editorial

Opaque Results of Federal Price Transparency Rules and State-Based Alternatives

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Opaque contracting and complex insurance plan design can prevent patients from knowing the true cost of their health care. To control the rising costs of health care, there is a push for increased price transparency among stakeholders.[1] The challenge is successful policy design and implementation.

On January 1, 2019, the Centers for Medicare and Medicaid Services (CMS) issued mandate CMS-1694-F, which requires inpatient and long-term care hospitals to publicly display a list, or chargemaster, of their standard charges for items and services provided.[2] The reports must be updated annually and provided in electronically importable format (eg, .XML, .CSV files). We commend the focus on price transparency; however, this mandate falls short of its stated goal to "empower patients through better access to hospital price information." For the insured patient, chargemaster prices demonstrate a poor correlation between the insurer payment and the patient cost-sharing responsibility.[3] Conversely, there are state-led initiatives, such as the California Public Employees Retirement System (CalPERS),[4] which have successfully implemented robust price transparency programs using a public all-payer claims database (APCD), demonstrating that price transparency can be a dominant solution (lower total and out of pocket [OOP] costs without worse outcomes). Price transparency is most useful for patients when costs are accurate, relevant, and paired with value-based insurance that minimize OOP costs for services deemed highest value.

A TEST CASE: SHOPPING FOR CANCER SCREENING IN CHICAGO

Chargemasters may be a negotiation starting point, but because most commercial insurers pay hospitals based on negotiated rates, the chargemaster price often has little correlation to payments. Uninsured and out-of-network privately insured patients may be billed the chargemaster price; however, hospitals often offer discounts. In the majority of cases, chargemasters are not intended for direct-to-consumer interpretation.[3]

To probe the utility of the CMS-1694-F, we simulated the experience of a hypothetical patient comparison shopping in Chicago for common cancer screening tests. Using the Illinois Health and Hospital Association member list (https://www.team-iha.org/member-resources/hospital-directory), we identified all hospitals within 50 miles of central Chicago. Of 66 hospitals, 58 (88%) had a public chargemaster listed on their Web site as of May 5, 2019. Aggregating the listed prices for five common cancer screening tests (Papanicolaou smear for cervical cancer, colonoscopy for colorectal cancer, bilateral screening mammograms for breast cancer, prostate-specific antigen for prostate cancer, and chest computed tomography [CT] for lung cancer), we found wide variation among listed prices, ranging from a three-fold difference ($18 to $640) for Papanicolaou smears to a 59-fold difference for screening chest CTs ($49 to $2,898).

The chargemasters contained difficult-to-interpret codes, making identifying the desired service challenging. If a service can be identified, the patient encounters a wide range of listed charges, and it is unknown whether the listed price is inclusive of all costs associated with the procedure or test. Furthermore, because these listed prices likely do not reflect what a patient (or the insurance company) will ultimately pay,[3] it is unclear how useful this information is in making a comparative cost-based decision. In addition, none of the lists evaluated had quality scoring to assess value. Therefore, assuming a patient is (1) motivated to seek out listed prices and (2) able to find the chargemaster and identify the particular service in question, these prices may be misleading or, at worst, harmful. It is plausible that if these costs overestimate what the patient would actually pay, it could motivate the delay or omission of care entirely because of cost concerns. Expecting to pay nearly $3,000, as listed by one chargemaster, for a screening chest CT, a test with demonstrated survival benefit,[5] may cause hesitation.

STATE-BASED ALTERNATIVES

Many states are concurrently pioneering price transparency reform. As of January 1, 2019, 17 states had implemented all-payer claims databases. Five additional states have passed statutes to develop an APCD. These APCDs account for negotiated prices, as opposed to prenegotiation charges, which better represent the true cost. Many databases incorporate quality metrics to aid in decision making.

For example, CalPERS is a state-based initiative with encouraging cost containment data. CalPERS purchases coverage for 1.3 million state government

Author affiliations and support information (if applicable) appear at the end of this article.

Accepted on July 3, 2019 and published at jop.ascopubs.org on August 12, 2019: DOI https://doi.org/10.1200/JOP.19.00354

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employees and was built on the assumption that insurer and provider-focused initiatives would be of limited efficacy in decreasing costs if individual consumers are unaware of the price of the care. CalPERS uses reference pricing, whereby employers place a limit on what they will contribute toward payment for a particular procedure.[4] Consumers who select a provider that charges less than the purchaser's limit have minimal cost sharing. Those who select a provider charging above the contribution limit must pay the difference, and this excess payment does not count toward the patient's deductible or OOP maximum. The results of CalPERS has been encouraging—for colonoscopy procedures, use of lower-priced facilities increased from 68.6% in 2009 to 90.5% in 2013, with no change in complication rates.[6] Similar findings in arthroscopy procedures showed a 14.3% increase in the use of lower-cost freestanding surgical centers, with no change in the rate of surgical complications.[7] CalPERS saved $7.0 million (28%) and $2.3 million (13%) in spending for colonoscopies and arthroscopy, respectively, in the first 2 years after implementation.

RECOMMENDATIONS FOR A WAY FORWARD

Price transparency legislation is ongoing at both the state and federal levels. President Trump promoted transparency as a main pillar of his agenda in the American Patients First proposal in May 2018. We put forth the following considerations:

- All states should be encouraged to develop APCDs; a strength is the flexibility to accommodate variation across different states' health care markets.
- Cost data should be interpretable and inclusive.
- Standardized, evidence-based quality metrics should be incorporated into transparency models to account for value.
- There should be minimal cost sharing for procedures below the median (or some variant thereof) of APCDs and deemed to be of high value.

Price transparency is a bipartisan goal among policymakers. The pursuit of price transparency by CMS, via CMS-1694-F, in an inherently opaque market is laudable, but mandating the publication of chargemasters in their current form does little to empower patients through better access to hospital price information and to create a consumer-centered marketplace. We should instead look to the states that have had data-supported success with APCDs. Price transparency for patients needs to be accurate, with patient-level relevance paired with meaningful quality metrics, and interpretable, so that patient-facing information brings clarity, not obscurity.

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AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST AND DATA AVAILABILITY STATEMENT

Disclosures provided by the authors and data availability statement (if applicable) are available with this article at DOI https://doi.org/10.1200/JOP.19.00354.

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Final approval of manuscript: All authors
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Stock and Other Ownership Interests: Penrose Therapeutics, Abbott/AbbVie

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Research Funding: Merck
Travel, Accommodations, Expenses: Tapestry Pharmaceuticals
Other Relationship: Gerson Lehrman Group

No other potential conflicts of interest were reported.

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