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The Cost of Cost Transparency for Hospitals

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07.01.2019

Background

As healthcare reform continues to be a dividing issue in Washington, both sides seem to agree on at least one element: price transparency. Trump's executive order was issued on Monday (June 24, 2019). It is part of a bipartisan effort in Congress to lower healthcare prices and improve price transparency for patients. However, the executive order has a specific focus that has not in the past been the target of healthcare price reform: transparency in the negotiated rates between hospitals and insurance companies.

The executive order aims to help patients compare prices for "shoppable" healthcare services, which are those that are offered commonly and by multiple providers. It also intends to protect patients from "surprise billing," which is when patients receive higher than expected bills from out-of-network providers which they had "no opportunity to select in advance." As part of this, the executive order also aims to go one step further than requiring price transparency by offering patients "proper incentives" to seek information about the price of their healthcare services.

Summary of Trump's Executive Order

The stated purpose is "enhance the ability of patients to choose the healthcare that is best for them" and to allow patients to "know the price and quality" of healthcare services in advance in order to make fully informed decisions.

The executive order intends to shine a light on the "opaque pricing structures" between hospitals and third-party payors. In an ideal world, price transparency for patients would work to ultimately lower prices by allowing them to "shop" around for the lowest price. It follows an executive order issued by the White House in October 2017 which recommended price and quality transparency initiatives to allow patients to make well-informed decisions about their care (October 12, 2017). The characteristics of "effective price transparency" listed in that order, and cited in new executive order, include (1) distinguishing between the charges billed by

providers and the rates negotiated between payors and providers; (2) giving patients proper incentives to seek information about the price of healthcare services; and (3) providing useful price comparisons for "shoppable" services. These are services that are "commonly offered by multiple providers throughout the market," which according to the executive order make up a significant share of the healthcare market.

The new executive order calls for HHS and other federal agencies to propose certain regulations and issue certain reports within a stated time period. Among these are:

1. The Secretary of the Department of Health and Human Services (HHS) HHS must propose a regulation within 60 days which requires hospitals and doctors employed by hospitals to publicly post and regularly update their "actual prices." This includes standard charges as well as the discounted rates they negotiate with insurers. By requiring the reporting of "actual" prices, the executive order emphasizes that out-of-pocket costs to patients should be the prices disclosed. While many providers in the industry boast price transparency, the prices posted are rarely the final billed charges to patients, because the rates that providers negotiate with insurance companies and the government are often significantly lower than the "chargemaster" price which the provider views as "full-price." The executive order specifies that this information must be easy to understand and consumer-friendly. HHS also must include a mechanism to ensure compliance with this posting requirement.

1. Within 90 days, the Secretaries of HHS, the Department of the Treasury, and the Department of Labor departments must solicit public comment on how to require insurers and providers to "provide or facilitate access to information about expected out-of-pocket costs for items or services to patients before they receive care." This is not as strong of a directive – the agencies need only ask for public comment at this time - but shows a focus on making sure patients are able to access the reported information.
1. Within 180 days, HHS and other agencies must increase access to de-identified claims data from all payors in a way that ensures privacy. The idea is not only to increase patients' power to make healthcare decisions but to enable researchers to identify opportunities for improvement.

1. The Secretary of HHS, along with the heads of the Department of Justice (DOJ) and the Federal Trade Commission (FTC), must issue a report with recommendations on how "eliminate impediments to healthcare price and quality transparency in a way that promotes competition." Since the DOJ and FTC are the antitrust enforcement agencies, this could target provider consolidation. Once this report is issued, it will be clearer whether the government is focused on consolidation or other issues it views as barriers to price and quality transparency.
1. HHS must submit a report on other ways to eliminate "surprise medical billing."

1. HHS along with the secretaries of Defense and Veterans Affairs must create a "health quality roadmap," which lays out a strategy for developing common quality measurement techniques across government payors, aligning inpatient and outpatient measures, and eliminating low-value quality measures
1. The Treasury Department must issue guidance expanding health savings accounts. Health savings accounts are a type of tax-protected account that people use to pay medical bills and are used to cover low-cost preventative care under alongside a high-deductible health plan. The guidance must "expand the ability of patients to select health savings accounts." In addition, it must allow more funds to be carried over from a health savings account to a flexible spending arrangement without penalty at the end of the year (currently, up to $500 in unused funds can be carried over from one plan year to the next). The guidance is also directed to expand the definition of "eligible

medical expenses" under Section 213(d) of the Internal Revenue Code which will incentivize patients to use health savings accounts. Withdrawals from health savings accounts are treated as tax-exempt if they are used to cover qualified medical expenses under 213(d). Health savings account withdrawals cannot generally be used to fund insurance premiums. Health savings accounts are exempt from taxes because they give patients an incentive to pay providers directly, putting pressure on the healthcare market and less leverage to third party payors. This is the same fundamental idea behind the executive order. Using health savings accounts these to fund insurance premiums is in contravention to their original purpose. However, the new regulation must include expenses related to arrangements such as direct primary care arrangements and healthcare sharing ministries as part of "eligible medical expenses." Direct primary care arrangements are those in which a consumer pays a regular fee to have regular access to basic primary care services, rather than the typical arrangement in which the doctor bills a payor for services rendered. Since the arrangement won't cover emergencies, major medical problems, prescription drugs, or other services outside of primary care, patients still need insurance coverage. They are becoming more and more popular, and advocates for these arrangements argue that regular fees for direct primary care arrangements should be eligible for HSA reimbursement; however, the IRS has opined that these regular fees are not "qualified medical expenses." The executive order takes the opposite opinion. Similarly, health care sharing ministries are arrangements in which members of a religious group pool their assets through monthly payments to cover the medical expenses of other members. They are regulated by many states as health insurance and have often been shut down or warned for operating as unlicensed insurance producers. Fees paid to these arrangements would normally be disallowed for HSA reimbursement, but the executive order states otherwise.

1. Finally, the executive order calls for a "claims database" to be established within 180 days for research and analysis purposes, which will track patients' health care and payment history. It must protect patient privacy.

What Providers Need to Know

There is no immediate change triggered by the executive order. However, look for HHS and other federal agencies to propose regulations in the near future. The regulations, reports, and proposals are all required to be issued by the federal agencies within the next 60-180 days, so look for details on all of these requirements in the near future. The charges issued by the executive order were very vague, so we will need to wait for published regulations to understand what exactly will be required:

→ What is "standard charge information" – is this information per patient, per charge, or some other measurement? Will this be up to the hospital to decide? How often will this need to be updated?

→ Is the federal government cracking down on the consolidation of healthcare entities as part of its approach to consumer transparency and price reduction?

→ How will "surprise medical billing" be reduced in other ways?

→ In what format hospitals will be required to report? The requirement that the information be "easy to read" and "user friendly" is likely a response to criticisms of hospitals' posting of chargemasters, which are complex and obscure and normally reflect tens of thousands of billing codes for individual services that only experienced medical and billing professionals would be able to understand. In addition, a patient is rarely billed using only one billing code from a chargemaster after a trip to the hospital; therefore, consumers' access to these lists is unlikely

to actually drive consumer choice.

Hospitals should prepare for big surprises. When CMS required hospitals to post their "chargemasters" (which include only hospitals' base prices before any negotiated or discounted rates) in January of this year, the transparency exposed surprising fluctuation between charges, even for hospitals within the same cities. Never before have doctors and hospitals been required to post their discounted rates negotiated with insurers. This requirement could have a serious impact on hospitals. Already, members of the hospital and insurance industries have raised some concerns:

1. Antitrust concerns and price fixing concerns- Rather than decreasing prices, some hospitals may start driving up their prices when they realize they were charging less than competitors – opponents of the executive order often cite a 2003 study involving the ready-mix concrete market in Denmark that analyzed prices after the government required concrete-makers to disclose negotiated prices with customers. Prices increased 15-20 percent, and experts believe it was due to collusion. Hospitals will need to prepare for increased antitrust scrutiny and brush up on the rules against price fixing.

2. Concerns about proprietary contracts and competition among hospitals and payors.

3. Concerns about the protection of patient privacy as more information is made public by hospitals.

4. Concerns about turning the complicated healthcare industry into a "business of selling a service or commodity," as healthcare decisions have deeper and lifelong consequences for patients and families and should not be treated like other consumer industries, according to some hospitals. See Odette Bolano, Understanding Cost Transparency from the Perspective of a Catholic Health System, THE IDAHO STATESMAN (Jan. 28, 2019) https://www.idahostatesman.com/opinion/readers-opinion/article225205395.html.

Many state laws and hospital associations have attempted to enforce price transparency in recent years, but have had difficulty with hospital compliance. And, hospitals have never been required to drill down to their actual billed prices – this could be costly as it could involve a new method of tracking and reporting charges.

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