Health & Retirement Services of Illinois
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OUR NEWS LETTER

Why don't more people shop for health care? Online tools exist, but most don't use them

Lisa Schencker Contact Reporter Chicago Tribune

Susan White prepares to undergo an MRI with technologist Jen Espino at Smart Choice MRI on July 17, 2018, in Chicago. Increasingly, providers other than hospitals offer straightforward services, such as MRIs, at relatively low costs.

At Rush University Medical Center on the city's West Side, the median charge for a vaginal birth was $16,703 last year.

Three miles away, at Norwegian American Hospital, it cost about half that: $8,873.

Most patients don't pay those charges, instead paying a sum based on rates negotiated between hospitals and health insurance companies. But even after those negotiations, stark differences often remain — disparities that can hit the wallet hard.

Though consumers have long bemoaned rising health care costs, few people shop for health care the way they might shop for a car, comparing prices. Some don't realize a procedure can cost tens of thousands of dollars more at one hospital versus another. Others would rather rely on referrals or don't know where to go to find information. Hospital prices vary for a number of reasons, including differing overhead costs, market dynamics and, in some hospitals, a need to offset the costs of complex services by billing higher rates for simpler ones.

Now, the Trump administration wants to make it easier for patients to comparison shop for medical care, proposing a rule that would require hospitals to post their charges, before insurance, on their websites. The administration also is considering whether that posted information should reflect rates negotiated with insurers.

Some consumer advocates cheer the administration's proposal as a step toward greater price transparency. But hospitals and many experts say such a move likely wouldn't make much of a difference, pointing to existing online price comparison tools that often go unused by consumers. They also question the usefulness of posting charges before insurance.

In Our Newsletter

“Everybody wants to try to find a path forward to increase price transparency, but it is very complex,” said Sandy Kraiss, Illinois Health and Hospital Association vice president of health policy and finance. “We just don’t see that this is the best approach to advance that.”

Consumers who want to know how much a hospital procedure will cost already have a number of options.

They can call hospitals to get individual estimates, and sometimes, they can go to hospital websites. Late last year, west surburban hospital system Edward-Elmhurst Health became one of the few systems to post a pricing tool on its website to help consumers estimate out-of-pocket costs based on their insurance plans.

The Illinois Department of Public Health also lists median charges, by hospital, online in its hospital report card, but those figures show only list prices, not how much a patient will actually pay after insurance.

Insurers offer many of the most comprehensive price-comparison tools. In many cases, consumers can log onto their insurance companies’ websites to compare their individual, out-of-pocket costs for procedures at different hospitals.

But most consumers don’t.

Illinois’ largest insurer, Blue Cross and Blue Shield of Illinois, has had an online tool in place for about eight years for members to compare prices and quality — partly as measured by outside organizations — across hospitals. Yet less than 10 percent of members use the tool, said Thomas Meier, the insurer’s vice president of market solutions.

It’s not an uncommon result. Nationally, only about 20 percent of Americans have tried to compare prices before getting care, according to the results of a 2016 survey by Public Agenda, a New York City-based nonprofit.

Experts chalk up the low numbers to several factors, including a lack of consumer knowledge, interest and time.

“A lot of it is member awareness,” said Meier with Blue Cross and Blue Shield of Illinois. “I think a lot of the members don’t understand even what an (in-network) versus out-of-network provider is, let alone that 44 different providers would charge 44 different amounts for an MRI.”

Also, for many consumers seeking health care, price isn’t top of mind, said Sunita Desai, an assistant professor in health policy at New York University. She was lead author of a study published in the journal Health Affairs last year that found only about 12 percent of a large population of employees who were offered a price transparency tool used it.

Patients in the throes of a medical emergency don’t have time to price shop. Those who do have time may trust only certain doctors. And in some cases, price shopping might not help a patient save money, Desai said. Finding a lower-cost service helps a patient only if that service costs less than his or her insurance deductible or out-of-pocket maximum.

“People aren’t necessarily using them because, in some cases, they don’t really have any incentive to do so,” said Sally Rodriguez, chief of staff at the Washington, D.C.-based Health Care Cost Institute, of cost transparency tools.

Rachel Parsons of Chicago's West Town neighborhood, for example, shopped around for physical therapists after giving birth to her daughter earlier this year. She found a clinic she liked, but it was out-of-network and would have cost $160 a visit, so she passed.

She didn't, however, shop around for a hospital before giving birth. She went to the hospital where her midwife practiced that also took her insurance. She assumed that regardless of where she went, childbirth would be so pricey that she'd hit her family's deductible. "With hospitals, they're expensive no matter what you're doing," Parsons said.

Other consumers don't see the upside of taking the time to shop around because they typically hit their deductibles or out-of-pocket maximums each year.

Jose Vazquez, of the West Loop, shops for some services that his insurer won't cover, but mostly he's careful to make sure tests and drugs are covered by his insurer before taking them. But otherwise, Vazquez, who has pulmonary fibrosis, doesn't see higher out-of-pocket costs if he goes to one in-network provider versus another. He knows he'll almost certainly hit his out-of-pocket maximum each year, leaving him little incentive to shop.

"It's kind of hard not to hit it, especially when dealing with a chronic illness," Vazquez said. "It's not something you can really think about."

Still, shopping for services can save cash across the health care system — for patients, for their employers and for insurance companies, which foot large portions of patients' bills. Self-insured employers also pay much of their workers' health care bills. Employers that aren't self-insured may face higher rates from their insurers if their employees' medical claims climb.

So perhaps it's no surprise that many in health care are encouraging consumers to shop.

Blue Cross and Blue Shield of Illinois and UnitedHealthcare work with some employers to offer incentives for employees to choose lower-cost, high-quality services. With Blue Cross, for example, workers can receive checks of $25 to $500 for choosing certain providers.

"People who use our tools save 36 percent over folks that don't use our tools," said Katherine Bisek, a vice president for the insurer. "Higher prices don't necessarily equate to higher quality or better outcomes."

Research backs up the assertion that higher prices don't necessarily mean higher quality. Price differences often have to do with local market dynamics and negotiations between hospitals and insurers, Bisek said. Some hospitals are also more expensive than others because they have to offset the costs of treating complex patients, said Kraiss with the Illinois hospital association. Prices vary quite a bit across the Chicago area, with knee MRIs running anywhere from $142 to $4,736, vaginal childbirth from $5,417 to $28,249, and back surgery from $9,051 to $156,900, according to UnitedHealthcare.

But such pricing disparities aren't the main reason many hospitals don't post prices online, Kraiss said. Rather, hospitals have let insurers lead the way in offering price transparency tools because a patient's final bill depends largely on an insurance plan, she said.

Others, however, suspect hospitals don't make prices more accessible because they don't want to be put at a competitive disadvantage. Increasingly, providers other than hospitals offer straightforward services, such as

MRIs, at relatively low costs. Those providers don't have to offset the costs of other services and can have lower overhead, said Rick Anderson, CEO of one such chain, Smart Choice MRI.

He said greater price transparency in health care is long overdue and he hopes it encourages consumers to shop around.

"If I'm in the emergency room having bypass surgery, I'm not asking how much, but when it comes to things that are routine ... I'm going to shop because I can and I should," he said.

Some Doctors, Patients Balk At Medicare's 'Flat Fee' Payment Proposal

By **Martha Bebinger, WBUR** July 31, 2018

The Trump administration announced a plan Friday that would affect about 40 percent of the payments physicians receive from Medicare. Not everybody's pleased.

The Centers for Medicare & Medicaid Services calls its proposed plan a historic effort to reduce paperwork and improve patient care. But some doctors and advocates for patients fear it could be a disaster.

The CMS plan, published in Friday's Federal Register, is now open for public comment until early September. It would combine four levels of paperwork required for reimbursement, and four levels of payments, into one form and one flat fee for each doctor's appointment (although there would still be separate filing systems for new and established patients).

In a letter previewing the plan to doctors earlier this month, CMS Administrator Seema Verma said that physicians waste too much time on mindless administrative tasks that take time away from patients.

"We believe you should be able to focus on delivering care to patients," Verma wrote, "not sitting in front of a computer screen."

Initially, that sounded pretty good to Dr. Angus Worthing, a rheumatologist in Washington, D.C. Then he tested the claim with his own analysis.

During a typical 15- to 45-minute appointment with a patient, Worthing figured, "I might spend one to two minutes less in front of the computer, documenting and typing."

Dr. Kate Goodrich, CMS' chief medical officer, noted that "saving one to two minutes per patient adds up pretty quickly over time."

But Worthing said the small savings in time is not worth the reduced payment he'd get. The CMS plan would offer a flat fee for each office visit with a patient, whether the doctor is a primary care physician or a specialist.

Rheumatologists, in general, could expect a 3 percent reduction in Medicare's reimbursement because they typically see and bill for more complicated patients, said Worthing, who chairs the government affairs committee for the American College of Rheumatology.

And he noted that his personal net income from Medicare patients would drop even more — by about 10 percent. That's because 70 percent of his costs — for rent, payroll and other expenses — are fixed or rising.

Worthing is leading efforts by rheumatologists to persuade CMS to adjust its funding formula before the plan goes into effect in January.

"The proposal is well-intentioned but it might cause a disaster," he said, if it leads to fewer medical students going into rheumatology and other specialties that require doctors to manage complex patients. And physicians might stop taking Medicare patients altogether, or avoid those with more difficult problems.

Al Norman, a 71-year-old Medicare patient, said he can see that disaster coming.

“If you’re frail or if you are very healthy, you’re worth the same to a doctor [under the proposed plan], and obviously that means that the people who are more disabled or frail are less desirable patients,” said Norman, who worked on elder care issues in Massachusetts before retiring last year.

Many doctors predict that the proposed payment changes would establish a financial incentive to see fewer Medicare patients. Goodrich, the Medicare official, disagrees.

“That’s an unintended consequence we wanted to mitigate on the front end and avoid,” Goodrich said. Under the proposed system, doctors who need more time with patients could file for an “add-on” payment of $67 per appointment. That would require a small amount of additional documentation, she admitted, but would still reduce a doctor’s keyboard time, according to CMS estimates.

This “add-on” payment is “intended to ensure that physicians are being appropriately compensated for seeing the most complex patients,” Goodrich said.

Still, critics of the plan say there are other unintended consequences CMS may not have anticipated.

Dr. Paul Birnbaum, who has been practicing dermatology in the Boston area for 32 years, said he’s worried that paying doctors a reduced fee per appointment would translate to lots of short visits.

“You would just see more people,” Birnbaum said. “You’d move people through faster. And so you have somebody come back for repeat office visits**.** And *that*, over time, would be inflationary.”

More frequent trips to the doctor would mean more copays for patients and higher costs for Medicare, he said.

The Trump administration is not suggesting the payment changes would save Medicare money. In her letter to doctors, Verma said some physicians would see their Medicare payments increase.

And it’s not just doctors who treat elderly patients who are likely to be affected. If the Medicare payment changes take effect, private insurers might follow suit, in part because it’s easier for all insurers to use common billing procedures.

Theoretically, obstetrician-gynecologists would be among the biggest winners; they treat fewer complex Medicare patients. Still, many OB-GYNs are worried about the coming changes, too.

“There will be winners and losers, and my real fear is it’s not the physicians [who will lose the most]. My real fear is that it’s the Medicare beneficiaries,” said Dr. Barbara Levy, vice president for health policy at the American College of Obstetricians and Gynecologists.

Some Medicare advocates are urging CMS to postpone these changes and consider a trial run.

“If we’re going to talk about this kind of wholesale, large-scale reconfiguration of the way reimbursement is given to doctors,” said Joe Baker, president of the Medicare Rights Center, “it’s probably best to do that in a demonstration project where we can closely study the ramifications.”

CMS hopes to enact any changes to Medicare fee schedules on Jan. 1, 2019.

The main challenge remains convincing patients and physicians that the changes are worth doing in the first place.

Trump Administration Loosens Restrictions On Short-Term Health Plans

By **Julie Appleby** August 1, 2018

Insurers will again be able to sell short-term health insurance good for up to 12 months under final rules released Wednesday by the Trump administration.

This action overturns an Obama administration directive that limited such plans to 90 days. It also adds a new twist: If they wish, insurers can make the short-term plans renewable for up to three years.

The rule will "help increase choices for Americans faced with escalating premiums and dwindling options in the individual market, said James Parker, a senior adviser to Health and Human Services Secretary Alex Azar.

But the plans could also raise premiums for those who remain in the Affordable Care Act marketplace — and the short-term coverage is far more limited.

"We make no representation that it's equivalent coverage," Parker said.

The Trump administration's approach is expected to please brokers and the insurers that offer the coverage.

"To restore these to 364 days — as originally drafted — is exactly what we are looking for," said Jan Dubauskas, general counsel for the IHC Group, speaking before the final rule was released. The IHC Group is an organization of insurance carriers headquartered in Stamford, Conn.

She said she expects IHC to offer 12-month versions as soon as the rule goes into effect, which will be 60 days after it is published.

Administration officials estimate plan premiums could be half the cost of the more comprehensive ACA insurance. They predict about 600,000 people will enroll in a short-term plan in 2019, with 100,000 to 200,000 of those dropping ACA coverage to do so.

Just over 14 million people are enrolled in ACA plans this year.

Short-term plans are less expensive because, unlike their ACA counterparts, which cannot bar people with preexisting health conditions, insurers selling these policies can be choosy — rejecting people with illnesses or limiting their coverage.

Short-term plans can also set annual and lifetime caps on benefits, and cover few prescription drugs.

Most exclude benefits for maternity care, preventive care, mental health services or substance abuse treatment.

Some policy experts, including those from the Center on Health Insurance Reforms at Georgetown University, warn that allowing increased use of the skimpier coverage offered by short-term plans could leave some patients in financial or medical difficulty.

“If you get cancer, your plan will not cover oncology drugs, which can cost an average of $10,000 a month” and “if you are pregnant, you will have to find another way to pay for the cost,” averaging about $32,000 for prenatal care and delivery, the center said in a recent post.

Allowing short-term plans to last longer is the latest move to change regulations issued by the Obama administration. In June, the administration released final rules on association health plans, which grants greater leeway to small businesses and sole proprietors to join together to purchase insurance that doesn’t have to meet all the ACA’s requirements, although AHP plans are more robust than short-term plans.

Those changes to Obama-era rules, and other congressional actions, are expected to impact the cost of coverage for individuals in the ACA marketplace.

Premiums for the average benchmark ACA plan rose by 34 percent this year, according to a recent Congressional Budget Office report.

Factors driving the increase include medical inflation, but the CBO also cited the administration’s decision last fall to drop payments to insurers for lowering deductibles for certain low-income policyholders.

That same report expects premiums for ACA plans to increase 15 percent next year, in part because many consumers may be less likely to buy coverage without the threat of a tax penalty. The tax bill approved last year by Congress stops this financial penalty as of 2019.

Short-term plans, if they appeal to many consumers, could also play a role.

By drawing younger or healthier consumers out of the ACA marketplace, the short-term plan expansion will add up to a 1.7 percent increase to premiums next year, according to the industry lobbying group America’s Health Insurance Plans.

Short-term plans have been around for decades, meant as a stopgap for job changers, students and others who found themselves without coverage.

Under the Trump administration directive, insurers also can renew the short-term coverage for the same amount of time as the original plan — maxing out at 36 months.

HHS officials said current law allows the plans to have this longer shelf life, although critics are likely to argue that — when you factor in the renewal option — a plan that lasts three years cannot be considered short-term.

Supporters of the new rules say the short-term plans won’t affect the ACA market as much as critics fear because the plans will mainly appeal to those consumers already sitting on the sidelines, or those who don’t get a subsidy.

Already the vast majority of people who buy ACA coverage through federal or state exchanges qualify for premium subsidies.

Brokers will likely be pushing the plans, as they often pay higher commissions than do ACA plans.

And, for insurers, profit margins tend to be higher for short-term plans compared with ACA coverage. The plans have limits on coverage. Also, insurers are not held to the ACA requirement that they spend at least 80 percent of premium revenue on plan members' medical care.

Both supporters and critics of short-term plans say consumers who do develop health problems while enrolled could, in theory, hang on until the next open-enrollment period and buy an ACA plan during the sign-up period because the ACA bars insurers from rejecting people with preexisting conditions.

That part of the law is under threat, however, in a case brought by Texas and 19 other states that seeks to declare that provision and two other parts of the ACA unconstitutional.

In early June, the Department of Justice said it would not defend the law against the Texas case, which is on appeal and may eventually end up at the Supreme Court.

Frequently asked questions (FAQs)

General FAQs

All physicians and other clinicians included on Physician Compare are enrolled in Medicare, meaning they treat people with Medicare. However, some clinicians may not accept Medicare-approved payment amounts , or may not be accepting new Medicare patients. You should always contact the clinician to ask if they accept Medicare-approved payment amounts, if they're accepting new Medicare patients, and to verify their practice location. For instructions on how to search Physician Compare, go to "How do I get the search to work?"

All physicians and other clinicians on Physician Compare treat people with Medicare. When a clinician or group accepts the Medicare-approved amount as full payment for covered services (called "Medicare assignment"), you pay less out-of-pocket, and you won't be billed for more than the Medicare deductible and coinsurance. Contact the clinician or group to check if they accept the Medicare-approved payment amounts. Learn more about Medicare assignment.

If your doctor is enrolled in Medicare but not listed on Physician Compare, it may be because we don't have certain information from them in our system. Send us the name of your doctor, their location, and their specialty to PhysicianCompare@Westat.com. We'll look into why your doctor isn't listed.

Some types of doctors may not be located close to you, but it's unlikely that there are no doctors enrolled in Medicare in your area. Check your search terms to make sure that there were no errors, and try your search again. If you need more help, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Watch this video for a demonstration on how to use Physician Compare. To begin a search, use the search box on the home page and enter your zip code, city and state, address, or landmark in the location field. Then, enter a search term like a clinician's name, a group name, a medical specialty, a medical condition, a body part, or an organ system. When you begin typing, you will notice a drop down menu with related specialties. Select from the drop down menu and click "Search." You should get a list of clinicians and groups depending on your search criteria.

When you search on Physician Compare, you'll get a results page with a list of clinicians and/or groups. If a clinician or group has performance information available on their profile page, you'll see a star icon labeled "Performance information available." On their profile page, you can click on the heading labeled "Performance" or "Patient survey scores" to view more.

To learn more about performance information on Physician Compare, visit the Improving health care quality page.

Pneumococcal shots

How often is it covered?

Medicare Part B (Medical Insurance) covers a pneumococcal shot to prevent pneumococcal infections (like certain types of pneumonia). Part B also covers a different second shot if it's given one year (or later) after the first shot. Talk with your doctor or other health care provider to see if you need one or both shots.

Who's eligible?

All people with Part B are covered.

Your costs in Original Medicare

You pay nothing for pneumococcal shots if your doctor or other qualified health care provider accepts assignment.

A Concierge Approach to Health Insurance

By Heather Punke August 6, 2018

Most people don't think about how health care works until they need it to work for them. A new breed of advocate may help them navigate their coverage and care.

Michelle Ghibaudy, a health advocate for Blue Cross and Blue Shield Plans in Illinois, Montana, New Mexico, Oklahoma and Texas, recently answered a call from a member who wanted to complete a health survey.

The caller wanted to qualify for a reward under her plan's incentive program for healthy choices.

During the call, however, Ghibaudy learned the woman recently moved and didn't have a primary care doctor in her new city. Also, the member was a cancer survivor and would need a new oncologist. She was also due for a colonoscopy.

Ghibaudy helped the caller find an in-network primary care doctor, booked an appointment and gave her a list of in-network oncologists. Then she found a quality gastroenterologist nearby and the lowest-cost setting for the colonoscopy. That earned the caller another reward under a program offered under her plan to encourage members to shop for quality cost-effective care.

"A member wouldn't necessarily think about doing all of that," Ghibaudy says. But she was able to take care of it in one phone call because of a program called Health Advocacy Solutions.

How we got here

In a word, the health care system can be confusing. Most people don't think about how it works until they need it to work for them. That level of support for people needing help with health care is more important now than ever before.

We take the member out of the middle and don't leave them with a to-do list.

Confusion drives up costs, both for members and the employers that provide health insurance. The total cost of health care per employee in 2018 is around $14,000, according to a 2017 survey of large employers by the National Business Group on Health.

To help, many employers are investing in services that may simplify the health care system for their employees, saving everyone money.

"There is a big increase in the number of employers offering decision support, concierge services and tools to help employees navigate the health care system," Brian Marcotte, CEO of NBGH, said in a news release on the survey.

"The complexity of the system and proliferation of new entrants has made it difficult for employees to fully understand their benefit programs, treatment options and where to go for care," Marcotte said.

Follow the money

Entrepreneurs and investors see a big opportunity to make money in simplifying health care. Companies have sprung up to provide services they say may smooth the path to the most affordable care options. Their services include care management, customer service and evaluating the value of medical services and facilities.

“As patients expect more and more of the health system — modeled after the seamless consumer experience they receive from other industries — we can expect to see more providers and startups offering services to reduce the friction between patients and the health system,” says Megan Zweig, director of research at Rock Health, a venture capital fund dedicated to digital health.

These types of services aim to save money in myriad ways. For one, engaging members in their care through phone calls and digital platforms may lower costs significantly by guiding them to lower-cost, higher-quality providers and care locations.

By easing the path to care, the approach may help members get and stay healthy, which can save money for self-funded employers that pay for their employee’s health care. With data and predictive analytics, services can also reach out proactively to members who may need help managing health conditions and avoid a costly hospitalization.

A national employer that was an early adopter of Health Advocacy Solutions has experienced a 7 percent reduction in overall health care costs from the prior year, seeing results from both clinical management and significantly increased member engagement.

Members are taking advantage of cost-effective locations of care, including virtual visits for non-emergent illness and digital self-service tools, reducing their out of pocket expenses and getting cash rewards when they shop for care.

Becoming an advocate

Ghibaudy is seeing these market changes first-hand in her job with Blue Cross and Blue Shield Plans in Illinois, Montana, New Mexico, Oklahoma and Texas, under the Health Advocacy Solutions program.

“We take the member out of the middle and don’t leave them with a to-do list,” Ghibaudy says.

An insurer may have the upper hand on stand-alone companies providing these services because insurers have first-hand knowledge about benefits, networks and claims. “We can adjust claims and answer network questions right away,” says Lydia Ferguson, director of analytics consulting for the Health Advocacy Solutions product.

Under Health Advocacy Solutions, Ghibaudy works in a “pod.” The pod includes nurses and others who are trained to know what benefits are available to their assigned groups of members. Members have a single phone number on their member ID card that connects them directly to the pod for their questions.

The advocates help with claims, give out-of-pocket price estimates for procedures, locate in-network providers and more. The nurses provide holistic health management to coordinate care across medical and behavioral needs.

The health advocates also call members directly. They welcome new members to their health plan and educate current members about programs that may benefit them.

Recently, Ghibaudy made an outbound call to welcome a new member and make sure he had his member ID card. From that one call, she discovered the member had questions she could answer about his benefits. Also, his son needed surgery, so she was able to make sure the provider and facility were in his health plan's network.

"That one call out to welcome him," she says, "turned into getting all those things taken care of."

To contact us: go to www.healthcareil.com or Call (800) 739-4700