Price Transparency: The Effect on Healthcare Providers and Consumers

Published on February 14, 2020

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The Centers for Medicare & Medicaid Services (CMS) finalized the requirement for all non-federally owned hospitals in the United States to publish standard charges lists, effective January 1, 2021. The new price transparency rule is intended to clarify and encourage competitive healthcare pricing, but could the intended outcomes backfire?

Healthcare price opacity and the vast disparities from one facility to the next for similar procedures have made it increasingly difficult for patients to understand pricing structures and shop for valuable services.

The Government Accountability Office (GAO) conducted a report in 2011 titled, "Health Care Price Transparency: Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care." Though the title of the report may not be groundbreaking, the evidence provided was used in the passing of this regulation.

The report references several barriers in the healthcare system that make it difficult for consumers to obtain price estimates in advance for healthcare:

- The difficulty of predicting healthcare service needs in advance
- Complex billing structures that result in bills from multiple providers
- A variety of insurance benefit structures
- Concerns related to the public disclosure of rates negotiated between providers and third-party payers

According to the GAO report, transparency initiatives with access to pricing data from providers and insurers are the best approach to providing a reasonable estimate of consumer costs.

The final rule dictates hospitals must establish, update, and make public their unnegotiated prices and individual payer-negotiated rates for the items and services provided in five different charge lists:

1. Gross charge: The full, un-negotiated charge for services and items, as shown on the hospital's ChargeMaster list.
2. Payer-Specific Negotiated Charge: The individual negotiated rates the hospital has with each health plan and insurance payer.
3. Discounted Cash Price: The negotiated cash price of items and services provided.
4. De-identified Minimum Negotiated Charge: The lowest charge that a hospital has negotiated with all third-party payers.
5. De-identified Maximum Negotiated Charge: The highest charge negotiated with all third-party payers.

Transparency won't arrive without cost. The total estimated burden for each hospital is expected to be 150 hours and $11,898.60 for the first year, then drop to 46 hours and $3,610.88 for subsequent years. Also, hospitals out of compliance will be subject to a civil monetary penalty (CMP) of up to $300 per day.

Disclosing these standard charges is expected to impact the healthcare market from two different angles. First, the available data will provide the public with the information necessary to make more informed decisions about their care. Is this an optimistic assumption? The data may be available, but will it prove to be an enormous conglomeration, impenetrable to consumers?

Language has been included to combat the potential data mountain. The regulation states that prices must be published in a legible, machine-readable, consumer-friendly format to ensure information is easily searchable and appears in plain language. The CMS believes transparency

in healthcare pricing is critical to transitioning patients from passive participants to active consumers.

Secondly, price transparency is expected to increase market competition, driving down the cost of health care services. But, will this backfire? Is it possible that healthcare prices could be driven higher as hospitals move to match their competitor's pricing?

We won't know until next year. What we do know is that action is necessary to promote public access to healthcare costs; though, many are skeptical the new requirements will take effect as written with a year for potential protests to the regulations.