Georgetown University Health Policy Institute
CENTER ON HEALTH INSURANCE REFORMS

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New Health Care Transparency Requirements: Recommendations for Optimizing Pricing Data to Reduce System Costs

By Sabrina Corlette, Megan Houston, Maanasa Kona, Rachel Schwab, and Nia Gooding

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Authors

Sabrina Corlette, Megan Houston, Maanasa Kona, Rachel Schwab, and Nia Gooding

The Center on Health Insurance Reforms (CHIR), based at Georgetown University's McCourt School of Public Policy, is composed of a team of nationally recognized experts on private health insurance and health reform. We work regularly with a multidisciplinary group of faculty and staff dedicated to conducting research on issues related to health policy and health services.

CHIR faculty and staff study health insurance underwriting, marketing and products, as well as the complex and developing relationship between state and federal rules governing the health insurance marketplace. CHIR provides policy expertise and technical assistance to federal and state policy-makers, regulators and stakeholders seeking a reformed and sustainable insurance marketplace in which all consumers have access to affordable and adequate coverage.

Introduction

High and rising health care costs are projected to consume 20 percent of the U.S. economy by 2027, squeezing workers' wages, reducing our economic competitiveness, and forcing difficult budgeting decisions for federal and state policymakers. The primary reason health care costs disproportionately more in the United States than in other developed countries – without better health outcomes – is the prices we are paying for health care goods and services. In the commercial insurance market, which covers almost 180 million Americans under the age of 65, the biggest driver of health care costs is the price insurers pay for hospital-based services.

Knowing what providers, particularly hospitals, are being paid, and by whom, can be useful for:

- Health services researchers, to help inform federal and state policies designed to bring down rising costs;
- Health care purchasers, particularly employers, to help select health plans and networks that deliver quality care at a reasonable price; and
- Health insurance regulators, to help assess insurers' proposed premium rates and improve insurance affordability.

Recent federal regulations require hospitals and health plans to publicly post their prices. To be useful, the data need to be accessible and in a format that can be analyzed by, at a minimum, the stakeholders and officials cited above. However, many hospitals are not yet complying with the new transparency requirements, and the data they have posted has in some cases been hidden from web search engines or provided in a format that makes analysis difficult.

To gain insights into the potential for this data and generate recommendations for public policies that could ensure it is fully optimized, we convened a meeting of 21 health care researchers, purchasers, and state and federal insurance regulators on June 14, 2021. See Appendix. The group's discussion was grounded by the Wakely Consulting Group's review and analysis of pricing data reported by hospitals under the federal requirements. This report summarizes that discussion and the participants' recommendations.

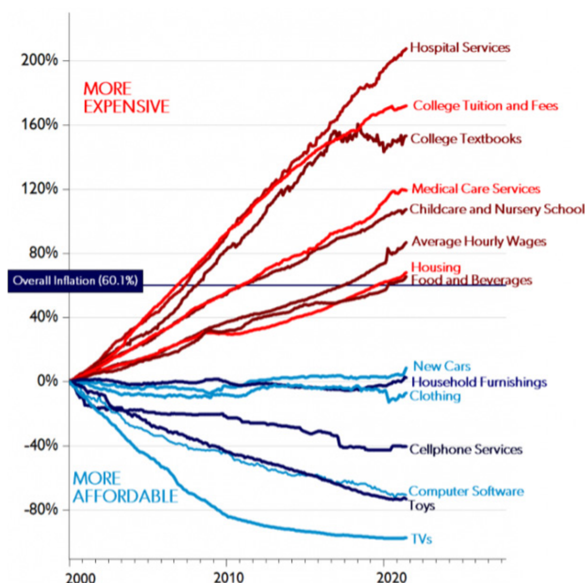
Background

Since 2000, hospital prices have grown by over 200 percent (compared to average inflation of 60 percent). See Figure 1. Commercial health insurers, who are supposed to negotiate with hospitals and other providers for the best deal on behalf of their customers, have largely failed at controlling prices. In many cases, insurers are actually incentivized to keep provider prices high, because they are paid fees based on a percentage of total costs. This may be why both insurers and providers have strong incentives to keep the prices they negotiate for health care goods and services hidden from consumers and purchasers alike.

However, prior to the new transparency requirements for hospitals and health plans, there have been other important sources of data on the negotiated commercial prices for health care items and services. Close to half of states have all-payer claims databases (APCDs) and private organizations such as FAIR Health and the Health Care Cost Institute collect, analyze, and report on prices for hospital and other health care items and services. These sources of data have some limitations. For example, these databases generally do not allow analysts to link the negotiated price of a service to a particular insurer or health plan. State APCDs are also currently prohibited from requiring self-funded employer plans to submit their claims data.

Some economic analyses suggest that greater transparency in health care pricing can lead to

Figure 1. Price Changes: January 2000 to June 2021 Selected US Consumer Goods and Services, Wages



Source: Bureau of Labor Statistics, as compiled by American Enterprise Institute. https://www.aei.org/carpe-diem/chart-of-the-day-or-century-6/.

lower prices and more efficient outcomes. Federal regulations requiring all hospitals to publish their charges, including the rates they negotiate with commercial insurers, went into effect on January 1, 2021. Similar federal requirements for health insurers and group health plans to publish the rates they negotiate with in-network providers will be in place starting January 1, 2022 (collectively, the "transparency rules"). However, federal regulators have indicated they will delay enforcement of many of the new requirements for health plans until July 1, 2022. See text boxes.

Hospital Transparency Rule: Key Provisions

Hospitals must publish 5 types of charges for (1) all items and services in a "machine readable" format and (2) 300 "shoppable" services in a consumer-friendly format:

1. Gross charges
2. Discounted cash price
3. Payer-specific negotiated price
4. De-identified minimum negotiated rate
5. De-identified maximum negotiated rate

Health Plan Transparency Rule: Key Provisions

Health insurers and group health plans must:

- Disclose cost-sharing amounts at the request of enrollees
- Publish in machine-readable format, for all covered items & services:
  1. Negotiate rates for in-network providers;
  2. Historical out-of-network allowed amounts and billed charges; and
  3. Negotiated drug prices

In publishing the new requirements, the federal Centers for Medicare & Medicaid Services (CMS) touted the benefits of greater transparency for health care purchasers, health services researchers, and health insurance regulators. For example, employers who purchase health benefits could use carrier-specific pricing data to select third party plan administrators (TPAs) that will negotiate the best prices, or to design provider networks to include only providers that offer the best outcomes for the lowest price. CMS predicts that information technology vendors, such as web and mobile app developers, will further innovate to offer user-friendly comparison tools to payers, purchasers, and others once the price information is available.

In its rulemaking, CMS also argued that the pricing data would help consumers make more cost-effective choices among providers of elective services, and hospitals can comply with the requirement to provide consumer-friendly pricing data by posting a web-based price estimator tool. However, the data on the utility of this information for individual consumers seeking health care services is less than clear. Others have argued that this data could help consumers who wish to dispute a hospital or other provider charge they find excessive or inappropriate.

Hospital providers lost their lawsuit to prevent implementation of the transparency requirements, but to date many have either been slow to post the data or not complied at all. Others have posted pricing data but kept it hidden from web-based search engines or only partially complied with federal requirements. Analyses of hospitals' implementation efforts to date suggest wide variation in the availability, display, and utility of the pricing data being posted. However, hospitals may be making a rational calculus that the risks of displaying pricing data that they have long considered proprietary – and that could increase pressure to lower their rates – outweigh the modest penalties (currently capped at a maximum of $300 per day) they will have to pay for non-compliance.

In a rare display of bipartisanship, committee leaders in the U.S. House of Representatives urged CMS to increase its oversight and enforcement efforts including regular audits and a review of the penalty amounts for non-compliance. In April 2021, CMS began sending warning letters to hospitals where an audit or a complaint indicated they were out of compliance; these hospitals are given 90 days to fully comply. A July 2021 proposed rule would increase penalties to up to $5500 per day for the largest hospitals. However, as of this writing, CMS has not publicly issued financial penalties to any hospital.

Congress continues to show a strong bipartisan interest in greater transparency of health care costs and prices. Legislation enacted in 2021 includes requirements that:

- Group and individual market health plans must include information on deductibles and out-of-pocket maximums on enrollees' insurance cards;
- Insurers and group health plans must provide an explanation of benefits for scheduled services at least three days in advance;
- Contracts between insurers and providers may not include gag clauses prohibiting the insurer from disclosing provider-specific cost, price, or quality information, or from accessing de-identified claims information for the purposes of analysis or improvement;
- Insurers and health plans must report on prescription drug and spending information; and
- The Secretary of Health & Human Services must make one-time grants to eligible states to establish or improve existing APCDs.

Provider-Payer Price Data Holds Significant, but Currentlly Untapped, Potential

Provider-Payer Price Data Holds Significant, but Currently Untapped, Potential

Meeting participants agreed that publicly posted hospital pricing data has the potential to move health care markets in a variety of ways. The new data can help researchers more accurately measure price variation, inform innovations in public policy, empower employers, and enable regulators to enhance their oversight of insurers' proposed premium rates or enforce state-level caps on cost growth.

There was general consensus that consumers will be the least likely to find the data useful, given limited success of existing tools for consumer-level price shopping and the fact that most consumers select hospital and other providers entirely or partially based on the recommendation of their treating health professional. Hospital and other pricing data could be fed into decision-support tools for clinicians to be used when making referrals, but to date, interventions attempting to get physicians to consider cost in health care decision-making have not been very successful. Even absent use of the data by consumers and providers to choose lower cost sites of care, participants agreed that pricing information specific to insurers and providers can be valuable to researchers, policymakers, employers, and regulators.

Impacts for Research and Policymaking

The prices that commercial insurers pay for health care goods and services have been notoriously opaque, with both payers and providers going to great lengths to hide this data from the public. The health policy researchers attending the meeting expressed excitement about the potential implications of greater access to data on negotiated prices. Even heretofore limited access to this data has helped support public policies to help constrain health system costs. For example, one state official noted that his state's efforts to place annual growth caps on health care costs was a direct result of their analysis of hospital price growth across the state. Others noted that more widespread access to this data can enable federal and state policymakers to better target the largest drivers of health care costs in the system.

Meeting participants also noted that this data will help researchers and, through them, policymakers evaluate policies already in place. For example, several states have enacted laws aiming to constrain health care spending or increase investments in primary care services. Officials in these states can use the availability of privately negotiated prices, including those negotiated on behalf of self-funded employer plans, to assess and improve on these policies. As one official said, "Having [the data] available on an ongoing basis would be incredibly valuable for monitoring [the impact of our law] and also for looking at additional measures that need to be put in place."

Impacts for Employers

Representatives of employers agreed that having more information about what their insurers and TPAs are paying for care will strengthen their ability to extract lower prices from providers. There was consensus that the data may prompt more employers to engage in direct contracting, cutting out their TPAs from the negotiations. Several noted that currently, many self-funded employers face challenges accessing their own claims data from their TPAs. This limits not only the opportunity to engage in direct contracting (which is currently feasible for only a few large, sophisticated employers), but also employers' ability to assess where they are paying the most for specific services, as well as which providers are operating the most efficiently. Access to the federally required pricing data could help employers work with their TPAs to develop narrow or tiered network designs, or to peg patient cost-sharing for certain elective services to a median or reference price.

Employers are also hopeful this data will prompt TPA vendors and insurers to compete over who can extract the best prices from providers. They noted that currently, many TPAs and insurers provide assurance that they are getting the best

discounts from providers in the market; this data will allow purchasers to verify these claims. "We do have an [APCD]," said one employer, "but using this data could potentially be a more timely way to see what [promised price discounts] would actually mean." Other purchaser representatives suggested that this data will prompt new contracting practices with their TPAs, such as inclusion of more granular performance targets related to cost growth and prices in agreements.

Another employer participant expressed hope that the availability of this pricing data, and greater awareness among employers that their TPAs or insurers may not be delivering the best value for them, could prompt more to participate in employer purchasing alliances or cooperatives, such as the Peak Health Alliance in Colorado. Many experts believe that such purchasing alliances are the only means by which employer purchasers can counter the growing market power of an increasingly consolidated hospital industry.

Impacts for Insurance Regulators

State insurance regulators annually review health insurers' proposed premium rate increases, and in many states they are empowered to reject rates that are unreasonable or excessive. Rarely, however, do they have the authority to look behind insurers' projections about increases in unit costs to the reimbursement rates they have negotiated with hospitals and clinicians. Further, state regulators have the power only to review rates for fully insured health plans; 67 percent of privately insured people are in self-funded employer plans exempt from state regulation.

While the state regulators represented at our meeting have access to state APCDs that can provide a window into provider prices and cost drivers, self-funded employer plans often do not submit data to APCDs. As one state regulator put it, their APCD "is…useful for looking at cost drivers in the fully insured market…but because of the absence of comprehensive self-insured data… it simply isn't reliable or usable." These officials are hopeful that the data hospitals and insurers are required to report under the new federal rules will help round out their current understanding of state-level cost trends and enhance rate review capabilities.

Additionally, several states are pursuing efforts to monitor and even cap system-wide cost growth. Others have implemented individual market reinsurance programs and public option plans that must meet specified premium reduction targets. Meeting participants believe these efforts, and the enforcement of any growth caps or premium reduction targets, could be enhanced by greater availability of hospital and insurer-specific pricing data.

Room for Improvement: Implementation to Date

In their current state, the pricing data has significant limitations. The Wakely Consulting Group's review found that few hospitals had yet to publish usable data under the new federal regulations, even several months after the January 1, 2021 implementation date. Further, Wakely's analysis was hampered by a lack of uniformity in the way that the data is being reported and defined, questionable data quality, the lack of any connection to other sources of data, as well as other limitations.

Lack of Compliance

In line with a growing body of evidence that hospitals are not fully complying with the transparency rules, one of the researchers studying the data described this period as "an era of non-compliance." They reported that there are "many holes across hospitals" even among those that have published some pricing data. An employer representative further shared that in their own examination of hospital compliance within their state, they found that most hospitals have not published data for the majority of the 70 services mandated by CMS, and that only one hospital has published prices for all of them. The Wakely analysts pointed to difficulties in determining whether a hospital that has reported a portion of its insurer-specific rates has omitted any rates it has negotiated with other insurers. However, Wakely and a few participants noted that the number of hospitals publishing data has

grown since January 2021, suggesting that some may have just needed some extra time to gather and report the required data elements.

Meeting participants also raised questions about what level of reporting should constitute compliance, an issue that CMS has also sought public comment on in recently proposed rules. One noted, “hospitals can be compliant as they see it, and just post…something that’s not usable.”

Lack of Uniformity and Quality

The Wakely analysts observed that even when hospitals did comply with the regulations, the data are “consistently inconsistent” in how each element is defined and displayed. There is no centralized repository for the pricing data; users must go from hospital website to hospital website in order to access and analyze the information. Furthermore, hospitals are publishing this data in “different ways…[there are] lots of different formats, from Excel to comma-separated values, but also in terms of the fields and values that are represented.” In general, analysts noted that hospitals reporting on the same procedures may vary in how they bundle bills for different services associated with that procedure. They may diverge in how they bill for medications or supplies and technology, or have different estimates for the length of time required to perform a service.

Other hospitals may be deliberately occluding the data from meaningful analysis. For example, one hospital has published its data set “with all columns crammed into a single column,” according to one analyst, rendering it essentially “unusable.” Another hospital uses its own, hospital-generated codes for services, rather than the more commonly used Current Procedural Terminology (CPT) or Diagnosis-related Group (DRG) codes. The analysts found that the skill required to assess the data currently available is “outside the scope of a typical user or researcher.” An employer also noted that many hospitals are not including certain common procedures among the 300 reported codes that purchasers would typically look for when shopping for services.

Furthermore, hospitals are generally not including a data dictionary when they publish the required pricing data, making interpretation of the data very difficult. A data dictionary is a collection of names, definitions, and attributes about data elements that are being used or captured in a database. As one participant put it, without a data dictionary “you have no idea what you’re getting.”

Meeting participants were also skeptical of the data quality being reported by hospitals relative to more traditional claims databases; although there are currently no clear ways to identify errors or otherwise audit for quality, participants noted that data quality was often times poor, such as data elements missing from certain fields, inconsistency with other reported values, or outliers highly suggestive of an error.

Recommendations for Optimizing Hospital and Health Plan Pricing Data

Participants generated a number of recommendations to improve the accessibility and usability of hospital and health plan pricing data. These include:

Enhancing Oversight and Enforcement

Several meeting participants argued that the current maximum penalty for hospitals – $300 per day – is too low to incentivize widespread compliance with the transparency rules. Following the meeting, CMS proposed increasing the annual penalty to up to $5500 per day. If finalized, these increased penalties could help expand the number of hospitals that publish pricing data, but that does not mean that hospitals will be posting data in an accessible or usable format.

Beyond penalties, CMS has a number of tools to boost hospital compliance. Meeting participants thought that the first step would be to reduce the current flexibility granted to hospitals on how to display the data. Uniform reporting and display requirements would help not only end-

users but also government auditors to assess whether a hospital has fully complied with both the letter and spirit of the rule. Meeting participants with extensive experience navigating datasets described how federal regulators could publish guidance for hospitals (and health plans) that spells out granular reporting and display requirements. They also noted that such requirements should not be a heavy lift, as “the infrastructure on both sides” exists to enhance price reporting.

CMS has stated that it has been and will continue to audit hospitals’ websites and accept complaints from users to monitor compliance. Meeting participants broadly agreed that CMS should devote greater resources towards such audits and oversight and publish the results, in order to reduce the widespread lack of compliance that exists today.

States can also play a role. States are responsible for licensing hospitals and health systems, giving them significant leverage to assess these entities’ compliance with state and federal laws. In addition, the health plan for state employees is often the largest commercial purchaser of hospital services in a state, giving the plan some market power to request compliance among the hospitals in its network.

Once the health plan transparency requirement are in effect (January 1, 2022), state departments of insurance will be the lead agencies to assess compliance for health insurers that offer state-regulated health plans. However, during our meeting state officials noted that this new role has not come with new resources, and expressed some concern about the potentially overwhelming amount of data that the plans will be required to report. One suggested that CMS limit the initial release of plan pricing data to a more targeted set of providers and services. “You need to be able to walk before you can run,” he noted. Limiting insurers’ flexibility over the format and display of the data can also ease state regulators’ enforcement burden.

Meeting participants also suggested that large health care purchasers could supplement the enforcement efforts of government officials. Some purchasers could use their provider or TPA contracting process to motivate more widespread compliance. Indeed, some participants indicated that their contracts already include boilerplate language requiring that vendors comply with all relevant federal and state laws. They noted that these clauses would most likely encompass the federal transparency regulations, although one participant thought that being “specific about this particular regulatory scheme” in their third-party contracts would prompt greater attention and compliance.

Improving Data Access

A second key step to optimize the transparency regulations is to ensure that users can actually find the data. CMS recently proposed increasing access by requiring hospitals to publish the data in a way that is “accessible to automated searches” through a link posted on a publicly available website. The agency is also considering requiring hospitals to use a “CMS-specified URL” along with “CMS-specified naming conventions” or to post their files to a single, centralized portal.

However, even if these proposals are finalized, reviewing and analyzing the data will remain burdensome because researchers would still need to access hundreds of separate files to assess, for example, hospital price variation within one state. Further, when hospitals choose to comply by providing a price estimator tool, data analysis can be more challenging. Meeting participants recommended that CMS create a “centralized repository” with a “standardized collection format” for the hospital price data. While one participant recognized that this would be a “significant undertaking,” many felt that the effort would be worth it to ensure “utility downstream.”

Standardizing the Data

Meeting participants shared the view that CMS must become significantly more detailed in its guidance to hospitals about how the data is presented. Some also thought it would be beneficial for CMS to create a template format, which would become a “safe harbor” for hospitals and plans to use if the wish to avoid being out of compliance with the regulations. Additionally, because the data must be updated annually, meeting participants urged CMS to provide guidance on whether hospitals can overwrite the prior year’s data, or whether they should publish a new file every year.

Citing wide variation in how hospitals currently label insurers and health plans, meeting participants also called for CMS to mandate greater clarity and standardization in how insurers and plans are identified. A similar mandate will likely be needed for the data insurers must publish in 2022 to ease identification of different hospitals, health systems, and other provider groups. In that same vein, meeting participants also agreed that CMS should develop a data dictionary that hospitals must use.

Transparency 2.0: Developing Data Connections

Although the federal rules do not currently require hospitals to post Medicare or Medicaid payment rates alongside the commercially negotiated rates for the required services, several meeting participants felt strongly that the absence of this information hinders useful analysis of how commercial insurers are performing in their efforts to extract price discounts from providers. They called on CMS to require hospitals to display their commercial prices as a percentage of the Medicare rate, or at least require commercial and Medicare rates to be displayed side-by-side. CMS could also do this itself if it creates a centralized repository.

Additionally, employer representatives felt strongly that a hospital's performance on quality metrics should also be displayed with the pricing data. Many employees are likely to resist efforts to develop plans with narrow provider networks if providers are chosen solely on the basis of price; network designers will need to demonstrate that, for the price charged, the hospital delivers the best possible outcome and patient experience. "In order for [the data] to be usable for a purchaser," one said, "we need to have quality measures side-by-side with price measures."

Conclusion

Meeting participants agreed that the new hospital and health plan transparency requirements have the potential to strengthen the market power of employers relative to consolidated hospital systems and insurers, enhance regulatory oversight, and provide researchers with an abundance of information to inform policymaking. However, in their current iteration, the federal rules do not yet support these goals. During our meeting, participants generated several recommendations for federal regulators, including increased enforcement, lowered barriers to access, greater standardization of data reporting, and the inclusion of additional data elements such as Medicare rates and quality scores. Most, if not all of these recommendations could be implemented by CMS without additional statutory authority. Ultimately, greater transparency alone will not bring the increasingly untenable costs of our health care system under control. But because transparency may be a necessary predicate to more muscular cost containment measures, improving access and usability should be a priority.

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Appendix

List of Attendees

Ge Bai
Johns Hopkins University

Marilyn Bartlett
National Academy for State Health Policy

Niall Brennan
Health Care Cost Institute

Deborah Bryant
Center for Consumer Information and Insurance Oversight

Michael Cohen
Wakely Consulting Group

Michael Conway
Colorado Insurance Commissioner

Suzanne Delbanco
Catalyst for Payment Reform

Kate Harris
Colorado Division of Insurance

Maureen Hensley-Quinn
National Academy for State Health Policy

Sarah Lindberg
Green Mountain Care Board

Matthew Lynch
Center for Consumer Information and Insurance Oversight

Douglas McCarthy
Issues Research

Syed Mehmud
Wakely Consulting Group

Eric Pfeifer
Wakely Consulting Group

Sara Rothstein
32BJ Health Fund

Gloria Sachdev
Employers' Forum of Indiana

Aditi Sen
Johns Hopkins University

Nick Shaneyfelt
Wakely Consulting Group

Patrick Tigue
Rhode Island Office of the Health Insurance Commissioner

Chris Whaley
RAND Corporation

Jeff Wu
Center for Consumer Information and Insurance Oversight

Georgetown University Health Policy Institute

CENTER ON HEALTH INSURANCE REFORMS

Georgetown University Health Policy Institute
3300 Whitehaven Street, N.W., Suite 5000
Washington, DC 20007
Telephone (202) 687-0880
http://chir.georgetown.edu/