Right-to-Shop Programs: Encouraging Patients to Shop for High-Value Health Care

With the share of Gross Domestic Product spent on health care reaching crisis levels,[1] experts on both sides of the political spectrum are demanding better value for the dollars spent on health care. Programs that give patients incentive to choose better value health care get widespread support from both political parties. In the past few years, many states considered enabling or implementing right-to-shop or savings reward programs, in which an insurer creates an incentive program that gives patients financial rewards for choosing providers with lower than average costs.

How Right-to-Shop Programs Work

Prices for medical services can vary significantly depending on where they are performed. For example, according to a report by NPR, CT scans in the Fort Myers area range from $474 to about $3,700. Traditionally, if a patient has a flat co-pay or has reached their deductible for the year, he can be insulated from the cost difference. With a right-to-shop program, however, the insurer typically shares any savings from the choice of a lower-cost provider with the patient, giving the patient a financial incentive to seek a higher-value provider even with a flat co-pay or met deductible. Under a right-to-shop program, when a doctor recommends or prescribes a medical service, the patient would call his insurer or use an on-line tool to compare costs for different providers. The patient can then balance costs, travel distance, and other factors to choose the best treatment location for him.

In a typical example provided by the Foundation for Government Accountability, a patient needs a knee replacement surgery and has a fixed cost-sharing amount of $6,000 for the procedure. He has the option to have the procedure at two nearby facilities, both with 5-star quality ratings, but one has a price to the insurer of

$25,000 and the other costs $60,000. If the patient chooses the cheaper location, the insurer writes a check to the patient for half of the difference in the cost between the option he chose and the average cost in the area.[2] In this case, the patient received a check from the insurer for $4,500, dropping his out-of-pocket costs for the surgery to $1,500. The patient can still choose the more expensive location at his set cost-sharing, but he will not receive any incentive payments from his insurer.

Right-to-shop policies, therefore, give patients a financial incentive to seek lower cost and high-quality care, even if they have a flat co-payment or have met their deductible for the year. Employers and others who pay for health insurance have tried other methods to give patients a financial incentive to choose high-value care, including using high-deductible health plans (HDHP). When covered by an HDHP, patients must pay the full cost of any medical care up to the deductible (which in 2019 is at least $1,350 for individuals and $2,700 for a family).[3] While the premiums for these plans are often lower than those for traditional health insurance plans, people with HDHPs often find it extremely difficult to pay the full cost for medical care before their deductible is met and therefore may choose to forgo necessary medical care. Right-to-shop programs, unlike HDHPs, preserve the ability of patients to get necessary care because their cost-sharing remains the same, but also allow patients to be rewarded financially when they choose cheaper providers. Furthermore, with right-to-shop programs, in contrast to reference pricing, this financial incentive to seek low-cost, high-quality care is independent of any threshold or reference price.

State Initiatives to Encourage Right-to-Shop Programs

New Hampshire became the first state to implement right-to-shop policies in 2015 when the state commissioned Anthem to develop a right-to-shop program for its employees. In the first three years of the program, approximately 90% of program enrollees have shopped at least once, with two-thirds earning a financial incentive for choosing lower cost care, saving the state $11 million in three years.[4] In 2017, Maine also passed right-to-shop legislation that requires insurers to design a health plan in which enrollees are “directly incentivized to shop for low-cost, high-quality

participating providers for comparable health care services,"[5] for all small group health plans with a health savings account. In 2018, Utah also passed a right-to-shop law that requires Utah's Public Employee Health Plan (PEHP) to set up a savings reward program that offers financial incentives to patients, including premium discounts, rebates, reductions in out-of-pocket costs, when they use lower-cost, high-quality providers.[6] The popularity of right-to-shop programs is increasing rapidly. For example, Kansas, Kentucky, and Massachusetts established programs for their public employees andFlorida, Oklahoma, Arizona, and South Carolina considered legislation to establish similar right-to-shop programs.[7]

In just the first month of 2019, two states – Oklahoma and Minnesota – introduced bills to require some health plans sold in the state to implement right-to-shop policies.[8] Minnesota's bill is particularly comprehensive and appears to cover all health plans in the state. Specifically, the bill provides that "beginning January 1, 2020, each health plan company offering a health plan in this state must offer a shared savings incentive program to its enrollees…[and that program] must provide an enrollee with at least 50 percent of the saved costs for each comparable health care service resulting in comparison shopping by the enrollee."[9] Whether or not the state can gather the political will required to pass and implement such an expansive bill, Minnesota joins a handful of others looking for creative solutions to increasing the value of money spent on healthcare without shifting more of the cost burden onto patients.

Limitations to Right-to-Shop Programs

Despite the growing momentum of states seeking to catalyze the creation of right-to-shop programs, three significant barriers prevent these programs from bending the cost-curve of rising healthcare expenditures.

First, these right-to-shop programs only work for "shoppable services." Specifically, the patient must have time to shop for the service (i.e. not an emergency service), multiple providers must offer the service within a reasonable distance of the patient, and information about the relative costs and quality of those providers must be provided in an easily understandable format to the patient. Shoppable services

include diagnostic tests, laboratory test, many outpatient procedures, and elective surgeries like joint replacements. Economists estimate that between one-third and one-half of all spending on healthcare services is for shoppable services.[10]

Secondly, right-to-shop programs may not result in substantial savings because there may not be a wide variation in prices or there may be a limited number of providers for a health service in the patient's neighborhood. In a detailed analysis of private insurance claims for 528,000 active and retired nonelderly autoworkers and their dependents, researchers at the RAND corporation estimated that implementing a reference pricing program would save only 5% of the total spending.[11] Additionally, the savings may be outweighed by increased plan complexity and the analytical and financial resources needed to create and manage the program. (For more information about reference pricing, see The Source blog). While right-to-shop programs differ from reference pricing programs, they are similar in that they only apply to shoppable services and require the patient to actively seek out and act on pricing information. Nonetheless, reference pricing and right-to-shop programs place pressure on the highest priced providers to lower their rates and may save millions of dollars annually.

Lastly, to shop for higher-value care, patients must have access to the negotiated rates paid by their insurer to providers. While most insurers have websites to allow enrollees to access their out-of-pocket costs information, very few allow patients to see the negotiated rates for services for each provider in the area. In fact, many providers assert trade secret protection for pricing information, making it difficult for insurers to give patients access to that information.[12] Whether pricing information qualifies for trade secret protection is a matter for the courts and, to our knowledge, no court has definitively ruled on the issue.[13] Nonetheless, the threat of legal action from providers often keeps patients from accessing the information. In addition, providers with significant market power often demand anti-steering provisions in their contracts with insurers, preventing insurers from steering patients to lower cost providers. These anti-steering provisions may violate antitrust laws.[14] On the other hand, the Supreme Court, in *Ohio v. Am. Express Co.*, held that American Express's use of anti-steering provisions in contracts with retailers do not violate federal antitrust laws,[15] casting uncertainty over potential antitrust enforcement. (See The Source's coverage of these cases for more detailed analysis.)

Therefore, states wanting to encourage the use of right-to-shop policies should consider passing legislation specifying that contracts between insurers and providers must not prevent patients from accessing pricing information when using that information to shop for higher value care.

Conclusion

As healthcare costs continue to rise, all stakeholders are searching for ways to eliminate wasteful spending. Since insurance insulates patients from the full cost of their medical care, policymakers seek ways to encourage patients to shop for higher value care, particularly as the cost of treatment is often unrelated to the quality of the provider. Right-to-shop programs represent a new wave of policies to give patients a financial incentive to seek out more cost-effective providers without exposing them to additional financial responsibilities. As these policies demonstrate their effectiveness in saving money both for government programs and for private insurers, many states are considering and passing legislation to encourage their use. To maximize the effectiveness of right-to-shop policies, however, states must ensure that patients have access to the necessary information when making decisions about where to receive treatment.

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[1] Alan Weil, ***Health Affairs*Launches Council On Health Care Spending And Value.** *Health Affairs Blog.* July 12, 2018. Available from: https://www.healthaffairs.org/do/10.1377/hblog20180711.164617/full/.

[2] In this example, the average cost in the area was $34,000, so the difference between the location the patient chose and the average was ($34,000-$25,000 = $9,000). The insurer splits the savings with the patient and wrote a check to him for half of this amount or $4,500.

[3] **IRS Announces 2019 HSA Contribution Limits, HDHP Minimum Deductibles, and HDHP Out-of-Pocket Maximums.** *Thompson Reuters.* May 10,

2018. Available from: https://tax.thomsonreuters.com/blog/irs-announces-2019-hsa-contribution-limits-hdhp-minimum-deductibles-and-hdhp-out-of-pocket-maximums/.

[4] Josh Archambault and Nic Horton. **Right To Shop: The Next Big Thing In Health Care.** *Forbes.* Aug 5, 2016. Available from: https://www.forbes.com/sites/theapothecary/2016/08/05/right-to-shop-the-next-big-thing-in-health-care/#31bda24b4f60.

[5] Maine LD 445/SP 147 (2017).

[6] Utah HB 19 (2018).

[7] **The Right to Shop: More Access to Local and Affordable Health Care**. October 28, 2016. Available from: https://palmettopromise.org/right-shop-access-local-affordable-health-care/.

[8] The bills in Oklahoma are HB 2417 and SB 218. The bill in Minnesota is SF 3.

[9] MN SF3 (2019) §1 Subdivision 2(a) and Subdivision 5(b).

[10] Health Care Cost Institute. **Spending on Shoppable Services in Health Care**. *HCCI Issue Brief #6*. March 2016. Available from: https://www.healthcostinstitute.org/images/easyblog_articles/110/Shoppable-Services-IB-3.2.16_0.pdf and Chapin Whiteand Megan Eguchi. **Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle**. *National Institute for Health Care Reform Research Brief #28.* October 2014. Available from: https://nihcr.org/analysis/improving-care-delivery/prevention-improving-health/reference-pricing2/#ib4.

[11] While and Eguchi 2014.

[12] Muir, Morgan and Alessi, Stephanie and King, Jaime S., **Clarifying Costs: Can Increased Price Transparency Reduce Healthcare Spending?** (February 25, 2013*). UC Hastings Research Paper No. 38*. Available at SSRN: https://ssrn.com/abstract=2224151 or http://dx.doi.org/10.2139/ssrn.2224151.

[13] In Cardiac Pacemakers, Inc. v. Aspen II Holding Co., 413 F. Supp. 2d 1016 (D. Minn. 2006) and Emergency Care.

Research Institute v. Guidant Corp., 2007 U.S. Dist. LEXIS 67658 (E.D. Pa. Sept. 12, 2007), the federal district courts denied motions for summary judgement. This denial means that whether the pricing information at issue in the case was a trade secret was an issue of material fact. Both cases ended in a confidential settlement without a ruling on the merits of Guidant's claim of trade secret protection for prices. See reference 10 for more discussion.

[14] The United States District Court for the Western District of North Carolina recently held that these anti-steering provisions can violate antitrust law, specifically Section 1 of the Sherman Act (https://www.justice.gov/atr/case-document/file/966051/download). Following this ruling, Atrium Health (formerly Carolinas HealthCare System) reached a settlement with the Department of Justice and the state Attorney General which prohibits Atrium from using or enforcing anti-steering provisions in contracts with insurers. More recently, the California Attorney General filed a lawsuit alleging Sutter Health's use of anti-steering provisions violated the state's Cartwright Act.

[15] Ohio v. American Express Co. 138 S. Ct. 2274, 201 L. Ed. 2d 678 (2018).