Insight

The Price Transparency Executive Order

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Executive Summary

- The Trump Administration issued an executive order on transparency in health care pricing that required the Secretary of Health and Human Services to pursue five specific actions, including requiring hospitals to post information on negotiated rates for services.
- The executive order also seeks to expand the use of Health Savings Accounts and Flexible Spending Accounts, allowing consumers to spend these tax-advantaged dollars in more places.
- The ultimate impact of the executive order depends on the details of the requirements, but encouraging transparency in hospital prices might not encourage competition in reality, as consumers typically do not pay directly for their services.

THE ORDER'S SUBSTANCE

On Monday, President Trump signed an executive order (Order) that aims to increase price transparency, to improve the reporting of care quality, and to remove some current restrictions on Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs). The Order is part of the administration's broader push to lower the cost of health care.

The Order has several provisions, but the Secretary of Health and Human Services (HHS) must act on each initiative in the Order within the next six months. On some, however, the secretary must act much more quickly, perhaps giving a sense of the administration's priorities. The Order directs the HHS Secretary to do five major things:

1. Within 60 days of the Order's signing, propose a rule that would require hospitals to post information on negotiated rates for shoppable items and services in a format that is easily accessible to the consumer;
2. Within 90 days, issue an advance notice of proposed rulemaking on a proposal to require providers and insurers to notify consumers of their expected out-of-pocket costs for a given item or service before the consumer receives it;
3. Within 180 days, work with the relevant secretaries to develop a "Health Quality Roadmap" that would align and improve reporting data and quality measure for all federal public health programs—Medicaid, Medicare, the Children's Health Insurance Program, TRICARE, and so on;
4. Within 180 days, increase access to de-identified claims data from "taxpayer-funded" health care programs for researchers; and
5. Within 180 days, issue guidance to expand the prevalence and uses of HSAs and FSAs so that HSAs might be compatible with more plans, and be used to pay for more types of preventative care, direct primary care arrangements, and health care sharing ministries; and that the amount FSAs can roll over into the next year without penalty may increase.

Of the five directives above, the greatest potential for change in the health care marketplace resides in the first—which makes sense, as the emphasis of the Order is on increasing price and quality transparency. The rest of this paper will comment on the likely effects of potential price transparency rulemaking and explain what the Order intends for HSAs.

THE IMPACTS OF COMPLETE PRICE TRANSPARENCY

It has been observed that health care providers often charge vastly different prices for the same service, item, or procedure. In general, this administration's interest in price transparency is positive. As consumers compare prices for expensive goods or services, competition is increased, and downward pressure is placed on those prices. There are, however, significant questions as to the effects of this Order.

The Insurance Factor

First and foremost, the Order ignores the single most significant reason for the variation in prices: Very few people pay directly for their health care. An intermediary—the health care consumer's insurance provider—negotiates prices for the health care services purchased by

most people. Therefore, most of the time, the best price that a consumer can pay for a service is the price that their insurer has negotiated for its network. There may be multiple insurers negotiating with a single provider, leveraging their market share in order to provide the best price for their beneficiaries. So, for those enrolled in an insurance plan, price transparency rules may induce them to switch to an insurer that has negotiated the best rate. In the individual market, such incentives would mean increased unpredictability for insurers.

Meanwhile, people who are insured through their employer are often limited in their ability to shop for health insurance. According to Kaiser's 2018 Employer Benefit Survey, 80 percent of those who receive their insurance through their employer have only one or two plan options.[1] For those people, shopping for the better rate would mean shopping for a different job. On the other hand, where a certain employer plan has negotiated with a provider for the best rate for a given service in a given area, that rate would be unavailable to everyone else.

What complete price transparency would mean in practice is the revelation of all insurer-provider negotiations. And once all the prices are public, sooner or later the prices will reach some sort of equilibrium. When this happens, it is unlikely that insurers and providers would settle on the lowest price.

There is also the possibility that consumers receive access to health care prices and fail to act. Currently, there are insurers that offer pricing tools for people enrolled in their plans. The Council of Economic Advisers' 2019 Economic Report of the President cited various studies showing that patients do not utilize pricing tools that are currently available to them. In fact, it cited one study that showed that insurance plans that provide price comparison tools saw only 2 to 3.5 percent of enrollees use them.[2]

The Vagueness of the Order

There is a certain amount of vagueness to the Order that makes it impossible to tell its exact impact. For example, the Order states that the HHS Secretary shall propose a rule that would "require hospitals to publicly post standard charge information" and that this information would be based on negotiated rates, among other things. In other words, the publicly posted charge information could be made up of some sort of composite of rates that insurers have negotiated instead of every single rate negotiated by each and every provider and insurer. The effects of such a rule could vary depending on how the secretary carries out this Order.

THE HSA PORTION

The Order also directs the Secretary of HHS to do various things with respect to HSAs. Currently, only those who are enrolled in a high-deductible health plan (HDHP) qualify to open an HSA. Even then, the types of services for which HSA funds can be spent are limited. An HDHP may provide some preventive-care services below the minimum deductible threshold or without a deductible at all, and HDHPs formed after the Affordable Care Act are required to cover such services without a deductible. The Order seeks to beef up HDHPs with more pre-deductible covered services by expanding the definition of preventive-care services

Also, HSAs cannot be used to purchase care through direct primary care arrangements or health sharing ministries. The Order directs the secretary to propose regulation that would treat expenses related to these types of arrangements as compatible with HSA rules.

The Order's proposed HSA changes will likely put upward pressure on premiums for HDHPs, but they would also make them more appealing to people with chronic conditions. Expanded HSA use would also have tax implications. So, the overall effects of the HSA portion of the Order on both HDHP enrollment and federal revenue is uncertain.

[1] http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018

[2] https://www.whitehouse.gov/wp-content/uploads/2019/03/ERP-2019.pdf

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