LEGAL UPDATES

# Administration Issues Cross-Agency Guidance Targeting Health Care Pricing and Focusing on Hospitals and Health Plans

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On May 22, 2025, the U.S. Department of Health and Human Services, Department of Treasury and Department of Labor (the "Agencies") announced new steps intended to "strengthen healthcare price transparency." This guidance follows an Executive Order on price transparency issued in late February and covered in an earlier Lathrop GPM Client Alert. This cross-agency effort focuses on hospitals and health plans and takes steps to tighten requirements that currently apply.

## Hospitals Required to Disclose "Actual" Prices

As part of this update, the Centers for Medicare & Medicaid Services (CMS) posted new guidance on its Hospital Price Transparency website. For several years now, hospitals have been required to make public certain details about pricing information that applies to the various items and services the hospital provides. Hospitals are required to do this in two different ways, through a: (1) a consumer-friendly list of standard charges for a limited set of services; and (2) a more comprehensive machine readable file (MRF) that includes all standard changes for the hospital's items and services. These requirements are intended to help consumers understand how much they should expect to pay for health care services and more generally to assist in demystifying how pricing works for services rendered in the hospital setting.

In the new guidance, CMS indicates hospitals should take two important steps related to the level of detail included in the MRF:

- Hospitals are expected to post the actual price of the items/services that they provide in the MRF. The specifics of how this will work depends on the reimbursement methodology that applies to the hospital. For example, with respect to items/services encoded in the MRF with a standard charge methodology based on a case rate, fee schedule or per diem methodology, CMS' expectation is that hospitals display a payer-specific negotiated charge as a dollar amount. Where hospitals are paid based on a percentage of a fee schedule, hospitals are directed to indicate that the payer-specific negotiated charge is a percentage, provide additional information about the type of fee schedule and display an "estimated allowed amount." Hospitals that have case rate or per diem payment methods will need to display the dollar amount for

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the service package base rate, along with a payer-specific estimated allowed amount and payer-specific negotiated charge algorithm.

- CMS had previously permitted hospitals to display a dummy code (specifically, a "999999999") in situations where hospitals had insufficient historical information to derive the estimated allowed amount required to be included in the hospital's MRF. The agency observed, however, that hospitals were using the "nine 9s" much more frequently than expected. As a result, CMS will require hospitals to instead use the actual dollar amount and will no longer permit use of the nine 9s. Hospitals will be required to display the average dollar amount the hospital has received for the items/services at issue over the 12 months prior to posting the MRF.

In its guidance, CMS goes to great length to explain that these changes are based on the 2024 Outpatient Prospective Payment System/Ambulatory Surgical Center final rule, where the agency stated: "Hospitals are required to display the standard charges as they are established, such that, if the hospital established a standard charge as a dollar amount, the hospital would display the standard charge as a dollar amount." [1] The enhanced requirements have been announced against a backdrop that shows an uptick in enforcement this year against hospitals related to alleged noncompliance with price transparency requirements.

## New Guidance for Health Plans & Issuers Related to Disclosure Format

In the same vein as the requirements noted above, most group health plans and health insurance issuers (collectively, "Plans") are required to disclose on a public website information about in-network provider rates for covered items/services, out-of-network allowed amounts and billed charges and negotiated rates and historical net prices for covered prescription drugs. As is the case with many health care data reporting requirements, there has been concern that the information reported by Plans has been overly complex, redundant and difficult for consumers to parse. The Agencies issued several frequently asked questions (FAQs) related to compliance with the governing regulatory reporting scheme (the "Transparency in Coverage Final Rules"), a requirement that has been on the books for Plans since November, 2020.

In the FAQs, the Agencies announced that they will be releasing updated data formats (known as schemas) related to the disclosures Plans are required to make. The expressed intent is to strengthen disclosure requirements and to take steps "towards fulfilling the promise of radical transparency." The changes will require Plans to implement updated schemas for the MRFs that are in line with these goals. According to the Agencies, the changes will:

- Decrease duplicative data by requiring Plans to list provider groups only once (with provider groups subsequently referenced instead of redefined for each negotiated rate used by the Plan);

- Implement a table of contents file for Plans or policies that share negotiated rates, which will reduce the total number of files that need to be provided;

- Limit data redundancy by requiring use of a custom place-of-service code for prices that apply to all locations, instead of listing all places of service for each negotiated rate;

- Mandate clear disclosure of provider network information, with the goal of making it easier for users to navigate the Plans' data.

The new schemas will be finalized on October 1, 2025. It appears that Plans will have four months to complete the necessary updates to build files that comply with the new requirements. Plans are expected to be able to comply with the new requirements by February 2, 2026.

## Request for Information on Improving Prescription Drug Price Transparency

Finally, the Agencies issued a Request for Information (RFI) seeking input from the public on how to most effectively increase price transparency for prescription drugs. The RFI seeks feedback on prescription drug price disclosure requirements, including information on existing prescription drug file data elements and information on implementation generally. Specifically, the Agencies are looking for feedback on the following reporting obligations faced by Plans:

- Potential improvements in disclosure requirements, such as ways to simplify or streamline reporting and whether there are any items/services that should be excluded from the MRF.
- Enhanced reporting related to pre-rebate and post-rebate drug pricing and whether Plans should be required to disclose specific data about actual drug prices that apply in bundled payment arrangements or alternative payment models;
- Whether there are unnecessary or irrelevant disclosure requirements that should be removed;
- The extent to which the Agencies should require standardized formatting for the manner in which Plans and pharmacy benefit managers (PBMs) store and maintain pricing information for prescription drug dosage units;
- Whether Plans should be required to identify PBMs or other parties that manage the Plan's pharmacy benefits.

If readers are interested in commenting in response to the RFI, two options are available:

- Electronically, via the https://www.regulations.gov site and by following the option to "Submit a comment."
- Via regular mail at the following address: Office of Health Plan Standards and Compliance Assistance, Employee Benefits Security Administration, Room N-5653, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington DC, 20210, Attention: 1210-AC30.

If you have any questions about the new price transparency guidance, please contact Jesse Berg or your regular Lathrop GPM attorney.

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[1] 88 Fed. Reg. 81540, 82996 (Nov. 22, 2023)