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HB18-1358: The Health Care Price Transparency Bill Creates a Blizzard of Red Tape, Will Increase Health Care Costs, Expose Providers to Heightened Legal Risk, and Likely Will Not Help Patients

By Linda Gorman

Bill Context

Americans pay for their health care in a variety of ways. People paying cash for services pay posted prices or prices individually negotiated with providers. Those who pay individual health plan premiums pay network providers the amount their insurer has negotiated, covering deductibles and copays with cash. Employers negotiate using competitive bidding, long-term partnering, and various specialty managers for things like disease management and pharmaceutical benefit carve-outs. Medicare pays providers amounts set by the federal government. Colorado Medicaid pays prices set by the State of Colorado.

A vast array of businesses delivers pricing information to individuals and employers in the private sector even though the amounts that large insurers pay for hospital services is considered private, commercially sensitive, information. Urgent care providers post their cash prices. Outpatient surgery centers provide firm fixed prices for procedures. Other firms bundle services for individuals and employers, providing a fixed price quote good for 60 days. Businesses help individuals negotiate service prices in advance, provide nationwide pricing information, and audit hospital bills for errors.

Medicare payment rates are controlled by the federal government rather than by the market. They are typically referred to as reimbursements rather than prices. Reimbursements are based on codes for individual medical services. The amount Medicare pays for an individual episode of care depends upon the various codes assigned to the episode, and the amount of reimbursement attached to each code. Most state Medicaid systems piggyback on Medicare coding using reimbursements set by each state.

Each reimbursement amount may undergo various adjustments.¹ In theory, the Medicare Inpatient Prospective Payment system provides a base payment for inpatient acute care. In fact, adjustments may double Medicare's base payment rate. Highly paid hospitals tend to be teaching hospitals with relatively low Medicare patient volumes and relatively high Medicaid patient volumes. Hospitals with the lowest prospective payment base tend to be community hospitals.²

Hospital chargemasters list prices for hospital services organized by Medicare codes. The 2016 chargemaster for Stanford Health Care lists prices for 41,019 codes. In the real world, people seldom pay chargemaster prices for hospital care. A study of 88 million unique individuals with health insurance claims at hundreds of acute care hospitals between 2007 and 2011, estimated that chargemaster procedure prices were 157 to 193 percent higher than the prices paid. There was relatively little correlation between list and transaction prices, or between Medicare reimbursements and transaction prices.

Medicare paid 53 percent of private rates for inpatient care, 55 percent for hip replacement, 56 percent for knee replacement and 27 percent for MRIs.³ There is research suggesting that Medicare and Medicaid reimburse some hospitals for some patients at less than cost. State and federal grants to favored facilities may help fill the reimbursement gap.

Federal law limits a state's ability to dictate what employer plans must do. States may regulate health insurers and license hospitals and physicians, but they may not require employer plans covered by ERISA to report information on payments and other information to the state. States may

license Medicare Advantage plans as insurers and those who provide Medicare services, but federal preemption laws protect Medicare plans from state laws imposing marketing, quality guidelines, or network adequacy requirements on Medicare plans.

What the Bill Does

In general, the bill requires all health care providers, facilities, and pharmacies licensed by the State of Colorado to post their list or chargemaster prices in easily accessible formats, both print and electronic. Providers must publish all prices charged by those who provide services at their site. Companies providing health coverage must provide detailed information on their contracts, negotiated prices, and networks. The bill includes detailed specifics on what must be published. It gives the Executive Director of the Department of Health Care Policy and Financing and the Colorado Board of Pharmacy the ability to regulate the amount and frequency of disclosures. The bill requires that all providers and facilities keep track of all changes in their price lists. There is no time limit on records retention.

If facilities or providers fail to comply with the requirements of the bill, services for patients must be billed at the lowest established payment rate. If pharmacies or pharmacists fail to comply, the Colorado Board of Pharmacy may discipline them or suspend their licenses.

Analysis

This bill produces a red tape blizzard that will increase Colorado health care costs by unnecessarily increasing overhead and, if the Federal Trade Commission is correct, reducing health care price competition. The costs created by its extensive disclosure requirements will likely provide little additional benefit to people who pay for health care. The financial penalties in the bill also increase the legal risk faced by people providing health care products and services in Colorado.

To figure out the cost of an episode of care, each patient must know the codes that apply to his case. It takes time to acquire that kind of specialized knowledge. The people who know this have experience in coding, often take advanced courses in it, and generally specialize in a type of medical practice.

The bill's disclosure requirements will allow competitors to figure out the cost structures and pricing behavior of their rivals. In a 2015 letter, the Federal Trade Commission informed Minnesota state legislators considering a similar law that requiring the publication of competitively sensitive information on insurer contract pricing may "chill competition" in markets with limited numbers of competitors, high barriers to entry, and a steady or increasing demand for services, conditions that exist in Colorado's hospital and health coverage markets.⁴ The FTC also worried that published prices increase the likelihood of tacit or overt collusion among oligopoly suppliers because they make it easier to identify competitors offering price cuts.

Violations of the disclosure requirements required by the bill will make hospitals and other providers liable for refunds equal to the difference between their billed rates and the lowest reimbursement they receive. With some reimbursement rates just 30 percent of private pay rates, refunds aggregated over a group of patients may make suing providers a lucrative undertaking.

Finally, given federal laws on preemption for ERISA self-funded employers, Medicare, and federal employees, this law may apply to only a fraction of the health care coverage market.

- ¹ Centers for Medicare & Medicaid Services. December 2016. Acute Care Hospital Inpatient Prospective Payment System. ICN 006815. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AcutePaymtSysfctstht.pdf>
- ² Sam Krinsky et al., "Variation in Payment Rates under Medicare's Inpatient Prospective Payment System," *Health Services Research* 52, no. 2 (April 2017): 676–96, <https://doi.org/10.1111/1475-6773.12490>.
- ³ The correlation between chargemaster and negotiated prices was .25 to .48 on a number of common procedures. Zack Cooper et al., "The Price Ain't Right? Hospital Prices and Health Spending On the Privately Insured," Working Paper (Cambridge, MA: National Bureau of Economic Research, December 2015), 14.
- ⁴ Marina Lao, Deborah L. Feinstein, and Francine Lafontaine, "Amendments to the Minnesota Government Data Practices Act Regarding Health Care Contract Data," June 29, 2015, https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-regarding-amendments-minnesota-government-data-practices-act-regarding-health-care/150702mimnhealthcare.pdf.