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CLIENT ALERT

Despite Issuance of Final Rule on Price Transparency, Are Health Care Rates Too Complicated to Be "Consumer Friendly"?

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The Centers for Medicare & Medicaid Services ("CMS") recently issued a final rule requiring hospitals to publicly disclose their rates, including negotiated rates with third-party payors regardless of product line, by January 1, 2021 ("Final Rule").[1] The Final Rule's intent is to increase price transparency so that health care consumers can "shop" for health care services. The Final Rule does not exclude any particular type of health plan, product, or line of business, except for rates that are not negotiated (e.g., fee-for-service Medicare or Medicaid).

Hospitals that are deemed non-compliant are subject to fines of up to $300 per day, up to a maximum of $109,500 per year.

The Final Rule has been subject to pushback from hospitals. Most notably, on December 4, 2019, the American Hospital Association, joined by other industry groups, filed a lawsuit against CMS in federal court over the Final Rule. The plaintiffs assert that the Final Rule exceeds the scope of the Patient Protection and Affordable Care Act, which provides the basis for the rule, and violates the First Amendment by compelling speech, among other reasons.

This Client Alert will address the overall scope of the Final Rule and illustrate the challenge of making a hospital's negotiated rates "consumer friendly" for individuals shopping for health care services.

There is a similar, but proposed, rule regarding price transparency requirements that would be applicable to payors (including self-funded plans and insurers), which will be the subject of a separate Client Alert.

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[1] The Final Rule, which will be codified at 45 CFR Part 180, is available at https://www.federalregister.gov/documents/2019/11/27/2019-24931/medicare-and-medicaid-programs-cy-2020-hospital-outpatient-pps-policy-changes-and-payment-rates-and.

Scope of the Final Rule

The Final Rule applies to any facility that is licensed or approved to operate as a hospital pursuant to a state's licensing law, irrespective of Medicare enrollment status or designation. Hospitals that operate under a single license as part of a health system must each separately disclose negotiated rates with third-party payors, and otherwise comply with the Final Rule's requirements. Further, the definition of "hospital" under the Final Rule includes critical access hospitals, inpatient psychiatric facilities, sole community hospitals, and inpatient rehabilitation facilities, and excludes ambulatory surgical centers or other "non-hospital" sites of care.

A hospital must disclose prices for all items and services—including bundled services or "service packages"—that the hospital may provide to patients under either an inpatient or outpatient classification and for which the hospital has established a standard charge. Examples of these items and services include, but are not limited to, supplies, procedures, room and board, use of the facility fees, employed professional charges, and any other items or services for which a hospital has established a charge. Because bundled services are included within the definition of "items and services," hospitals must also provide inpatient case rates or diagnosis related group ("DRG") pricing information.

Specifically, the Final Rule requires a hospital to disclose in a machine-readable format any rates that (1) are gross (i.e., chargemaster) charges; (2) the hospital has negotiated with "an entity that, by statute, contract, or agreement, is legally responsible for payment of a claim for a health care item or service; (3) are discounted cash prices, or "self-pay" prices; and (4) are its de-identified minimum and maximum negotiated charges, or its lowest and highest negotiated rates for all items or services, regardless of payor.

Besides the disclosure of rates in a machine-readable format, hospitals are required to determine 230 "shoppable"[2] services, in addition to the 70 CMS-identified shoppable services, and make publicly available a list of their payor-specific negotiated charges for each of those shoppable services in a "consumer friendly" manner. The list of 70 mandated services includes evaluation and management, medical/surgical, laboratory, and radiology services.

Using the Disclosed Rates to Make Health Care Decisions

To demonstrate how the Final Rule would impact both hospitals and consumers when making health care decisions, the following example walks through how a potential patient could make use of the data required by the Final Rule and the limitations hospitals will have in providing reliable information.[3]

John Doe is an employee of a large corporation through which he receives health coverage, and he is in need of a knee replacement. He has been having knee trouble for years and has been receiving physical therapy and periodic non-surgical interventions, but his orthopedist now recommends that John finally get the knee replaced.

[2] "Shoppable" means elective services or those planned in advance.

[3] There are other potential implications of the data disclosed pursuant to the Final Rule, most notably in the negotiation of rates between hospitals and payors; those implications may be the subject of future Client Alerts.

John's orthopedist has privileges at Memorial Hospital and would like to perform the procedure there, but John wants to make sure he won't pay too much out of pocket for the procedure and decides to price the procedure at home before deciding where he will have it done (and by whom).

John has never put much thought into his insurance; he's always gone to in-network providers, and has paid what always seemed like a reasonable copay when he went. As a threshold issue, if John is a savvy consumer, he may realize that he has a relatively small copay or coinsurance with a low deductible with his plan and that as long as he goes to an in-network hospital, he will not have to pay more than his copay and deductible. His analysis may then be as simple as checking to see whether Memorial Hospital is in-network,[4] and, if it is, he may have no use for the price transparency data. This does not, of course, take into account "surprise bill" issues created by out-of-network professionals providing services at Memorial Hospital, or other similar issues, but the price transparency data likely would not address that issue, either. Plus, John may also know that his state has a relatively robust surprise bill law, so he's not likely to have to pay more than his deductible at an in-network hospital and simply end his inquiry there.

But let us assume that John knows that he has a high-deductible plan that will impose a greater financial burden on him. So, he goes home and checks his insurance card, and sees that he has insurance from State General Health Insurance, and his insurance card has a "PPO" stamp on it. He goes to Memorial Hospital's consumer-friendly shoppable services pricer tool, and first notices that "State General Health Insurance" is broken into many different companies with a variety of names, such as "Group Health, Inc.," "AmeriHealthGroup," and "HealthCorp." John isn't sure which one he has; he looks at his insurance information from his employer and all the brochures just say "StateGenHealthIn." After spending an hour looking at all the literature and finding no answer, John finally calls the help line on the back of his card. While on the telephone with customer service, he finds out that his insurance is provided through HealthCorp, a subsidiary of State General Health Insurance.

John goes back to the pricer tool from Memorial Hospital and takes a look at HealthCorp. He is then presented with another question that he doesn't know the answer to: Is his insurance fully insured or self-insured? John ends up emailing his human resources representative and finds out that his health insurance is fully insured. He goes through a similar exercise to find that his insurance is a "large group" PPO product.

With this information, John goes back to Memorial Hospital's pricer tool, and enters that he's looking for a full knee replacement on an inpatient basis using rates negotiated with his plan and product. The tool takes him to DRG code 470, "Major Joint Replacement of Reattachment of Lower Extremity without MCC,"[5] and finds that the rate for that DRG is $18,000. He goes

[4] Note that plans often rent their networks to other entities and that hospitals do not always know if a particular rate applies to such entities. So, knowing if a particular hospital is "in-network" is not always straightforward.

[5] This does not address a potential adjustment based on acuity, nor does it, as explained later in this section, account for potential services outside the DRG code. Further, while a knee replacement is a fairly simple example because there are limited potentially applicable DRGs, it is unclear how this example would work with a procedure or illness that has the potential to implicate multiple DRGs that cannot be determined in

through the same exercise for the other hospital in his town, and finds that DRG 470 at that hospital for his coverage is $15,000.

These rates will likely have a number of disclaimers because, in order to calculate the rate, the hospital was required to convert the rates from the All Patients Refined DRG methodology in the relevant payor agreement to a dollar amount and then make a variety of assumptions as to what the payor might do when processing a claim for such service based on the terms of the agreement. Such agreement might include the following common adjustments:

- "lesser of" language (comparing chargemaster rates to negotiated rates and paying the lesser of both);
- downgrades to a different DRG code;
- application of "site of service" adjustments, bundling, and other payor payment policies;
- pass-through costs (including, but not limited to, the cost of the replacement joint "implant");
- carved-out services payable by a separate vendor contracted with the payor (as negotiated by patient's insurer, which may include radiology, laboratory, or other services);[6]
- services billed by professionals not employed by the hospital (including, but not limited to, anesthesia);
- additional services that the patient's surgical and care team may deem appropriate or necessary in the course of the procedure and recovery that are not included in the DRG code referenced above; and
- any downgrades or denials of payment because the patient and/or hospital did not notify payor of service in advance or obtain prior authorization for the service or the applicable payor determined that the service was not medically necessary.[7]

In addition, Memorial Hospital could run into more substantial issues in disclosing rates for such DRG if it participates in a bundled payment arrangement for a joint replacement "episode" whereby the overall rate is much higher, but the bundle covers services outside of the DRG code, such as 90 days of services both before and after the actual joint replacement

advance. For example, someone who may be shopping for his or her cancer treatment may not know whether or not the applicable hospital may determine to perform a surgical intervention.

[6] Hospitals will not be able to determine the costs of services that are explicitly carved out of their participation agreements with payors.

[7] There are various other factors that may affect the rate that are not relevant to the consumer but may be of concern to the hospital. A hospital may, for example, accept a lower rate but have the ability to earn more pursuant to a shared savings or shared risk arrangement applicable to the service. While this would not affect the patient, it would be relevant to hospitals and payors analyzing the data.

surgery. (For other services, the pricer tool might simply state "n/a" because the hospital is reimbursed on a capitated basis for all service provided to that particular patient population.[8])

John isn't quite sure what to make of all these disclaimers, other than that his knee replacement isn't going to cost what the pricer tool says it will—but he's not sure what it will cost in the end.

Knowing these estimated rates, John then has to return to his benefit plan to understand what he has to pay out of pocket. He hasn't had any major medical expenses before this procedure, so he's unfamiliar with his deductible and the distinction between copayments and coinsurance. He does a little research and understands that inpatient hospital procedures have a 20 percent coinsurance obligation (he also goes back to check that the knee replacement is inpatient), and he has a $5,000 deductible. He has to check how much of his deductible he's used, and sees that it's very little—and he's not going to exceed it at either hospital with the quoted rates. So, then John does the math to see his obligation at Memorial Hospital will be $3,600, and only $3,000 at the other hospital—but he knows both amounts are subject to many disclaimers.

After this exercise, John is ready to choose where he wants his knee replacement done. He must also consider in all of this whether his orthopedist has privileges at the other hospital, and, if not, whether saving $600 is worth both finding a different orthopedist who has such privileges and having the procedure performed by a physician other than the one who has been treating him since his knee pain began.

Conclusion

The example above is offered to provide a glimpse into the complexity of health care pricing and reimbursement. The example also demonstrates that even complete rate transparency by hospitals may not be enough to affect a health care consumer's spending practices because (1) the issue is too complicated to generate a reliable cost estimate for the patient; (2) even if such an estimate could be generated, obtaining and understanding it may be too burdensome for consumers; and (3) it's too difficult to estimate the value that a consumer places on continuing his or her care with his or her physician and reliance on his or her physician's medical advice. There are many hurdles that hospitals must overcome to meaningfully comply with the Final Rule, and it is questionable if they will even be able to provide useful data to consumers. And even if they are able to, it is questionable whether consumers will be able to make effective use of the data. Our current health care system may be too complex for price transparency to effectively achieve its intended goals.

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[8] The Final Rule also does not address whether an intermediary entity that contracts with payors on a capitated basis on behalf of a hospital (e.g., an accountable care organization or an independent practice association) is itself a "payor" for which the hospital would also be required to disclose rate data; such information would, presumably, be of little use in achieving the Final Rule's intended purposes, as neither payors, other hospitals, nor consumers would find much use in capitation rates paid to an intermediary entity and downstream reimbursement rates that may be based more on corporate structure and cash flow than the value of care.

This Client Alert was authored by **Jackie Selby, Gregory R. Mitchell,** *and* **Sidra S. Galvin.** *For additional information about the issues discussed in this Client Alert, please contact one of the authors or the Epstein Becker Green attorney who regularly handles your legal matters.*

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