler and more transparent have so far been unsuccessful, but the need for such clarity has only grown. Providing better information to patients should start when an individual joins a health plan. The patient's premium, co-pays, and deductible should all be clearly communicated, as well as any financial support the plan will not accept at the pharmacy counter or as part of a patient's deductible. The burden of clear communication should be placed on the health plan with high standards of accountability for those plans. Those plans that do not comply should incur substantial consequences, including significant fines or other costly penalties to underscore the importance of providing this very basic information for patients.

Every year or two, health insurers, PBMs, and pharmaceutical manufacturers negotiate new rebates. These changes can affect formulary placement, restrict access, and increase a patient's out-of-pocket costs.[4] Prescription drug/therapy rebates and concessions are among the leading reasons the American healthcare system is so opaque, but even

[2] https://www.nytimes.com/interactive/2021/08/22/upshot/hospital-prices.html

[3] https://www.fiercehealthcare.com/payer/nationwide-out-pocket-spending-grew-10-to-1-650-per-person-2021-expect-to-continue-through

[4] https://www.milliman.com/en/insight/a-primer-on-prescription-drug-rebates-insights-into-why-rebates-are-a-target-for-reducing#4

more concerning is the fact that these rebates and other concessions are inappropriately influencing prescribing decisions. Put differently, health plans are making access decisions based on rebates, not based on efficacy and safety data. Contracts between health plans and entities in the health supply chain are a closely held secret; but rebates are often higher in therapeutic areas with competing treatments.[5]

In the health sector, decision-making should always be driven by what is in the best interest of the patient in consultation with their healthcare provider. Healthcare reimbursement decisions should be based on patient outcomes and any financial risk should be supported by the validity of the clinical and/or real-world data. Any concessions made to the health plan should be provided to the patient at the point of sale.

Eliminating the Safe Harbor

A more direct approach to removing this type of perverse incentive would be to eliminate the safe harbor under the Anti-Kickback statute for prescription drug rebates. This action would end the current incentives for preferred formulary placement by PBMs and health insurers based on rebate levels. Eliminating the safe harbor would likely add transparency in net pricing and improve the competitiveness across most classes of medicines.

Rethinking Health Insurance

Another important health policy question in the 21st Century surrounds the role of health insurance. Traditionally, health plans were designed to protect a patient from unexpected, high medical costs. With the advances in science and medicine, our ability to treat many conditions has improved and become more cost effective over time.

For unexpected, expensive, and catastrophic conditions, health insurance is a financial necessity to ensure all patients have access to the highest quality care and most innovative medicine available. Yet, considering that patient premiums, deductibles, and OOP costs increase almost annually, do patients need to rely on conventional health insurance for routine healthcare and chronic diseases with well-established and affordable therapies?

We need to actively explore alternatives to the status quo. For example, perhaps health insurance should be reserved for those high-cost health events that require substantial resources, the highest quality of healthcare, and the most cutting-edge medical

[5] https://www.managedcaremag.com/archives/2016/5/rebates-and-coupons-run-rampant-diabetes

interventions. For those patients in need of routine healthcare and who have their chronic condition under control, a fresh model that operates more as a subscription-style service for their healthcare needs could be a more convenient and affordable option.

Progress in the Commercial Market

While J.P. Morgan, Amazon and Berkshire Hathaway made a high-profile attempt to lower healthcare costs only to close the doors on their healthcare joint venture a few years later, there have been some promising examples of success.

One consumer-facing product that has found a way to work within the larger healthcare payment system – for the patient – is GoodRx. By using the GoodRx card at the pharmacy counter, the best discounts anywhere in the system will be applied to a patient's prescription, which in turn, may substantially lower their OOP costs. GoodRx actually works completely *outside* of a patient's insurance in order to access the best price in the current market. This is just one example of how the opaque and influential rebating systems keep costs for patients artificially high to benefit these plans.[6] While government health plans have outlawed discount cards, GoodRx can be a valuable option for Medicare or Medicaid patients because it works outside their government-sponsored health plan. One main drawback for patients who use GoodRx to get the best price is these prescription drug costs will not apply to their deductible; which may prevent some patients from gaining access to their full health benefits. This means each patient must estimate where they will spend their health dollars each year to determine if the savings at the pharmacy counter are the best value for their individual circumstances.

Costco has a reputation for passing along as much savings to members as possible, and that is the same strategy they are using for prescription drugs. In 2020, Costco took a minority stake in Navitus, an "alternative" pharmacy benefit manager, with the intent of passing all revenues back to employers, and only profiting from their per-member fee.[7] This model differs substantially from PBMs and health plan models that seek a concession at every point in the supply chain. While PBMs give preferable treatment to those offering higher rebates, the Costco and Navitus model circumvents the traditional incentives and improves access for patients based on what their doctor recommends.

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[6] https://fortune.com/2021/04/29/goodrx-prescription-drug-costs-pbms/

[7] https://www.bloomberg.com/news/articles/2021-04-22/costco-cost-health-care-approach-differs-from-amazon-amzn-walmart-wmt

Another company named HealthEngine has developed a platform that allows health systems to improve use of their vacant space by competing for a patient's patronage for routine health procedures. Unlike rebates, HealthEngine uses supply and demand to create a real marketplace for patients and healthcare providers. On the HealthEngine portal, hospitals disclose their prices for certain procedures and based on a hospital's availability they may choose to lower their price. The savings generated from the discounted rate are used to lower the patients OOP cost.[8]

Promising Legislative Action

There are a number of bills pending in Congress that would address various pieces of this problem. Two examples include:

H.R. 2163/S. 464: Safe Step Act

Step therapy is a tool insurers use to force patients to try their preferred drug rather than the one prescribed by their physician. While step therapy can help control costs, when abused by insurance companies, it can undermine clinical judgment of healthcare providers and prioritize higher rebates that insurers receive over a patient's health.

The Safe Step Act aims to improve step therapy protocols and ensure patients are able to access the best treatment for them safely and efficiently. It establishes a clear and transparent exemption process when it is clear a patient needs the specific medicine prescribed by their healthcare provider. The bill also requires group health plans to respond to exemption requests in a timely manner – 72 hours.

H.R. 3173/S. 3018: Improving Seniors' Timely Access to Care Act

Prior authorization is a practice that requires physicians to obtain pre-approval from health plans for medical treatments or tests before rendering care to their patients. While prior authorization is intended to ensure people receive clinically appropriate treatments, and to control the cost of care, the process has become a cumbersome administrative burden. Physicians or their staff to spend the equivalent of two or more days each week negotiating with insurance companies. That is time that could be dedicated to patient care. The HHS Inspector General raised concerns about the practice in a 2018 audit noting that Medicare Advantage (MA) plans ultimately approved 75% of requests that were originally denied.

The Improving Seniors' Timely Access to Care Act would help protect patients from unnecessary delays. This bipartisan bill will streamline prior authorizations and bring needed transparency and oversight to the MA program. It establishes electronic prior

[8] https://www.healthengine.com/

authorization (ePA) program and requires MA plans to adopt ePA capabilities. It would standardize and streamline the prior authorization process for routinely approved items and services and result in more real-time decision making. This legislation would also increase transparency around MA prior authorization and protect beneficiaries from unnecessary disruptions in care due to prior authorization requirements.

Conclusion

Fundamentally, the patient still has little control over pricing and healthcare decision-making. Providing patients with healthcare cost information that is clear and easy to understand is a necessary first step. While transparent cost information by itself won't solve the problem, without it, patients cannot hope to see savings and lower costs in their healthcare.

Transparency is essential in promoting patient-centric healthcare decisions and achieving transparency will require rethinking our approach.