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CMS Price Transparency Push Trails State Initiatives

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As we charge into 2019, price transparency continues to be a cornerstone of federal health care policy geared toward lowering the price of health care — but more data does not necessarily lead to more information.

In fact, although the requirement to publish chargemasters is currently in effect, the federal initiatives continue to trail behind a number of enactments in states around the country.

CMS Guideline to Publish Chargemasters

Hospital chargemasters have been available online for about a month now under the Centers for Medicare & Medicaid Services' implementation of Section 2718(e) of the Public Health Service Act enacted by the Affordable Care Act, which requires each hospital operating within the U.S. to publish a list of the hospital's standard charges for items and services provided by the hospital.

CMS issued guidelines in the fiscal year 2019 Medicare Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Long-Term Care Hospitals final rule, directing hospitals to publish their standard charges in "machine-readable" format on the internet and update the information at least

annually. But it remains to be seen whether such data will really contribute to the type of transparency consumers need to effectively shop for health care.

More data is available, yet information to help consumers make informed decisions about health care still is a challenge. The transparency mandate may be seen as a step in the right direction, but several important issues have been brought to light recently:

- Data may not be in a format that the average consumer can understand.[1] The actual mandate was vague in its requirement to publish “standard charges” in machine-readable format. CMS did not define “standard charges” for the purposes of the mandate.[2]
- Chargemaster information does not tell a patient what their out-of-pocket expenses will be if they have insurance. The data disclosed by hospitals does not capture negotiated rates with payers, nor does it account for the complex variations in health plan coverage.
- Actual services provided and charges may depend on a variety of nontransparent factors such as determinations of co-morbidities, severity, physician preferences and other patient-specific health factors that are difficult to foresee.

CMS Administrator Seema Verma has acknowledged[3] in a tweet that the information is not “patient-specific,” but that the mandate “is an important first step & sets the stage for private third parties to develop tools & resources that are more meaningful & actionable.” Verma also started a Twitter campaign[4] asking individuals to report to her via Twitter with the hashtag #WheresThePrice if they cannot find a hospital’s chargemaster.

A 2010 Florida appellate court case illustrates how even a court may not view the chargemaster rate as a realistic determinant of what is charged. The case grapples with how a hospital charge for emergency medical services could be set under a Florida statute that limits provider reimbursement to out-of-network health maintenance organizations to the lesser of the provider’s charges, or the usual and customary charges for similar services in the community.

In Baker County Medical Services v. Aetna Health Management,[5] the court rejected the provider’s argument that “usual and customary charges” include only amounts billed or the chargemaster rates. On the contrary, the court interpreted the statutory language to mean that “usual and customary charges” include amounts billed and amounts received by the provider for payment of similar services (with the exception of amounts paid by Medicare or Medicaid) — the fair market value of the services.

At the federal level, the question remains just what other steps are likely to be taken. Legislative proposals have been and continue to be made, but at this point, they do not appear to be moving forward with any clear prognosis as to their timing or ultimate outcome.

State Price Transparency Initiatives

Although the CMS mandate became the first national requirement to publish chargemasters, the idea of making charges available to patients is not new; some states have required disclosure of pricing information for years. For example, since the early 2000s, California hospitals have been required to submit chargemasters, a list of average charges for 25 common outpatient procedures, and the estimated percentage increase in gross revenue due to price changes each July for publishing on the state agency website.[6] The data submitted is in a much more readable format — namely, the services corresponding to the charges are written in plain language.

Massachusetts paved the way with its 2012 law (Chapter 224 of the Acts of 2012, "An Act Improving Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency, and Innovation") requiring insurers to provide, upon request, the estimated amount the insured will be responsible to pay for proposed admissions, procedures or services with the information available to the insurer at the time. The law required providers to disclose the charge for the admission, procedure or service upon request by the patient within two working days. This statute is interesting because it is directed toward enabling patients to understand what their personal out-of-pocket expenses might be, rather than an objective chargemaster price that does not take into account an individual's insurance coverage.

More recently, in 2018, Colorado enacted the Transparency in Health Care Prices Act (S.B. 17-065).[7] This law requires hospitals to post the prices of the 50 most used diagnosis-related group codes, and the 25 most used outpatient current procedural terminology (CPT) codes or health care services procedure codes with a plain-English description (not defined) of the service and to be updated at least annually.[8]

"Health care price" is defined to mean the price charged to a patient before negotiating any discounts, and does not include any amount that may be charged for complications or exceptional treatment or the amount charged if insurance covers any portion of the services.[9] The statute specifically provides that the price may be determined from (1) the price charged most frequently for the service during the previous 12 months; (2) the highest charge from the lowest half of all charges for the service during the previous 12 months; or (3) a range that includes the middle 50 percent of all charges for the service during the past 12 months.

Insurers and providers are not the only key players being required to submit price data. Oregon passed a sweeping drug price transparency law (H.B. 4005, 2018)[10] that requires drug manufacturers to report certain price or cost information, including, the net percentage increase in the price of the drug from the previous calendar year, the factors that contributed to the price increase, and the direct costs incurred by the manufacturer to manufacture, market, distribute and research the ongoing safety and effectiveness of the drug. In addition, manufacturers must report the profit attributable to the prescription drug during the previous calendar year, as well as the introductory price when it was approved for marketing by the U.S. Food and Drug Administration and the net yearly increase in price of the drug for the previous five years.

Policymakers continue to seek ways to make health care prices more transparent, but the real issue is not a lack of data, it is a lack of information. The recent CMS mandate shines a national spotlight on price transparency initiatives but falls short of truly enabling patients on a national scale to make informed financial decisions about health care. State initiatives have and continue to be more effective in cultivating health care price information for patients.

Other Recent Developments on Price Transparency Policies

At the end of 2018, the Health Resources and Services Administration announced[11] it would move the effective date of its final rule to implement civil monetary penalties for manufacturers who knowingly and intentionally overcharge a 340B-covered entity beyond the ceiling price for covered drugs to Jan. 1, 2019. The rule requires 340B manufacturers to disclose the maximum per-unit ceiling price to hospitals for covered drugs on a website only available to participating hospitals and providers.

Lastly, the U.S. Department of Health and Human Services' Office of Inspector General recently proposed changing the Anti-Kickback Statute safe harbors for drug discounts.[12] The rule would eliminate protection for certain drug manufacturer rebates to pharmacy benefit managers, Medicare Part D plans and Medicaid managed care organizations, in favor of new safe harbors to give drug discounts directly to patients and for fixed-fee arrangements between pharmacy benefit managers and drug manufacturers.

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[1] here.

[2] 83 Fed. Reg. 41144, 41687 (Aug. 17, 2018).

[3] here.

[4] here.

[5] Baker Cty. Med. Servs. v. Aetna Health Mgmt., Ltd. Liab. Co., 31 So. 3d 842 (Fla. Dist. Ct. App. 2010)

[6] here.

[7] here.

[8] Colo. Rev. Stat. § 25-49-101 et seq.

[9] Col. Rev. Stat. § 25-49-102.

[10] here.

[11] here.

[12] here.