Insight

Primer: Recent Health Care Transparency Initiatives

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Executive Summary

- While the Biden Administration has touted its efforts to roll back Trump-era policies, it appears aligned with the previous administration's efforts to boost transparency in the health care sector, and specifically for hospitals, insurers, and drug prices.
- Advocates for these rules argue that they will empower patients and constrain health care costs by increasing competition and exposing profiteering, while critics contend transparency will do little to aid patients already constrained by insurer networks and will encourage consolidation.
- It is too early to determine whether the Trump Administrations actions will have the cost-containing impact advocates predict or will instead disrupt health care markets and lead to consolidation as opponents argue.

Introduction

While the Biden Administration has openly touted its efforts to roll back Trump Administration policies, there is at least one area where the two appear aligned: health care transparency. President Trump issued an executive order in 2019 ordering the Department of Health and Human Services (HHS) to propose regulation requiring hospitals to disclose standard charge information, including negotiated rates and prices of shoppable items and services between insurers and health care providers. As a result of this executive order, a number of Departments issued rules regarding hospital and insurer transparency with both rules also including drug pricing transparency provisions. President Biden's HHS Secretary, Xavier Becerra, has expressed his support for health care price and quality transparency, indicating these Trump Administration initiatives could have staying power.

Nevertheless, while these efforts appear to have bipartisan support, some parties have raised objections, and evidence thus far does not clearly support the rules' efficacy. This primer explains the most prominent actions on transparency that the Trump Administration took and outlines the available evidence around their impact and some objections that have been raised.

Hospital Transparency

In response to Trump's 2019 executive order, HHS along with the Departments of Treasury and Labor finalized their hospital transparency rule in November 2019. The objective was to enable consumers to seek more affordable health care options by requiring hospitals to publicly disclose "standard charges." Specifically, hospitals must publicly disclose, in a machine-readable[1] and consumer-friendly format, five types of charges for their 300 most shoppable services: gross charges, discounted cash prices, payer-specific negotiated charges, deidentified minimum negotiated rates, and deidentified maximum negotiated rates.

The American Hospital Association (AHA) challenged the final rule in the U.S. District Court for the District of

Columbia on December 4, 2019, arguing that negotiated rates between various stakeholders is confidential information. Additionally, the AHA stated that the requirement for hospitals to disclose "standard charges" did not equate to "negotiated rates," because negotiated rates are privately set, non-standard rates by nature.[2] The court ruled in favor of the Trump Administration and allowed the hospital transparency rule to take effect January 2021. The Centers for Medicare and Medicaid Services (CMS) has since outlined a process for addressing noncompliance. If the hospital violates one or more of the rule's provisions, CMS will require a Corrective Action Plan (CAP) to achieve compliance. Additionally, if the hospital fails to submit a CAP, the hospital will then be charged a civil monetary penalty of no more than $300 per day (or $109,500 annually), and a list of facilities in violation will be publicly published on the CMS website.

The Trump Administration estimated the total cost of the hospital transparency rule to be $328.6 million—borne predominantly by hospital systems—and that it would result in an increase in paperwork hours of 900,300.

Evidence on the impact of hospital transparency is limited. One potential source is state-level transparency initiatives. As of May 2020, only six states required providers, health plans, or both to make available all estimated costs and pricing information. Additionally, 11 states required price estimates under specified circumstances, while 33 states had no health care transparency laws at all.

In a study published in *Health Affairs*, researchers mounted an online publicity campaign to drive awareness of New Hampshire's public price transparency website. The campaign resulted in a 600 percent increase in site visits, but health care consumers nevertheless largely remained with their current providers. *Health Affairs* concluded that the minimal success of price transparency tools in reducing health care spending thus far is driven by structural factors limiting a consumer's ability to utilize the pricing information, not a lack of awareness of the tools in place. In other words, pricing information is of limited utility to patients given that they are largely limited to the rates negotiated by their own insurer.

At the federal level, a February 2021 report by Turquoise Health—a new health care comparative tool that pulls each health care provider's estimated costs for comparison of providers in a consumer's area—estimated only 2,000 hospitals were highly compliant with the federal transparency rule out of nearly 6,000 hospitals reviewed.

According to a February 2021 report from *Medical Economics*, as hospitals work to integrate transparency through utilization of new software, consumers are still encountering barriers to accessing accurate health care cost estimation, potentially putting the hospitals at risk for corrective action. To achieve transparency, many hospitals are using a specific tool, the MyChart price estimator, that requires consumers to enter their personal and insurance information to provide accurate estimates but does not allow them to view a cost estimate without their insurance policy information. The report identifies 10 additional reasons that hospitals may be in violation of the rule and suffer the consequences including:

- Downloadable spreadsheets and price estimator tools are non-existent or impossible to find;
- The hospital only lists chargemaster rates, not the cash or negotiated rates from all payers;
- The hospital only lists the cash rates, or only lists chargemaster rates and tells the consumer to calculate the cash rate based on a percentage discount;
- The hospital only lists the deidentified maximum and minimum negotiated rates;
- The hospital only lists the Diagnosis-Related Groups (DRGs) and not Current Procedural Terminology (CPT) codes;
- The hospital does not include ancillary fees that would typically be part of a particular procedure or DRG;

- The hospital does not allow the consumer to see the negotiated rate without entering his or her policy number;
- The hospital lists only the supply costs;
- The hospital uses only internal codes and not searchable CPT codes; and
- The hospital provides downloadable files but no user-friendly format or price estimator tool for shoppable services.

Additionally, under Section 2718(e) of the Public Health Service Act, CMS is unable to enforce this rule on ambulatory surgery centers (ASCs) and physicians not directly employed by the hospital. Some suggest this rule could push hospitals to direct outpatient procedures to ASCs and thus recommend minimizing incentivization for hospitals to direct surgeries to ASCs as a means to avoid public disclosure of these charges.

The publicity around transparency requirements has driven curiosity about health care costs, but the magnitude of the impact that hospital price transparency has had on consumer decision-making or the health care market broadly are not discernible yet.

Insurer Transparency

In response to the Trump executive order from 2019, CMS also finalized the "Transparency in Coverage" rule in October 2020. The rule requires insurers and plans to disclose cost-sharing estimates at the request of a consumer and to publicly release negotiated rates for in- and out-of-network rate history and drug pricing information. This final rule anticipates insurer transparency will enable consumers to estimate their cost-sharing prior to receiving health care, encouraging cost-comparisons for competition between providers, similar to the goal of the hospital transparency rule. The specific elements that a plan or insurer are required to disclose to the consumer are as follows.

- *Estimated cost-sharing liability*: This includes estimates of the cost-sharing liability for services or items rendered by certain providers.
- *Accumulated amounts*: This is the amount of financial responsibility that a participant, beneficiary, or enrollee has incurred at the time the request for cost-sharing information is made, either with respect to a deductible or an out-of-pocket limit.
- *Negotiated rates*: Required to be expressed as dollar amounts, this is the amount a plan, insurer, or third party on behalf of a plan or insurer has agreed to pay an in-network provider for covered items and services so long as it complies with the terms of their contractual agreement.
- *Out-of-network allowed amounts*: This figure is relevant when a participant, beneficiary, or enrollee requests cost-sharing information for an item or service covered under his or her insurer but delivered by an out-of-network provider.
- *Items and services content lists*: This list of covered items and services for which cost-sharing information is disclosed is relevant when a participant, beneficiary, or enrollee requests the cost-sharing information for an item or service that is subject to a bundled payment arrangement.
- *A notice of prerequisites to coverage*: When applicable, notice to the individual that a prerequisite—meaning medical requirements satisfied prior to a plan or insurer offering coverage of another item or service—may be necessary when requesting cost-sharing information of a specific item or service.
- *A disclosure notice*: This notice includes a statement to consumers advising them of their potential exposure to balance billing.[3]

The Transparency in Coverage final rule also includes two methods for facilitating the accessibility of health care pricing information for consumers and stakeholders. First, the rule requires non-grandfathered group health plans—those plans that are subject to the Affordable Care Act's (ACA) insurance regulations—as well as health insurers offering non-grandfathered coverage within individual and group markets to display out-of-pocket costs and negotiated rates for all health care items and services, including prescription drugs. HHS will also require an initial list of 500 shoppable services available through an online, self-service tool for plan years beginning January 1, 2023, with the remainder of items and services required to be disclosed for plan years beginning on or after January 1, 2024. Second, the final rule requires non-grandfathered plans to publicly disclose costs using three separate machine-readable files: one file showing negotiated rates for covered items and services, the second displaying historical payments and billed charges of out-of-network providers, and the third detailing historic net prices as well as in-network negotiated rates for all prescription drugs as covered by health plan or insurance by pharmacy location.

The final rule also amended the ACA's Medical Loss Ratio (MLR), allowing insurers to claim credit for "shared savings payments" made to a consumer who selects a more affordable, yet higher quality provider. The intention of modifying the MLR is to ensure that insurers are not required to pay MLR rebates as a result of a plan design that provides health benefits to consumers not captured in existing MLR revenue or expenses.

The Trump Administration estimated the total cost of the Transparency in Coverage rule to be $34.5 billion, and that it results in an increase in paperwork hours of 53,210,971. These costs are expected to be borne primarily by health plan issuers and third-party administrators. As a result, federal spending on premium tax credits is expected to increase per year due to an estimated increase in insurance premiums in the individual market by the following:

- $1,047 million in 2022;

- $623 million in 2023;
- $216 million in 2024; and
- $218 million in 2025.

The Trump Administration's transparency efforts were met with opposition from insurers and major health organizations, but all sides appear to agree on the need for patients to have access to cost-sharing information. In their comments responding to the Transparency in Coverage proposed rule, the AHA argued that the mandatory disclosure of negotiated rates would lead to confusion among patients and "greater consolidation in the commercial health insurance industry," as well as that it would not lead to more informed decisions regarding health care among consumers. The AHA stated that the negotiated rates were not of importance to the consumer, but disclosure of out-of-pocket expenses would be a more relevant and meaningful measure of cost-comparison.

CMS stood by the perspective that price transparency is crucial to providing consumers with meaningful information at an attempt to control the growth of health care costs. The "Transparency in Coverage" rule is currently slated to and will be fully phased in by 2024. For plan years beginning on January 1, 2022, plans are required to publicly disclose the rates for covered items and services that are negotiated between in-network providers, the historical payments made to out-of-network providers, and this information for all covered prescription drug prices. Additionally, as mentioned, for plan years beginning January 1, 2023, enrollees must have access to cost-sharing information for over 500 shoppable services as well as cost-sharing information for all services for plan years beginning on January 1, 2024.

Drug Pricing Transparency

In order to tackle ever-rising drug prices, some researchers have urged greater drug pricing transparency and emphasized that continuous advancements in health care also lead to greater production of complex medications, thus requiring more testing, and ultimately further increasing spending. The Trump Administration undertook numerous initiatives to expand drug pricing transparency, including four executive orders directing CMS and other HHS agencies to guide increased competition and lower drug costs through the development of new tools, models and regulations—with limited success to date. Congress has also undertaken to address drug prices in recent years without success (the American Action Forum's Tara O'Neill Hayes summarizes some of these efforts here).

The aforementioned Transparency in Coverage final rule included provisions requiring insurers to publish, in a machine-readable format, list prices and historical net prices of prescription drugs, beginning in January of 2022. CMS argued that access to such information will give researchers the ability analyze such data and facilitate creative private-sector solutions and encourage price comparison within the health care market.

Pharmacy benefit managers (PBMs) sit at the center of the prescription drug supply chain and administer prescription drug programs for over 230 million Americans. PBMs attempt to assist patients in accessing necessary prescriptions while saving money, but they have in recent years become a target of criticism. The American Pharmacists Association expressed support for the Transparency in Coverage rule, arguing PBMs actually increase the costs of prescription drugs in many cases. In contrast, the National Association of Chain Drug Stores warned the rule could result in higher drug costs for patients due to disclosure of PBM-negotiated pricing.

Conclusion

Policies to increase transparency in health care costs have become increasingly popular across the political spectrum in recent years. Conservatives, as evidenced by the Trump Administration's rulemaking efforts, see transparency as crucial to bringing greater marker forces to bear on rising health care costs. Progressives, on the other hand, are more suspicious of private sector actors in the health care industry and see transparency as exposing profiteering to sunlight. Broadly speaking, transparency is a good thing, especially in complicated transactions involving expensive goods or services. Even in uncomplicated transactions, knowing the various prices facilitates an effective marketplace.

At the same time, patients are constrained in their ability to utilize pricing and outcomes data. Patients can still only go to the providers in their network to get the negotiated prices, and they will still have to pay the same negotiated rate regardless of what other insurers have negotiated. As pricing arrangements become public, prices are likely to equalize. It's not guaranteed, however, that the lowest price previously available will be the one that the market settles on. Shining light on the various discounts insurers negotiate is more likely to lead to fewer discounts than to more people getting them.

For the moment, the Biden Administration seems likely to continue the Trump Administration's policies on health care transparency, or even expand them. But in the near term, the effectiveness of these policies will be difficult to ascertain.

[1] Machine-readable files are digital representations of data or information in a file that can be imported or read into a computer system for further processing.

[2] https://affordablecareactlitigation.files.wordpress.com/2019/12/hospital-groups-lawsuit-over-illegal-rule-mandating-public-disclosure-individually-negotiated-rates-12-4-19.pdf-.pdf

[3] Balance billing refers to the practice of providers billing patients for the difference between the providers' billed charges and the sum of the amount paid by the plan or issuer and the amount collected from the patient initially in the form of required cost sharing.