HHS Rule Could Disrupt How Hospitals And Insurers Set Rates

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The most recent proposal in a series of efforts by the Trump administration to increase price transparency in health care is one that may eventually require hospitals and providers to publicly disclose the payer-negotiated rates charged to insurers for health care services.

On March 4, 2019, the U.S. Department of Health and Human Services released a proposed rule on health care information technology. This proposed rule was issued to implement provisions in the 21st Century Cures Act, a bipartisan law passed by Congress in 2016 that sought to encourage innovation and technological acceleration in the health care industry. A large part of the legislation aimed to change requirements for electronic health records to encourage interoperability between doctors and hospitals — so that one health care provider with an electronic health system could communicate electronically with another provider with a different electronic system. Most of the proposed rule lays out technical guidelines for how providers should accomplish this goal.

Buried in the 700 pages of text, however, HHS officials tucked in potentially explosive questions about the publication of payer-negotiated rates — information that has historically been seen as commercially sensitive and proprietary. These questions show that the administration is willing to push the envelope in the name of transparency, and past actions give an indication of just how far the administration may go.

The proposed rule specifically asks, “If price information that includes a provider’s negotiated rates for all plans and the rates for the uninsured were to be required to be posted on a public website, is there technology currently available or that could be easily developed to translate that data into a useful format for individuals?”

It also asks, “Should price information be made available on public websites so that patients can shop for care without having to contact individual providers, and if so, who should be responsible for posting such information?”

Currently, prices for medical procedures are privately negotiated between hospitals and insurance companies and are kept confidential. The American Hospital Association opposes making negotiated prices public, and argues that it would cut competition, not enhance it. The AHA argues that consumers instead want information on what their out-of-pocket costs will be.

A February 2019 Health Affairs analysis on hospital prices found that most health care inflation comes from rising prices for hospital care. By analyzing growth in prices for inpatient and hospital-based outpatient services using negotiated prices paid by insurers, the study found that between 2007–2014, hospital prices grew by 42% compared to 18% for physician prices. For

hospital-based outpatient care, prices grew 25%, compared to 6% for physicians. Annually, on average, hospital prices have increased by 5%, which ends up incorporated in insurance premiums.

The proposed rule indicates the administration's reasoning behind asking these questions about disclosing payer-negotiated rates. HHS states that transparency in pricing will ultimately lead to lower costs by (1) empowering patients to make informed health care decisions and (2) increasing competition that is based on the quality and value of the services patients receive. The proposed rule blames the "fragmented and complex nature of pricing" for inefficiency of the health care system and negative impacts on patients, providers and other stakeholders.

The proposed rule states that HHS is considering future rulemaking to "expand price information for the public, prospective patients, plan sponsors, and health care providers." The comments received by HHS will inform future policy changes related to the public disclosure of negotiated rates. At the request of stakeholders, including health care provider organizations and industry representatives, HHS extended the public comment period by 30 days, which now closes on June 3, 2019. The proposed rule has received 237 comments to date — but will likely receive more as the deadline approaches.

How Did We Get Here?

The questions asked in the proposed rule are the latest in a string of policy initiatives aimed at increasing transparency in health care pricing.

In October 2018, HHS proposed that drug-makers that advertise drugs through direct-to-consumer television advertisements include the list price of the drug in the ad. HHS noted that the 10 most commonly advertised drugs have list prices that range from $535 to $11,000 per month. While drug-makers argued that the list price is not a meaningful number because most consumers do not pay the list price, HHS argued that many Americans have high-deductible plans and pay the list price until the deductible is met and insurance will cover the cost.

In August 2018, the Centers for Medicare & Medicaid Services (CMS) issued a rule requiring hospitals to post standard charges, or the "chargemaster" online, effective Jan. 1, 2019. A hospital "chargemaster" is the master list of prices for the 100 most common Medicare inpatient hospital services.

Hospitals have argued that the list prices for services are meaningless for patients since those that have insurance will not pay the "sticker price." The administration, however, believes that posting prices publicly will lead to more transparency and that could ultimately reduce costs for patients.

CMS Administrator Seema Verma has acknowledged that the agency has no way to enforce the posting of hospital chargemasters online, but in the absence of enforcement tools, launched a Twitter campaign to hold hospitals accountable for their lack of compliance called #WheresThePrice.

On Jan. 18, CMS Administrator Seema Verma launched her #WheresThePrice challenge on Twitter, urging individuals to visit their local hospitals' websites, look for their pricing information (chargemasters) and if it is not publicly available, tweet @SeemaCMS #WheresThePrice. The Twitter challenge has had mixed results, though responses from consumers and advocates have been largely positive. The primary criticism from hospitals has been that list prices do not paint an accurate picture as provider negotiations with insurance companies are not factored in to what is posted online. CMS sees full public disclosure as a first step in their transparency initiative.

#WheresThePrice has gained significant traction on social media with an estimated reach of over 90,000 and over 91% positive mentions. Some of these tweets of noncompliance, however, appear to be a result of consumers not fully investigating hospitals' websites or hospitals publishing chargemasters in obscure places and using abbreviations, billing codes and medical terminology that most patients are unable to understand.

Despite this, there is evidence that hospitals are feeling pressure. On April 10, Memorial Healthcare System responded to Verma's tweet writing, "Memorial Healthcare System provides prices for common medical procedures. Self-pay rates and insured rates are available," and on Feb. 8, American College of Physician Advisors wrote, "We would like to know too! Chargemasters do not show anyone how much the cost of services are since it's different depending on insurance coverage or lack thereof."

The administration's recent request for comment on publishing payer-negotiated prices goes one step further. Not only would hospitals be compelled to publish the "sticker price" for popular Medicare services, but they would have to publish the actual rates that they negotiate with insurers.

What Happens Next?

While Don Rucker, the HHS national coordinator for health IT, has stated that they have had extensive discussions with the White House on this issue, many insurers and hospital groups have been unaware or are currently examining the proposal more closely.

Currently, the prospect of mandated hospital price disclosures is unlikely to result in real rulemaking, since it was not formally proposed in the proposed rule. Rather, HHS took an intermediate step by seeking comment to inform future rulemaking. Further, a policy mandating disclosure of payer-negotiated rates might require congressional action and could result in legal action by many hospital and physician groups including the American Hospital Association and the American Medical Association.

According to some policy experts, hospital price transparency alone is not expected to result in lower overall health care spending or lower prices for consumers, since patients typically have little to no choice in selecting their hospital, and many consumers do not look at the price of health care services before accessing care. Ultimately, the negotiating power lies within insurance companies and physicians.

The administration and Congress, however, have consistently emphasized increased transparency itself as a policy goal. There also seems to be more bipartisan support for increased transparency in health care prices than other health care policy areas. The House

of Representatives has recently considered a number of transparency initiatives regarding the price of drugs, and the Senate has consistently named fixing surprise billing as a top priority for legislative action this year. Surprise billing occurs when individuals with insurance coverage receive large bills, not covered by insurance, from out-of-network providers.

The request for comment on publishing payer-negotiated rates is a signal that the administration is serious about moving the needle toward price transparency, and that the administration believes that it will ultimately lower patient costs. It is likely there will be future rulemaking from the administration in this space, and the agencies will use comments received during the comment period for this rule to inform future rulemaking.

As the rule noted, “increased consumer demand, aligned incentives, more accessible and digestible information, and the evolution of price transparency tools are critical components to moving to a health care system that pays for value.” Industry stakeholders should continue to monitor the administration’s moves in this space, and should pay close attention to the administration’s analysis of the comments on payer-negotiated rates when the final rule is published.

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