The Sunshine Act, 5 Years Later

By Joseph S. Eastern, MD

You may recall that, in mid-z013, the government launched the physician payment Sunshine Act bureaucracy, as mandated by the Affordable Care Act of 2010. The intent was to make relationships between pharmaceutical manufacturers and health care providers more transparent, by requiring the manufacturers to report to the Centers for Medicare 8(Medicaid Services all payments and other "transfers of value" provided to physicians and teaching hospitals.

Since CMS has been collecting this information (and publishing it online each September) for 5 years now, I thought I would have a look at what has been learned to date, and what may have changed as a result.

Not much, apparently. In 2014, I predicted that attorneys, activists, and the occasional investigative reporter might peruse the data for their own purposes, but the general public would have little curiosity or use for the information. That appears to be the case thus far; there is no evidence that significant numbers of ordinary citizens have looked at the data or drawn any conclusions from it, perhaps be- cause of the difficulty in accessing it (the website was widely panned when it debuted, although improve- ments have since been made); or perhaps because neither CMS nor anyone else has offered the public any assistance in interpreting the raw data. Whether patients think less of doctors who accept an occa- sional industry-sponsored lunch for their employees, or think more (or less) of those who educate other providers or conduct clinical re- search, remain open questions.

One measurable unintended the increasing cians to provide legitimate feedback, or otherwise interact at all with industry, probably out of fear that they might one day have to explain a payment that could be construed by someone with an ax to grind as a conflict of interest. This is a shame, since there is no better way to de- velop new therapies, or to design solutions to the huge problems facing modern health care, than to actively involve doctors.

Furthermore, it is not clear how well the industry has complied with the law, or how effectively the gov- ernment is enforcing it. The law authorizes fines of up to $150,000 annually, rising to $1 million for in- tentional Violations; and while Ver- mont announced in late 2013 that it had levied 25 fines totaling $61,250 for violations of its somewhat stricter version of the statute, I could find no evidence of any similar enforcement by CMS or any of the other states with standalone conflict of interest laws.*

All of that said, the law's ques- tionable impact and apparent lack of enforcement do not mean you can ignore it.

Increased transparency and scruti- ny of physician financial interests ap- parently are here to stay. The data are still being collected and displayed for anyone to see, so you still want to be certain that what is reported about you is accurate.

This means keeping your own re- cords of any money, food, or supplies that you receive from any pharma- ceutical company, and making certain that it is in fact *your* information—and not someone else's—that is published.

(CMS initially released a free smart- phone application to facilitate that independent record—keeping process, but the app apparently is no longer available.)

Because all data must be reported to CMS by March 31 annually, you need to set aside some time each April or May to review this informa- tion. lf you have many (or complex) industry relationships, you should probably contact each manufacturer in January or February and ask to see the information before it is submit- ted. Then, review it again after CMS gets it, to be sure that nothing has changed.

You do have 2 years after the data go live to pursue corrections, but in the interim, the incorrect informa- tion remains online. So, it's best to fix it in advance of publication.

If you don't see drug reps, accept office lunches, attend industry din- ners, or give sponsored talks, don't assume that you are not included in the database. Check anyway; you might be indirectly involved in a compensation that you were not aware of, or you may have been re- ported in error.

*California, Colorado, Maine, Massa- chusetts, Minnesota, Vermont, West Virginia, and the District of Columbia had their own laws in place addressing industry relationships with providers before the ACA was enacted. Maine re- pealed its law in 2011.

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