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**Moving Markets:**  
Lessons from New Hampshire's Health  
Care Price Transparency Experiment

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# Contents

## About the Authors

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## Methodology and Data Source

HSC researchers conducted 22 interviews between August and November 2013 with New Hampshire insurers, providers (hospitals, ambulatory surgery centers, imaging centers), legislators, and policy experts to gain their perspectives on how price transparency initiatives are affecting the New Hampshire health care market. Each interview was conducted by a two-person research team; notes were transcribed and jointly reviewed for quality and validation purposes. All interview data were coded and analyzed using Atlas.ti, a qualitative software program.

## About the Foundations

This research was a joint project of the California HealthCare Foundation and the Robert Wood Johnson Foundation.

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For more than 40 years the **Robert Wood Johnson Foundation** has worked to improve the health and health care of all Americans. As the nation's largest health-focused philanthropy, we work with a diverse array of organizations and individuals to identify solutions and achieve comprehensive, measurable, and timely change. The Foundation brings experience, commitment, and a rigorous, balanced approach to the programs we support. We are striving to build a culture of health that will enable all Americans to live longer, healthier lives now and for generations to come.

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Over the last decade, New Hampshire has pioneered health care price transparency to support cost-conscious consumer behavior and, ultimately, spur competition and increase efficiency among health care providers.

In 2003, the state mandated one of the nation's first all-payer claims databases to collect provider pricing information. Using the claims data, the state in 2007 launched HealthCost, a publically available website that provides median bundled prices — both facility and physician payments — for about 30 common, mostly outpatient, services.<sup>1</sup> Unlike many early state-sponsored price transparency efforts that reported only hospital charges — retail prices that bear little relationship to the actual negotiated prices paid by private insurers — HealthCost presented provider-specific, insurer-specific median amounts paid for each service — potentially a much more useful consumer tool to compare prices.

How well has price transparency worked to fulfill the goals? This report looks at the steps taken in New Hampshire and how they have affected health care markets across the state. It updates a 2009 report by the Center for Studying Health Systems Change, which found no evidence that HealthCost had changed plan-provider leverage or provider price variation two years after it was in place.<sup>2,3</sup>

The new analysis, based on interviews with a wide range of health care stakeholders and experts, shows that consumer use of HealthCost has remained modest and that the program did not fulfill a primary goal of directly encouraging consumer price-shopping. However, the research found a wide belief within the state's health care and policy communities that HealthCost was important in highlighting wide gaps in provider prices — particularly between hospital outpatient departments and freestanding facilities, but also among different hospitals.

## Background: The New Hampshire Market

Most of New Hampshire's 1.3 million residents live in the state's southern urban corridor, where the three largest cities — Manchester, Nashua, and Concord — are located. The southeastern Seacoast Region and central Lakes Region are home to much of the state's remaining population. Northern New Hampshire, in contrast, is sparsely populated.

Among New Hampshire's 26 acute-care hospitals, 13 receive Medicare payments under the prospective payment system (PPS) based on expected resource consumption. The remaining 13 are small rural institutions designated as critical-access hospitals, which receive cost-based Medicare and Medicaid payments. Most private insurers negotiate hospital payment rates as a percentage of Medicare rates. PPS hospitals are in the southern urban corridor, the Seacoast and the Lakes regions; critical-access hospitals are in rural areas, primarily in the north.

The greatest degree of provider competition exists in the southern urban corridor; Manchester and Nashua are the only cities to have two hospitals. In both cases, the two hospitals are located near each other. However, even in these cities, competition traditionally has been limited by the fact that, in both cities, one hospital has a religious affiliation and the other does not; many people have longstanding, deeply held preferences for one or the other. Outside the urban areas, the degree of hospital competition is substantially lower, and in rural areas, the hospital market is geographically segmented.

The dominant health plan in New Hampshire's commercial insurance market is for-profit Anthem Blue Cross Blue Shield, a WellPoint subsidiary. State data show Anthem held 44% of the commercial health insurance market in 2011, while national for-profit Cigna and regional non-profit Harvard Pilgrim Health Care had shares of 24.5% and 21.7%, respectively.<sup>4</sup> However, the data likely understate enrollment in self-insured products; market observers believed this likely results in an underestimate of Anthem's market share. Cigna's membership is almost exclusively in the large group market, while Harvard Pilgrim competes in all market segments and is Anthem's only significant competitor in the small group market.

## Heightened Awareness of Price Variation

HealthCost heightened awareness of wide provider price variation, prompting state policymakers to launch subsequent public price transparency efforts, including several reports since 2009 analyzing key cost drivers of New Hampshire health care spending.<sup>5</sup> In supporting the view of high hospital price levels and trends as principal drivers of private-sector health spending, these reports intensified public scrutiny of high-price hospitals, and together with HealthCost, collectively helped change market dynamics, according to market observers.

Provider price variation “became part of...the fabric of communication about health care.... It permeated and still [permeates] every conversation” among health care stakeholders, according to one policy expert interviewed for this study. In turn, many respondents credited the changed market environment with helping to bring about two important developments in New Hampshire: a rebalancing of health plan-provider contracting leverage and a move toward new insurance benefit designs.

## Changes in Plan-Provider Leverage

Several respondents in the current study suggested that soon after the 2009 HSC study, the balance of plan-provider negotiating power began shifting significantly in New Hampshire, a result in large part of public transparency efforts highlighting wide variation in hospital prices. As evidence of this shift, most respondents pointed to a very public 2010–11 showdown between the state’s largest insurer, Anthem Blue Cross Blue Shield, and Exeter Hospital, the most expensive hospital in the state. In June 2010, Anthem announced it would terminate Exeter’s contract at the end of the year, citing Exeter payment rates that were nearly 50% higher than some competitors’ rates.<sup>6</sup> Exeter countered with a proposal to limit rate increases to an average of less than 3% a year, but Anthem successfully held out for a new three-year contract, signed in early 2011, that reportedly cut rates overall rather than just reducing rate hikes.<sup>7</sup> Respondents universally regarded the outcome as an “undisputed win for Anthem,” as one market observer said.

Heading into the Anthem contract negotiations, Exeter, which serves the state’s Seacoast Region, had long been a high-price outlier, with many observers noting that a prestigious reputation and an affluent, loyal patient base insulated the hospital from pressure to lower prices. However, the price comparisons made available by HealthCost and subsequent public reports helped shine the spotlight on Exeter’s outlier status. As one market observer suggested, “The sunshine effect [of price transparency]...changed the ground rules [of plan-provider contracting].... There’s recognition now that contractual negotiations are going to be somewhat in the public eye, in a way they never were in the past.” Indeed, the Anthem-Exeter showdown was well documented by the local news media at the time, with at least one newspaper report using HealthCost price comparisons to provide evidence of Exeter’s high prices.<sup>8</sup> As a result, according to a respondent familiar with the negotiations, “Public and employer sentiment was very supportive of [Anthem] during that dispute” — a reversal of historic patterns where “health plans don’t usually come out on the good side of those arguments...as far as public opinion is concerned.”

**There was a very public showdown between the state’s largest insurer, Anthem Blue Cross Blue Shield, and Exeter Hospital, the most expensive hospital in the state.**

Respondents suggested that the outcome of the Anthem-Exeter contract dispute discouraged other high-price providers from trying to “play hardball...[especially] with Anthem” in rate negotiations. As a result, most respondents perceived that provider price variation has narrowed in recent years, as higher-price hospitals reportedly reduced rates or at least moderated their trends.<sup>9</sup>

In addition to price transparency’s sunshine effect influencing the plan-provider contracting environment directly, several market observers also suggested that changes in health insurance benefit design — facilitated by public price transparency efforts — helped to further shift the balance of plan-provider leverage.

## Benefit-Design Changes

One of the major developments in the last few years has been the shift toward insurance products with benefit designs that give consumers financial incentives to be price-conscious when they choose providers. New Hampshire has experienced a more pronounced shift toward such benefit designs than health care markets elsewhere. Many respondents viewed the state's focus on price transparency as facilitating or accelerating benefit-design changes; they also noted that, in turn, the shift in benefit structures increased the relevance and usefulness of consumer price transparency tools. Shifts in benefit design include the following.

### High-Deductible Health Plans (HDHPs)

With HDHPs<sup>10</sup> exposing consumers to more out-of-pocket costs at the point of service, consumer incentives to price-shop when choosing providers increased accordingly, especially for outpatient services. Statewide enrollment in HDHPs soared from 1.5% of commercial enrollment in 2006 to 18% in 2011, steeper growth than the national trend.<sup>11,12</sup> HDHPs gained even greater traction in the small group market (2 to 50 workers), where they accounted for 29% of enrollment in 2011.

Most market observers noted that HDHP growth is a broader national trend that would have occurred locally in the absence of public transparency efforts. However, some respondents did suggest that, at the margin, New Hampshire's focus on price transparency may have facilitated HDHP growth, by highlighting wide provider price variation and laying the groundwork for employers to adopt benefit designs that "put more of the onus on enrollees to choose efficient [providers]," according to one market observer. Respondents also noted that HDHPs, with their higher out-of-pocket exposure, have increased consumer demand for health plan-sponsored price-shopping tools.

### Site-of-Service/Tiered-Copayment Products

A more targeted and recent benefit-design innovation — one that now pervades the state's small group market — features steep cost-sharing differentials for laboratory services and ambulatory surgeries, depending on whether a patient chooses a hospital-based or free-standing facility. When patients use independent labs, they incur no out-of-pocket costs, and when they use freestanding ambulatory surgery centers (ASCs), they are subject only to copayments ranging from \$75 to \$100, depending on the service. In contrast, those who choose a facility designated as a hospital outpatient department are subject to their policy's full deductible and copayment or coinsurance requirements.

For the subset of consumers enrolled in HDHPs, the cost-sharing differential between hospital-based facilities under the tiered-copayment benefit is especially stark. Anthem first introduced this benefit design, which it calls Site of Service, in 2009, and now embeds the feature in all small group products. Because nearly all independent labs and freestanding ASCs are concentrated in the more urban, southern region of the state, with a few scattered in the central Lakes Region and southeast Seacoast Region, this benefit design poses greater access challenges for consumers living in the sparsely populated northern area of the state.

Many likely have to travel significant distances to use a preferred provider. Of the independent labs, LabCorp, for example, has no facilities north of Exeter (Seacoast Region) and Quest has no facilities north of Gilford (Lakes Region) — requiring drives of up to two or three hours for many consumers in the north country. Recently, Anthem announced that two northern hospitals — Androscoggin Valley and Upper Connecticut Valley — have been designated as low-price options for both lab services and ambulatory surgeries, thus providing more alternatives for consumers. Reportedly, these hospitals renegotiated payment rates with Anthem to qualify as low-price providers under the Site of Service benefit design.

Between 2009 and 2013, Anthem was the only health plan featuring a product with this type of tiered-copayment benefit design. According to executives of multiple health plans, the lower premiums offered for these products enabled Anthem to gain significant market share, especially in the acutely cost-conscious small group

market. In January 2013, Harvard Pilgrim — Anthem’s only notable competitor in the small group market — launched its version of the benefit design — called LP for low-cost provider. Unlike Anthem, however, Harvard Pilgrim has not made tiered copayment a standard (mandatory) feature across its entire small group product line. Approximately half of Harvard Pilgrim’s small group enrollees are covered by products with tiered copayments for lab services and ASCs.

Tiered-copayment designs have been gaining traction with many of New Hampshire’s larger employers as well. Approximately 70% of Anthem’s large group members are enrolled in products with the Site of Service design. In 2014, the state government — New Hampshire’s largest employer — transitioned its entire workforce to the Site of Service benefit design.

## The benefit design changes have helped inject competition into the rural critical-access hospital market.

Health plans reportedly are exploring opportunities to expand the tiered-copayment design to other services with large price variations between hospital-based and independent providers. Services under consideration include high-end imaging, physical therapy, and occupational therapy. However, key barriers have prevented these services from being integrated into the benefit design to date. For imaging, there has been a dearth of lower-price, independent facilities in New Hampshire. One health plan executive noted that some national imaging companies are now exploring whether to launch operations in the state. For physical therapy and occupational therapy, the key barrier to tiered cost sharing has been enrollees’ difficulty in distinguishing between hospital-based and independent facilities, because many hospital-owned clinics are not on hospital campuses. As a result, enrollees might mistakenly believe they are using an independent facility — and eligible for minimal cost sharing — when they are actually using a hospital-based facility subject to high out-of-pocket costs. Educating enrollees about the subset of facilities eligible for lower cost sharing poses a challenge to health plans, and failure to do so might trigger significant consumer backlash against health plans.

Several respondents suggested that price transparency played an important role in facilitating tiered-copayment benefits. As one policy expert said, “Having that [HealthCost price comparison] information out there may have helped lead insurers and employers to think of more unique benefit designs like site of service...and tiered- or preferred-provider networks.” Other market observers had a somewhat different view, noting that health plans, including Anthem, already were well aware of broad provider price variation and perhaps “would have had site-of-service-type products on the drawing board” even without price transparency. But they also observed that by focusing public scrutiny on price variation, HealthCost and other public transparency efforts likely made employers more receptive to tiered-copayment benefit designs and more willing to deal with any employee pushback against the restrictions.

## Price-Shopping Tools with Incentives

Health plans have expanded their consumer price-shopping tools by making them more user-friendly, providing more specific price estimates, and offering meaningful financial incentives to consumers for choosing lower-price providers. These reward-based shopping tools can be featured along with site-of-service/tiered-copayment designs, or they can be offered independently. The most prominent example of a reward-based shopping tool is Anthem’s Compass SmartShopper program, which supports price shopping for more than 40 high-volume, elective outpatient procedures — for example, mammograms and colonoscopies — and diagnostic tests, such as CT scans and MRIs.<sup>13</sup> Enrollees can compare out-of-pocket costs for different providers on the SmartShopper website or by telephone, because, as one transparency expert noted, “Many people still like to have their hand held throughout the communication process.” If patients opt to have procedures performed at a lower-price provider recommended by SmartShopper, they receive a substantial financial reward, usually about \$100. Enrollees receive a smaller reward if they choose a lower-price, but not the lowest-price, provider. Rewards can be larger for services that have more significant price variation.

SmartShopper was launched in 2010 to serve large, self-insured employers, most notably the city of Manchester and the state of New Hampshire. In January 2013, Anthem introduced SmartShopper to the fully insured small group market, embedding the feature into all small group products.

Harvard Pilgrim has a similar shopping tool called SaveOn, which is structured much like SmartShopper, but also provides nurses who can help enrollees make an appointment at the lower-price provider. SaveOn is a phone-only service, but Harvard Pilgrim also has launched an online price-shopping tool — called Now iKnow — that allows consumers to compare their out-of-pocket costs for different providers. Both the Now iKnow and SaveOn tools are available to all of Harvard Pilgrim’s commercial enrollees in New Hampshire.

Hospital respondents throughout the state noted that their volumes for elective outpatient services have declined as a result of these reward-based price-shopping tools, combined with tiered-copayment benefits. The access challenges are considerably greater for patients in the northern area of the state, as they likely would have to travel considerable distances to earn rewards for using lower-price providers.

Unfortunately, the benefit-design changes described above do not reach all consumers. New Hampshire residents lacking health insurance constitute a key group of consumers who are beyond the reach of the new private-sector benefit designs and price-shopping tools. As several respondents observed, self-pay patients — in contrast to the commercially insured — have long been price shoppers, because the extent of their out-of-pocket exposure makes them more sensitive to price variation. Thus, uninsured consumers are the group most likely to benefit from public transparency programs and most likely to be affected when those programs are not kept up to date. (As a result of both data issues and staffing constraints, HealthCost data currently are available only through 2010.) However, as several respondents noted, public awareness and use of HealthCost was limited overall, and many uninsured consumers who attempt to price shop continue to do so “the low-tech way,” simply by calling different providers to ask for price quotes.

## Competitive Responses by Hospitals

By leading some consumers to switch to lower-price providers, new benefit designs such as tiered copayments and reward-based shopping tools have spurred hospitals to attempt to retain or regain patient volumes. Hospital responses include the following.

### Introduction of Lower-Priced Alternative Care Settings

Several hospitals have launched non-hospital-based labs, ASCs, urgent care centers, and other outpatient facilities. These facilities have a substantially lower pricing structure than hospital outpatient departments. Perhaps the most prominent example is the Surgery Center of Greater Nashua, a new ASC jointly sponsored by three of the state’s major hospitals — Dartmouth-Hitchcock Medical Center, St. Joseph’s Hospital, and Southern New Hampshire Medical Center. Another example is a new urgent care center owned by Wentworth-Douglass Hospital in the Seacoast Region. This facility’s prices reportedly are 35% less than the hospital’s emergency department prices for the same services.

In many cases, these hospital-owned facilities are still more expensive than their independent, freestanding counterparts. In such cases, the facilities do not qualify as low-priced providers under site-of-service/tiered-copayment benefit designs, but they might still prove attractive to consumers — including public employees — not subject to those benefit designs. And, even for consumers subject to tiered copayments, paying out of pocket for some routine services, such as lab work, may be a viable alternative, especially if the facility can combine the advantages of convenience, hospital brand-name recognition, and reasonable pricing. Also, for the large number of consumers who can earn financial incentives under Anthem’s and Harvard Pilgrim’s reward-based price-shopping programs, using a mid-priced facility allows them to earn rewards — albeit lesser rewards than would be earned for using the lowest-price providers.

## Negotiation of Lower Contract Rates

Respondents reported that some hospitals have renegotiated lower payment rates for certain services with specific insurers to qualify for participation in site-of-service/tiered copayment benefit designs. Androscoggin Valley and Upper Connecticut Valley have been designated as low-price providers under Anthem's Site of Service benefit design, presumably after negotiating lower rates with Anthem. In addition, Concord Hospital lowered its lab rates, and Lakes Region General Hospital and Franklin Regional Hospital lowered both their lab and ASC rates, to become low-price provider options for Anthem's Site of Service enrollees. The new Surgery Center of Greater Nashua also has rates low enough to earn low-price Site of Service designation. Other hospitals reportedly are in similar discussions with Anthem and Harvard Pilgrim to lower payment rates for lab services and ambulatory surgeries to earn preferred status.

Market observers noted that the benefit-design changes, which they credited in part to public price transparency efforts, have helped inject competition into the rural critical-access hospital market. These hospitals have long held geographic monopolies, and until the new benefit designs incentivized consumers to travel to minimize out-of-pocket costs, there had been little reason for the hospitals to compete on price.

## Hospital-Sponsored Price Transparency

Some low- to mid-price hospitals have implemented their own price transparency initiatives to focus attention on their favorable prices relative to competitors. Hospitals that have price transparency websites generally display charges (retail list prices) for common inpatient and outpatient services — information of limited usefulness to insured consumers, because each insurer negotiates its own prices with each hospital. Hospital websites also often display the discounted price that uninsured patients can expect to pay for each service. Hospitals that

have introduced lower-price care settings typically use their transparency sites to highlight the reduced prices available at these facilities. Only a few hospitals have transparency websites, but it has become more common for them to provide price quotes by telephone. The New Hampshire Hospital Association (NHHA), whose members include 20 of the state's 26 hospitals, has developed best practices for responding to patient requests for price information. NHHA also is posting charges on its website for 50 common outpatient procedures at all New Hampshire hospitals.

## Pressure on Hospitals

Hospital efforts to respond to changing market demands by becoming more price-competitive may not be sufficient to save some institutions from having to merge to stay in business or having to close altogether, according to most respondents. Indeed, in some cases, the effort to become more price-competitive might even hasten the demise of certain hospitals — for example, in the case where a hospital with already low or negative margins undertakes price reductions that outpace its cost-cutting efforts.

Not all respondents, even in the hospital sector, viewed impending hospital consolidation as a negative development, with several observing that 26 hospitals exceeded the needs of a population of 1.3 million people. In particular, market observers questioned whether many rural areas should have local hospitals at all, with one observer suggesting, "we could turn some of the hospitals in the northern part of the state into helicopter landing pads" to transport patients to larger hospitals in the south.

Adding to the pressure on hospitals is Anthem's recent decision to offer only a limited network of hospitals in the products it is selling on the federal health insurance exchange for New Hampshire. Anthem is the only insurer participating in the state's exchange in 2014, and its narrow network excludes 10 of the state's 26 hospitals. And, Anthem's payment rates to hospitals for exchange products reportedly are no higher than Medicare rates. Hospitals described this as a significant rate cut compared to commercial rates, and to the extent that state residents newly covered by exchange products previously had individual insurance, that view is accurate. But to the extent that state residents buying on the exchange previously lacked insurance, the impact on hospitals of

**The New Hampshire Hospital Association is posting charges on its website for 50 common outpatient procedures at all New Hampshire hospitals.**

receiving Medicare rates is less certain and, in some cases, may be beneficial.

Hospital executives noted that the new Anthem narrow network compounds many longstanding payment challenges for New Hampshire hospitals. According to several hospital respondents, New Hampshire's Medicaid payment rates are among the lowest in the nation, putting extra pressure on hospitals to negotiate commercial rates high enough to subsidize Medicaid care.<sup>14</sup> Many respondents viewed the absence of state income, sales, and payroll taxes as the key to what one market observer described as "perennial revenue shortfalls" that cause state policymakers "to squeeze providers continually on Medicaid [rates]."

Recent tightening of New Hampshire's Medicaid payments represents an additional pressure on hospitals. Since 1991, the state has levied a Medicaid Enhancement Tax (MET) on its 13 PPS (non-rural) hospitals. Originally, the tax's purpose was to maximize federal Medicaid disproportionate share hospital (DSH) funding, which helps subsidize care for low-income, uninsured people. Until 2010, all MET funds were returned to the hospitals through DSH payments. However, beginning in 2010, a change in state funding methodology resulted in nine hospitals receiving lower DSH payments than they paid in MET taxes. And, beginning in 2012, the state cut Medicaid payment rates but did not reduce the hospital tax, prompting 10 hospitals to sue the state — the litigation is ongoing.

Several hospital respondents contended that price transparency initiatives, by focusing on a very limited set of outpatient services, were engaging in a form of "cherry picking" that was misleading and biased against hospitals. They noted that hospitals — unlike freestanding facilities — are obligated to accept all patients regardless of insurance status and to provide a full range of inpatient services, including unprofitable services that require cross-subsidization. On the first point — the need to subsidize Medicaid and uninsured patients — health plan executives and market observers believed hospitals had a valid complaint. However, on the second point — the need to cross-subsidize less-profitable or unprofitable services — several non-hospital respondents suggested that the system of hospital pricing needs to evolve to the point where the price for each hospital service is closely tied to the cost of providing that service. One market

observer noted that "the current system [of hospital pricing] is much too opaque...[and] byzantine," and suggested that one of price transparency's key contributions would be to lead eventually to a system where relative prices are more closely tied to relative costs.

## Implications

New Hampshire has played a more active role than nearly any other state in fostering price transparency. Most New Hampshire stakeholders agreed that the state's actions influenced health care market dynamics — not by stimulating consumer shopping directly, as most policymakers originally had envisioned, but by focusing attention on the wide variation in provider prices and thus helping to foster changes in benefit design. The new benefit designs have increased consumer financial incentives to compare prices and choose lower-price providers and, in turn, have increased the usefulness and relevance of health plan price-shopping tools. Without the initial investment in public price transparency, many respondents believed that changes in benefit design and introduction of price-shopping tools in the private sector would have gained little traction.

New Hampshire's experience also points to the limitations of price transparency on a number of dimensions. First, the structure of the New Hampshire market imposes limits on the degree to which the public disclosure of provider prices can stimulate provider competition. A small market with relatively few providers — many of them vertically integrated and some with geographic monopolies — New Hampshire has limited opportunities to steer consumers to lower-price alternatives. As noted, tiered-copayment benefits have yet to expand beyond lab services and ambulatory surgeries, because other services, such as specialty imaging, lack low-price alternatives in the state. Perhaps a larger market with more independent/freestanding providers, or even more vigorous competition within the hospital sector itself, might see greater impact from investment in public price transparency. On the other hand, some observers suggested that being in a small market was precisely what allowed a policy intervention like HealthCost to capture the attention of all the major market players. It led to more transparency efforts and ultimately influenced private-sector benefit designs in ways that shifted patient incentives and, ultimately, patient volume.

The New Hampshire experience also highlights the limitations of using price transparency as a tool to contain health costs by squeezing commercial payment rates in a market with Medicaid payment rates widely regarded as inadequate. If hospitals face too much pressure to compete on price for privately insured patients, it may threaten their financial viability. The extent to which that ultimately will happen depends on how close hospitals are to exhausting their cost-cutting opportunities. However, the larger point is that the savings that can be reaped from the commercial sector as a result of transparency efforts are likely to be more limited than some policymakers expect in a market where commercial payments have to compensate substantially for chronic Medicaid underfunding.

Price transparency proponents often assume that if provider price gaps narrow and price trends moderate, purchasers and consumers inevitably benefit through a reduction in health insurance premium trends. However, as many hospital executives and some market observers noted, how much that happens depends heavily on the structure of the insurance market. In New Hampshire's market, the largest insurer has for-profit status, which may lead to a substantial portion of any gains extracted from hospitals accruing to the insurer's shareholders rather than local insurance purchasers. The Affordable Care Act's medical-loss-ratio provision should mitigate, at least in part, the potentially adverse impact on the local community, since it requires insurers to spend at least 80% to 85% of premium dollars on medical care. Insurers falling short of these standards must provide rebates to their customers. State policymakers can also address this issue through regulatory oversight of premiums or by attracting more competitors into the insurance market.

Finally, without meaningful quality information, price transparency does not allow purchasers or consumers to assess overall value when choosing providers. New Hampshire does have some quality transparency — for example, a report card sponsored by the New Hampshire Purchasers Group on Health — but it is confined to hospital comparisons and does not address quality of independent or freestanding alternatives. Currently, under tiered-copayment and reward-based benefit designs, consumers are being steered to low-cost providers with no quality information other than the assurance that inclusion in the insurer's provider network is evidence that a quality floor exists. For routine lab tests, this may not pose an issue, but for ambulatory

surgeries and many other outpatient services, providing consumers with quality information is critical if they are to compare value across providers. Further, it is important to note that in the absence of quality information, many consumers may draw the erroneous conclusion that high prices signal high-quality care. This assumption is likely to lead consumers to push back more vigorously against health plan efforts to steer them to low-price providers.

### **Because health care pricing is a local phenomenon, the fact that New Hampshire is a small state with only a few markets does not alter the dynamics at play in each individual market.**

Overall, the New Hampshire experience offers important lessons for other states considering transparency efforts. It illuminated the interplay of transparency, media attention, employee benefit designs, and health plan/hospital negotiations which can (and did) lead to a change in the balance of power for high-price hospitals.

Because health care pricing is a local phenomenon, the fact that New Hampshire is a small state with only a few markets does not alter the dynamics at play in each individual market. The same principles would apply in large states with a multitude of markets. Although it might have been useful to study New York, California, Illinois, Florida, or Texas because of their large size, the Granite State was the only one that had the fundamentals of transparency in place, including a five-year-old consumer-facing price website.

## Endnotes

1. New Hampshire's HealthCost website is at [www.nhhealthcost.org](http://www.nhhealthcost.org).
2. As of January 1, 2014, HSC merged with Mathematica Policy Research.
3. Ha T. Tu and Johanna R. Lauer, *Impact of Health Care Price Transparency on Price Variation: The New Hampshire Experience*, Issue Brief No. 128, Center for Studying Health System Change, Washington, D.C. (November 2009).
4. New Hampshire Insurance Department, *NH Insurance Carriers-Membership Summary*, Concord, N.H. (June 18, 2012), [www.nh.gov](http://www.nh.gov) (accessed December 19, 2013).
5. Several reports have been released by the New Hampshire Insurance Department and one by the New Hampshire Center for Public Policy Studies.
6. Clark, Joshua, "Anthem May Cut Exeter Hospital from Network," *SeacoastOnline* (September 19, 2010).
7. Sanborn, Aaron, "Exeter Hospital Accepts Anthem's Terms; Contracts Yet to be Signed" *SeacoastOnline* (February 18, 2011).
8. Clark, Joshua, "Higher Costs of Services Snags Exeter Hospital's New Deal with Anthem." *SeacoastOnline* (November 07, 2010).
9. Unlike the 2009 HSC report, the current analysis does not include a quantitative component examining changes in provider price variation, because data from HealthCost and the underlying New Hampshire Comprehensive Health Information System dataset are currently available only through 2010.
10. A high-deductible health plan typically had a deductible of at least \$1,200 for individual coverage and \$2,400 for family coverage through 2012. These minimum deductibles were raised to \$1,250 and \$2,500, respectively, as of 2013.
11. New Hampshire Insurance Department, *Supplemental Report of the 2007 Health Insurance Market in New Hampshire*, Concord, N.H. (December 19, 2008); New Hampshire Insurance Department, *Supplemental Report of the 2011 Health Insurance Market in New Hampshire*, Concord, N.H. (February 27, 2013)
12. Nationwide HDHP enrollment grew from 4% in 2006 to 17% in 2011. Kaiser Family Foundation, Menlo Park, CA, and Health Research & Educational Trust, Chicago, Ill. *Employer Health Benefits 2013 Annual Survey* (August 2013).
13. Anthem's SmartShopper program is powered by a third-party vendor, Compass Healthcare Advisers. Each insurer or self-insured employer purchasing the SmartShopper tool can decide which services to include, from a menu of over 100 services.
14. This assertion is supported by unpublished data from NHHA using American Hospital Association (AHA) Annual Survey data on Medicaid payment-to-cost ratios, but data from other sources are scarce and not entirely conclusive. A 2010 report by the New Hampshire Department of Health and Human Services comparing New Hampshire Medicaid rates to those of other New England states found that an overall benchmark of hospital inpatient and outpatient payment rates could not be calculated due to the different payment methodologies used by states. However, comparisons of select service categories performed by hospitals (e.g., imaging, lab and pathology services) did show lower Medicaid rates in New Hampshire than in other New England states. See New Hampshire Department of Health and Human Services, Office of Medicaid Business and Policy, *New Hampshire Medicaid Provider Reimbursement Rate Benchmarks for Key Services, 2010*, Biennial Report (October 2010).