Price transparency: New requirements and considerations for hospitals

Haitham Aly, ASA, MAAA
Phil Ellenberg, MS
Shyam Kolli, FSA, MAAA, CEBS
Josh Reinstein, FSA, MAAA

Price transparency has been a key agenda item for President Trump's administration ever since he took office three years ago. In June 2019, the president signed an executive order to make healthcare prices more transparent.[1] As a follow-up to the executive order, on November 1, 2019, the Centers for Medicare and Medicaid Services (CMS) released a final rule establishing requirements for hospitals operating in the United States to establish, update, and make public a list of their standard charges for the items and services they provide.[2] The provisions of the final rule are effective on January 1, 2021.

The lack of price transparency in the healthcare market in the United States is well known by healthcare consumers and stakeholders. There are several reasons that can make estimating healthcare costs before receiving care difficult for consumers. One of the key challenges is the variation in billed charges and negotiated rates between insurance companies and providers. The majority of Americans have health insurance coverage through insurance companies (or payers), which negotiate prices with hospitals and providers. The negotiated prices between payers and providers have historically been confidential, subject to nondisclosure agreements, and, in some cases, considered trade secrets. Health economists and other experts state that, without widespread and sustained transparency in pricing, healthcare cost containment cannot occur.[3] CMS believes this rule is an important first step in achieving price transparency in the healthcare industry.[4] Opponents of the policies adopted in the final rule argue that these requirements will impose a significant burden on hospitals and may lead to confusion without providing any relevant information.

This paper provides a summary of key provisions of the final rule that apply to hospitals, briefly touching on topics that require additional consideration by parties affected by the rule.

Who is affected by this rule?

CMS has deferred to state agencies' licensing guidelines with respect to which entities qualify as a hospital. The regulations define a hospital as "an institution in any State in which State or applicable local law provides for the licensing of hospitals, that is licensed as a hospital pursuant to such law, or is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standard established for such licensing."[5] This includes Critical Access Hospitals (CAHs), Inpatient Psychiatric Facilities (IPFs), Sole Community Hospitals (SCHs), and Inpatient Rehabilitation Facilities (IRFs). Federally owned or operated[6] hospitals are exempt from the rule, as they do not negotiate rates with third-party payers.

What information needs to be made public?

The regulations adopted in the final rule require hospitals to publish standard charges for items and services.[7] CMS defines "items and services" as "all items and services, including individual items and services and service packages that could be provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a standard charge."[8] Examples of items and services that would apply include supplies, room and board, and medical procedures, as well as services provided by employed physicians and nonphysician practitioners who are employed by the hospital. Examples of service packages include but are not limited to bundled payment arrangements, per diem contracts, and inpatient case rates.

[1] Exec. Order No. 13877, 84 FR 30849.

[2] The full text of the final rule (45 CFR Part 180) with comment period is available at https://www.federalregister.gov/documents/2019/11/27/2019-24931/medicare-and-medicaid-programs-cy-2020-hospital-outpatient-pps-policy-changes-and-payment-rates-and.

[3] Boynton A. & Robinson, J.C. (July 7, 2015). Appropriate use of reference pricing can increase value. Health Affairs.

[4] Exec. Order No. 13877, op cit., 84 FR 65528.

[5] 45 CFR, op cit., 180.20.

[6] 45 CFR 180.30(b).

[7] 45 CFR 180.50(a).

[8] 45 CFR 180.20.

There are five types of standard charges that hospitals are required to make public:[9]

1. Gross charge amount: The charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts. This would not include any standard charges for service packages. This is commonly referred to as the "billed amount."
2. Payer-specific negotiated charge: The charge that a hospital has negotiated with a third-party payer for an item or service. This excludes Medicaid or Medicare fee-for-service (FFS) rates, as they are not negotiated payments. This amount is commonly referred to as the "allowed amount."
3. Cash discounted price: The charge that applies to an individual who pays cash (or cash equivalent) for a hospital item or service. Hospitals that do not offer cash discounts may display the hospital's undiscounted gross charges.
4. De-identified minimum negotiated charge: The lowest charge that a hospital has negotiated with all third-party payers for an item or service.
5. De-identified maximum negotiated charge: The highest charge that a hospital has negotiated with all third-party payers for an item or service.

The regulations require hospitals to publish their standard charges in two ways: 1) a comprehensive machine-readable file that makes public all standard charge information for all hospital items and services, and 2) a consumer-friendly display of common shoppable services derived from the machine-readable file.[10]

THE COMPREHENSIVE FILE

In an effort to make the files comparable across hospitals, the following data elements are required for the comprehensive machine-readable file:[11]

- Description of each item or service (including both individual items and services and service packages)
- All five standard charges as defined above
- Any code used by the hospital for purposes of accounting or billing for the time or service, e.g., Current Procedural Terminology (CPT) code, diagnosis-related group (DRG)

While hospitals have discretion over where to post the file, there are a number of requirements with which they must comply:

- The file must be displayed on a publicly available website and clearly identify the hospital location with which the standard charge information is associated.[12]
- The hospital must ensure the data is easily accessible and without barriers; the data must be accessed free of charge, without having to establish a user account or password, and without having to submit personally identifiable information (PII).[13]
- Updates to the file must occur at least once every 12 months and must clearly indicate the date of the last update.[14]

THE SHOPPABLE FILE

The provisions of the final rule require hospitals to publish standard charges for 300 shoppable services. Shoppable services are defined as services that can be scheduled by a healthcare consumer in advance. Furthermore, when a service is customarily accompanied by the provision of ancillary services, the hospital must present the shoppable service as a grouping of related services.[15] Examples of ancillary items are laboratory, radiology, prescription drugs, operating room, or therapy services. The rule includes a list of 70 required services that must be published by all hospitals. The 70 required services are outlined explicitly in Table 3 of the final rule and are grouped into the following broad categories:[16] Evaluation and Management Services, Laboratory and Pathology Services, Radiology Services, and Medicine and Surgery Services. The remaining 230 services included in the file are up to the discretion of each hospital. If a hospital does not offer one or more of the 70 required services, it must include additional services it provides in order to have 300 total services published in the file. The hospital must also indicate which of the 70 required services are not provided at a given location.

[9] 45 CFR 180.50(b)(2)-(6).

[10] 45 CFR 180. Examples of acceptable machine-readable formats include, but are not limited to, .XML, .JSON, and .CSV formats. A PDF would not meet this definition.

[11] 45 CFR 180.120.

[12] 45 CFR 180.50(d)(1) & 45 CFR 180.50(d)(2).

[13] 45 CFR 180.50(d)(3).

[14] 45 CFR 180.50(e).

[15] 45 CFR 180.60.

[16] Exec. Order No. 13877, op cit., 84 FR 65571-65572.

How will compliance with the requirement be monitored and enforced?

CMS will create a process for monitoring hospital compliance with the regulations adopted in the final rule. This will include evaluation of complaints made by individuals or entities to CMS, a review of the individuals' or entities' analyses of noncompliance, and potential CMS audit of hospital websites. If CMS determines a hospital is not compliant with the requirements, then the actions it takes will generally, but not necessarily, occur in the following order:

- Provide a written warning notice[17]
- Request a Corrective Action Plan (CAP) from the hospital[18]
- Impose a Civil Monetary Penalty (CMP) on the hospital and publicize the penalty on a CMS website if the hospital fails to respond to CMS's request to submit a CAP or comply with the requirement of a CAP[19]

CMS may require hospitals to submit a CAP if it determines that a hospital's noncompliance includes a failure to make public its standard charges in the format and manner required by the regulations.[20]

CMS may also impose a CMP on a hospital that it identifies as noncompliant. The maximum daily dollar amount of a CMP to which a hospital may be subject is $300, even if the hospital is in violation of multiple discrete requirements. CMS will provide written notice to the hospital of the imposition of a CMP.

The hospital may appeal a CMP within 30 calendar days by requesting a hearing to defend or justify any reasons for noncompliance.[21]

Considerations

WILL INCREASED TRANSPARENCY IMPACT HEALTHCARE COSTS?

From the patient perspective, introducing a level of price transparency may guide healthcare consumers to seek lower-cost services when possible. However, other factors in seeking and receiving healthcare services can play a role in determining whether healthcare costs will be affected. Consumers may not be knowledgeable enough about the appropriate treatment plan and tend to rely on their specialists and/or primary care physicians for advice on quality hospitals or the right procedures or treatments for their conditions. The economics of purchasing and the decision-making process will be different with healthcare compared to the process when purchasing other commodities because of the difference between needs and wants when health is involved. In addition, consumers may not be fully incentivized to seek low-cost care under traditional preferred provider organization (PPO) plan designs. High-deductible health plan (HDHP) designs may increase these incentives due to greater cost sharing. Access is also likely to be a key factor in how providers react to the provisions of the final rule. Rural hospitals may have less incentive to bring costs in line with the market due to a lack of competition, while hospitals in areas with multiple systems would be expected to compete on both price and quality. The rule cites some studies suggesting the potential for certain costs to increase due to low-cost providers increasing their prices to be in line with the rest of the market.[22] The finalization of the rule may influence the future decisions of healthcare consumers, hospitals, and third-party payers. The direction and magnitude of these decisions will dictate how healthcare cost is impacted.

WILL THERE BE AN IMPACT ON PROVIDER-PAYER CONTRACTING?

Rate comparisons on the 70 shoppable services required by the rule may reshape provider/payer relationships, and could be points of contention in future contract negotiations. Again, geography will play a factor here; hospitals with negotiated rates lower than their competitors may seek to increase their rates on the basis that they are below market. Hospitals with rates higher than their competitors may feel market pressure to bring their rates down. Negotiations during the provider/payer contracting process incorporate additional considerations other than merely agreeing on prices for particular services (i.e., volume and quality). Payers will know whether their current negotiated rates with a hospital are low, medium, or high compared to that hospital's rates for other payers and could use this information in future contracting discussions

WILL PROVIDERS PAY THE PENALTY INSTEAD OF REPORTING THEIR RATES?

The maximum annual penalty for noncompliance is $109,500. Contrast this with CMS's estimated cost of compliance, which is estimated to be $11,899 per hospital in the first year and $3,611 per hospital in subsequent years.[23] Hospitals may opt to simply incur the penalty; however, noncompliance could result in additional costs to the hospital. These costs may include increased complexity with future contract negotiations, added costs from a public relations standpoint, and potential legal fees.

[17] 45 CFR, op cit., 180.70(b)(1).

[18] 45 CFR 180.70(b)(2).

[19] 45 CFR 180.70(b)(3).

[20] 45 CFR 180.80.

[21] 45 CFR 180.90.

[22] Exec. Order No. 13877, op cit., 84 FR 65548-65549.

[23] 84 FR 65525.

WILL THE FINAL RULE PROVISIONS FACE LEGAL CHALLENGES?

Litigation may delay implementation of the regulations beyond their effective date of January 1, 2021. Opponents of these new regulations argue that reimbursement rates are considered proprietary and requiring them to be publicly available violates intellectual property rights. Further arguments have been made that the regulations do not accomplish the goal of educating the public of true out-of-pocket costs. The American Hospital Association (AHA), the Association of American Medical Colleges (AAMC), the Children's Hospital Association (CHA), and the Federation of American Hospitals (FAH) have announced their intent to pursue legal action against the U.S. Department of Health and Human Services (HHS).

WHAT ABOUT QUALITY?

Although CMS addresses aspects of quality of care in its preamble to the final rule, the regulation itself focuses on price transparency and does not adopt regulations related to quality of care. While price is often a key factor when individuals select a provider, quality is also an important consideration. From cars to houses to food, some consumers have shown a willingness to pay higher prices for goods and services they determine to be of higher quality. Hospitals with higher prices than their competitors may need to find ways to demonstrate higher quality in order to avoid losing market share.

Conclusions

Price transparency in healthcare has been a hot topic for many years, with proponents believing it is an essential piece in the effort to contain healthcare costs. Accordingly, the final policies adopted by CMS are an attempt to increase price transparency for consumers. There are differing opinions in the industry on the potential effectiveness of these policies in providing meaningful information for consumers to make better-informed purchasing decisions. While CMS asserts these requirements are an important step in achieving price transparency in the healthcare industry, many questions remain. There is an argument that the final rule provisions do not achieve the goal of providing patients with their true out-of-pocket costs, and instead may confuse consumers.[24] Implementation, interpretation, and litigation, among other factors, will help determine whether the new hospital price transparency requirements are successful in reaching CMS's stated goals

[24] AHA (November 15, 2019). Hospital and health system groups on public disclosure of privately negotiated rates final rule. Press release. Retrieved January 8, 2020, from https://www.aha.org/press-releases/2019-11-15-joint-statement-national-hospital-and-health-system-groups-public.

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CONTACT

Haitham Aly
haitham.aly@milliman.com

Phil Ellenberg
phil.ellenberg@milliman.com

Shyam Kolli
shyam.kolli@milliman.com

Josh Reinstein
josh.reinstein@milliman.com