Legal Consult: Price Transparency for Whose Benefit?

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"Consumerism" has for some time been touted as an alternative to health care reform efforts such as Obamacare and Medicare For All. The argument goes that, if only health care consumers had accurate quality and price information, they could make their own decisions and thereby drive down the cost of care in a real market setting. Prior efforts to provide such information have had a mixed record, and it is not clear to what extent individual patients are able and willing to comparison shop regarding health care goods and services. Now the federal government is proposing two rules that would require hospitals and health insurance carriers to provide such information to their patients and subscribers. At least for the near term, it appears that any benefit from these new rules may accrue largely to others, and not directly to patients, but the ultimate impact of the new rules might be enormous.

The two rules were published on November 27, 2019 in the Federal Register. The first rule concerns hospitals and is in its final form with an effective date of January 1, 2021. The second rule concerns health insurers and is currently in proposed form. Under the rules, hospitals are required to post online a list of payer-specific negotiated charges as well as chargemaster charges and payer-anonymous minimum and maximum negotiated charges, as well as discounted cash prices payable by self-pay consumers. In addition, hospitals must post online a second list of the same sort of charges for of up to 300 "shoppable services" using a plain-language description of the service and adding information about the location where the service is provided. The two lists would be updated annually.

The proposed health insurer rule would require a health insurance issuer or group health plan to provide an estimate of the beneficiary's cost-sharing liability for a covered service, in response to a specific request from the beneficiary and through provision of a written description or an internet-based self-service tool. In addition, beneficiaries would be informed about the in-network negotiated amount as well as the out-of-network allowed amount for the item or service and information as to whether that item or service is subject to a prerequisite such as prior approval. If the beneficiary requests information about an item or service that is part of a bundled payment arrangement, the payer must provide a list of the bundled items and services included in the cost-sharing information. In addition, the payer would be required to post in-network negotiated rates on a publicly-accessible website that is updated monthly.

If you were to design a system to provide patients with actionable intelligence to enable them to purchase the highest quality health care for the lowest cost, you might want to ensure such a system provides them with comparative quality and cost information for a variety of providers. The two federal rules do not do that. The final hospital rule does provide patients with insurer-specific allowed charge information provided by the reporting hospital whose list the patient consults, and places that information within the context of the maximum and minimum allowed charges paid to that hospital for the item or service in question. The Department of Health and Human Services commentary to this rule repeatedly says that by doing so, the rule is intended to provide patients with a "full line of sight into their healthcare pricing." Significantly, however, this line of sight will not include a view of fee for service Medicare or Medicaid charges, since those are not negotiated by the provider. Moreover, in order to compare different hospitals' negotiated charges, the patient would have to consult multiple hospitals' lists. A comparison of different hospitals' quality metrics for a given item or service would require the patient to consult other resources, to the extent these are available.

> **"…the rule is intended to provide patients with a 'full line of sight into their healthcare pricing.'"**

If you were to design a system that would give patients specific information about their out of pocket costs for a given item or service, you would provide the type of information found on evidence of benefit documents, currently delivered only after the date of service. Although the final hospital rule does not provide that information, the proposed health insurer rule does, through the provision of information about how the patient stands with respect to his/her deductible or any out of pocket limits, as well as the required co-pays or co-insurance and prerequisites such as prior approvals or step-therapy requirements. The health insurer rule would require disclosure of the negotiated rate paid by the insurer for in-network as well as out-of-network providers. However, if the patient's cost-sharing liability (e.g., deductible, co-pay or co-insurance) is not affected by the negotiated rate, the negotiated rate need not be disclosed. This could happen if a deductible does not apply or if the co-pay or co-insurance amount is a flat dollar figure.

If you were to design a system to enable patients to determine where best to receive a service, you would provide patients with

comparative cost and quality information for a given service that might be provided in different types of settings – for example, a surgery performed in a hospital or in an ambulatory surgery center. You would also provide price information for services provided by non-hospital providers that are ancillary to the services provided by the hospital, such as physicians who are not hospital employees and independent physician groups, which bill and collect separately from the hospital. Neither of the federal rules require the provision of such information, since the statutory authority for the hospital rule is limited to hospitals and cannot require non-hospital providers or sites of care to publish price information.

The shortcomings in the hospital rule were highlighted by litigation filed by the American Hospital Association and other parties on December 3, 2019. Among other arguments, the plaintiffs make a First Amendment claim: that prices negotiated between hospitals and insurers have always been considered proprietary trade secret information the disclosure of which can be justified only if the disclosure advances a substantial governmental interest and the disclosure is narrowly tailored for that purpose. DHHS notes in response to the trade secrets argument that not only are the negotiated rates available to patients through EOBs, but "price transparency vendors" and "private entities that use crowdsourcing efforts" can gain access to the same information, as well as states that publish negotiated rate information. As to whether the rule is "narrowly tailored," the government seemingly concedes the point that the hospital rule provides a rather blunt instrument; at one point, DHHS says that disclosure of "standard charges" is "merely a necessary first step" in empowering health care consumers with price information.

Plaintiffs in the AHA case also argue that such disclosures would hamper rather than promote price competition since price negotiations would no longer occur in private. In the hospital rule, DHHS seems skeptical of this argument; it quotes a study as follows: "concealing negotiated price information serves little purpose other than protecting dominant providers' ability to charge above-market prices and insurers' ability to avoid paying other providers those same elevated rates." This language echoes the findings of the Massachusetts Health Policy Commission in its 2016 Cost Trends Report: "the HPC found that hospitals with higher market shares and those with certain large system affiliations tend to have higher inpatient prices that are not tied to increased quality . . .. The HPC also found that while some variation in pricing may support activities that are beneficial to the Commonwealth (e.g., provision of specialized services or stand-by capacity), much of the variation in inpatient hospital prices is likely unwarranted and reflects the leverage of certain providers to negotiate higher prices with commercial insurers." It is in the government's consideration of the effects of the rule on competition that the focus on the rule's benefits shifts from patients to others.

The anticipated benefits stemming from the disclosure of hospital negotiated charges accrue less to the "patient" than to the "general public." This is seen in the government's apparent expectation that the disclosed negotiated rate information will spur the development of "consumer-friendly price transparency tools." The importance to the government of the development of such tools is reflected in the fact that the hospital rule deems hospitals that offer "online price estimator tools that provide real-time individualized out-of-pocket cost estimates" to have met the regulatory requirement to publish charges for "shoppable services." DHHS notes in the preamble to the hospital rule: "While we cannot discount the possibility that some consumers may find required hospital data disclosures confusing, we believe that the vast majority will find the increased availability of data, especially as it may be reformatted in consumer-friendly price transparency tools, overwhelmingly beneficial." Here the government seems to contemplate the advent of healthcare-related websites along the lines of those that today exist in the travel, dining and hotel industries.

Should either or both of these rules come into effect as written, the impact on the health care landscape may be as dramatic as the advent of the Affordable Care Act. Initially it would appear those impacts will accrue to the benefit of health insurers and the creators of price comparison tools. Disclosure of privately-negotiated hospital prices in the concentrated eastern Massachusetts market might have dramatic effects beneficial to smaller and community-based hospitals and other lower-costs sites of care. More broadly, making negotiated prices public may reduce price disparities among providers and require them to compete on other terms, such as quality and convenience. Ultimately, diffusion of out-of-pocket cost information to the general public prior to service delivery through truly effective cost estimator tools concerning a broad range of items and services might finally effectively change individual patients' behavior and turn them into true health care "consumers."

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