The continuing saga of Hospital Price Transparency and surprise billing

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Introduction

On Jan. 1, 2021, the Hospital Price Transparency final rule became effective after several years of debate, and less than successful administrative efforts. Hospital price transparency, and the "surprise medical bills" emanating from the lack of that transparency, seem to have been problems for decades, arising from two sources:

1. Third-party insurer contracts with hospitals, and

2. Hospital exploitation of individual patient responsibility connected to lack of third-party insurance coverage.

Legal history

1. The Public Health Service Act, which was passed as part of the Affordable Health Care Act in 2010, required hospitals to publicly disclose "standard charges." However, we understand that "charge master charges" have just a remote connection to actual prices.

2. In the 2015 Medicare hospital inpatient fee schedule proposal, the Centers for Medicare & Medicaid Services (CMS) "encouraged" voluntary compliance with this requirement.

3. For FY 2019, CMS announced an update to its guidelines requiring the standard charges to be made available via a machine-readable internet accessible format. CMS explained this initiative under the "Transparency" and "Request for Information" topics in the following link: https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2019-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute-0.

4. On Nov. 27, 2019, HHS and CMS announced a comprehensive regulation implementing the price transparency requirements to be effective Jan. 1, 2021.

Pittsburgh Post-Gazette report

On July 16, 2021, the *Pittsburgh Post-Gazette* published and posted a damning report on this topic noting that, after more than a years' advance notice and nearly seven months after the federal "price transparency" rule requiring all hospitals to post the costs of their medical procedures became law, "scores of some of the largest hospitals in Pennsylvania are still failing to abide by a measure that was created to help change health care in America," reporting as follows:

- A review of Pennsylvania's 163 acute care hospitals found that about three-quarters are failing to follow the rule, either in whole or in part, creating obstacles for consumers who have long waited to have a greater role in their own medical care.
- "Most hospitals are not fully complying by a large percentage," said Cynthia Fisher, a health care advocate credited with convincing former President Donald Trump to create the rule.
- With medical costs driving hundreds of thousands of consumers into bankruptcy each year, the federal government this year unveiled a game-changing rule with the goal to allow people to shop online for health care like buying a car or staying at a hotel by comparing prices. "The data is abysmal."

Origins of problem

The first part of the problem arises because hospitals and other providers have traditionally, for decades, used "charge masters" for billing purposes, with charges many times in excess of either the actual cost or the actual average third-party reimbursement payment. This was done to assure the charge was high enough to exceed the allowable reimbursement from any third-party payor; billing less than the allowable reimbursement would result in collecting less than was possible under the circumstances. The resulting chaos is evidenced by

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every EOB you get; charges for some collection of services is $15,000 and the reimbursement is $982.57.

The second part of the problem impacts patients without third-party insurance company coverage who are not protected by the reimbursement agreement between the third-party insurer and the hospital, leaving the individual technically/legally responsible for the difference, i.e., by resulting in the "surprise bill," which will be addressed later herein.

Additional new rule

Presumably due to the lack of appropriate compliance with existing legal and regulatory efforts, CMS is taking further action.

On July 19, 2021, as part of the 2022 proposed Medicare Physician Fee Schedule, CMS is proposing several modifications designed to increase compliance and reduce the hospital compliance burden beginning Jan. 1, 2022, including the following:

1. Proposed Increase in Civil Monetary Penalties (CMP): CMS proposes to set a minimum CMP of $300/day that would apply to smaller hospitals with a bed count of 30 or fewer and apply a penalty of $10/bed/day for hospitals with a bed count greater than 30, not to exceed a maximum daily dollar amount of $5,500. Under this proposed approach, for a full calendar year of noncompliance, the minimum total penalty amount would be $109,500 per hospital, and the maximum total penalty amount would be $2,007,500 per hospital. CMS is seeking comment on alternative or additional criteria that could be used to scale a CMP such as: hospital revenue; the nature, scope, severity, and duration of noncompliance; and the hospital's reason for noncompliance.

2. Proposing to Prohibit Additional Specific Barriers to Access to the Machine-Readable File: CMS proposes to update the list of activities that present barriers to access to the machine-readable file, specifically to require that the machine-readable file is accessible to automated searches and direct downloads.

CMS also issued two sets of Frequently Asked Questions (FAQs) regarding this rule. Essentially, the guidance states as follows:

- Hospitals are free to choose whatever format they prefer as long as the information represents the hospitals' current standard charges as reflected in their charge masters in a machine-readable format.
- The transparency requirements apply to all items and services provided by the hospitals, including medical services, drugs, biologicals, etc.
- The transparency requirements do not transplant, replace or restrict hospitals from posting any other quality information or additional price transparency information on their websites.

The charge disclosure remains unsatisfactory without some relative baseline. One step that will make this more meaningful is disclosure of the typical Medicare payments for those services, as a reference point. CMS has released an online tool called "Procedure Price Lookup" which may provide some useful price comparisons, stating as follows:

"CMS is committed to addressing significant and persistent inequities in health outcomes in the United States and today's proposed rule helps us achieve that by improving data collection to better measure and analyze disparities across programs and policies," said CMS Administrator Chiquita Brooks-LaSure. "We are committed to finding opportunities to meet the health needs of patients and consumers where they are, whether it's by expanding access to onsite care in their communities, ensuring they have access to clear information about health care costs, or enhancing patient safety."

- https://www.cms.gov/newsroom/press-releases/new-online-tool-displays-cost-differences-certain-surgical-procedures

Surprise billing

Surprise medical billing has been an issue on both a state and federal level for a considerable period of time. The Robert Wood Johnson Foundation published a national report (https://www.insurance.pa.gov/Documents/Balance%20Billing/Kevin%20Lucia.pdf) on the matter in 2015.

The problem usually arises in two circumstances:

1. An uninsured patient is billed standard charges, which may be significantly higher than the provider accepts from federal and commercial third-party payors.

2. Services are either not covered or are only covered at out of network rates.

Pennsylvania does not provide comprehensive protection to patients, although the matter has been the subject of piecemeal protection over the years.

Congress passed the "No Surprises Act" to be effective Jan. 1, 2022, as part of the myriad pandemic protection and mitigation efforts, providing as follows:

- Enrollees in self-insured plans now have a mechanism for dispute resolution over surprise bills.
- The dispute resolution process is "final-offer" arbitration and should moderate offers by both payers and providers.
- Out-of-network providers are restrained in their ability to balance bill.
- Payers and providers are responsible for providing timely cost data to patients for potential services.

Implementing regulations are certain to follow.

Conclusion

Although Hospital Price Transparency and surprise medical billing have generated a lot of "heat" or emotional attention, I believe progress has been limited, if measured in actual action over a period of years, because, despite the significant adverse impact these issues cause, that impact is restricted to a relatively small cohort of individuals, i.e., individuals doing their own price shopping at hospitals and individuals with little or no medical coverage. Third-party insurers and large employer self-insured plans already have access and leverage with respect to negotiating hospital prices; it is the individuals who have large deductibles who are at the biggest disadvantage in selecting hospital providers. Surprise medical bills for out-of-network coverage for individuals who already have adequate health insurance are annoying but not necessarily catastrophic. Significant medical bills for individuals without insurance coverage are catastrophic at almost any level, especially when they are for "charges" rather than the real prices.

Given the significant positive income on few individuals adversely impacted and the relatively small financial impact on the providers, this would seem to be an easy fix.

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